

UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL, HUMAN AND MATHEMATICAL SCIENCES

Geography and Environment

Residential mobility, mental health, and welfare reform

by

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ABSTRACT

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RESIDENTIAL MOBILITY, MENTAL HEALTH, AND WELFARE REFORM

James Atholl Lowe

This thesis qualitatively examines the interplay between service users' residential mobility and mental health and assesses the ways in which each is influenced or determined by the other. Twenty-five service users in England were over a period of eighteen months interviewed in depth about their experiences of both residential mobility and mental health. These interviews were conducted against the backdrop of the on-going austerity-driven reforms to the welfare state that have witnessed the rapid promulgation of policies designed to spur service user entry into the formal labour market, via the use of restrictions on continued eligibility for particular sickness, disability, and housing benefits, and reductions in their monetary value.

Evidence from the interviews is used to test two of the primary models through which the residential mobility patterns of service users have been explained: displacement from unstable lodgings resulting in circulation through disparate residential settings; and entrapment in low quality accommodation in predominately deprived areas. The thesis finds evidence of both scenarios, and reports on the negative health experiences encountered therein. It demonstrates that the extent to which residential circumstances have a negative impact on mental health rests upon whether service users feel unable to exercise any control over their residential choices. The exercise of which is being further compromised by a hastily reformed system for determining on-going eligibility to welfare benefits and a wider retrenchment of the services and facilities around which users have often orientated their lives. Here, invasive and ineffectual medical assessments destabilise service users and threaten a reduction in income, enforced changes in accommodation, and the rupture of their carefully calibrated wellness strategies which, in the absence of wider service provision, are increasingly emplaced in and around users' own homes. The findings raise considerable questions about the operation of the welfare system and its impact for service users' health and residential stability.

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DECLARATION OF AUTHORSHIP

I,

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

.....

.....

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed:

Date:

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And finally to D, whose understanding and generosity allowed me to do this.

Chapter 1. Introduction: Mental health service users, residential mobility, and welfare reform

1.1. Background to the research. Why does it matter?

“Some people with mental health problems today are almost guaranteed to live a life in poverty ... And the challenge is that, all too often, people are just left to get to crisis point either because the health service simply can’t cope, or because they’re worried about admitting to having a problem in the first place. We have got to get this right ... I want us to be able to say to anyone who is struggling, ‘talk to someone, ask your doctor for help and we will always be there to support you’. But that support has to be there. And that poses a big challenge for government in terms of services and treatment. We have to be equal to it.” (David Cameron, Speech on ‘Life Chances’, 11 January 2016)

These sentiments will be familiar to those individuals who have the misfortune to experience serious and recurring mental health problems and who find themselves straddling various health and social services in search of the very sources of support to which the Prime Minister refers. These state agencies, overwhelmed by volume of numbers and degree of need, have struggled to meet the overlapping medical, psychiatric, therapeutic, social, housing, and welfare needs of this challenging and vulnerable population (Boffey, 2016; Gentleman, 2014). This is perhaps unsurprising, given the exponentially rising costs of providing comprehensive health and social services and the all too frequent economic, political and electoral cycles in which public spending and service expansion alternate with fiscal retrenchment and service cutbacks.

Presently, as public spending undergoes a prolonger period of retrenchment, the broader social and welfare spheres within which most mental health service users operate are increasingly threadbare. Despite recent government announcements of £1bn of additional funding to bring about a ‘revolution’ in mental health care and treatment, on top of strategies already pledged to bring about parity of regard

between general and mental health spending within the health and social services, there remains chronic underinvestment in mental health care and a substantial number of unmet health needs, including those in crisis (NHS, 2016). As macro policy changes once again roil public welfare bureaucracies, the experiences and insights of those frequently bottommost in the service provision hierarchy – the users – risk being obscured. These insights, understandably overlooked by data-driven analyses of complex policy outcomes, can reveal how frontline welfare facilities work in practice, and what their effects are on mental health and mobility. Thus, investigations which focus on qualitative aspects of a research question – personal understanding, perception and emotion – can bring to light experiences relevant to broader questions of policy that might otherwise not be represented. As the literature review in the next chapter will make clear, residential mobility in the context of welfare benefits generally, and the present policy of austerity specifically, are areas lacking in detailed qualitative inquiry. This is something the present study seeks to put right.

‘Crisis’, as a description of the plight of the apparatuses of care and support charged with looking after those experiencing mental ill health, and of the situation that individual service users’ can find themselves in, is a perception that has surrounded mental health services repeatedly since the advent of the policy of deinstitutionalisation. Known formally in the UK as ‘care in the community’, the distinct lack of ownership amongst those public bodies ostensibly responsible – “Everybody’s distant cousin but nobody’s baby” in Griffiths (1988) withering criticism, the fragmentation and reduction of services, the dispersal and displacement of hitherto confined psychiatric populations and their consequent high levels of residential mobility, led to many discharged patients becoming lost to the wider care system, with all the hazards and costs that implies. This fragmentation of services, self, and populace was a fundamentally geographical event. As suggested, the availability of services follows macro policy cycles; thus, as austerity – in the form of welfare reform and wider service retrenchment – once again bites, contemporary reports pointing to lapses in the breadth and depth of provision would seem to suggest that individuals’ dependence on welfare benefits assumes a renewed significance in attempts to prevent people from once again becoming displaced and residentially mobile and from slipping through the cracks

with the strain on individuals' health and to the public finances that this entails. Certainly, mental health service users, and the voluntary organisations that are increasingly expected to look out for them, are expressing concern about welfare reform and what this portends for health and residential (in)stability (NSUN, 2012; O'Hara, 2015; Ryan, 2016). Accordingly, the research project to be outlined here aims to interrogate that precise point and show why a qualitative investigation of mental health and mobility under a period of austerity matters.

1.2. The research project

"But the critical element of success will be to put the individual with their lived experience of mental health at the heart of each and every decision that is made"
(The Five Year Forward View for Mental Health, NHS, 2016)

This thesis, and the research project upon which it is based, is predicated on the idea that an individual's mental health and his or her residential mobility are related. It has two primary aims. First, to understand more fully the nature of that relationship - for example whether settlement or residential stability necessarily promotes better mental health outcomes (as might be supposed) than the alternative of residential mobility or instability; and second, to observe the impact that current reforms to the welfare state, specifically the emphasis on setting claimants down a path of 'work readiness' and the curtailment of entitlement to particular benefits, have on both mental (ill) health and (im)mobility. The research is designed to examine the two main models through which the social sciences have viewed the residential mobility of mental health service users: the first sees people with mental health problems displaced from stable housing conditions and instead circulated through a series of disparate and inappropriate residential settings; the second sees people becoming trapped in areas of high deprivation and service provision as a lack of income restricts their residential choices. The research aimed to test the applicability of these models as they relate to the historical and contemporaneous residential experiences of service users under the changed conditions of welfare reform. It does this through a series of longitudinal in-depth interviews with twenty-five mental health service users in England. It aims

not to present a definitive and replicable model or analysis of (perhaps new or changing) residential mobility patterns; rather the intention is aim for a deeper level of knowledge and understanding of service users' everyday experiences of residential mobility and welfare reform, and by so doing help to bring to the fore those aspects of their lives upon which they rely for stability and wellness.

1.3. Structure of the thesis

In addition to this introductory section, the thesis comprises seven further chapters. It continues, in Chapter 2, with an overview of the relevant literature, delving into several decades of scholarship in the field of mental health geographies and the comparatively more recent body of literature relating to mobilities, and how this has been both theorised and applied to mental health geographies. It then proceeds, in Chapter 3, to provide the contextual background against which the research was undertaken, by giving an overview of the current programme of welfare reform in the UK that interrogates its intellectual and ideological underpinnings and sketches out the implications of the reforms for mental health service users. This is followed, in Chapter 4, by a discussion of the methodological groundings for the study, its research design, and how it was implemented. The following three interlinked chapters form the core of the discussion, presenting findings on service users' experiences of residential mobility (Chapter 5), welfare reform (Chapter 6), and, in Chapter 7, the ways in which service users' own homes have become a key site in understanding how they strive to maintain stability and wellness. It concludes with Chapter 8, which seeks to provide a summary of the main findings and an analysis of the extent to which the research was able to answer the questions which it set, and gives pointers for further research. After the main bulk of the thesis come the references, followed by the various appendices that provide biographical notes on interviewees and copies of the relevant interview materials.

Part One: Review chapters

Chapter 2. Places, people, policy, practices: mapping mental health geographies. A review of the literature.

2.1. Introduction

“It is obvious to all (on the surface at least) that there is a geography to mental health; so how do we get to the bottom of it” (Jones, 2007, p442)

Detailed reviews of the literature on mental health geography are relatively few and far between, yet the most extensive among the current crop (Curtis 2010, esp. chapters 2, 5 and 7; Parr and Davidson, 2010; Philo, 1997; Smith, 2009; Wolch and Philo, 2000) offer a comprehensive sweep through the origins and development of this subfield, one that straddles health, social and cultural geography.

The danger bedevilling any literature review is the tendency, unconscious or otherwise, to rehash the work of those who have already tilled this soil. Thus, the reader may notice similarities in structure (and inevitably work reviewed) between Wolch and Philo and parts 2.3 and 2.4 of this review. Given the need for this review to survey the wide field of research grouped under the category of mental health geography (or, more accurately, mental health *geographies*) this is probably unavoidable. Subsequently, however, the review engages with the burgeoning area of ‘mobilities’ scholarship. The aim being to highlight the relevance of ‘mobility’ as a conceptual frame through which to view both the mental health geographies examined in preceding parts and the specific mobility questions inherent in the present research project. Indeed, it is through an engagement with the more theoretical aspects of this literature – particularly the work of Tim Cresswell in elucidating a political framework for the comprehension of mobility – that the existing literature can be (re-)assessed and the contribution of this project to that literature made clear.

This review breaks down mental health geography into three ‘eras’, each of which represents a broad methodological and theoretical approach to the subject, and which are presented in general chronological fashion, though they do nonetheless

overlap, often quite substantially. Accordingly, the review commences with an overview of the first iteration of mental health geography which had its origins in urban sociology but which subsequently became more closely aligned with the work of epidemiology. This was an era of *quantitative inquiry* largely using aggregative areal analysis that operated within the relatively strict confines imposed by a parent discipline that was overtly 'scientific' and seeking academic legitimacy as a spatial science. This is followed, in the second part, by an analysis of the way in which as the 1970s got underway mental health geography, though remaining largely quantitative in approach, began to think about how it might apply itself more forcefully to pressing urban social questions of poverty, exclusion and social abandonment. By the 1980s, mental health geography had adopted a *political-economic lens* through which to theorise the spatial consequences of these social problems, in particular the policy of the removal of formerly confined populations (especially those experiencing mental health problems) from institutions into the community. The third section charts the partial move away from quantitative investigations of mental health towards a research agenda rooted in social and cultural theory and which sought to 'recover' individuals experiencing mental health problems from the ragtag collective of 'the mentally ill'. This agenda, largely *qualitative* in nature, sought to challenge both common and geographical understandings of mental ill-health and did so by interrogating mental health as both a medical category *and* a social construction, and by placing a heavy emphasis on human subjectivity, diversity and individuality. It remains one of the dominant forces within mental health geographies today, and is the basis for the present study. The fourth, and final, part of the review introduces the conceptual literature surrounding *mobilities*, and the ways in which these can be applied to geographies of mental health. Mobility as an observed variable is inherent in much of the mental health geography research reviewed in the first and second parts of this chapter, though perhaps a rather under-theorised one. The intention of the mobilities section, therefore, is to use the more *conceptualised* notion of mobility offered by this literature, and in particular Cresswell's 'politics of mobility', to further illuminate the tableau of mental health geographies surveyed in the preceding parts and to provide an important bridge to the current research project. It will do so in two main ways. First, by establishing the importance of the emerging welfare policy landscape (outlined in detail in Chapter 3) in which

austerity in general, and the withdrawal or curtailment of benefits for individuals already experiencing residential and socioeconomic insecurity in particular has, by creating the possibility of lost homes and enforced moves, the potential to profoundly impact mental health service users' experiences of residential (im)mobility; and second, to show the extent to which the impact of the prevailing policy environment of welfare retrenchment is nonetheless contingent upon the characteristics and experiences of those exposed to it.

Overall, then, the aim of the review is threefold: first, to fit the different pieces of the mental health geographies jigsaw together so that the strong linear connections between the earliest work by urban sociologists through to the most recent incursions into the urban realm by mental health geographers are made clear; second, to emphasise the centrality of mobility in helping to understand these geographies more fully, and to provide a conceptual spur to Chapter 3 and its discussion of welfare reform; and third, to foreground the present research project and its potential contribution to this literature.

2.2. Quantitative geographies of mental health

The earliest geographically-based investigations into mental health were, somewhat ironically, often conducted by non-geographers. These established that the incidence of mental ill-health (and its diagnoses) varied, sometimes dramatically, across space: see Belknap and Jaco, 1953; Faris and Dunham, 1939; Hollingshead and Redlich, 1953; Hyde and Kingsley, 1944; Schroeder, 1942. Drawing on this knowledge, subsequent studies (for example: Giggs, 1973; Hare, 1956; Hollingshead and Redlich, 1958; Lapouse et al, 1956; Mezey and Evans, 1970; Turner and Wagenfeld, 1967) adopted a geographical approach to help frame research aimed at identifying which factors *external* to individuals could effect or even determine the onset and duration of mental ill-health, and to map the results.

2.2.1. The ecology of mental illness: the Chicago School and after

As in other areas of urban inquiry, the Chicago School was at the forefront of developments in the urban mental health field. In this instance, the 'classic' study in which space and place were first brought to bear on questions of mental illness (as opposed to the location of psychiatric facilities) was that by Faris and Dunham (1939). These urban sociologists investigated the relationship between the commencement of a diagnosed mental illness and individuals' residential locations in Chicago. Analysing over 30,000 hospital records, they plotted patients' pre-admission addresses and their psychiatric diagnosis onto a city map. This showed that a striking and significant concentration of patients – including those diagnosed with serious mental illnesses such as schizophrenia and/or substance abuse disorders - had been admitted to hospital from the socially disorganised and "deteriorated regions in and surrounding the center of the city" (Faris and Dunham, 1939, p35, quoted in Silver et al, 2002, p1457). This prevalence of serious mental ill-health was found to decline steeply as distance from the inner city increased, with proportionately far fewer patients hailing from the outer, more prosperous suburban areas. Faris and Durham attributed this clustering pattern to the impact that the social and physical conditions of the inner city had on its residents. In their view, life in the hardscrabble urban core played out against a background of physical dilapidation and was dominated by impoverishment, instability, exclusion and isolation. This terrain created an ecology that, in effect, incubated and exacerbated mental illness, which would subsequently flourish in those for whom the daily battle for survival had taken its greatest toll. The extent of their greater exposure to this inhospitable environment rendered (or even predisposed) inner city residents as more susceptible to developing serious mental illnesses than their suburban counterparts.

Faris and Dunham's main finding - that schizophrenia (as a proxy for serious mental ill-health) was concentrated in poorer inner city districts - found support in the studies by Hardt (1959), Hyde and Kingsley (1944), Hollingshead and Redlich (1953) and Schroeder (1942). The implication was striking: "that schizophrenia is a

disease of the poor rather than the well-to-do and offers a meaningful clue for further research" (Lapouse et al, 1956, p979).

This central finding became something of a totemic symbol for the future research agenda, which not only dominated epidemiological and sociological investigations of psychiatric illness over subsequent decades but which remains pertinent to the present day. This focus on distribution – discussed in more detail below - would collectively demonstrate a continuing, and seemingly systemic, concentration of people with severe mental illnesses residing in urban areas with high levels of socio-economic deprivation.

The attribution of cause to this pattern was more varied and has largely been grouped into one of two broad schools of thought: the first, building on Faris and Dunham, evolved into what would become known as the social causation (or breeder) model, and continued to emphasise how the ecology of a particular environment could effectively predispose some individuals to the inception of mental illness; the second, grouped together under the title of the social selection (or drifter) model, highlighted how mobility by those experiencing mental ill-health might account for their disproportionate residency in inner city areas. In either case, the early part of this era – roughly until the mid-1970s - represented a period of "intense preoccupation with factfinding and quantification ... [where] the urban ecosystem is a complex physical, biological and psychological admixture" (Shepherd, 1984, p401).

2.2.2. Social causation and the ecological tradition

Of the early studies undertaken in the ecological mould, Hare (1956) investigated the social class and diagnoses of patients admitted to hospital in Bristol. He found that patients diagnosed with schizophrenia were disproportionately from the lower socio-economic classes (who predominated in the inner city) and no factors external to class or location could adequately explain the observed distribution. While cautioning against too firm a conclusion being drawn about the role that particular social and environmental factors may play in the onset of mental ill-

health, it “does seem reasonable to conclude, however, that such factors are present” (Hare, 1956, p194). Similarly, Lapouse et al (1956) discounted non-environmental factors as viable explanations for the concentration of schizophrenia in lower income areas in Buffalo. They suggested that the answer may well lie in “the psychologic strains imposed by low income with the concomitant struggle to obtain the necessities of living, fear of unemployment, the lack of job satisfaction, the over-crowded and inadequate housing, the restricted educational and recreation opportunities, and the low social status” (p985).

Giggs (1973) too used hospital records to investigate pre-admission addresses of people admitted to hospital in Nottingham with a diagnosis of schizophrenia, and also found a noted concentration toward the “inner, slum areas of the city” where “a whole set of unfavourable life circumstances, notably low social status, high unemployment and low social cohesion … collectively assume their greatest intensity … Here, as in other large cities, there are pathogenic areas which seem to destroy mental health” (p71) - see Mezey and Evans (1970) for a similar study in north east London. This suggestion that the urban setting may cause schizophrenia was challenged by Gudgin (1975), who argued that the limited nature of the data analysed by Giggs – and in particular the lack of longitudinal data on patients’ residential histories - could not sustain the inferences he made from it and that unwittingly he had fallen into the ecological fallacy trap (Gudgin suggested that the more likely interpretation from Giggs’ data was that individuals had moved into these decaying residential neighbourhoods - an example of the aforementioned social selection or breeder hypothesis and which is discussed in more detail below). Picking up this theme, Dean and James (1981) used hospital admissions data to identify *which* social factors were relevant in the admission to hospital of persons diagnosed with schizophrenia, and medical case notes to understand *how* these social factors operate (their findings suggested social selection processes at work, rather than ecological ones).

Returning to the mental health geography of Nottingham over a decade and a half later, Giggs (1986) found an enduring concentration of schizophrenia in the inner city and other deprived and semi-suburban localities: “This persistence is remarkable, for the massive slum clearances and local authority housing

rebuilding programmes of the late 1960s and the late 1970s has dramatically altered and improved the quality of the built and living environment in large tracts of the inner city" (p959). Indeed, in 1993 Dauncey et al were able to conclude that in Nottingham there remained a "significant relationship between schizophrenia and a tendency to originate in areas of urban deprivation" (p618). Using data from 1998 and 2000, Curtis et al (2006) found that hospital admission rates for acute psychiatric conditions in both London and New York City were positively and significantly associated with levels of deprivation independent of local demographic factors or questions of ease of access to hospitals.

More recently, Silver et al (2002) 'revisited' Faris and Dunham and investigated the 'structural characteristics' of neighbourhoods in four US cities. They found that neighborhood level disadvantage was associated with "higher rates of major depression and substance abuse disorder, and that residential instability was associated with higher rates of schizophrenia, major depression and substance abuse disorder. However, the effect of neighborhood disadvantage became nonsignificant when individual SES [social and economic status] was controlled for" (p1466). They maintained, however, that "just because a set of individual-level characteristics mediates the effect of a contextual variable does not necessarily imply that the context has no causal influence on the outcome ... individual socioeconomic achievements must be conceptualized, to some degree, as a *function of* the opportunities and conditions of life inherent in the neighborhood environment ... the observation that individual SES mediates the effect of neighborhood disadvantage does not imply necessarily that the neighborhood is unimportant as an etiological factor in this disorder" (p1466-7).

Other studies within the quantitative genre can be seen as moving away from Faris and Dunham's emphasis on the ecology of the inner city, focusing instead on the social and economic characteristics of neighbourhoods or households/individuals. These built upon and significantly enhanced the quantitative tradition through the deployment of multi-level models and advanced methods of longitudinal data analysis. For example, in their study, Propper et al (2005) determined that for common mental disorders the characteristics of individuals were most important: "it is people, rather than place, that matter"

(p2080). Similarly, Weich et al (2005) drew out the role that household features might play in addition to individual and neighbourhood characteristics. They found that whilst deprivation indices at the electoral ward level in Britain did not influence the inception and maintenance of common mental disorders local factors at the household level did. The difficulty – or impossibility? - of delineating precisely how neighbourhood factors or individual characteristics interact with or determine mental ill-health accounts for the continuing research in this field (Mair et al, 2008, provide a helpful tabulated overview of 45 such studies).

2.2.3. Social selection processes: spatial filtering into the ‘urban core’

In contrast to the social causation model, studies under the social selection (or ‘drift’) model questioned the idea that the conditions of the inner cities *alone* caused the onset of mental disorder and its concentration in these geographical localities. Instead, this research focused on the role that residential instability and mobility – such as physical migration to or from the inner city or mobility up or down the socio-economic scale – might play, and suggested that the concentration of large numbers of individuals with mental health problems in the inner city was largely the outcome of a complex process of spatial ‘filtering’. It held that, in a deprived locality largely devoid of amenities and opportunities, the more upwardly mobile of inner city residents would consciously seek to leave. Those remaining, who lacked either the wherewithal or the ability to leave, would be subject to a form of ‘social stagnation’ that served to further limit their ability to take advantage of any future opportunities to move. These residents would, over time, be joined by others who, subject to downward social mobility and/or the onset of mental health problems, would either ‘drift’ or consciously move into the inner cities, where affordable accommodation was available, and the existing residents lacked the political heft to restrict residential access to their neighbourhoods. This systematic ‘pooling’ of needy individuals in the inner cities would, in time, result in a concentration of social and medical services in the urban core which, in turn, would act as a pull factor for further ‘service-dependent’ individuals to follow suit and relocate to the inner city. This section considers those more recent studies within the epidemiological tradition that have identified social selection processes

as accounting for the geographical concentration of mental ill-health in the inner city (for earlier work see, for example, Dean and James, 1981; Gerard and Houston, 1953; Goldberg and Morrison, 1963; Gudgin, 1975; Turner and Wagenfeld, 1967). The political and economic *implications* of this geographical concentration and concomitant pooling of services and resources is considered immediately after in the third part of the review. The fourth, on mobility, revisits some of this territory in preparation for outlining the present research study.

McNaught et al (1997) found that the prevalence of individuals diagnosed as suffering from schizophrenia in the London borough of Camden could be attributed primarily to “a significant excess movement of people with schizophrenia from outer London to this inner London area between 1986 and 1991” (p310). Shern and Dilts (1987) found that the excess of chronically mentally ill individuals living in the urban core of Denver was the outcome of their formal assignment by discharging hospitals and “the same characteristics which made Denver an attractive discharge alternative during the 60’s most likely have continued to attract the selective migration of chronically mentally ill patients to the area” (p22). Curtis et al (2009) found that in New York proximity to hospital care was associated with higher rates of hospital use and posited that an element of drift could in part be responsible. Support for drift theories in North America also come from Breslow (1998), who found that heavy users of psychiatric services in Albany, New York, moved to be close to the area in which the services were offered, and McCarthy et al (2007), who found similar results in Virginia; see Loffler and Hafner for evidence from Germany (1999); Timms, from Sweden (1998). For studies focusing specially on residential instability see Appleby and Desai (1987), Abood et al (2002).

2.2.4. Summary

Some work has tended to see a combination of both social processes – drift – and structural forces – social conditions – as playing a part in explaining the enduring concentration of mental ill-health in deprived communities. In other words, they are “not mutually exclusive”; and, furthermore, each one varies in its importance across diagnostic categories of illness (Johnson et al, 1999, p496). See also

Dohrenwend et al, 1992. Other studies within the broader research tradition reviewed here have looked at factors outwith the strict confines of the social causation or social selection theories. For example, Thornicroft (1991) warned that the various socio-demographic factors implicated in the onset of mental ill-health can of themselves ‘mediate’ the referral process and can “indicate characteristics of groups at high risk of psychiatric *admission*” (Thornicroft, 1991, p482, emphasis added). Almog et al (2004) argue that increasing concentrations of psychiatric admissions observed in New York City between 1990 and 2000 from areas where rates of social and economic deprivation reached their peak were unrelated to either breeder or drift factors but more likely to health service administrative structure and funding allocation changes during that period.

This first part of the review has surveyed research from across the medical and social sciences, each of which has sought to understand the nature of the relationship between place and environment on one hand, and mental illness on the other. Within this broad sweep can be seen a small but distinctive group of studies by geographers that, alongside those by spatial epidemiologists, helped to lay the foundations for a geography of mental health. All of the research referenced here is situated within an ecological or epidemiological tradition, and is firmly based on quantitative principles of investigation. Research into matters of mental health by geographers has substantially moved away from this epidemiological tradition, a trend which began in the late 1970s and gathered pace during the 1980s (though work on regional differences in psychiatric morbidity continues to the present day – i.e. Lewis and Booth, 1992; Duncan et al, 1995; Weich et al, 2003, 2005 – these are mostly, though not exclusively, in the hands of psychiatric epidemiologists). In its place came research that, whilst remaining largely quantitative in nature, shifted its theoretical focus from questions of ecology and epidemiology to ones of political economy. This is the subject of the next section of this review: the political-economy of mental health geography.

2.3. The ‘political-economy’ of mental health geographies

This second part of the literature review charts how the theoretical underpinnings of geographical research into mental ill-health began in the 1970s to move away from an emphasis on epidemiology and ecology toward analyses located within a political-economic approach. The early 1970s saw the epidemiological tradition, as exemplified by the social causation-social selection duopoly, being supplemented – though not yet supplanted – by a more nuanced research agenda that aimed to place mental ill-health into a broader political and economic framework. It is probably most helpful, therefore, to view the changes of the 1970s as producing divergent research paths rooted in quantitative geography: first, the epidemiological tradition, under the auspices of which studies continue to be undertaken today; and second, a more politically-engaged agenda which sought to situate mental health geography within broader political and economic theory. Thus from the mid-1970s it would be reasonable to henceforth talk of mental health geographies in the plural.

2.3.1. Deinstitutionalisation, the ‘public city’ and the rise of the service-dependent ghetto

“[A] wide variety of service-dependent needs exist ... and they typically will not be met without public intervention in the market. The public city is part of the process of residential differentiation which is a functional component of capitalist urbanization. Two important historical trends intersect to facilitate this growth of the public city: the residential and commercial abandonment of obsolescent inner cities, and the rapid deinstitutionalization of service-dependent populations. Community practices of exclusion and state planning policies are implicated in the growth of the public city” (Dear, 1980, p238).

Strongly influenced by a renewed interest amongst economic geographers in welfare geography and location theory, and particularly the location of *public*

facilities (DeVerteuil, 2000), the emerging mental health geographies of the 1970s began to investigate the role of the state and its connection with the geographical distribution of mental health. In essence, this meant looking at the practice and consequences of the policy of deinstitutionalisation, which had led to the rapid discharge of the majority of psychiatric patients from asylums and other institutions to alternative forms of community mental health provision¹. Deinstitutionalisation saw ex-psychiatric patients swelling the ranks of existing vulnerable and impoverished populations in poorer inner areas of the cities (thus fitting in with the social selection model discussed earlier). However, rather than leaving their analyses there, or offering a few tentative recommendations to policy makers about the need to be cognisant of the location of the service users when allocating resources, researchers now sought to connect the movement of ex-psychiatric patients to the inner cities – and the development of ‘psychiatric ghettos’ - with the wider and more profound patterns of urban economic structural and spatial change then in their infancy.

This work set about exploring the emerging spatial relationship between discharged populations (particularly those termed ‘mentally ill’), the local communities into which these populations would be discharged, and the state and its role in managing the transition from asylum to community. These spatial patterns were forged against an unfolding backdrop of radical economic restructuring: urban industrial decline and the migration of revenue-generating businesses and households out of cities to their suburban peripheries. These spatial-economic processes threatened “a self-reinforcing cycle of neighborhood decline and service-dependent concentration” (Wolch, 1980, p333) with a residual population in the inner city dependent on public welfare to meet its daily needs: what Dear (1980) termed ‘the public city’, in which the interlocking processes of discharge, patient drift to the inner city, and the resulting provision of public services, are not “some arbitrary creation resulting from the aggregation of many individual service-dependent decisions, but a structural feature which is both functional and convenient in contemporary urbanization” (p231). This creation of

¹ This literature review is necessarily concerned with the outcome of deinstitutionalisation, or the ‘post-asylum geographies’. There is a rich, fascinating and deeply troubling literature on the geography of the asylum, however, a full reading of which is necessary to appreciate how mental

the ‘service-dependent ghetto’ caused consternation among urban geographers, who worried about the consequences of the “clear debasement of the urban condition” they were observing (Wolch, 1979, p271); further, perhaps conscious, echoes of the Chicago school urbanists of the 1920s/1930s. As Smith (1975), put it: “For geographers seeking relevance this issue seems tailor-made” (p53).

The tension between the needs of discharged populations, the apparent wishes of the communities into which individuals were to be discharged, and the requirement of the state to balance these competing interests offered a fruitful avenue for new research. This “conflict-orientated dimension to location theory” (DeVerteuil, 2000, p56) allowed geographers to move beyond the purely mechanistic treatment of equity and efficiency and instead apply the theoretical insights afforded by location theory to real world outcomes.

One of the first attempts to delineate the service dependent ghetto was that of Dear (1977a), who used a case study in Hamilton, Ontario to illustrate the wider consequences of the policy of deinstitutionalisation now in progress across north America. He too found that, post-discharge, patients congregated in the city’s downtown core, with its plentiful supply of cheap short-term accommodation (the type of lodging described as “seedy residential hotels” in ‘the dumping ground of the disadvantaged”, Wolpert and Wolpert, 1974, quoted in Smith, 1975, p53). This concentration was a result of either their direct assignment by the discharging hospital to downtown accommodation, or as a consequence of having drifted there from other, initial discharge locations elsewhere in the city. Dear claimed that the volume of individuals being discharged under the policy of deinstitutionalisation, and the hastily made arrangements for doing so, were placing great strain on community mental health facilities, and which “have essentially transferred the hospital backwards into small scale community-based settings ... [and resulted in] an increasing resistance to community psychiatric facilities” (Dear, 1977a, p589).

It was the hostility – based largely on stigma and prejudice - shown by receiving communities to the idea of accommodating deinstitutionalised patients in their midst that helped explain both the forced and voluntary concentration of ex-psychiatric patients in the inner city and the concomitant rise of the ‘psychiatric

ghetto' – geographical trends that were "manifestations of the development of a new 'asylum'" (Dear, 1977a, p594). Importantly, however, Dear allowed for the possibility that this 'asylum without walls' might have both negative *and* positive aspects for patients, not least in the provision of public facilities and services. And further, echoing Smith (1975, p53) – "What is it like to be mentally ill? What does it mean to be hospitalized and to be released into an unfeeling community" – Dear suggested that the views of patients themselves should be taken into account before decisions were made by policy makers and service providers about how formally to respond to the presence of the psychiatric ghetto.

By bringing community resistance into his analysis, Dear signaled a research path for this branch of mental health geography during the 1980s (discussed in more detail below); and, crucially, both he and Smith, by stating the need to consider the views of patients, anticipated by a decade one of the central demands of the qualitative research agenda that would gain prominence, and subsequently dominance, during the 1990s, and which is assessed in part three of this literature review. In their book *Not on our Street*, Dear and Taylor (1982) delved further into the key role played by local communities in the creation of the post-asylum geographies now being mapped in North America. Bringing location theory more formally into contention, they noted "the explicit recognition of nonuser attitudes to facilities as a vital consideration in locational decision-making" (Dear and Taylor, 1982, p4). Those planning community mental health services and facilities all too frequently fell foul of 'non-users', whose invariably virulent opposition to the siting of such facilities in their neighbourhoods was contributing to a crisis in the level of community mental health provision. Ex-psychiatric patients themselves were powerless bystanders suffering the collateral damage. For comparable studies in the British context see for example: Burnett and Moon, 1983; Eyles, 1988; Huxley, 1993; Moon, 1988; Parr, 1991; Sixsmith, 1988. The power exerted by this NIMBY (Not in my back yard) sentiment, allied to the fiscal squeeze about to commence in public welfare provision, particularly in North America, was to have devastating consequences for people experiencing mental health problems as the 1980s unfolded.

2.3.2. From the service dependent ghetto to a landscape of despair

Building upon their previous work (Dear, 1977a, 1977b; Dear and Taylor, 1982; Wolch, 1979, 1980, 1981), Dear and Wolch (1987) catalogued this catastrophic collapse in the life circumstances of deinstitutionalised psychiatric patients and other welfare dependent and vulnerable populations in their landmark '*Landscapes of Despair*'. Using a conceptual framework grounded in theories of structure and agency, it elucidated the outcome of the complex interplay between society and space. In almost forensic detail, the authors catalogued the ways in which the *social process* of deinstitutionalisation begat a *physical manifestation*, the service dependent ghetto. This is "functional for the deinstitutionalized; it is a spatially limited zone where individual support is made possible through proximity" (p21). Almost immediately, however, the service-dependent ghetto was to encounter the unyielding social force of economic restructuring and deep fiscal retreat by the welfare state, in which "[t]he new community care is characterized by a plethora of political jurisdictions and is currently besieged by a system-wide retrenchment" (p102). A reduction in the rate of welfare payments to individuals, a shrinking and more competitive market for affordable accommodation, and, in the face of continued suburban obstinacy, an increasing unwillingness on the part of city authorities to provide services for more than their 'fair share' of the needy, resulted in the stealthy dismantling of the service-dependent ghetto. The immediate consequence of which was a 'crisis', both figuratively, in the tatters of the 'failed' policy of deinstitutionalisation (or 'care in the community' in the UK context) and literally, in the urban iconography of daily hopelessness, unmet psychiatric need and homelessness: the 'landscape of despair' from which the book took its haunting title.

With levels of homelessness reaching endemic proportions in north American cities – particularly in California - Dear and Wolch foresaw the crisis as prefiguring a return to institutionalisation as a formal policy response. In California, they noted that following their displacement from the fractured service-dependent ghetto, the deinstitutionalised were to be found circulating through an ever-increasing number of institutional and often inappropriate penal or carceral settings, or else were enduring "the pathology of everyday life on the streets", an experience which "is

actively creating a new set of social problems that are likely to perpetuate a crisis of homelessness" (p199). In response, the authors suggested that if deinstitutionalisation can be viewed as a 'failure' it is because its implementation took place under markedly different social and economic circumstances to those which prevailed at its conception, and because the abdication of responsibility by wealthier suburban communities left financially floundering city authorities shouldering an unsustainable burden. Though pessimistic about the chances of it coming to fruition, Dear and Wolch suggest that rather than pursue a return to the same, or indeed new, forms of institutional care, deinstitutionalisation should instead be made a 'reality', through the dispersal of responsibility and resources more equitably across geographical space: "Though location *in* the community does not guarantee support *by* the community, dispersion can facilitate the kind of social integration that ghettoization constrains" (Dear and Wolch, 1987, p202).

Dear and Wolch's searing indictment of the tragedy of deinstitutionalisation in north America has long been considered a landmark text (see DeVerteuil and Evans, 2010, for a thorough appraisal of its legacies), though the applicability of the concept of the service-dependent 'ghetto' beyond north America has been found wanting. For example, Milligan (1996) argued that in Scotland the legislative foundations of the policy of deinstitutionalisation, coupled with greater centralised planning and control and a more powerful voluntary sector, ensured that the post-asylum landscape differed significantly from that commonly observed in north America: instead of a 'ghetto', services and the populations dependent upon them had in fact been scattered quite widely, and these services and facilities had encountered significantly fewer NIMBY-esque objections. Similarly, in New Zealand, Gleeson et al (1998) reported a more dispersed service dependent population as a consequence of higher levels of welfare provision (in particular social housing), lower levels of overall inequality, and the particular legislative and administrative outcomes of welfare reform (see Kearns and Joseph, 2000). Nonetheless, as a work of scholarship 'Landscapes of Despair' represents the apex of attempts by geographers in the 1980s to synthesise the geographies of mental health within a political-economic framework. In its fierce political engagement with its subject matter, its exposition of power and powerlessness inscribed into and being able to be read from the landscape, it can also be seen as

sitting on the cusp of the new era of culturally-inflected, post-structuralist human geography that was to come to prominence during the 1990s, and which would bring about almost revolutionary changes to how geographies of mental health were both theorised and practised.

2.3.3. Summary

The epidemiological and ecological traditions of early geographical forays into the subject of mental health and the city were largely superseded in the 1980s by an approach grounded in political-economic theory. By updating classical location theory to take into account the inherent conflict between the different social groups effected by the policy of deinstitutionalisation, and by investigating the power differentials therein, the research of this period revealed how the enduring concentration of mental ill-health in inner cities were a spatial expression of the larger social and economic processes that reverberated through western societies through the 1970s and 1980s. These new mental health geographies not only showed these macro processes at work, but also began to display a tangible concern for the lives, and life chances, of the individuals - mentally ill and service dependent - at the sharp end of powerful forces way beyond their control. This sense of people with mental health problems being seen as *subjects* – albeit largely as economic victims - rather than epidemiological data points, provides a useful bridge to the ways in which mental health geography was to change once again as an alternative, more subjective, research agenda of the 1990s began to emerge. This is the subject matter of the following part of this review.

2.4. Qualitative mental health geographies

“In traditional inquiries into the geographies of mental health and illness, the individual is often overlooked as a source of information about health and place, and relegated to the status of unproblematised geographical units” (Parr, 1999a, p196)

This third part of the literature review aims to outline the how the quantitative methods traditionally employed by human geographers investigating mental health were supplemented, and ultimately largely supplanted, by a new, mostly qualitative framework. Some of the traditional methods of quantitative research were by the early 1990s being seen as limiting the ability of geographers to understand mental health more fully. The majority of geographical studies from the quantitative era of mental health geographies did not explicitly present those experiencing mental ill health as individual human beings (or, perhaps, owing to the limits imposed by a more traditional epistemic approach, they were not able to). Rather, they were generally presented as intangible units of data under observation – “diagnosed bodies in urban space” (Parr and Butler, 1999, p6) – as in the epidemiological/ecological studies, or else part of an homogenous body of people collectively labelled ‘mentally ill’ and swept across space at the whim of much larger and more dominant forces, as under the auspices of the political-economy approach to mental health outlined in part 2 of this review. Those few studies that did tentatively raise the question of what the *experience* of mental ill-health might mean or feel like (see Smith, 1975, 1976; Dear, 1977 p594) tended to become lost in the midst of the dominant research traditions of the time that too often saw those classified as mentally ill reduced to mapable units of data, or otherwise obscured in lists of socio-economic variables or hieroglyphic-like equations: “what has been missing in accounts of the history and geography of madness, asylums and community care – at least until recently – are accounts of the *lived geographies* of (ex- and present) mental patients” (Parr and Davidson, 2010, p263).

2.4.1. Re-orientating mental health geographies: the ‘new’ qualitative framework

“[T]he way we talk about people ultimately influences the way we act towards them” (Smith, 1975, p57; quoted in Philo, 1997, p74)

The broadening of mental health geographies can be seen primarily as an attempt by geographers to analyse mental health in a more qualitative and reflective way. Its hallmarks include: an emphasis on the personal and subjective, and on the value of individual experience, self-identity, and agency; the fluidity and mobility of these identities; the recognition of and respect for difference and multiplicity over singularity; the acceptance of feelings as being as valid a proposition for research as thoughts; an acceptance of the idea of mental illness being in part a social construction and a consequent desire to reframe accepted notions of mental illness as a lived experience, as opposed to seeing it wholly as a medical condition; the concurrent rejection of normative understandings of the rational and the irrational; a deep reluctance to represent or be seen to represent or appropriate others’ voices; the emphasis on the partiality and incompleteness of any attempts to capture others’ experiences, feelings and understandings; and research being undertaken at often much smaller and more various geographical scales – from specific locations in a city to analyses of individual bodies. As a consequence, studies within this new framework re-orientate “attention from the analysis of space, forsaking a panoptic overview of distributional patterns, policies and politics to more interpretative engagements with the fusions of disability, identity and place ... [which] are beginning to frame a range of inquiries in terms of differences between people coded by society as mentally ‘abnormal’ and those deemed ‘normal’. The dominant conception of people with mental health problems duly transfers from one centred on ‘deviance’ to one preoccupied with ‘difference’” (Wolch and Philo, 2000, p143). Difference itself, though, is not an unproblematic term, suggesting as it does a variation or transgression from the ‘norm’. Here, though, its use is intended not to make a value judgement about what constitutes normality, but rather to allow for different states of being, or identities, to be equally valued. This is a crucial point, and one that underpins the bulk of the research to be reviewed in detail below.

For a geographer such as Hester Parr, the language in which mental states of being are addressed and discussed are paramount in these new geographies: “mental illness’ and various diagnoses associated with this pathologisation are not accepted as the final word on how alternative mental states can be understood” (p182). Instead, she prefers to speak of ‘madness’ which “does not invite any essentialised or medical explanation, but rather refers to mind/body differences which are individually distinct” (p182). This plea for the acceptance of people with mental health problems on their own terms finds an echo in Vanessa Pinfold’s ‘safe havens’ that she hopes will eventually provide a safe space for ‘mad-pride’. The work of both scholars is discussed later in this section.

In addition to the broader economic, social and political forces under which people with mental health problems must exist, and which were the subject of the political-economic approach to geographies of mental health, the new framework has allowed for culturally-inflected and psychoanalytically-grounded examinations of the power of medical terminology, and how its largely uncritical acceptance by academic disciplines has entrenched the stigma surrounding mental illness – a stigma which sees the ‘mental patient’ as unpredictable, unreliable and in need of controlling and one which therefore implicitly undermines the “validity of the voice of the person with mental health problems” (Parr and Davidson, 2010, p266). In exposing these discourses – and their binary dualisms that force individuals into homogenous categories of ‘us’ (the sane, the rational, the normal) as opposed to ‘them’ (the mad, irrational, different ‘Other’) – these geographies have exposed how academia has often appropriated, and at worst silenced, the voices of those who may have most to tell us about their situations. (In this sense, these new mental health geographies can be seen as analogous with the scholarship that excavated the historical geographies of asylums and which exposed a past in which the mentally ill had been rendered mute – see Philo, 1997, for an overview; also Philo, 2004). Furthermore, by allowing individuals to relate their experiences directly, rather than having them interpreted on their behalf by scholars or ‘professionals’, these geographies have showed how those conceived of and labelled as mentally ill are, through their daily activities and behaviour, engaged in a process of resistance to this restrictive categorising of them and their lives.

Crucially, by maintaining a firm grasp of the key disciplinary tools of space and place, the mental health geographies of the qualitative era have largely avoided the typecasting that has befallen other areas of social and cultural geography, where the research output is adjudged by some to have disappeared into a postmodern cul-de-sac of irrelevance. Criticism has been levied, however, over the extent to which the place-specificity in some studies and corresponding lack of generalisability has left mental health geography unable to influence or inform policy- and decision-making at the macro level – as had been the intention of the political-economic approach (see Wolch and Philo, 2000; Smith, 2009).

2.4.2. Mental health geographies of recovery and resistance

“[P]eople with mental health problems are not simply ‘cared for’ in the community, or always sitting in smoky hostels or out begging for food (although this does occur). Rather, a range of everyday geographies of community life are now ones routinely inhabited by this group, often in ways that demonstrate significant human agency, creativity and even resistance to restrictive social norms and medicalization” (Parr, 2008, x)

Hester Parr, one of the scholars at the forefront of the new mental health geographies, has striven to recover the dehumanised ‘mental patient’ from geography’s theory and practice, and allow him or her the choice to reveal their lives in all their complexity. Rejecting what she sees as geographies of ‘enclosure’, which reflect both the spectre of the psychiatric asylum and the privileged academy of the quantitative era, she instead seeks to usher in new geographies of ‘disclosure’ that would involve repositioning geography away from representations of mental illness toward representations *through* mental illness (Parr, 2006, 2008).

One of the key themes to emerge from her work is a determination to allow these formerly amorphous ‘patients’ to themselves present their own, often multiple identities, and to do so on their own terms. In so doing, she wants to stress how they are active agents working in a multiplicity of ways at a series of different scales to determine and have some level of control over their own pasts, presents

and futures. (This concept of the ‘mental patient’ as having his or her own agency and being capable of resistance has a relatively long lineage in the sociological and psychiatric annals of ‘anti-psychiatry movement’ – see Goffman, 1961; Foucault, 1967; Laing, 1967 - but had until recently been largely neglected in mental health geographies).

Accordingly, as the quote at the head of this section suggests, she is at pains to challenge those normative readings of the post-asylum landscape in which people with mental health problems are viewed through a series of binary categories – the included versus the excluded, insiders versus outsiders, the same as ‘us’ versus someone different, proximity versus distance. Instead, Parr attempts to dislocate these terms in favour of more nuanced understandings of how personal geographies of mental health are conceptualised and lived by those experiencing mental health difficulties, revealing as she does so that the static categories outlined above cannot capture the complexity of the daily lives of people with mental health problems, who can be simultaneously included and excluded, can be both proximate and distant and who themselves can exclude other individuals.

She has done so through a series of different participatory engagements with people experiencing mental health problems and who were connected to a variety of ‘support’ projects or who used supportive spaces in both urban and rural areas (see Parr, 2008, for an overview). Her analyses have attended closely to the strategies by which people with mental health problems understand and negotiate different social, physical, and virtual spaces, what their feelings are about them, and how these feed into multiple and varied identities. Her research has delineated the personal and social daily geographies of people with mental health problems in a variety of settings, including urban public space (Parr, 1997, 1999b), the virtual spaces of the internet (Parr, 2002), the social-therapeutic spaces of an art (Parr, 2006) and a gardening project (Parr, 2007). In each of these research encounters she has shown people with mental health problems being active in shaping their own personal geographies: she has delineated the creative, self-determined and disruptive use of public urban space as acts of resistance against imposed medical identities (Parr, 1997, 1999b), probed the ways in which contemporary technologies in the form of social media are changing geographies

of social support, cohesion and belonging (Parr, 2002), examined how art-making can create spaces for personal recovery and belonging which undermine hegemonic representations of mental illness that maintain distance between the 'other' and the 'same' (Parr, 2006), and analysed the ways in which an urban horticultural project may offer potential pathways to 'social citizenship' (Parr, 2007). Across her body of work, she has revealed these to be simultaneous acts of recovery and resistance and, in so doing, has decisively helped to shift mental health geographies away from a focus on the mechanics of deinstitutionalisation, and toward an alternative agenda in which the particular life worlds of people experiencing mental health problems, their encounters in space and the social imprint these leave on them and others, are enunciated.

Aiming to "communicate a sense of the humanity behind the label 'living in the community with mental health problems'", Pinfold (2000, p202) conducted extensive research with people with mental health problems who were engaged with a community mental health rehabilitation and support service. The service aimed to reduce the degree of social isolation individuals experienced in order to bring about the restoration of their clients health and social functioning to 'normal levels'. She found that the methods by which individuals were expected to achieve this normalisation – participation in educational or work opportunities, and increased residential, social, financial and emotional independence - often sat uncomfortably with their own conceptions of what activities were possible or which places were conducive to them feeling settled at any given time. Clients and the service also differed markedly both in their perceptions of how to judge 'isolation' and in considering what this might mean or feel like to different individuals. Pinfold argued that this imbalance in expectations, combined with the stigma still attached by the wider community to the clients' often 'unorthodox' characteristics of personal appearance and behaviour, led individuals to create their own, more comfortable, pathways to rehabilitation even though on the surface these might appear to entrench their apparent isolation. In fact, these physical and metaphorical 'safe havens' allowed individuals to engage with everyday life on their own terms and at a pace and in settings more conducive to their own needs:

“[T]he research revealed that many users’ networks were characterised by socio-spatial isolation: large periods of time spent alone, small social networks and small activity spaces. However, isolation is generally not a binary variable ... and isolation affects different parts of people’s lives, its intensity changes over time and its debilitating quality is also inconstant. Service users are not passive players in the rehabilitation landscape, moreover: they are active participants shaping, as well as being shaped by, socio-medical pathways that are negotiated using personal coping mechanisms to sustain everyday equilibrium. Instead of absolute positions, individuals often occupy a (preferred) evolving middle-ground between isolation and integration, between states of dependency and ones of independence” (p210).

What comes to the fore in the work of both Parr and Pinfold is the effort they have placed in undermining normative concepts of the experience of mental illness. Through allowing individuals experiencing mental health problems to articulate their own often very different understandings of apparently straightforward terms such as care in the community, rehabilitation and recovery, they have helped relocate the lens of mental health geography to a more critical and radical position and, in doing so, they have helped to rescue mentally ill people themselves from near invisibility in previous iterations of mental health geography. It is noteworthy, too, how the conception of space in studies of qualitative era differ from that considered under the political-economic approach. Instead of landscapes of despair, in which people with mental health problems were seen as being largely *reactive* in space, to possible ‘landscapes of wellbeing’ in which people with mental health problems “strategically adapt and take ‘care of themselves’ creating their own identities and geographies of wellbeing in the process” (DeVerteuil and Evans, 2010, p293).

2.4.3. Mental health geographies of exclusion

The repositioned mental health geographies hold in common a desire to help break down the us/them divide that serves to sustain both prejudice towards people experiencing mental health problems and the stigma attached to the 'condition' itself. They seek to unpick overly restrictive conceptions of mental illness solely as a medical condition, rather than as a *lived experience* (Parr and Davidson, 2010). In her ethnographic research with patrons of an advocacy group for current and ex-users psychiatric services, Parr (1999a) uses the example of the forcible administration of psychiatric medication to emphasise again the inseparability of mind and body, and the impact this has. She notes that:

"For many people who experience mental health problems the disruptions to both their senses of self and their everyday routines, including their feeling of control over time and space, are extremely distressing realities which prompt varied strategies of coping. For some, the ability to regain control and routine in time and space is intimately tied to the effects of the powerful medications that help control 'symptoms' ... for many people interviewed in Nottingham regulation of mental states by medication can lead to a perceived lack of individual control over the body, and there is undoubtedly a sense in which people's socio-spatial lives may be dictated by medical treatment as individuals taking medication cope with, and try to regularise, its effects" (Parr, 1999b, p189-190).

Implicit in this conceptualisation of the interconnectedness of the mind and the body is the importance of feelings, and the legitimacy of the emotional experience of living with mental ill health as an area for valid geographical research: such research seeks "to bring 'to life' emotional geographies of exclusion *and* inclusion in order to further examine the relations of – and disruptions to – social difference" (Parr and Davidson, 2010, p263).

Other researchers operating within the qualitative framework of mental health geographies have stepped back from looking primarily at the experiences of people with mental health problems to instead examine other parts of the mental

health landscape of the twenty-first century. Here, there are what might be referred to as policy geographies of mental health. For example, in a series of studies, the design principles of new spaces of in-patient care were investigated for their impacts on wellbeing and the creation of therapeutic landscapes (Curtis et al, 2007), their influence on models of care and treatment (Curtis et al, 2009), the implications for the roles and experiences of informal carers (Wood et al, 2013), and the ways in which they intersect with ideas surrounding social control and risk to create spaces of 'compassionate containment' (Curtis et al, 2013). Continuing the containment theme, the ways in which the high profile political rhetoric in the UK surrounding the purported failure of 'care in the community' might presage a return to re-confinement for people with mental illness (Moon, 2000), and how the stigma and fear of people with mental health problems this engendered has been uncritically incorporated into national legislation (Lowe, 2009), have seen geographers grappling with the knotty questions of politics and the law. Similar legal-political entanglements have been investigated by Carpenter (2000, who looked at whether the broader political and ideological context under which deinstitutionalization and welfare state restructuring occurred (a neo-liberal agenda in north America and the UK, versus a more social democratic tradition in Sweden and Italy) had a bearing on the success and acceptance of the policy.

Some researchers have used the 'conceptual openness' (Parr and Butler, 2010) afforded by the cultural turn in human geography to update for the new qualitative era familiar geographical perspectives on mental health and the city. In a spellbinding piece entitled 'Burger King, Dunkin Donuts and community mental health care', Caroline Knowles (2000a) shadowed the lives of people with serious mental health problems who, having been effectively abandoned by the welfare authorities, were living highly marginal lives on and around the streets of Montreal. With clear political engagement she described their predicament:

"There is no special place in this city for the mad. They must stay on its edges, use its fast food joints, malls, churches and the streets on certain terms. Their lives are organised through a patchwork of facilities, none of which is especially about (i.e. designed for) them or their needs. Not the clients of a modern welfare state and its sophisticated psychiatric services,

these are people administered through the revamped relic of 19th century religious philanthropy and the doughnut shops of the global age" (Knowles, 2000a, p223).

Like Faris and Dunham and Dear and Wolch before her, she traced their paths through the unwelcoming terrain of the inner city but, most importantly, she allowed them to speak directly about their experiences. Here, in the absence of any serious community mental health support or direction, individuals scrabbled together survival routines across both public and *private* spaces of the city that provided for those daily needs that remained resolutely unmet by retreating public welfare authorities.

2.4.4. Summary

Knowles' paper draws together the different threads that have been used to ground the structure of this review - a deep interest in the distinctive urban realm, the policy context of the post-deinstitutionalised landscape and the withdrawal of the state from the provision of public welfare, and the strategies and tactics through which people with mental health difficulties are obliged to live their lives, and their consequent high levels of mobility – and is therefore a useful place to bring this section on qualitative mental health geographies to a close. The next section of the review will consider in depth the last of the threads identified in Knowles' study but as yet largely unarticulated in this review: that of mobility, and the ways in which it may interact with, be a consequence of, or act to determine the real and imagined geographies of people with mental health problems.

2.5. Mobility

“He said ‘O Riddley you known bettern that you know the same as I do. What ben makes tracks for what wil be. Words in the air pirnt foot steps on the groun for us to put our feet in to” (Hoban, 1982, p116)

“[D]anger lies in the potential valorization of newness in mobilities research ... There is a tendency to proclaim ‘gee-whiz’ technologies ... Similarly there is a constant urge to claim newness for theories that emphasize or deal with mobility in a hyperactive world, a space of flows, or a world of non-places ... I would also advocate a strong sense of historical consciousness. People and things have always moved and mobility did not start in the twenty-first century” (Cresswell, 2010a, p555)

2.5.1. Introduction and the mobilities ‘turn’

When mental health geography has treated human movement - or the lack thereof - as an explanatory factor in the spatial distribution patterns of mental ill-health, it has tended to do so in a rather one dimensional manner: the incorporeal ‘mentally ill’ semi-voluntarily adrift across the urban plane, or pushed and pulled by forces way beyond their control. If, however, movement is instead figured as ‘mobility’, then a more nuanced picture of these spatial patterns, and the experiences of those involved in creating them, can be drawn out. This section of the literature review introduces the conceptual literature surrounding the mobilities ‘turn’, before analysing in more detail the mobilities inherent in mental health geographies, and connecting these to the present research project.

The announcement of a new mobilities ‘paradigm’ (Sheller and Urry, 2006) has been presented as the zeitgeist of the social science research agenda for the early twenty-first century, where ‘society’ as an ontological approach is replaced with an alternative based on movement (Adey, 2010). Unlike movement, though, mobility is a relatively tricky concept to pin down. Whilst movement - “a spatial displacement of something across, over and through space” – is clearly implicit in

any definition, mobility is also *relational*, that is, it is continually occurring with, against, through or alongside some other thing or things which are themselves far from static (Adey, 2010, p13). It is this ‘friction’ (Cresswell, 2010b) against other things, allied to the idea of fluidity and change in pace (and place) that imbues movement with meaning and thus allows it be theorised as mobility (Adey, 2010). The upending of traditional frameworks of fixity and boundedness, and their replacement by one that takes the fact of mobility as the starting point has particular, and perhaps somewhat alarming, implications for the theory and practice of geography, with its emphasis on place and location (Cresswell, 2010a). Accordingly, recent years have seen the growing prominence of scholarship on both the theoretical implications for geography of the mobilities ‘turn’ and on different ways that geography can engage with the mobilities research agenda (Adey, 2010; Bergman and Sager, 2008; Cresswell 2010a, 2010b, 2011; Cresswell and Merriman 2011; Merriman 2009).

This section of the literature review will look first at how geography has historically and conceptually engaged with mobility, before narrowing the focus to the ways in which mental health geography has taken it into account. This necessarily covers quite a substantial area of research but several clear themes emerge from the literature: first, that despite somewhat grandiose claims made on its behalf as representing an apex of liberation and powerfulness, mobility is not new, and is experienced and represented in both positive and negative ways, with the value placed upon it varying temporally, spatially and contextually; second, that unlike movement, mobility takes into account the texture of movement - that is, rather than being primarily or solely concerned with where someone or something is coming from or going to, it is also interested in how it is experienced, what it feels like, and whether it is subject to any resistance; third, it pays attention to the wider socially patterned, hierarchically organised and power-laden context in which mobility occurs – a reading of mobility that becomes particularly important when set against the broader policy context of the welfare reforms set out in Chapter 3 and the implications these reforms have for the economic and residential stability of the participants in the present study.

2.5.2. Geography and mobilities

Tim Cresswell both emphasises the longstanding interest in mobility within the discipline, and is at the forefront of elucidating the ways in which mobility might be brought into more fruitful conjunction with the theory and practice of geography. He asks how geography should respond to mobility as a “geographical fact that lies at the centre of constellations of power, the creation of identities and the micro-geographies of everyday life” (Cresswell, 2010, p551). Importantly, he does so by taking as a starting point the fact that geography has the longest lineage of the social sciences in researching the ‘mobile’. In other words, geography is not coming to the mobilities research agenda for the first time. As examples, he cites the established research fields of migration, transport geography and geographies of tourism, which are all concerned with the central question of movement and the associated impacts on people and places, to more recent work in cultural geography on transnationalism, with an emphasis on ‘routes’ as well as than ‘roots’, and argues that mobility – as an “entanglement of movement with meaning and power” (p553) – is implicated in much geographical scholarship. Merriman (2009) too sees a long tradition of mobility in the geographical literature – from the spatial science laws of the 1960s that supposedly governed the rational movement of things through space, through phenomenological approaches to human geography in the 1970s that concerned themselves with individuals’ daily movement patterns and their reactions to the places and things they encountered on their travels, to Marxian geographies emphasising flows and cycles, and humanistic and cultural geographies with their interest in the interaction of people and places.

Geography, then, has perhaps enjoyed something of a head start over other social sciences in taking into account the ways in which mobility can be brought into its analyses of space and place. As suggested above, the scholarship of ‘time geography’ by Hagerstrand (1970), in which individuals’ daily movement patterns were analysed in the context of the social or structural constraints upon them, should be cited as an early example of work that frames movement in the sorts of ways being called for by advocates of the mobilities turn. It also seems that, particularly through the way it has reconceptualised space and place as being

always (re)made by the people, objects, ideas and social forces that move in, through or around them, geography has to some extent already anticipated Adey's demand that – "mobilities must be seen as involved in the making and remaking of spaces and contextual backgrounds" (Adey, 2010, p39). McCann (2010, p121) suggests that "mobilities scholars are clear on their intellectual debts" and elsewhere (p109) cites the work of Harvey (1985) on the spatiality of capitalist accumulation, and Massey (1991) on time-space compression associated with globalisation and the implications for sense of place, as examples of where these debts lie.

In their introductory chapter to an edited collection on mobilities, Cresswell and Merriman (2009) emphasise that the call for geography to become *more* engaged with the fact that things are mobile is not solely a new academic infatuation. They quote a call from Crowe (1938) for geographers to become more attuned to the contextual nature of movement, when they have for too long:

"Advanced a static geography ... incapable of seeing movement except as pattern ... The study of things moving will at least take us a step along the right road, for, as compared with static distribution, movement implies three essentials – origin, destination, and an effective will to move. Movement does not take place in a vacuum, it is effected upon the surface of the earth and it is very largely through movement that Mankind becomes conscious of its geography (Crowe, 1938, p14; quoted in Cresswell and Merriman, 2011, p1).

This historical understanding of the importance of movement and mobility has allowed geography the breathing space to critically interrogate the new mobilities paradigm, which to its credit it has largely done. In particular, proclamations that a mobility focus represents some radical new departure that opens up the geographical research agenda and challenges the supposedly hitherto fixed points in its firmament, have come under close scrutiny and, as suggested above, been found wanting. Also contentious is the notion that mobility itself is somehow a recent phenomenon. As illustrated in one of the opening quotes to this part of the literature review, an interest in and understanding of mobility is not novel. Through

his historical geographies of tramps and vagabonds, Tim Cresswell has demonstrated that groups such as these have been defined culturally and legally by and through their movement - specifically their resistance to attempts to impose upon them more static, culturally acceptable norms of movement, behaviour and place; see also Sibley, 1995, for a similar examination of how the mobility of Roma populations is seen by fixed populations as problematic and threatening.

Similarly, scholars have also been criticised for 'hyperbolic' claims that see 'everybody' moving in 'dramatic and significant ways' which perhaps obscure as much as they reveal: "[t]his focus on the spectacular space and outstanding event highlights a broader distortion in geographical writing that tends toward the notable rather than the mundane. Yet when all is said and done, the space most intimately inhabited, traversed and practised is that familiar, often homely space that forms the all too unnoticed backdrop to the unreflexive habits of domesticity, shopping and work, and associated forms of banal movement which reproduce the meanings, material form and function of place" (Binnie et al, 2007, p166). Movement, therefore, has not always been celebrated as a positive and liberating action; neither is it always being undertaken in necessarily remarkable ways. To do either risks concealing both the ways in which it has been presented as threatening and practised by unconventional and morally suspect outsiders, or elevating its status above the rather mundane forms it so often takes.

These reservations aside, it is important to see how the concept of mobility, as opposed to movement as traditionally understood as an unproblematic event, can move geography's epistemology (and ontology) in potentially rewarding directions, and is particularly pertinent to the current research study. The next section of this review outlines the ways in which this could happen, primarily through the development of a mobilities perspective that pays close attention to the contextual background against and through which movement occurs, that considers movement at multiple geographical scales, for example from individual bodily movements to global flows, is interested in the movement of ideas and objects as well as people, and which recognises that some things are freer to move than others, and as a consequence some can stay or are forced to remain still (Cresswell, 2010a; 2011).

2.5.3. A ‘politics of mobility’

Despite the valuable insights such an approach may generate, a meaningful and critical reading of mobility and immobility will question the relative worth accorded to each of these states of being, and will make connections with the macro socio-economic and policy context of neo-liberalism and its valorization of mobility as an inherent social good. It will also reveal the ways in which the ever-changing interpretations and representations of mobility are essential to our understanding of the mobile itself – they too are the context in which it can be understood or seen in different lights:

“Mobility has been figured as adventure, as tedium, as education, as freedom, as modern, as threatening ... Geographers, social theorists, and others have been complicit in the weaving of narratives around mobility. We have alternately coded mobility as dysfunctional, as inauthentic and rootless and, more recently, as liberating, antifoundational, and transgressive in our own forms of representation” (Cresswell, 2010b, p19-20)

Bringing together theoretical insights from scholars from across academic disciplines – including Bauman (1998), Deleuze and Guatarri (1987), Lefebvre (2004), and Virilio (1986) – Cresswell (2010b) has attempted to delineate a ‘politics’ of human mobility. He suggests six key elements of mobility, each of which is mutually constituted with the social relations in and through which the mobility occurs. First, that mobility involves *force*, in which people respond to internal or external forces by choosing or being compelled by others to engage in some form of movement. Second, movement involves *velocity*, with differential social value accorded to different speeds. Third, there is a *rhythm* to movement, which can be simultaneously repetitive yet open to difference or alteration. Fourth, movement is not distributed evenly across space but occurs through *routes*. Fifth, movement involves *feeling* – movement is experienced through the human body. Sixth, that mobility cannot occur without *friction*, as it necessarily involves coming into contact with other things and must come to an end at some point. This political dimension reveals that ‘mobility’ is not unproblematic either as a concept or as a

theoretical starting point for research. Human mobility remains intricately entwined with questions of power and identity, and operates not in a vacuum removed from prevailing policy prerogatives but is deeply embedded within them: “There is a politics and geography of power bound up with practices and discourses of both mobility and fixity ... The geographies of mobilities are inseparable from particular materialities ... New connectivities and mobilities produce geographies of exclusion, disconnection, inequality, and immobility” (Merriman, 2009, p135).

This politics of (im)mobility is reflected in scholarship that has invoked ideas of citizenship and mobility rights (and, as a later chapter will suggest, welfare rights too), and thus brings into sharp relief questions of human power and powerlessness in a mobile world. The contemporary political lexicon is, of course, replete with references to freedom, the advantages bestowed upon those who are physically or socially mobile, and the diminished quality of life experienced by those who are stranded, stuck, still or otherwise excluded from the ‘blessings’ of mobility (Bergmann and Sager, 2008). Sheller (2008) applied a tripartite concept of freedom in her dissection of mobility and its associated spatial (in)justices. She argues that the freedom of people to be mobile operates at three distinct but interconnected scales: first, personal mobility freedom, that is the degree to which individual or bodily mobility abilities are unevenly distributed; second, sovereign freedoms, the allocation of which are dependent upon the broader social and cultural environment which will privilege some at the expense of immobilising others; and third, civic freedoms, which relate to the extent to which civic societies will seek to either encourage or constrain mobility. From this emerges a very uneven mobility landscape in which:

“There is no single meaning or experience of freedom, but many different combinations of the positive and negative, the fair and the unjust, the physical and the informational. And in a sense each of these freedoms of mobility also has its own forms of resistance, subversion and countertactics. Personal freedom of mobility centers on the scale of the body: how the body moves, where it can move, when it can move. Sovereign freedom of mobility, in comparison, extends beyond the individual body to encompass issues of governance, legitimacy, and the exercise of power whether in a

familial home, an organization, a city or a nation; thus it concerns mobilities at larger scales. And civic freedoms of mobility likewise extend beyond the individual body to the collective mobilities of multiple publics, of social movements, of bodies of citizens and far-flung networks of communication" (p30).

How researchers in health and mental health geography have used similarly *critical* interpretations of mobility in their own fields will be explored in the next section, which also serves to highlight the contribution the present study – with its focus on individual service user experiences of mobility and questions of stability and security against the dominant policy context of welfare reform – can add to this area of scholarship.

2.5.4. Health geography and (im)mobility

Health geography has historically engaged with questions of mobility through its longstanding analyses of the relationship between health and migration (Gatrell, 2011). This research has generally been conducted within an epidemiological framework, for example by investigating the impact that migration has on the health profiles of origin and destination populations, through attempting to determine if migrant populations (or individual migrants) are generally healthier or unhealthier than non-migrant populations (Bentham, 1988; Boyle et al, 1999; Newbold, 2009; Singh and Siapush, 2001), or whether the decision to migrate is based to some degree on health selectivity, including whether some health conditions or illnesses are more likely to result in a move and if so, how this selectivity may determine the form that the migration takes, for example the degree of distance involved in the migration (Boyle and Norman, 2010; Larson et al, 2004). There is also a large literature that has sought to trace apparent connections between both historical and contemporary mobile populations and the spread of contagious disease (see Gatrell, 2011, chapter 8, for a helpful overview; also Boyle and Norman, 2010, p348-355).

More recently, the focus has shifted toward investigations of the health status of migrants themselves, including before, during and after their migration, and how this was experienced and felt, rather than focusing solely on the impact their movement has on other more stable populations (Argeseanu Cunningham et al, 2008; Lara et al 2005; McDonald and Kennedy, 2004). This can be seen as reflecting the more qualitative nature of health geography as connections have been forged with cultural and social geographies. In the same vein, other studies (Ahmed, 2000; Craddock, 2002; Cresswell, 2000; Kraut, 1994; Leavitt, 1997) have interrogated not the role that migration might play in the transmission of disease, but rather how migration has been *represented* as posing a risk to the physical (and moral) health of receiving communities, and the role that political and media discourses play in sustaining the image of the disease-carrying 'immigrant' in popular public consciousness. This can be seen as illustrative of the ways in which movement has been prefigured as being subversive: "[I]t is often through their very *movements and proximities* that bodies are marked as 'different' in the first place and one expression of this is the common tendency to regard migrants as harbingers of disease" (Boyle and Norman, 2010, p347, emphasis added). A recent example in which migration loomed large - as both the explanatory factor in the spread and transmission of disease and as representing a sallying threat to a healthier host population - was during the 2003 SARS outbreak in Toronto. A particular kind of globally-interconnected transnational hypermobility was presented as having borne the disease from Hong Kong to Toronto and back to Manila, with its counterpart, bounded *immobility*, becoming one of the primary tools used by the authorities in their efforts to limit the contagion (Ali and Keil, 2006). Here, then, it is the apparently unfettered mobility of a few, rather than the disease itself, that is branded as imperilling the health of the many and which is seen to be creating distinctive geographies.

Equally, fettered mobility can also endanger health: for some people, their mobility proceeds only in a downward direction. In their research into health selective migration and deprivation, Norman et al (2005) investigated the relationship between migration and the widening mortality and morbidity gaps of different areas in the UK. They asked whether these gaps had widened because relative health status in particularly areas had deteriorated, or rather because individuals with

similar characteristics had become clustered together over time. Using longitudinal data, they found clear evidence of health-selective migration, with those experiencing poor health status becoming more likely to live in deprived areas. They attributed this to a complex interplay between in- and out-migration to and from the most deprived areas: those moving into the most deprived areas were found to have worse health than those who had moved out; conversely, those who migrated into the least deprived areas enjoyed better health status than those who left. Those who were *immobile* and remained in the most deprived areas had the worst health. Immobility thus implies that a combination of individual and structural process are affecting those in poor health and residing in deprived areas and leading to a degree of spatial *entrapment* (Dunn, 2000). Smith and Easterlow (2005) argued for a reconceptualisation of the relationship between health inequalities and place, one which takes into account the ways in which individuals' health histories and health conditions *themselves*, through their encounters with external forces – including health institutions and housing markets, and political and cultural norms - impact on life chances and opportunities. They suggest that health itself is used as a marker for inclusion or exclusion. Criticising existing research they claim that:

"[T]he possibility that people whose health is already compromised might actively be placed into deprivation is rarely entertained. At best the wider literature is confused, using 'disadvantaged' and 'in poor health' as if they were similar and interchangeable, so masking the way health conditions may be 'mapped onto' places by people as they negotiate a path through the markets and institutions that shape and encase their lives" (p177-8)

Further, they suggest that the degree of entrapment experienced by people may sometimes contain an element of selectivity. Noting that individuals' feelings about a place can often operate to trump what may objectively be seen as their best interests: "[P]roperties are more than bricks and mortar, more than a roof over one's head; they are homes with complex historical and emotional geographies, which are bound into health experiences in all kinds of ways ... selective entrapment is a powerful force, which is not only built into structures and institutions but also ingrained in emotions and imaginations" (p184). Smith and

Easterlow's reconfiguration of health selective mobility is important, suggesting that there is a delicate interplay between the *emplacement* – or enforced mobility – of individuals with poor health status into certain areas, their subsequent (perhaps semi-selective) *entrapment*, and their potential future *displacement*.

2.5.5. Mobility and mental health

The mobility patterns of individuals experiencing mental health problems have often been represented as residential *instability*, whether as 'drift' to the service-heavy inner cities, or the concept of hypermobility, in which individuals 'churn' through the revolving door of various institutional or community settings, and whose personal mental health histories are closely entwined with periods of psychiatric treatment, particularly inpatient treatment: "Patients who measured low on residential instability would be seen as generally maintaining enduring and consistent ties to some form of supportive environment and might be thought to have more favourable psychiatric outcomes. As events change and instability increases in living situations, outcomes would be more unpredictable, though probably less favourable; social supports decrease, alienation increases, hospitalizations rise" (Appleby and Desai, 1987, p516-7, quoted in Tulloch et al, 2011, p 859).

A series of analyses – primarily quantitative – in both North American and European settings have attempted to bring a semblance of order to the often chaotic jumble of residential patterns that people experiencing mental health problems leave in their wake. Overall, they can be seen to have used three broad categories to define the nature of residential mobility: first, the likelihood of a residential move having taken place; second, the direction in which the move occurred, for example, from rural to urban, or intra-urban, or closer to particular facilities; and third, the frequency of moves. These have subsequently been used to analyse the individual determinants of residential mobility for people with mental health problems – including both general demographic characteristics, including sex, marital status, ethnic origin and age, along with more specific factors,

including type or number of diagnosed mental disorders, area of residence and service need.

The majority of studies that have shown that individuals experiencing serious mental health difficulties have greater residential instability than the general population² have focused on these different socio-demographic determinants (Abood et al, 2002; Breslow et al, 1998; Dauncey et al, 1993; Dembling et al, 2002; DeVerteuil et al, 2007; Lamont et al, 2000; Lix et al, 2006, 2007; McCarthy et al, 2007; McNaught et al, 1997; Tulloch et al, 2011); though see also Lesage and Tansella (1989), who argued that the specific conditions of mental health policy and service provision in Italy results in individuals experiencing mental health problems having no greater degree of residential mobility than the general population.

Some studies have questioned whether residential mobility per se should be represented as always constituting a negative outcome for individuals with mental health problems and have instead asked if, in certain places or circumstances, its counterpart - residential immobility or entrapment – might be seen to represent a greater threat to mental health (Drukker et al, 2005; Ross et al, 2000; Whitley and Prince, 2005). Ross et al 2000 claim that in “affluent neighbourhoods, stability is associated with low levels of distress; under conditions of poverty the opposite is true” (p581). They argue that areas of high socio-economic deprivation will often see higher levels of social disorder and that, for these areas, unlike more affluent ones, stability does not result in lower levels of social disorder. Residents therefore may feel powerless to leave and their entrapment in such places can have deleterious impacts on their mental wellbeing. With distinct echoes of the ideas of the ecological school of thought promulgated by the Chicago school, these deprived areas are representative of neighbourhoods of “last resort, where people

² There is a substantial literature on the residential mobility patterns of the general population, often linked to questions of labour and housing markets. These have found, in general, that younger households and wealthier ones move more frequently than older ones, and that low-income households often find themselves ‘stuck’ in low quality housing often in the private rented sector (Clark and Huang, 2003). The British Household Panel Survey showed a broadly consistent level of just under half of respondents expressing a desire to move home, with approximately one in ten doing so each year, two-thirds of whom remained within the same local authority area (Boheim and Taylor, 2000)

remain, not because they choose to, but because they have no other options" (Warner and Pierce, 1993, p499; quoted in Ross et al, 2000, p582). Drukker et al (2005) reached similar conclusions in their study in Maastricht. By contrast, Kearns and Parkes (2003) found that outside London residents of poor areas who reported dissatisfaction with attendant social disorder were in fact equally likely to be mobile than entrapped; the converse was true in London, which they attributed to the low availability of social housing constraining the opportunities for people to move. The practical consequences of some aspects of welfare reform – such as financial penalties for occupying more space than deemed necessary or limitations of the amount of housing benefit that a claimant can receive in high cost areas – look likely to unsettle these patterns before too long.

There are clearly close connections between the work on mobility and mental health and earlier iterations of the more quantitative era of mental health geography discussed earlier. For example, McNaught et al (1997) analysed the residential mobility of individuals diagnosed with schizophrenia who were living in the former Hampstead health authority area in north London in 1986 and 1991. They found that whilst the number of individuals diagnosed with schizophrenia was similar in both the 1986 and 1991 surveys, only half of those identified in the 1986 survey remained in 1991. Those who left had been replaced by other individuals who had moved into the area, often from outer London, and whose personal residential histories included a significant number of moves. In North America, Dembling et al (2002) found that one third of individuals in Virginia with three or more in-patient admissions had changed their county of residence compared with 15% among the general population. Further, it was found that that patients and the general population were moving in contrary directions, with patients moving into areas that were experiencing a decline in the overall population and leaving those areas which were experiencing population growth. At the scale of the city, recent studies in Winnipeg (DeVerteuil et al, 2007; Lix et al, 2006, 2007) have found that individuals experiencing serious mental health problems were also more likely to move than the general population, to be moving in a counter direction to general trends of urban population movement, and to experience a degree of spatial entrapment that retained them in the inner core of the city where services were accessible and available and accommodation relatively affordable.

The ways in which the residential mobility of people experiencing mental health problems may intersect with, or be determined by, the nature and structure of service provision, and in particular, admission to hospital, has also been extensively addressed in the literature. For example, Tulloch et al (2011) investigated a sample of psychiatric admissions in south London and discovered that the majority of changes of address occurred around the time of admission and subsequent discharge. They posited that an individuals' (potentially temporary) location on an inpatient psychiatric ward "defines a *place* and *time* at which mobility from one residential environment to another is likely to occur" (p859) (see also Caton and Goldstein, 1984). Also in London, Lamont et al (2000) found that rates of residential mobility for individuals experiencing serious mental ill-health and subject to admission to hospital were higher than for those under the care of community mental health teams; and those resident in the inner city were significantly more likely to display unstable residential patterns than those resident in outer boroughs. In a detailed examination of the problems residential instability causes for continuity of patient care, they note how the management procedures and cultures of hard-pressed psychiatric services can exacerbate these problems. They note that community mental health services are "increasingly examining the status of patients before they are taken on for care, and those who are in very unstable accommodation are often not taken on by the local teams on the grounds that they are likely to move shortly ... [resulting in] a sub-population of highly mobile patients – rootless and generally unwanted in an overcrowded metropolis – who use a disproportionate amount of in-patient services and add significantly to bed pressures" (Lamont et al, 2000, p168). Highly 'geographically mobile' individuals were found to have longer stays in hospital than their more geographically stable counterparts, and Lamont et al acknowledge the worrying implications for patients' potential future residential stability following discharge given that "[h]ousing is at a premium in London, and if accommodation is left unoccupied for long periods it is usually repossessed. Patients with severe mental illness are often evicted at the point of admission and therefore have a geographical move forced on them at the time of discharge. If the move is to another area with different mental health services, it is easy to see how a cycle of readmissions can develop." (Lamont et al, 2000, p168).

2.5.6. Mental health and homelessness

“Far from random, homeless mobility in the 1990s was largely shaped by the geography of human service providers such as drop-in centers, shelters, and transitional housing. The destruction of many skid row districts notwithstanding, most homeless services are channeled to poorer, heterogeneous inner-city neighborhoods through opposition from wealthier, better organized communities” (DeVerteuil, 2004a, p393)

“[O]ver the past twenty years, structural factors have produced an imbalance between available low-income housing units and the demand for them, setting the stage for homelessness. Personal vulnerabilities have determined who, within this context of housing scarcity, becomes homeless (Sullivan et al, 2000, p444).

Individuals with mental health problems have been described as the most poignantly visible group swelling the ranks of the street homeless (Sullivan et al, 2000). It is not the intention here to review the extensive literature on the broader connections between mental health and homelessness (for an overview of which see Breakey, 2004; Fazel et al, 2008), rather it is to focus on the how residential mobility can be used to illuminate the complex interplay between the state and its policies and institutions, space, and the life circumstances of individuals with mental health problems. In their investigation of the connections between homelessness and mental illness among a sample population in New York, Hopper et al (1997) emphasised the importance of large statutory agencies in operating to prolong and/or deepen residential instability. They argued that, in addition to individual risk factors and broader structural, social, and environmental conditions, ‘homeless service systems’ and their ‘street-level bureaucrats’ played a pivotal role in shaping an ‘institutional circuit’ in which individuals would be increasingly directed to impromptu and inappropriate residential settings which, moreover, ensured their clients ongoing patterns of extreme residential instability as they churned through the system:

“[D]e facto ‘solutions’ to precarious housing – shelters and custodial facilities linked to haphazard chains of time-limited occupancy – should be

considered among the inertial forces that sustain homelessness among persons with severe mental illness" (Hopper et al, 1997, p659)

That institutions are neither neutral nor stand aloof from social outcomes but rather play an active role in sustaining homelessness amongst individuals with mental ill-health (as well as more generally) echoes the work of the political-economy approach to mental health geography. DeVerteuil (2003) demonstrates how the state, private and voluntary institutions involved in providing services and facilities for poor and disadvantaged populations (including the homeless and residentially unstable people with mental health problems) have since the 1980s become largely co-opted by macro policy imperatives which emphasise the management of scarce resources over the provision of assistance. This policy framework represents a deliberate strategy in which institutions and organisations formerly dedicated (at least ostensibly) to the amelioration of hardship must instead now manage, coerce, and occasionally mitigate the life circumstances of poor and potentially disruptive populations:

"This new poverty management is based on large-scale global and national dislocations ... Within the United States this shift has engendered a countercyclical retrenchment and devolution of the national welfare state, beginning in the 1970s and accelerating during the Reagan-Bush years. Under pressure to respond, institutions sought to minimize caseloads and costs, as well as to privatize services. The resulting fragmentation of service providers, lack of an explicit continuum of care, and expedient cutbacks encouraged the circulation and institutionalization of so-called 'disruptive' populations across a diverse array of unrelated, time-limited settings – including standard residential dwelling units, shelters, jails, prisons, hospitals, rehabilitation centers, single room occupancy (SRO) hotels, and the street" (p361).

Here, then, the response of the state to the challenges posed by individuals with severe mental health problems, the homeless and other marginal or 'difficult' populations, is to repeatedly shoehorn them into an ill-fitting and ill-equipped system, one that alternates between institutional control and community

indifference, and the outcome of which is at best the maintenance, and at worst the nourishment of the exclusion and alienation these groups must endure (Craig and Timms, 2000), a crucial point to bear in mind when considering the apparatus and operation of the various aspects of welfare reform outlined in the next chapter. Wilton (2003) and Mifflin and Wilton (2005) provide further evidence from case studies in Ontario. There, state and federal housing and welfare reform policies deepened the poverty of individuals with mental health problems and in so doing fatally undermined the efforts of *other* government policies aimed at enhancing the quality of individuals' lives and reduce the levels of stigma associated with mental illness. This should not be a surprise, however, as under the neo-liberal welfare orthodoxy promulgated in north America and the UK "welfare state restructuring is promoting the further defunding of the poor", including the withdrawal of benefit payments that help promote residential stability (DeVerteuil, 2005, p385). One of the implications of this system of crisis management is a form of hypermobility undertaken by homeless individuals with mental health problems as they circulate across spaces both public and private and are churned through institutional settings (DeVerteuil, 2003, 2004; Hopper et al, 1997; Knowles, 2000a). As outlined earlier, however, mobility *per se* is neither inherently positive nor negative. For people with mental health problems, the inclination of others is, understandably, to view these more frenetic forms of mobility as embodying the seemingly inevitable consequences of individuals' powerlessness in the face of much stronger forces. However, through a different lens it is possible to see aspects of hypermobility as representing the best opportunity to meet basic needs:

"[T]he tenacious, stressful, and sometimes ingenious, strategies for securing basic needs evolve into patterns of subsistence ... Given the extremely constrained residential opportunities of the very poor, a strategy of *voluntary mobility* may be indispensable in avoiding utter destitution and literal homelessness" (DeVerteuil, 2003, p363).

Thus mobility, as a self-determined response by individuals to particular daily circumstances, can be involve a modicum of agency on the part of individuals. Nevertheless, mobility as a *daily strategy* is unlikely to meet the *longer term* welfare needs of individuals (DeVerteuil, 2003). Instead, it contributes to "a

deepening sense of fragmentation and lack of belonging, adding further layers of distress. It is not that mobility itself inherently produces uncertainty and distress: like others, the mad treat global, national and urban pathways in making their lives as a sequence of places in time. But the *nature of the urban pathways that they tread and the purposes of survival* for which they tread them likely adds layers of stress, uncertainty and dislocation to already difficult lives" (Knowles, 2000a, p222). Within this figuring of mobility there are carefully constructed nuances relating to specific circumstances in which freewill could reasonably be said to be enacted, as opposed to those in which individuals choose mobility as the least worst option, or are left with no choice at all: "We can and must recognize the homeless as active agents. We must also document the multiple ways in which the state regulates them so extensively that their navigation of movement becomes a perpetual and often fraught challenge" (Herbert, 2010, p259). Precisely how mobility is figured depends both in large part upon whether it is seen as being undertaken voluntarily or is enforced. It must also be situated within the broader "constellation of power relations" inherent in all spatial practices (Gilbert, 1998, p596). The precise lines of demarcation in these power relations are unclear:

"Clearly, the relationships between mobility/immobility and power/powerlessness (i.e., mobile is to powerful as immobile is to powerless) do not operate in the same way for different groups in and across space-time. Although more power (e.g. gained from court rulings) might afford more mobility (e.g. citizens' inter-state migration), more mobility (e.g. homeless people forced to vacate public space) does not impart more power" (Jocoy and Del Casino, 2010, p1947).

So, while the hypermobility of individuals with mental health problems is part of a self-determined strategy that allows them to furnish their basic needs of survival, the ability to be mobile does not automatically endow them with greater power, not least because of the severe limitations placed on the exercise of individual agency under the iniquitous circumstances of the new poverty management framework (a framework which is increasingly reflected in welfare reform in the UK) :

“[T]his circulatory tendency is exacerbated by a critical lack of affordable housing and a revanchist urban realm. As a result, vulnerable groups such as the mentally disabled involuntarily cycle across unrelated (institutional) settings – victims of a ‘revolving door’ policy. Along the way they encounter a series of inadvertent, informal, and inappropriate institutional settings. For instance, many mentally disabled individuals find themselves in settings that offer no mental health treatment or services ... [a]s institutional cycling becomes a way of life, the mentally disabled become institutionally dependent, adapting to the rhythms of these settings” (DeVerteuil, 2003, p364).

This research reviewed here provides a crucial insight into the complex interaction between the exercise of mobility by individuals with mental health problems and the social relations under which this operates: “neither powerful/powerlessness nor placelessness/containment map cleanly onto dichotomies of mobility/immobility. In some cases, empowerment lies in increasing mobility, in others it lies in enabling settlement” (Jocoy and Del Casino, 2010, p1961).

2.5.7. Being housed, being homed: geographies of home

“Housing can be produced in multiples of units, but homes are made one at a time” (Ridgway et al, 1994, p408)

“Bricks and mortar resist intervention and permutation, as they accomplish a measure of stasis. And yet, buildings stabilise imperfectly” (Gieryn, 2002; quoted in Clapham, 2011, p365).

Jocoy and Del Casino’s use of the word ‘settlement’, quoted in the final paragraph of the preceding section, is important. It suggests a pause, an element of stasis, immobility; perhaps, eventually, a permanence. It implies the emplacement of a person into some form of stable, ordered, accommodation. Yet it can also be seen as indicating the possibility of something more significant than a person solely being housed. Being settled instead in a dwelling place, a home, as opposed to

mere accommodation. Thus, before concluding, this review will touch upon the geographical literature relating to the making of and experiences of 'home' for people with mental health problems. First, though, a brief caveat: there is insufficient scope within this review to cover that literature in which questions of mental health are touched upon but which is primarily focused on assessing the efficacy of various supportive housing programmes and initiatives that aim to ensure successful transitions from street homelessness to stable accommodation (for examples, see Hwang et al, 2001; Kreindler and Coodin, 2010; Pearson et al, 2009). Rather, the research project is interested in how mental health service users experience one particular aspect of housing: the question of (the) 'home'; what it is, how it comes about, how it is felt and experienced, and what implications it has for the study of mental health service users', their residential mobility, and their entanglements with the welfare state.

'Home' as a concept has become increasingly problematised in the geographical imagination. Building on earlier, humanistic geographies of landscape, place and placelessness (Buttimer, 1980; Relph, 1976, 1981, 1985; Tuan, 1979, 1980), and feminist critiques of the potentially exclusionary and fearful nature of the domestic sphere (Varley, 2008), cultural geography has been at the forefront of shaping the ways in which the discipline considers the home (Brickell, 2011). A multidimensional concept (Somerville, 1992), it is increasingly recognised as both 'material and imaginative' (Blunt and Dowling, 2006) and as structured by its relations with forces external to it but which nonetheless exert defining influences upon it (Massey, 1992). Far more than solely a place of residence, the home is viewed as "a material and affective space, shaped by everyday practices, lived experiences, social relations, memories and emotions" (Blunt, 2005, p506). It can be thought of as a 'mental state' (Duncan and Lambert, 2003), with 'psychosocial benefits' that a house alone is incapable of providing (Padgett, 2007), and which engender a sense of being at home that is about more than physical location and is better seen as "a verb rather than a noun" (Mallett, 2004). In this broad reading, then, home is much more than bricks and mortar and is formed, re-formed, negotiated and renegotiated/recreated in the interaction between the dwelling, its inhabitants and external social forces over time, interactions which "create complex and contradictory emotional geographies of residential space" (Smith,

2004, p91). As such, “the home is a vital space for understanding the micro-geographies of social and spatial uncertainty which influence, and are influenced by, wider structural forces of unhomeliness, alienation, and homelessness” (Brickell, 2012).

One key idea that has been used to explore the differences between a house and a home, that has looked at how a sense of a home is created in the intermingling between person and place, and how this sense differs between individuals, is that of ‘ontological security’. This concept, originating with Giddens (1991), refers to “the feeling of well-being that arises from a sense of constancy in one’s social and material environment which, in turn, provides a secure platform for identity development and self-actualisation” (Padgett, 2007, p1926). As with the politics of mobility delineated by Cresswell, the notion of ontological security is, in fact, a helpful conceptual frame through which to consider more generally the residentially and socio-economically insecure lives led by many mental health service users. Like ‘home’, the concept of ontological security is subjective to individuals and their particular circumstances, and is thus not entirely free of ‘conceptual fuzziness’ (Padgett, 2007) itself. Nonetheless, to generate feelings of ontological security a home would need: to impart a sense of steadiness, reliability and permanence; to be a space for the quotidian rhythms of everyday life; to provide a sense of control over one’s life (what Kearns et al, 2000, referred to as ‘freedom to’ and ‘freedom from’); and allow the formation of personal identities (Dupris and Thorns, 1998).

Thus, the concept of ontological security can help underpin investigations into the home and the role it plays in generating and sustaining individual wellbeing or, conversely, creating and maintaining ill-health and discontent. This is important because whilst “[h]uman beings spend more than 90% of their lives indoors ... we know much more about ambient environmental conditions and health than we do about the built environment and health” (Evans, 2003, p536). In the literature, the home is characterised in terms that find an echo in mental health geographies of the asylum. The home is a confined space, that attempts a separation (albeit partial and incomplete) of the private from the public, inside from out; it is spoken of as a haven, retreat, or refuge from social forces and psychological stressors

(Mallett, 2004; Ogden, 2014; Somerville, 1992), though in particular feminist readings of ‘home’ confinement operates rather differently, with the excluded other not necessarily being ‘out there’ but rather trapped within a space which can be “a privileged place for some but ... a site of fear and oppression for others” (Varley, 2008, p50). Nonetheless, for people with mental health problems, we may expect to find that the home plays a crucial role in their efforts to gain or sustain stable mental health. In Olin et al’s (2011) study, participants treated their homes as a sanctuary, a place of withdrawal, “characterised by a calm tempo” in which they could concentrate on activities and tasks that were of interest to them (p142). Unsurprisingly, they found among their participants “a desire to preserve the home as a safe area in an unsafe world” (p141). Similarly, Alaazi et al (2015) in Canada, Bretherton and Pleace (2015) in England, Marcheschi et al (2015) in Sweden, Padgett (2007) and Smith et al (2015) in the United States all reported that home environments typified by markers of ontological security such as stability, safety, ownership of space, self-control, and privacy, aided more positive health outcomes for mental health service users: “People feel better and have better mental health when they can control their surroundings. When opportunities for control over the environment are thwarted, helplessness can occur” (Evans, 2003, p544). Nonetheless, an ontologically secure home does not in and of itself offer sufficient foundations for a meaningfully rewarding existence. As Padgett (2007, p1934) reminds us, “just as a house (or apartment) does not make a home, a home does not make a life”, with – in the context of the present study - other factors including the degree of dependence upon welfare services generally, and individual financial benefits in particular, of crucial importance in the sustaining ontological security: a point to which this thesis will return to later.

2.6. Conclusion

This review has brought together an array of scholarship and presented it under the designation ‘mental health geographies’. The diversity of both the literature, and the disciplinary fields from which it emerged, required an attempt to organise it coherently. This was done not by theme but rather by what I have termed eras, in which I argued that distinct theoretical and methodological underpinnings could be

discerned. I now briefly summarise each of these eras and the major insights they have provided. I then turn to examine where gaps might emerge from this extensive literature and how the present research study can contribute to scholarly understanding in each of these areas.

2.6.1. The three eras of mental health geography

Quantitative mental health geographies have furnished ample evidence of the disproportionate concentration of mental ill-health in inner urban areas, and theorised on the likely processes that explained it. Particularly helpful to the present study is the emphasis on 'drift' as an explanatory factor. I shall return to this below. By concentrating on economic urban restructuring and the response of the state, and specifically the policies of deinstitutionalisation and welfare retrenchment, the 'political-economy' era deepened our understanding of the reasons behind the continuing spatially-skewed distribution of mental ill-health toward the inner cities. Equally important, it sought to highlight the human and social implications for those at the sharp end of these processes. The qualitative era, by focusing on the socially constructed nature of 'madness', and turning the disciplinary lens downwards in scale, helped in effect to put a human face onto the previous omnipresent 'mental patient' and, crucially, elevate individualised understandings of mental illness to the same level of validity as more medicalised formulations. These three eras formed parts 1 to 3 of the review. Part 4 was concerned with *mobility*, both as a variable for understanding mental ill-health and its spatial distribution, and as theoretical device with which to open up existing mental health geographies and those under consideration in the current study.

2.6.2. The foundations for the present study

There are two main absences in the literature reviewed here. Together they form the basis for this study. First, while we often know *how* people with mental health problems have been residentially mobile we often don't know *why*. This is because missing from the literature are qualitative investigations that probe more deeply residential mobility as it is felt and understood by individuals with severe and

enduring mental health problems, and which account for how they relate their experiences of (im)mobility to their mental health. Second, figuring movement as mobility is important because it helps to set that movement within the prevailing socio-economic and policy context in which it is occurring. Substantial policy changes in the field of public welfare are afoot and these have potentially significant implications for the mobility of people with mental health problems, not least of which is the threat of enforced residential moves that would see people lose not only their homes but also the carefully calibrated strategies for seeking and maintaining varying degrees of wellness that increasingly occur in and around these homes. In other words, their senses of ontological security are potentially at risk. Potential compulsory relocations are an inherent consequence of alterations not just to housing benefits but also of cuts and changes to out-of-work and disability benefits, the overall effect of which would be to loosen the safety net which collectively they provide and which helps sustain the mental health of service users more cost effectively than would prolonged stays in hospital or the kinds of odysseys through the plethora of residential settings that have been noted here. Thus, while evidence is beginning to emerge from ongoing studies into the broader impacts on health (including mental health) of changes to out of work and disability benefits there has been no consideration to date of the likely impact of these and other individual elements of the UK welfare reform package on the residential mobility of mental health service users or on their ontological security.

The primary themes taken from each of the four parts of the review – the concentration of mental ill-health in the inner city; the impact of neo-liberal economic and welfare restructuring; the experience of living with mental health problems; mobility as a politically laden concept involving elements of emplacement, entrapment and displacement – are thus the foundations upon which the present study seeks to build. Each of these are key to both the research framework for the present study, and the broader context in which it is to take place: first, the largely urban setting of the fieldwork; second, the latest round of welfare restructuring being unleashed across the UK; third, the impact of these reforms on the residential mobility of people with mental health problems, and what the implications may be for their sense of ontological security; and fourth, how people understand, experience and relate these mobilities.

This study is based on a desire to fill in these gaps by developing a deeper understanding of the ways in which external forces – such as the operation of the welfare and benefits system within the prevailing policy context of its reform – and personal motivations based on individual attributes and experiences over the lifecourse operate jointly to determine residential mobility. What has led to a person moving or, conversely, staying put? How many moves have been involved? Where have they led people to and from? How and why did mobility come to an end? How were they experienced? What feelings are entwined with each of these scenarios? Are these feelings embedded in place? The factors identified by Vega et al (1987) as being central to an understanding of the mental health implications of migration – the reasons behind the migration, the emotion it engenders, and the ease or difficulty involved in its undertaking – signpost a way into these questions. They are also analogous to three of Cresswell's six elements of the politics of mobility detailed earlier – namely *force*, *feeling* and *friction*; these, and the remaining three – *velocity*, *rhythm* and *route* – offer a framework for analysis that this study will use in subsequent empirical chapters to help elucidate how people with mental health problems themselves understand their own mobility and which also allows for an engagement with the more theoretical concepts of hypermobility, emplacement, entrapment and displacement that have been drawn out in the literature. The 'markers' of ontological security – permanence, control, routines and identity – can similarly be used as a basis upon which to analyse and interpret 'home' and to consider the ways in which this theme can deepen an understanding of experiences of (im)mobility.

Despite their differences in approach, each 'era' of mental health geography *has* recognised mental ill-health as creating unique challenges for the individuals experiencing it, and sought either indirectly or latterly via more activist-orientated research to emphasise the grim reality that too often "individuals with mental health problems seem destined to continue to experience socio/spatial 'exclusion', they will continue to have their human rights denied, and they will continue to suffer from a lack of political capital and economic freedom" (Smith, 2009, p69).

This review has tried to demonstrate that there is still far to go to 'get to the bottom' of the geography of mental health; a task made more complicated by the fundamental welfare reforms being enacted in the UK, the analysis of which forms the next chapter of this thesis.

Chapter 3. Cut adrift? Mental health service users and the receding welfare state

“[D]ominant understandings of poverty and under/unemployment have been reformulated in terms of ‘welfare dependency’, low motivation, and inadequate ‘employability’ ... In a world of flexible job markets, it is argued, all those who can work must work, active work/welfare policies removing the option of a ‘life on benefits’” (Peck and Theodore, 2001, p431)

“Of course in the most severe cases of sickness and disability it is right that welfare should support them, but even then, it must be about more than sustainment alone. It should be about helping people to take greater control over their lives” (Work and Pensions Secretary, Iain Duncan Smith, 2014)

“Whilst the economic and political dimensions of the [financial] crisis have been the focus of considerable academic and media coverage, the human costs of the austerity measures have received less attention” (Pearce, 2013, p2031)

3.1. Introduction

This chapter aims to set the strands of the research agenda identified in the preceding chapter – the housing histories and residential mobility patterns of mental health service users - against the unfurling background of the reforms to the welfare state being promulgated by this and previous governments. These reforms carry with them profound and potentially disturbing implications for all working-age individuals who rely wholly or in part on social security benefits to meet their basic needs (Hamnett, 2011). Yet the changes, and the manner and rhetoric of their introduction, present particularly acute challenges for people with mental health problems, who are more likely to be unemployed than the general population (Boardman and Rinaldi, 2013), are thus disproportionately reliant on a number of interlinked welfare benefits and services for support, and who have, as the previous chapter makes clear, so often been on the sharp end of fundamental policy shifts. In fact, both the intended and unintended outcomes of broad macro

policy is crucial in understanding where mental health service users find themselves: from asylums via deinstitutionalised living amongst a steadily decreasing level of social support, attempts to re-impose control upon those being cared for in the community, to the present landscape of welfare reform and the possible withdrawal or shrinkage of the benefits upon which many rely. Thus, the residential mobility of mental health service users has all too frequently been dependent upon the policies and programmes of the state and its agencies. Currently, the policies most likely to impact residential mobility are to be found in the field of welfare. Here, restrictions on entitlement (including reassessments for ongoing entitlement) to sickness and disability benefits, a focus on 'work-led' recovery, and fundamental changes to the system of housing support for low-income people, presage both a fundamental overhaul of the welfare state and a recasting of its relationship with those most reliant upon it.

Hence, policy matters, and to understand why the likely impacts on people with mental health problems are potentially so significant, one must necessarily consider both the *official* policy objectives of the reform programme and the less formal but nonetheless crucial *political and ideological* background to it. Bringing these two together shows how and why officially stated policy intentions can go awry when it comes to the practical matters of implementation and operation. Against a background of austerity, and given the political controversy surrounding the reforms, this divergence is in large part a consequence of the excessive rhetorical fanfare that accompanied their formulation and introduction. And it is in this divergence that one can begin to see why these reforms have been viewed with suspicion and alarm by service users, welfare rights' advocates, and academic commentators alike.

Accordingly, this chapter begins by setting out the official reasoning for reform. This is followed by an attempt to establish the political context of the reforms in which the stated policy intentions must be balanced against the prevailing political context in which they were to occur. An overview of the changes to the key planks of the benefits system is then provided, before narrowing the focus to what the emerging consequences of the reform might be for people with mental health problems.

3.2. Contemporary UK welfare reform

The planned reforms to the welfare state by the current Conservative and previous coalition government have been cast as “perhaps the most radical reshaping of the British Welfare system since its introduction post-1945” (Hamnett, 2011, p147). The full complement of changes – to unemployment, sickness, disability and housing benefits – are ongoing and, recent 2016 setbacks aside, the broad thrust of the reforms have enjoyed widespread media and Parliamentary support (or perhaps acquiescence), with public attitudes toward welfare spending also appearing to have both hardened behind the ‘need’ for reform and to have become more jaundiced about the deservingness (or otherwise) of current welfare recipients (British Social Attitude Surveys, 2012, 2015). Previous attempts by all UK governments since 1979 at ‘welfare retrenchment’ have been a mixed bag, not least because attempts to break away from a ‘Fordist’ welfare state can prove politically perilous and difficult to justify in times of economic expansion; as Kemp (2000) presciently observed, however, “it is presentationally easier for governments to push through cuts during periods of fiscal austerity than when public spending is in surplus” (p267). Thus, the government has justified its ‘radical’ reform on the grounds of both economic urgency and the principles of social justice:

“A benefits system has shaped the poorest in a way that has trapped generation after generation in a spiral of dependency and poverty. This has cost the country billions of pounds in cash payments and billions more in meeting the social costs of failure” (Iain Duncan Smith, 2010a)

The above quote from the then Work and Pensions Secretary gives a fair summary of the thinking that encapsulates the government’s view of its welfare reform policies and proposals, couched as it is in terms of fairness (concern for those reliant upon the welfare state) and affordability (indefensible burden to the public purse). This particular formulation for explaining and justifying the need for reform is echoed through all of the key government publications and statements outlining and accompanying welfare reform(i.e. Duncan Smith, 2010a, 2010b;

DWP, 2010, 2015). These can be broadly summarised as follows, illustrated with examples from these sources.

1. There exist a significant number of working-age individuals who with additional support and encouragement could be working but are instead unemployed and reliant on out-of-work and other costly benefits:

- *“Today, five million people are on out-of-work benefits in the UK, and 1.4 million of them have been receiving out-of-work benefits for nine out of the last ten years ... we have one of the highest rates of workless households in Europe” (Duncan Smith, 2010b)*
- *“[T]oo much of our current system is geared toward maintaining people on benefits rather than helping them to flourish in work” (Duncan Smith, 2010b)*

2. This is problematic. By creating dependency upon benefits, the welfare system operates to entrap people into, rather than deliver them from, poverty:

- *“[W]e need reform that tackles the underlying problem of welfare dependency” (DWP, 2010)*
- *“[W]elfare dependency took root in communities up and down the country, breeding hopelessness and intergenerational poverty” (Iain Duncan Smith, 2010b)*

3. This is neither fair to those so entrapped nor to those in work who prop up the welfare state through taxation. As such, the welfare state in its current form represents a colossal policy failure, the costs of which are morally and financially insupportable:

- *“The welfare bill has become unsustainably expensive, but the real price of this failure has been paid by the poorest and the most vulnerable themselves” (DWP, 2010)*

4. Such a situation cannot be tolerated and, indeed, the ongoing fallout from the global financial crisis demand not further tinkering with a broken system (as pursued by previous governments, Labour and Conservative alike) but a wholesale reform:

- *“Successive governments have ignored the need for fundamental welfare reform, not because they didn’t think that reform was needed but because they thought it too difficult to achieve. Instead of grasping that nettle, they watched as economic growth bypassed the worst off” (Duncan Smith, 2010b)*
- *“With five million people trapped on out of work benefits and almost two million children growing up in households where nobody works... Only root and branch reform will do” (Duncan Smith, 2010a)*

5. This reform is necessary to rescue people from the poverty into which so many are entombed, and to ensure that the truly needy are appropriately cared for and looked after:

- *“The changes to the welfare system [include] a new ‘claimant commitment’ showing clearly what is expected of claimants whilst giving protection to those in greatest need” (DWP, 2015)*
- *“There are insufficient incentives to encourage people on benefits to start paid work” (DWP, 2015)*

6. This is not, however, a one way street: just as people are right to look to the state to help them in times of need and when in great distress, the state has an obligation to expect people to also work to relieve themselves of the poverty in which so many have so sadly fallen:

- “*In the coalition agreement we announced our intention to simplify the benefit system to encourage people to move into work and make sure that those able to work must show a willingness to work as a condition of receiving benefits*” (DWP, 2015)

These excerpts show the overarching principles upon which the welfare reforms are based and which have guided the changes that have been made to particular welfare benefits. The specific alterations to those benefits that are of greatest significance to mental health service users – namely out-of-work sickness, disability, and housing benefits – are reviewed in detail later in this chapter.

Despite the government’s attempts to offer reassurance over its intentions, the reform proposals have fuelled great alarm among mental health, disability and welfare rights’ campaigners (and the political left more broadly), and the philosophy, reasoning and evidence upon which they are based has been subject to a volley of academic critique (Bambra and Smith, 2010; Grover and Piggot, 2010; Hamnett, 2011; Houston and Lindsay, 2010; Lindsay and Houston, 2011; Patrick, 2011a, 2011b, 2014; Pearce, 2013; Roulstone, 2011, 2015; Schrecker and Bambra, 2015; Slater, 2014; Wiggan, 2012; Wright, 2012; for a contrary view see Mead, 2011, and his fore-runners, Himmelfarb, 1995; Murray, 1984, 1994). The arguments advanced by these critics, which are overwhelmingly reflected in the literature surrounding welfare reform and which are echoed by experts both inside and outside of academia, are examined in the following section.

3.3. Ideological underpinnings?

“[T]he existence of substantial evidence calling into question punitive welfare reforms raises the question of how successive governments, especially the current UK Coalition, deliberately set aside that evidence ... it seems prudent to expose and scrutinize the institutional ignorance that lies at its core; an ignorance that is not one of blissful unawareness, but rather of rational calculation” (Slater, 2014, p13).

“ROY: Un-ethical. Are you trying to embarrass me in front of my friend?

JOE: Well, it is unethical, I can't ...

ROY: Boy, you really are something. What the fuck do you think this is, Sunday School?

JOE: No, but Roy this is ...

ROY: This is ... gastric juices churning, this is enzymes and acids, this is intestinal is what this is, bowel movement and blood-red meat – this stinks, this is politics, Joe”

(Kushner, 1995, ‘Angels in America’).

Academic analyses of the post-2010 welfare changes - and their antecedents under the previous Labour governments upon which a great number of Coalition welfare policies were built – have tended to focus on what they perceive to be the ideological and political imperatives driving the policy and its presentation, it having been largely too early to make any meaningful and rigorous evaluation of their longer term outcomes (that evidence which exists in relation both to the implementation of reform, and its early impacts, is considered later in section 3.4., which analyses the detailed changes to individual benefits).

Critics of welfare reform argue that hovering in the background, discernable behind the haze of official policy justifications, is a less *publicly* pressing though by no means politically unimportant ideological desire to significantly and perhaps irrevocably squeeze the size and *role* of the state in some areas (Roulstone, 2011), whilst in others facilitating an expansion of its more punitive elements (Slater, 2014; Wacquant, 2009). They suggest this is part of a wider neo-liberal

discourse to both shrink welfare state and tilt it away from universal provision and toward greater conditionality (Patrick, 2014; Pearce, 2013; Peck, 2001; Peck and Theodore, 2001; Peck and Tickell, 2002; Schrecker and Bambra, 2015). As a result, they perceive “a deep and targeted form of austerity that the Coalition chose to adopt, targeting a large proportion of the cuts on the poorest in society” (Gibb, 2015, p155), and see a politically motivated and regressive policy shift, one cloaked in the mantra of responsibility, fairness and affordability, but one in which different social groups, with differing relationships to the welfare state, are rhetorically lumped together as unacceptably reliant upon its supposed munificence.

From these analyses, several interlinked themes emerge - summarised below - and it is apparent how potentially problematic the impacts of the second and third could be for mental health service users:

1. The welfare state as financially and morally unmaintainable.
2. The rescaling of social problems to the individual level through a discourse of ‘rights and responsibilities’.
3. The repositioning of the benefits system to spur entry into employment.
4. Increasing conditionality within the payment of welfare benefits.
5. The marketisation of the operation of the welfare system, and the contracting out of services to the private and not for profit sectors.

Several papers (i.e. Patrick, 2011a, 2011b, 2014; Roulstone, 2011; Schrecker and Bambra, 2015; Wiggan, 2012) take as their starting point the need to weave a particular – and neo-liberal infused - narrative of the welfare system in order to justify reform proposals as the only sensible and affordable alternative to an unsustainable status quo: a position some scholars (i.e. Peck, 2006, p682) have satirised as neo-liberal policy elites presenting themselves as the “lonely voices of reason ... principled outsiders in a corrupt, distracted, and wrongheaded world”. Thus, the welfare state is, through rhetorical if not necessarily official channels, represented as a broken, bureaucratic, fiendishly complex and ruinously expensive system that sustains worklessness and dependency, and which has entrenched rather than alleviated poverty and social exclusion. Whether, in fact,

the picture painted of the welfare system is correct is, it is suggested, secondary to the need to validate its shrinkage (Wright, 2012). Nor, these critics argue, is there sufficient evidence that the policy prescriptives of the government are either necessary or likely to succeed (Bambra and Smith, 2010; Hamnett, 2011; Houston and Lindsay, 2010; Lindsay and Houston, 2011; Roulstone, 2011; Slater, 2014; Wright, 2012). Indeed, for the neo-liberal agenda, it is claimed, failure is not seen as evidence of having administered the wrong medicine but rather of having used an insufficient dosage (Peck and Theodore, 2001). From the perspective of critics, this narrative appears to be sustained in part by the rough and tumble of political rhetoric that targets its message carefully to particular audiences. Thus, those out of work and claiming their social security entitlements appear from various announcements to have been depicted as feckless and work-shy, as perhaps lacking sufficient levels of personal responsibility and have sadly become dependent on state handouts. Alternatively, they can be represented as victims ensnared in a culture that rewards dependency and punishes hard work. Either way, the reform programme is argued by critics to represent a determined attempt to individualise social problems (Lindsay and Houston, 2011), to tactically ignore the persistent evidence of the umbilical cord between structural inequality and poverty (Slater, 2014) and the systemic barriers to regular employment for people with mental health problems, and to ensure that “the problem of poverty and unemployment is transformed from evidence of market failure and income inadequacy under neo-liberal hegemony to one of state and person failure” (Wigan, 2012, p401).

This rescaling of social problems to the individual level is argued to be a necessary condition in order to decisively shift the state-citizen relationship from Fordist welfare capitalism to post-Fordist workfare capitalism (Bambra and Smith, 2010), and people with mental health problems reliant upon benefits are part of the collateral damage of this process. Central to this shift is the rhetorical and practical elevation of the moral value of paid work, the possession of which demarcates the responsible citizen (Patrick, 2014). No longer shall the state provide universal benefits on the basis of need to passive recipients. Instead, the system will be re-orientated “around the idea that benefits and services for people of working age need to be more focused on re-connecting claimants with the labour market,

through encouraging and compelling claimants to be ‘active’ in seeking employment” (Houston and Lindsay, 2010, p133). Closely aligned is the intention to marketise welfare to work programmes “as an antidote to an unresponsive, bureaucratic welfare state that stifled choice and community initiative” (Milligan and Fyfe, 2006, p33). This transference of responsibility to non-state contractors in the private and not-for-profit sectors – considered not just more efficient but more likely to ensure activation by claimants than state agencies such as JobCentrePlus and who will be offered financial reward for each successful removal of an individual from the benefits register into short-term employment (Wright, 2012) – represents yet further evidence of the creeping ‘shadow state’ (Macmillan and Townsend, 2006; Milligan and Conradson, 2006; Wolch, 1990) in which cash-strapped welfare authorities are shorn of responsibilities for the direct provision of services with the burden being lumped onto the supposedly cheaper and more flexible for- and not-for profit sectors.

Whatever the formulation used to promote the reforms – individual responsibility or incompetent victims - the brave new world of welfare promised by successive governments appears on the evidence thus far to offer scant comfort to the majority of current and future claimants³. The next section of this chapter suggests why. It surveys the impacts of the reform on three of the main planks of the welfare system - out of work sickness benefits, disability benefits, and housing benefits – probes the implications for people with mental health problems, and sets these against the official objectives of reform and the fears expressed by its critics.

³ The counter argument that could be advanced here is that a minority of those in long-term receipt of benefits, and whose ‘disabilities’ are relatively minor, could potentially benefit from the attempts at workplace ‘normalisation’ that are implied in the welfare reform policy rhetoric. It is my contention, however, that for the individuals under study in the current research project, few such positive outcomes are likely to be forthcoming, in the short term at least.

3.4. Individual benefit changes

3.4.1. Out of work sickness benefits: from Incapacity Benefit to Employment Support Allowance

Introduction to the Government's changes

“A central part of the Government’s plans to reform the Welfare State involves the first action for decades to tackle incapacity benefit dependency in many of our communities. In total more than 2.2 million people in Britain today are on incapacity benefits. Many of them have been abandoned, with little or no contact from the welfare state for as long as a decade or more. This represents a massive waste of the potential of a huge number of our fellow citizens” (Chris Grayling, employment minister, 2010)

Incapacity Benefit (IB) was the primary income substitute for those for whom long-term illness or disability prevented their participation in the labour market, eligibility for which was ordinarily determined by the claimant’s GP certifying them as being ‘unfit to work’. IB has something of a checkered history, with substantial increases in the number of claimants mirroring both the geography and temporality of large-scale industrial and manufacturing decline during the 1980s (Beatty and Fothergill, 2005): indeed, it has long been the suspicion that the Conservative governments of the 1980s may have deliberately allowed the IB claimant count to rise as a way of keeping the then politically more sensitive unemployment numbers down - allowing people to be ‘signed off’ as opposed to allowing them to ‘sign on’. Notwithstanding the irony of the political misuses to which it may previously have been put, and despite its whiff of paternalism (‘incapacity’), IB did nonetheless seek to front-load individuals’ (ill) health as the dominant factor in the assessment of entitlement - what we might now think of as a ‘health first’ approach and one which sought to balance questions of health as well as unemployment (Warren et al, 2013).

Given this history, however, recent governments came to accept that IB represented, in part, hidden unemployment as well as ill-health. Accordingly, they set out to determine whether the criteria for assessing both initial and ongoing

eligibility to IB (which was unconditional, higher paying, and largely non-means tested compared to Jobseeker's Allowance) were sufficiently rigorous to distinguish long-term and substantive *ill-health* from long-term and substantive *unemployment*. As a consequence, from 2003, the then Labour government introduced a series of 'activation' changes that required claimants to engage with new welfare to work policies aimed at smoothing the transition from long-term dependence on out-of-work sickness benefits towards employment. This process culminated in 2008 with the abolition of IB for new claimants and the introduction of its replacement, Employment Support Allowance (ESA) (Houston and Lyndsay, 2010). Included in its introduction was the requirement for all existing IB claimants to in future be reassessed for eligibility for the new benefit, the primary mechanism for which was the Work Capability Assessment (WCA) in which claimants were evaluated on their capability for either immediate participation in the labour market or for work related activities in preparation for future participation. The assessment assigned individuals to three groups: first, those who were found fit to work and could thus be transferred onto Job Seeker's Allowance (JSA); second, those judged capable of some work in the near future, subject to appropriate support and assistance, and who could be allocated to a work-related activity group; and third, those found unlikely ever to be able to work because of ill-health or disability, and who would be assigned into a 'support group'. Though inherited from the preceding Labour government, the WCA was presented by the coalition government as a crucial tool for both its immediate policy objectives in respect of the imminent reassessment of all existing IB claimants, and its wider ambitions for the welfare state:

"Work is good for people's health and well-being and is the best route out of poverty for most people. But all too often previous benefit regimes have consigned people to inactivity and written people off from the labour market despite evidence that many want to work. The Work Capability Assessment seeks to change this. It aims to identify accurately what people can do, rather than write people off due to their impairment. It is right that we should focus on what people can do, not what they cannot, and in doing so shift the culture of enforced State dependency to one of dignity and inclusion.

The WCA is the right test for the future and we are determined to ensure it is fair for individuals and fair for the taxpayer" (Duncan Smith, 2010c)

Critical perspectives

Critics of the reforms, however, noticed a continued rhetorical slipperiness at work, particularly over the extent to which the official policy imperatives governing the reassessment process – concern for those impoverished and immiserated by the operation of the welfare system – were subject to countervailing oratorical interventions - “[Welfare reform] will create a new world for benefit claimants. No more sitting at home doing nothing. No more excuses about it all being too difficult”, (Chris Grayling, 2010, quoted in Patrick, 2011, p5) - which appeared, to some observers at least, to prejudge the legitimacy of the ill-health of those who were to be so assessed:

“Clearly, that people have long-standing, unchanging ill-health should not be in question. The reframing of what constitutes capacity or incapacity for work calls into question whether claimants are therefore incapable of any work or work-related activity. Although being assessed as having partial capacity for work does not necessarily equate to being told that your illness is ‘fake’, government rhetoric and ensuing media coverage has led sickness benefit recipients placed in this position to perceive this latter message – a message which is having important impacts on the daily lives of long term sickness recipients by generating feelings of shame, stigma and isolation”
(Garthwaite et al, 2014, p326)

Opponents of the reforms were not, however, obliged to rely solely on the trickiness of political language in order to make their arguments. Despite pilot testing, the roll-out of the WCA reassessment process proved far from smooth, becoming rapidly bogged down in political and administrative controversy (House of Commons, 2011). Condemned by academics on grounds of flawed design and incompetent execution (Warren et al, 2014), the WCA was faulted for relying on a narrowly drawn medical model of disability that critics (correctly, in the end) argued was too rigid to capture the complexities of mutable mental health conditions

(Grover and Piggott, 2010; Patrick, 2011a, 2011b), and for the fact that 40% of the initial 'fit to work' judgments made by the private health companies that undertook the assessments were subsequently overturned on appeal (Lindsay and Houston, 2011). Indeed the workings of the WCA – introduced with no apparent assessment of its likely impact on mental health and with no plan to evaluate its overall effectiveness (Barr et al, 2015b) - became further dogged by controversy, and its critics emboldened, when the statutory annual independent reviews that would accompany its first five years of operation repeatedly cited its overly-mechanistic medical assessments and poor decision-making (Lindsay and Houston, 2011; Warren et al, 2014).

Early evidence and implications for research

In considering the report of the first annual review of the WCA, the House of Commons DWP Select Committee, in addition to emphasising its own distaste for some of the language surrounding both welfare reform and benefit claimants, found the WCA to be flawed, evidenced by:

- the high level of appeals and the high success rate for appellants
- the rapid rate at which individuals were put forward for repeat assessments
- the difficulty the assessment tools appeared to have in capturing mutable conditions, particularly mental health ones
- the volume of grievances expressed by those who had been assessed over how they had been treated during the process and about the accuracy of the outcome
- the failure of the private healthcare provider contracted to undertake the assessments to meet the standards expected of it, and
- the widespread distrust in which the reassessment system was held

(House of Commons, 2011).

The implications of the Committee's findings on experiences of the transition from IB to ESA, particularly for people with mental health problems, appear dispiriting, and are beginning to be reflected in the emerging evidence base, both academic, and anecdotally from experts in the field. Research has, for example, explored the

uncertainty and anxiety involved in awaiting an assessment, undergoing it, awaiting the outcome, potentially appealing the decision and then awaiting the outcome of the appeal: what Garthwaite (2014) in her research has referred to as the ‘fear of the brown envelope’. A merry-go-round system such as this might reasonably be expected to place significant pressure on those who may be least well placed to bear it. Indeed, as early anecdotal evidence (Farmer et al, 2011; MIND, 2011, Williams, 2012) suggested, and more recent academic research has begun to confirm (Garthwaite, 2014), in addition to a general increase in stigma and hostility, levels of anxiety, depression and suicidal ideation had all risen as a consequence of facing the WCA assessment (Barr et al, 2015), with perhaps the most alarming finding from this latter study being that the WCA is independently associated with an increase in suicides, self reported mental health problems, and the prescribing of anti-depressants.

The emerging picture certainly appears unsettling, and yet reforms to disability and housing benefits portend further change. The next section looks at the accompanying reforms to Disability Living Allowance, where the implications for people with mental health problems are similarly viewed by many experts as equally unwelcome.

3.4.2. Disability benefits

Introduction to the Government’s changes

“Personal Independence Payment will maintain the key principles of DLA, providing cash support to help overcome the barriers which prevent disabled people from participating fully in everyday life, but it will be delivered in a fairer, more consistent and sustainable manner. It is only right that support should be targeted at those disabled people who face the greatest challenges to leading independent lives. This reform will enable that support, along with a clearer, more straightforward assessment process. Personal Independence Payment will also be a more dynamic benefit – it will take account of changes in individual circumstances and the impact of disabilities, as well as wider changes in society,

such as social attitudes and equality legislation" (Maria Miller, minister for disabled people, 2010)

Disability Living Allowance (DLA) was a financial contribution towards the costs associated with disabled peoples' care and/or mobility needs and was intended to assist them to live as independent a life as possible. It was supplementary to other benefits - or indeed to earned income - and in 2011 was being received by 3.2m claimants, 500,000 of whom were doing so on grounds of mental ill health. The previous coalition government announced in 2010 its intention to replace DLA with a new payment entitled Personal Independence Payment (PIP). Like IB/ESA, the government promoted its reforms as being founded on the principles of fairness and sustainability. The expressed intention of the policy changes being to introduce greater rigor into the payment system, to ensure that the benefit is appropriately targeted to the most needy, is being applied in ways that maximised the opportunities for independent living for recipients, and which takes into account the changing nature of disabilities over time (DWP, 2010b). Again, as with IB/ESA, the concept of independence being applied here is closely aligned with the idea of paid employment being as important as state support in the alleviation of dependency and poverty. As the Minister noted,

"Just as we are committed to providing unconditional support to those who are unable to work, we know that work is the best form of welfare for those who are able to do so. That's why I want as many disabled people as possible to benefit from employment – it is not acceptable for anyone to be trapped in a cycle of dependency. By giving people the right level of support through Personal Independence Payment, I hope that many more disabled people will be able to work and enjoy the advantages that an active working life can bring" (Miller, 2010)

PIP was to be introduced for new claimants from 2013, with existing DLA claimants subject to an ongoing process of reassessment. This was to be conducted by Atos, the company similarly contracted to undertake the Work

Capability Assessment, with the government explaining the requirement for reassessment of existing claimants on the following grounds:

- The conditions for which people have been awarded DLA change over time, often imperceptibly
- Yet there is no process to systematically check that the awarding of the benefit remains correct
- DLA offers too many automatic entitlements
- The consequence is a system that rising caseloads and expenditure have rendered unsustainable
- Thus DLA is confusing, complex and poorly understood
- Reassessment of all recipients, with periodic reviews thereafter, will rationalise the system, make it more efficient, and better targeted to those who have greatest need and will gain the maximum benefit

(DWP, 2010b)

Critical perspectives

“Disabled people were often assumed to be deserving in a blanket sense, once they met certain eligibility criteria. Contestation and public outcry over faux-disability were very rare in the period of welfare state growth until the late 1990s”
(Roulstone, 2015, p677)

Critics have noted that the change to PIP was expected to save the Exchequer 20% of the cost (estimated at £12.6bn in 2012) of DLA by 2015-16 - a cut which has been described as being both ‘arbitrary’ (Patrick, 2011a) and unaccounted for and uncosted (Curtis, 2012). To opponents, the Government’s justifications for changing to the new payment involve similar - though perhaps more muddied and less aggressively rhetorical - arguments than those invoked to justify the removal of IB. In particular, they express surprise at the Government’s contention that the formal lack of reassessment under the DLA framework ensures that individuals who make sufficient recoveries from, or adaptions to, their disablement or impairment, continue to receive DLA that they may no longer require, noting that “DLA is generally claimed by those with more obvious and enduring impairments. All DLA claimants have already been assessed as eligible for the benefit”,

suggesting instead that the change “is clearly an attempt to review the threshold for support and the development is clearly premised on the view that access to DLA has been too generous” (Roulstone, 2011, p11). Indeed, in 2012 the Government was claiming to have identified £600m in annual ‘overpayments’ to recipients of DLA whose condition had changed sufficiently that they no longer qualified – though a comprehensive newspaper analysis by Curtis (2012) reported that the supposed overpayments were no such thing and in fact the DWP had, if anything, *underpaid* the benefit. As such, “[t]he evidence that disabled people are too well off or that disability, sickness and extra costs are now less heavily correlated is without foundation” (Roulstone, 2015, 678).

Academic critics also perceive two rhetorical sleights of hand. First, they claim to have detected an attempt to elide DLA with IB/ESA, whereby DLA is subtly misrepresented as an *out of work* benefit rather than the supplement to other income (from benefit or paid employment) that it actually is (Patrick, 2011a; Roulstone, 2011); this, they allege, has helped to fuel the “drip feed of negative media stories … [that] cast doubt on their deservingness of state support (Patrick, 2011a, p15). They note one potential consequence as being the absurdity that existing DLA claimants who currently work and who are reassessed as ineligible for PIP could risk losing the very payment that enables them to stay employed in the first place (Patrick, 2014). Mental health charities have also emphasised the importance of the preventative role that DLA plays in relation to mental ill-health: that is, being in receipt of supplementary financial income can in and of itself help sustain better mental health status (Centre for Mental Health et al, 2010). This small ‘cushion’ representing, in Patrick’s (2014) study, the difference between those who could just about cope financially, and those who could not. Second, detractors see the yoking together of the spirited language of the disability rights movement (‘independence’) with an intensely medicalised category of disability: “The borrowing of the word independence, a key word in the lexicon of the disabled people’s movement alongside an obvious effort to narrow eligibility and counterintuitive decisions as to just who is disabled seem clear evidence of an attempt to shrink the disability category in the absence of robust evidence” (Roulstone, 2015, p684).

Early evidence and implications for research

As with IB, (re)assessments for eligibility were to be carried by Atos. Long delays and backlogs in assessing new applicants meant that the commencement of reassessments of existing DLA claimants had been put back to late 2015 and thus the academic evidence base for the operation of DLA – PIP migration is slim, though anecdotal evidence provides plenty of stories of fear, anxiety, cuts to income and a reduction in both personal independence and the loss of existing employment (Guardian, 2016; McVeigh, 2016; Ryan, 2016a, 2016b). The widespread concerns being voiced over the changes to disability benefits appeared to be partially vindicated when, in the spring of 2016, the furore surrounding the resignation from the government of the Work and Pensions Secretary Iain Duncan Smith over his refusal to implement what he claimed to be unreasonable demands from the Treasury for additional cuts to disability benefits, lead to a reappraisal of parts of the reassessment programme and a (temporary) shelving of any further reductions in benefit values.

While critics are firm in their belief that the changes to PIP are as much about saving money as providing greater opportunities for independent living, this cannot easily be proved. Nonetheless, the need to reduce expenditure on DLA has been clearly stated as a policy priority (DWP, 2010b). Indeed, when commenting on the operation of the transition to PIP, the Independent Reviewer of the PIP Assessment remarked that “the design of PIP was also undertaken in a context of fiscal austerity ... So the design parameters for the new system have needed to balance the interests of taxpayers with the goal of targeting the new form of support on disabled people with the greatest challenges to remaining independent and participating in society” (DWP, 2014, p2), and further noted that DWP own estimates indicated that of existing DLA claimants only 75% are expected to continue to receive an award under PIP.

The independent reviewer also reported on the concerns that had been expressed about the PIP assessment not properly taking into account the difficulties that claimants with mental health conditions had in negotiating the assessment process, and whether this had an effect on these claimants receiving appropriate

outcomes from assessments and awards. Noting an insufficient evidence base with which to test the accuracy of these concerns, he recommended that the DWP undertake an evaluation of the effectiveness of the PIP assessment process for such claimants (DWP, 2014).

Mental health specialists point out the potential similarities between the WCA and the PIP assessment in terms of how they may undermine claimants with mental health conditions, noting that the impact for those who receive both IB and DLA is the unnerving prospect of two separate reassessment procedures: “People potentially affected seem to be coping by adding the change [from DLA to PIP] to their long and winding worry queue – a shaky ropebridge to be crossed immediately after negotiating the daunting obstacle course of incapacity benefit to employment and support allowance (ESA) migration” (Stenger, 2011, p18). Further, campaigners note this elision of DLA with being out of work has filtered down to the assessment process for eligibility for PIP, with assessments for ESA (which is an out of work benefit) being used to judge PIP assessments: “ESA is medically measuring your capability for work... DLA is not about capability for work. In fact, many people are enabled to work through receiving DLA” (Stenger, 2011, p18).

Taken individually, it is not unreasonable to assume that the changes to IB or DLA, the method of their introduction, the rhetorical background noise, and the concerns expressed about the validity of the assessment processes, present particularly stiff challenges for people with mental health problems and their ability to navigate the altered benefits landscape. Taken together, critics assert, they may prove positively harmful; add reforms to housing benefit, discussed in the next section, and they could end up being overwhelming. These are the propositions this research seeks to investigate.

3.4.3. Housing benefits

Introduction to the Government's changes

“[T]he measures announced will provide a fairer and more sustainable Housing Benefit scheme by taking steps to ensure that people on benefit are not living in accommodation that would be out of reach of most people in work. This will also begin to address the disincentives to work in the current system created by high rates of benefit” (DWP, 2010c)

Housing Benefit (HB) is the principle rental assistance programme for low-income tenants, operating in both the private and social rented housing sectors. The origins of the present system reflect the 1980s shift in the state's responsibility to provide public housing away from 'brick and mortar' and toward a programme of personal housing allowances and subsidies (Kemp, 2000). The original objectives of housing benefits were to ensure both 'affordability' and to prevent post-rent incomes from failing to meet household needs. Expenditure on HB rose significantly from £4.65bn in 1989/90 to £20bn by 2009/10 by which time it covered 4.766m recipients (by May 2012 this had climbed to 5.03m), the rising cost a consequence of both the increase in the number of households obliged to rent in the more expensive private sector and the rapid growth in the numbers of in-work households also becoming eligible (Gibb, 2015). Elements of the HB system could be seen as providing an open-ended system of financial assistance – both to tenants and their landlords (particularly in the private sector) – with insufficient checks and balances (Gibb, 2015). Efforts to reform HB also emerged under the previous Labour governments who argued that deficiencies in its conception and operation meant that by (mostly) paying rent in full it removed personal budgetary responsibility from tenants, gave landlords the incentive to peg rents to the maximum amount payable locally, acted as a disincentive to employment as the benefit is withdrawn as income increases, and was administratively byzantine and open to fraud (Kemp, 2000). As a consequence changes were implemented to the funding formula that set the contribution payable to tenants in the private rental market at a lower level than had previously been the case, followed shortly after by the introduction of a national 'cap' that would limit the maximum amount that could be claimed.

As part of their wider welfare reform programme the post-2010 coalition government announced its intention to implement further reforms in order to cut £1.75bn from total HB spending by 2014/15. This would involve reducing further the maximum amounts payable locally, substantially lowering the cap for existing HB recipients⁴, and, most controversially, the imposition of an under-occupancy penalty – the so-called ‘bedroom tax’ – in which tenants in the social rented sector deemed to reside in a property with surplus bedrooms would be penalised by having between 14% for one bedroom and 25% for two or more bedrooms of their housing benefit withheld.⁵

While questions of fairness, dependency and worklessness were prominent in official explanations for the policy changes –

“As it stands the benefits system is costly, ferociously complex, and rife with disincentives to work. This is unfair to those claiming benefits and even more unfair to the taxpayers who have to fund the system. Housing Benefit is a case in point. In some situations the State was supporting people to live in homes with such high rents that they had no realistic chance of earning enough to cover the rent independently and to escape benefit dependency. And in many cases those homes were more desirable than those afforded by low income non benefit claimants” (Lord Freud, welfare reform minister, 2011a)

- of three reforms examined so far, the changes to housing benefit were the ones in which the need for reform on grounds of sustainability was most explicitly linked to the prevailing fiscal climate and the government’s determination to reduce the size of the budget deficit –

“The background to the changes to the Local Housing Allowance arrangements is the budget deficit and the reductions in public expenditure that the Government is making to tackle it” (DWP, 2010c)

⁴⁴ The cap does not apply to a household in which a person is in receipt of DLA

⁵ Recipients of DLA will not be exempt from the bedroom tax

- with two of the three amendments to HB – the reduction in the local housing allowance and the lowering of the cap – being announced by the Chancellor of the Exchequer in the ‘Emergency Budget’ of June 2010. The announcement of changes to the size criteria for HB recipients in the social rented sector came later, with the rationale for the reforms again resting on the troika of fairness, affordability, and incentivising employment:

“We are also taking steps to tackle under-occupancy in the social rental sector. In England alone, there are around five million people on the social housing waiting list and over a quarter of a million tenants in overcrowded conditions. Yet at the same time we are paying for something approaching one million extra bedrooms with Housing Benefit. This is a luxury we cannot afford. It is not fair to the taxpayer and not fair to those in housing need. If people continue to live in a property larger than they need then we will expect them to make a reasonable contribution to its cost through a reduction in Housing Benefit. Housing Benefit reform will deliver consistency by encouraging families on benefits to make the same choices about where they live as families on low incomes. And it will deliver fairness, for families on benefits as they have a real chance of escaping benefit dependency for good and for those on low incomes and other taxpayers who will no longer foot the bill for rents they could not afford themselves” (Freud, 2011b)

Critical perspectives, early evidence, and implications for research

Critics see the formal policy narrative surrounding HB reforms as operating within the same moral discourse of rights and responsibilities and ‘fairness’ outlined in relation to IB and DLA. In particular, they suggest that HB has been portrayed as rewarding the feckless and irresponsible for producing large families that they could not support without recourse to benefits, the spiralling costs of which are seen as falling on the shoulders of ‘hardworking’ families: “Our constituents are working hard to give benefits to other people to live in houses that they can only

dream of. I do not think that is fair" (David Cameron, 2010, quoted by Hamnett, 2010, p2814).

Until the attempted imposition of further cuts to disability benefits in the spring of 2016 (now halted, albeit temporarily), the HB cap and, in particular, the bedroom tax have been the individual reforms which have seen the most effective criticism and, in the case of the bedroom tax, resistance (Gibb, 2015). For critics, the HB cap was viewed as an attempt, in the former mayor of London's words, to 'socially cleanse' poorer families from high cost areas - in particular central and inner London – and displace them to cheaper, more distant locales, an outcome which early, anecdotal evidence suggests has indeed come to pass with signs of displacement, entrapment, homelessness, and circulation (Couvee, 2012; Davies, 2012; Ramesh, 2012, 2013; Ramesh and Walker, 2012) resulting in "new forms of migration and mobility streams that are selective according to class and health" and which further entrench geographical inequalities in health (Pearce, 2013, p2037). Academic critics maintain that the bedroom tax, whilst representing a noteworthy policy failure in its stated terms of utilising the social housing stock more efficiently (Gibb, 2015), has instead been highly effective in financially penalising not only those who, in the governments words, 'choose' to carry on 'over-occupying', but the far larger number whereby the paucity of single bedroom residences in the social housing sector precludes a move to a smaller sized property, and for whom the only plausible alternative would be the private rented sector where potential losses as a result of the benefits cap could be greater than if the tenants stayed put and accepted the penalty of the bedroom tax. If tenants were nonetheless to migrate to the private rental sector, they "could end up financially worse off and be living in a lot less secure a tenancy. Meanwhile, the government could end up paying out more in housing benefit than if they had left them [tenants] alone" (Messere, 2013, p14). Whilst the direct implications of the housing benefits cap might seem to have greater consequences for poorer families more generally, the risk of displacement and circulation for people with mental health problems are nonetheless real, especially with the introduction of the bedroom tax, given the way in which mental health service users are dependent upon a series of carefully interlinked benefits in which eligibility for one may rest upon having been found eligible for another. Notwithstanding the

exemption for people claiming DLA from the HB cap, the reassessments underway in respect of eligibility for PIP could see some people with mental health problems having their eligibility taken away and could thus end up exposed to the full force of both the HB changes and the wider household benefit cap.

3.5. Research implications and conclusions

“Like privatisation, the cuts may permanently change the political and social landscape of Britain and they may reflect underlying economic, attitudinal and political shifts that are fundamentally reshaping the structure (and geography) of the welfare state” (Hamnett, 2014, p501)

“This [welfare reform] will change Britain for generations” (Iain Duncan Smith, 2010)

The ongoing march of welfare reform, resounding to the drum beat of austerity’s demands, appears, increasingly, to be cementing in place certain ideological precepts: the moral futility of much welfare, the dearth of deservingness amongst many of its recipients, its unaffordability. The apparent endorsement of this political project by voters in the general election of 2015 assuredly makes Hamnett’s prediction of a permanent and perhaps irrevocable shift in the social welfare system increasingly credible. The reverberations will be felt throughout welfare jurisdictions and the task of investigating the impacts is extensive, not least because “geographies of welfare spending and benefits are not simply outposts of political decisions. They can and do have an impact on other economic, social and political issues” (Hamnett, 2014, p492). One such issue is health. Another is residential mobility. As well as looking at the overall reach of the reforms and their impact for health and health inequalities (Garthwaite et al, 2014; Pearce, 2013; Schrecker and Bambra, 2015; Warren et al, 2014), contemporary research has begun to study the impact of individual reforms on particular vulnerable populations, including those in receipt of out of work sickness benefits (Barr et al, 2015a, 2015b; Garthwaite 2014; Garthwaite et al, 2014; Patrick, 2014), disability benefits (Power, 2016; Roulstone, 2015), and those being penalised by

the bedroom tax (Moffatt et al, 2015). Each of these studies has called for further research that captures the ongoing lived experiences of those ensnared in the welfare reform net. These represent missing geographies and are, it is argued, both a vital counterweight to wider government/media/policy debates on 'welfare' (Patrick, 2014), and crucial if we are to make sense of the human cost of austerity, offer critical insights into its material impacts, and provide cogent accounts of its consequences (Pearce, 2013). One latent – and, as yet, unexplored – consequence is the possibility that service users, ousted from their homes as a result of the vagaries of the welfare state, once again become residentially displaced across a familiarly forbidding post-welfare landscape. As previously suggested, enforced residential moves are an intrinsic – and seemingly intended – outcome of the benefit cuts and changes that recipients must now confront, and though the aforementioned studies have examined the impacts of austerity on health (including mental health) what has not yet been subject to detailed scrutiny is the bearing this has on residential mobility.

Thus also missing from the body of research and representing a significant gap is an exploration of the specific impact of the reforms on service users' mental health *and* their residential mobility. The welfare reform package as a whole (and the wider cuts to public services more generally) seem to presage a particularly difficult time for the majority of people with mental health problems who rely on benefits to meet their daily needs, even if, thus far, such difficulties may have been mostly confined to safely navigating a path through the new eligibility rules and requirements. And even here, the consequences of unfamiliarity, of invasive and unsettling medical assessments, can be profound for peoples' stability. The object of the present research study, then, is to see first the general impact of this suite of reforms on people with mental health problems, and second any impact on their residential mobility once they experience life under the new regime. The next chapter, on the methodology and objectives of the research, details how and where this was attempted.

Chapter 4. Research design and implementation

4.1. Introduction

“For too long seen as the subjects of research, to be treated, measured and questioned by others, [mental health] service users felt the need to challenge the power imbalance inherent in the form of research production and to take control of it: asking different questions, using different methods and finding out new things”
(Faulkner, 2012, p40)

As researchers delving into the lives of people with mental health problems, we should seek to avoid striding determinedly across a very personalized and ethically fraught research terrain, mapping out the ground and cordoning off those areas we consider the most promising. Instead, we should gain permission to enter, allowing our participants the opportunity to orientate us in worlds that may be substantially different from our own. Subsequently, we should tread tentatively - even warily – across this landscape, cognisant that with each step we take we may inadvertently blunder into a place that may have a profound emotional resonance for, and impact on, our ostensible guides. This, at least, was the imaginative framework within which the current research project was intended to be undertaken. The following discussion, of the research design and methodologies employed, demonstrates how I hoped to achieve these admittedly somewhat lofty goals.

4.2. Research aim and questions

The evidence presented in the literature review of the longitudinal residential mobility patterns of people with mental health problems is largely quantitative in nature. Qualitative approaches to mental health geography documented in that chapter sought to contextualise these mobility patterns through analyses of the macro-scale policy drivers behind them, yet they have generally eschewed individual accounts that deepen our understanding of how this mobility is played

out in practice over time (though see Knowles, 2000a). Thus, while this previous research has answered the 'where' (who moves or lives where), they have less often accounted for the 'why' (why do they move or live there), and rarely considered the 'how' (how has this mobility been experienced). Nor has there been any detailed consideration of the role that welfare benefit payments may play in the residential mobility patterns of individuals with mental health problems (DeVerteuil, 2005, has explored these questions with reference to homeless single women). Indeed, the roles that poverty and welfare reform play in the lives of people with mental health problems has not been prominent in social geographical research more generally (Wilton, 2004a), and there is a critical lack of local case studies that reveal "the inner workings of the local welfare state, impacts upon clients and local efforts to fight back" (DeVerteuil et al, 2002, p243). These are the gaps that this research seeks to fill.

This research project intends to address these omissions by *exploring, in the context of ongoing welfare reform, the interactions between mental ill-health and residential mobility as reported by persons with serious and enduring mental health problems.*

The specific research questions that follow have been structured with the following purposes in mind: first, to clarify the key research variables - mobility, mental ill-health, and welfare benefit payments - with a view to interpreting the interactions between them historically and contemporaneously; and second, to do so by foregrounding what individuals with mental health problems themselves say about the impact these interactions have on them and their lives. The first series of questions relate to *patterns of residential mobility*:

- How do persons with serious and enduring mental health problems account for their residential mobility (or lack thereof)?
- Have fluctuations in their mental health influenced decisions to change residence (or not)? What impact (if any) has a decision to change residence had on their mental health?

- Have decisions to move or stay put been made voluntarily, or have they been forced upon them?

And the second to the broader *social and welfare context*:

- What role has their receipt of welfare payments played in decisions – voluntary or involuntary - to move or stay put?
- How have they experienced the reformed process for assessing eligibility for welfare benefits? What has been the outcome of these assessments in terms of financial security, residential mobility and their mental health status?

4.3. Conceptualising the methodological framework

“While I am responsible for having produced the account of the lives described in this book, this was an interactive process in which the lives under consideration shaped, through their stories and challenges, the resulting analysis. My attempts to capture the ‘lived-ness’ of their lives has meant relegating theoretical and methodological debates and justifications of the framework to passing references and footnotes. I hope the reader will see this as it was intended: not as sloppy scholarship but as an attempt to tell a story in an accessible way” (Knowles, 2000b, x)

“[T]here are no coherent and neatly organised models of methodological procedure which can be adopted for a post-medical geography. Preferable to rigid ‘models’ of research practice, moreover, are flexible methods which seek to engage with the different subjective contexts of particular participants” (Parr, 1998, p350)

The research questions require a framework that is capable of generating both ‘facts’ about residential mobility (‘where’ and ‘when’) and interpretation (‘why’ and ‘how’), and which focuses attention on accounts provided by individual participants, primarily people with mental health problems themselves but also

professionals in the mental health field. This points strongly toward a series of in-depth interviews as the primary methodological tool, augmented by additional methods that allow for continued contact and involvement with respondents and their ongoing experiences in between interviews.

This approach situates the present study firmly within the qualitative studies in mental health geography reviewed earlier, which have frequently made use of in-depth interviewing (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000b; Mifflin and Wilton, 2005; Parr, 1997, 1999, 2006, 2007; Parr et al, 2004; Pinfold, 2000; Wilton, 2004a) often supplemented by ethnographic approaches (DeVerteuil, 2004b; Knowles, 2000b; Parr, 1999, 2000). Other techniques adopted by geographers involved with marginalized populations include the use of auto-photography (Johnsen et al 2008, during research on homelessness), personal diary writing (Meth, 2003, in respect of violence and fear amongst marginalized and impoverished women in South Africa), and engagements with online support groups (Parr, 2002, with persons with mental health problems).

4.3.1. Qualitative interviewing in human geography

The semi-structured interview is a mainstay of qualitative research in human geography, one that is often perceived as a relatively unproblematic ‘go-to’ technique for researchers wishing to capture individual experiences of social phenomena or processes. Its ubiquity – and apparent simplicity as a catch-all method – has ensured that it has been subject to considerable critique both conceptually and operationally, particularly over the nature of the interview encounter, the positionality of the researcher/subjectivity of the researched and the unequal power relationships inherent therein, and the way that these relations structure the very knowledge that the interview purports to reveal; all points relevant to this research and considered in more detail below (see Crang, 2002, 2003, for a comprehensive overview of the debates surrounding the use of the interview qualitative research).

That said, the ongoing popularity of the qualitative interview is testament to its ability both to generate rich descriptions of the social world (Frith and Gleeson, 2012) and provide insights into the interactions between structures and human agency: “Case studies allow researchers to explore the interplay of multiple factors in a given context … While it can be difficult to generalize from case studies, those grounded in theory and representative of other cases can offer broad insight” (Wilton, 2004a, p29). In this case, Wilton grounded his qualitative research with rooming house dwellers in a thorough analysis of Canadian welfare reform, as did DeVerteuil et al (2002) in their investigation of the practical impacts of contemporaneous reform unfolding in Los Angeles. The present study has taken a similar approach. Embedding a synthesis of the social and the material into research practice is a somewhat difficult task, but essential to avoid the two main pitfalls of qualitative research: first, the temptation to selectively edit qualitative data to fit pre-conceived notions; and second, an inability to move beyond respondents’ subjective accounts (Bailey et al, 1999). Precisely how I endeavoured to achieve this synthesis is detailed later in this chapter, where I outline the analytical and evaluative strategy.

4.3.2. Researching the lives of persons with mental health problems

“It is for the researcher to reflect on in what way the specific context of their proposed study might create vulnerability, rather than for the research team to assume that a particular group is vulnerable per se on the basis of their membership of a particular group or because they have particular characteristics” (Thompson and Chambers, 2012, p28)

While somewhat bullish, Thompson and Chambers are surely correct that belonging to a specific research population is of itself insufficient evidence with which to tag an individual as ‘vulnerable’. Seeing a particular research population – such as people with mental health problems – solely through a lens marked ‘especially vulnerable’ runs the danger not only of (once again) privileging and elevating the power and knowledge of the researcher over that of the participant (Parr, 1998) but of foreclosing opportunities to witness the demonstrations of

agency that Wilton refers to above. This section seeks to tease out some of the nuances of qualitative research with people with mental health problems, and the approach I outline here is intended to operate within the ethical parameters discussed in the opening paragraph: that a research process such as the one being embarked upon here should recognise difference and the potential ethical (indeed, I would say, *moral*) dilemmas, but that is should not be *paralysed* by them (Wolch and Philo, 2000). My analysis will start with an examination of the conceptual, ethical and practical issues to be attended to in respect of using in-depth interviews with people with mental health problems, before moving on – in the following section – to consider the precise methodology constructed for this study.

4.3.3. The interview and mental ill-health

In their attempts to humanise the hitherto largely disembodied ‘mental patient’, mental health geographers of the qualitative era aimed to place their participants’ subjectivity – through their voices and stories – at the forefront of their research:

“The concept of ‘voice’ invokes a politics of recognition and places the theorization and experience of the unheard at the centre of research activity ... The use of *voice* in the task of social analysis positions lives as a key source of social knowing. The voice narrating the story of its life in a particular set of circumstances opens a window onto that life, other lives and the broader social circumstances in which they are cast” (Knowles, 2000b, p10-11)

Acquiring these stories has often involved employing the in-depth interview as a primary research method. This is not, of course, unproblematic. One of the pioneers of the qualitative approach, Hester Parr, has cautioned researchers to be aware of the distinctive politics surrounding the use of interviews with respondents with mental health problems, and the need therefore to problematise the interview. One of the key challenges of doing so hinges on the ability to seek out, record, and relay the voices of ‘[O]thers’ whilst avoiding appropriating or taking ownership

of those voices (Pinfold, 2000; DeVerteuil, 2001, 2004b). Disentangling the researchers' positionality can be particularly fraught when undertaking research on mental health:

"Not only does the imbalance of power result from a researcher/researched dualism (perhaps reflecting issues of status, education, income, 'life' chances) there may also be a perceived 'sane/insane' dualism which can be reinforced by the very format of the interview" (Parr, 1998, p346-7).

She suggests that people with mental health problems will have amassed significant experience of being placed under the 'microscope' (Knowles, 2000b) in order to be interviewed, examined, interrogated, and analysed by professionals medical or otherwise, and that such encounters may subsequently have resulted in significant and life-altering decisions – be they diagnostic, pharmaceutical or the removal to hospital for compulsory treatment (Parr, 1998).

The interview itself can equally cause problems. Participants who experienced paranoid thoughts about being listened to, spied upon, or monitored, can be particularly sensitive to the intrusion caused by the use of a recording device; similarly, medication can lower participants' levels of concentration, negatively impact their ability to sustain the effort required to complete the interviews and leave them feeling exhausted (Parr, 1998; Pinfold, 1999). Equally, the interview device relying as it does on the spoken word may not be best suited to understanding non-narrative forms of remembering associated with certain manifestations of mental illness (Parr, 1998). However, the medical-pharmaceutical milieu in which some interviews may take place does not lessen the relevance or importance of what respondents say. On the contrary, "stories were sometimes mediated by the effects of medication, but these are the social/pharmacological conditions in which many of these lives are lived and anyway do not detract from the veracity of their testimony" (Knowles, 2000a, p215).

Unsurprisingly, then, the interview necessarily seems to involve "[i]ntrusion into peoples' lives, 'being visited' for research purposes, may be greeted with hostility,

especially if there are minimal perceived gains for participants" (Pinfold, 2000, p203); indeed, during the course of the research, participants can "stubbornly refuse to follow the rules" (Frith and Gleeson, 2012, p56). Good for them! one is tempted to reply, but more serious reflection is required. Indeed, 'reflexivity' is the epistemic buzzword when it comes to orientating and re-orientating oneself during the research encounter.

Across much of contemporary human geography (and the social sciences more generally) the onus is on the researcher to dismantle traditional and hierarchical research infrastructure. Instead, she or he should seek to position themselves with due sensitivity towards participants' subjectivity and in an attempt to narrow the positivist 'objectivity' gap between the researcher and the researched. Danger still lurks though. In seeking to avoid being too *distant* from participants we end up being too *close* to them and this, too, can be equally as problematic, not because we may compromise the supposed 'objectivity' of the data gathered (though many would disagree), but rather because by doing so we may unwittingly but nonetheless unfairly manoeuvre our participants into the position of supplicant. Despite a willingness to provide a safe, supportive and empathetic research encounter for participants, we may still leave them more vulnerable as a result:

"As a geography researcher I am neither trained nor consistently available for participation in 'therapeutic' conversations, and therefore could potentially inflict damage upon an individual's own coping strategy. There is a great difference between being a source of support in the 'safe space' of an interview context and being a sole, identified, demarcated therapist" (Parr, 1998, p346).

Closely bound up with this are the emotions that our relationships with research participants may engender. This is something that positivist iterations of human geography sought not just to downplay but to exclude from consideration altogether. Now, researchers are being asked to acknowledge emotions that may arise as a result of research encounters and our responses to them (Pinfold, 1999) because doing so "orientates us *differently* within our research interviews" (Laurier and Parr, 2000, p99). Consciousness about the instability of interactions during a

research encounter is not the preserve of the researcher. In fact, “researchers’ insecurities, conceptions of themselves and comfort levels in dealing with madness were often astutely observed and blatantly exploited by informants who drew them into their performances … These dialogues of performance significantly shaped the production of voices in the process of investigation” (Knowles, 2000b, p 14). Thus,

“however we seek to position ourselves in research (as confidants, benignly curious or facilitating empowerment), our participants will be actively trying to work out who we are, what we represent and why we want the knowledge that we are asking for” (Frith and Gleeson, 2012, p63)

4.3.4. Personal positioning: activist, or observer and reporter?

“Collective mobilization on the part of marginalized populations and related theoretical developments have raised difficult questions about the exploitative nature of traditional research relationships and the (in)capacity of social science researchers to contribute to progressive social change” (Wilton, 2004b, p127)

One consequence of this fear of exploitative research relationships has been attempts to align the researcher alongside the researched in common emancipatory cause, and tie the objectives of the study to those of activist movements seeking social change. Such approaches – often referred to as ‘participatory action research’ - aim to present a “more relevant, morally aware and non-hierarchical practice” (Pain, 2004, p652) and are considered to be particularly appropriate in circumstances where the population group under study may previously have been subject to research methods and processes that further marginalised or disempowered (Faulkner, 2012).

On the surface, the present research may seem an obvious candidate for a more activist orientated methodological approach. Yet I hold three interlinked reservations. First, the research objectives have not sprung from mental health service users themselves and therefore cannot credibly be presented as being

‘user-led’: my respondents will on some level remain lashed to my own research mast. Second, my status as someone who does *not* experience serious mental health difficulties is problematic: I cannot realistically claim to be able to adhere to those that *do* without in some way arrogating them or else marginalising myself from my own research. Third, I am not sure how comfortable, or indeed ‘good’, I would be in the role of researcher-as-activist, immersed in advancing the aims of a particular organisation or determinately pushing a pre-packaged political agenda: on a professional level, I have been swayed in part by the arguments for human geography to engage with and report on social experience in ways that maximises the (admittedly, small⁶) chances of being taken seriously within wider policy debates (Cameron and Gibson, 2005; Dorling and Shaw, 2002; Martin, 2001; Pain, 2006).

Such an admission may seem strange, given the stress I have previously placed on the qualitative over the quantitative, the subjective over the objective, feelings over thoughts. It is my contention, however, that the desire to use individual experience of coping with mental health problems, poverty, and the destabilising effects of welfare shrinkage and reform, is not incompatible with a wish to do so in a way that paints a broader picture of life under welfare restructuring and has something relevant to say to the agencies and authorities responsible. Whether they choose to take note or not is outwith my control; and, one might say, is where those of a more activist bent should step in.

There are two aspects, then, in my fumbling attempts to locate myself intellectually in this research territory: first, the theoretical anchors of my research methodology and personal position within it; and second, how the research findings are *themselves* positioned and the way in which they are relayed. I have found other scholars’ own positioning invaluable in helping bolster my own thoughts. In particular, Wilton (2004b) who, following Bourdieu, examines the possibility of *symbolic* as opposed to *direct* political action, suggesting that autonomy from

⁶ Readers must excuse the ‘Eeyore’-like tone employed here. Such pessimism comes not from having spent a lifetime at the coalface and seeing little or no substantive change. Rather, it is from having witnessed first-hand the disregard with which elite policy circles treat an ‘evidence-based’ approach, and the bureaucratic insensitivity and inertia that compound the very problems they are intended to address.

research participants allows the academic to more credibly pose as an impartial 'expert' in order to challenge powerful elites; and, once again, Caroline Knowles, who links both personal positionality and research intentions together in justifying her narrative approach:

"I have tried as far as possible to stand in the position of those whose lives we seek to understand ... [and] my own horror, incomprehension and sympathy is sometimes vicarious and sometimes visceral ... among stories that expose the outer limits of human existence and stand as a testament to human survival. These were stories I felt both troubled and privileged to hear, and which I have struggled to understand and retell with integrity while weaving them into a text. Contrary to fashionable claims, it is not possible to operate reflexively in understanding others in situations that do not mobilize the researcher's experience as central to the research frame ... my motivation for doing this research is political ... The existence of the system I describe is offensive. It dehumanizes us all and deserves to be exposed" (Knowles, 2000b, p27)

Within the research, I therefore aim to locate a space that allows a degree of detachment whilst maintaining 'sympathetic understanding' toward respondents (DeVerteuil, 2001) and which is capable of generating a politically necessary record of their mental health, mobility and wellbeing under contemporary conditions of welfare retrenchment.

4.4. From conception to implementation

4.4.1. Sampling and selection

"If qualitative research is to be used to initiate policy or improve the human condition, then its findings – as stories - must resonate with others in the wider society. Qualitative research has great potential for providing richly textured stories to inform on the human condition ... Nevertheless, most claims for transferability still revolve around achieving sample sizes that are unmanageable for qualitative

researchers, The central goal, however, is not sample size, but representativeness" (Baxter and Eyles, 1999, p180-1)

The complexity of the research subject matter resulted in me pursuing the most manageable routes of access into the research terrain. In practice, I decided to try to reach my target interviewees by working through appropriate non-governmental third sector organisations. To accomplish this, I made contact with various local mental health charities seeking to enlist their support in gaining access to appropriate participants. Out of the several dozen approached, two offered their assistance and in both cases I met informally with some of the service users at each site before seeking their agreement to be interviewed. The first research site, based in inner London, yielded eight interviews; the second, based in a large regional city, provided ten. Additionally, a call for participants was issued via the online newsletter of a national service user-led organisation. This generated around a dozen expressions of interest from across the country. After narrowing the list to those participants with whom it was practicable to engage in the research (because, for example, they were easily accessible to me either by virtue of my residence in London or my presence at Southampton), a further seven interviewees were recruited, giving a total of twenty-five participants. The intention had been to select research locations that were potentially emblematic of inner city environments with high levels of poverty, challenging housing conditions and a prevalence of services directed to their alleviation. The residential circumstances of twenty-two of the twenty-five participants met these criteria. The remaining four lived in smaller towns or cities in the south of England, though in each case these were either the most populous settlement in the respective county or the county town and were thus expected to provide as service-rich a backdrop as possible.

With a project of this kind, and within the constraints of doctoral research, obtaining a sample of individuals based on random population sampling lay way beyond what was feasible in terms of my capacity and funding. It was thus through my contacts with these organisations that I began instead the process of *purposive sampling*. The intention here being to gain sufficient research participants so that the point of saturation was reached and no recognisably new data was being generated from the interviews with newly recruited participants. I recognise the

potential hidden populations of individuals living in circumstances very much as I describe here who, by dint of their absence from the drop-in centres where I was introduced to the service users, or because their geographical location made their recruitment impractical, are also absent voices. My hope, though, is that the individual life experiences presented here are *characteristic* of those of those missing others. A more significant absence are those individuals with mental health problems who exhibit high levels of mobility and who would be unlikely to be captured by an enlistment strategy based on recruitment from user support groups and drop in centres that cater to a more static population. Accordingly, in the early stages of planning the fieldwork, efforts were made to source additional recruitment centres from places such as homeless shelters and hostels though in the end this proved not to be possible (see p214 for further discussion of this point).

Despite these limitations, this approach to sampling did enable me to identify particular individuals who would become my core informants (Snow and Anderson, 1993; Wiseman, 1970), the cultivation of whom enabled me to 'snowball' my sample size. The aim was to recruit sufficient numbers of 'information rich' (Mifflin and Wilton, 2005) participants through which "[t]he living and telling of life as stories highlights the individual choices unique to each biography, [and] in which individual life trajectories are as significant as the broader (social) spatial and policy concerns in which they are cast." (Knowles, 2000b, p10), but which nonetheless also allow the larger structural factors (benefit payments and mobility) to be explicated posteriori (DeVerteuil, 2001). This approach has been successfully used by the researchers in whose footsteps I tread (DeVerteuil, 2001; Hopper et al, 1997; Knowles, 2000b; May, 2000; Mifflin and Wilton, 2005).

This decision to focus on individual cases represented an attempt to gain a much deeper level of knowledge and understanding about individuals' lives and how they *experience* mobility and welfare reform than would be possible using a more conventional comparative study. Thus, I set out to secure thirty initial interviews with individuals with mental health problems with whom I would retrospectively construct their residential mobility patterns for the preceding eighteen months. Attrition notwithstanding, each interviewee would be re-interviewed after six and

then twelve months in order to build up a biographical picture that would help elucidate both the longitudinal and episodic aspects of these patterns (May, 2000) and the ways through which these might be related the status of both their mental health and welfare benefit payments. The longitudinal element of the research and the attendant emphasis on personal life stories are particularly important. These anchor individual “outcomes within a larger suite of personal, familiar, health and welfare contexts” (DeVerteuil, 2005, p397), unlike point-in-time snapshot surveys that fail to capture the ‘texture’ of the social world under study or the dynamic aspects of residential mobility, use the language of disability rather than biographic vulnerability, and thus only present what appears to be pathological behaviour (DeVerteuil, 2005; Snow and Anderson, 1993; Snow et al, 1994). As a consequence of delays in participant recruitment, and the knock-on effects on the overall time allowed for the completion of the fieldwork, it only proved possible to interview eight participants on the hoped for three different occasions (that is, at both the six and twelve month stages in addition to the initial interview). A further thirteen were interviewed twice (initially and again at the six month stage), with the remaining five only being questioned once.

These interviews took place in the following locations – the drop-in centres, participants’ own accommodation, other non-medical locations within the mental health system and, occasionally where circumstances dictated, at local cafes or other public places. The precise selection was done with the recognition that “[c]onsideration of localities that are meaningful to the participants is often fundamental in creating a social space where interaction can take place” (Parr, 1998, p349). I was cognisant (particularly at my initial interview with each respondent and/or on the occasions when I had first encountered them informally at the drop-in centres) of the need to ensure that my appearance and use of language did not operate to inhibit individuals from opening up to me (Frith and Gleeson, p64; Pinfold, 1999). As an incentive and reward respondents were paid £10 (in the form of non-cash convertible high street vouchers) for each completed interview.

These formal interviews were supplemented by methods to maintain contact with and check the status of interviewees between each round of interviews. Primarily,

this involved the use of electronic methods of communication, either directly with the participant or via relevant contacts at the respective drop-in centres. In addition, early encounters with the 'gatekeepers' from the charities yielded interesting insights, several of whom agreed also to be interviewed and this material has been included in Chapter 6 to lend support to service users' interpretations and experiences of welfare reform.

4.4.2. Ethical considerations

I have already outlined my own positionality vis a vis the research but detailed ethical planning was required to satisfy both my personal obligations to the interviewees and to the University Ethics Review Committee, who granted formal approval for the research to proceed. I now set out in detail the formal ethical mechanisms that were used to govern my interactions with my interviewees and the environment in which these took place. In doing so I also reflect briefly upon my own feelings in relation to how successful I was in adhering to these.

In respect of the main interviews – i.e. those with persons with mental health problems – the ethical research guidelines issued by the British Psychology Society (BPS) were used as the template for this study (British Psychological Society, 2010). Founded upon the broader principles of respect, competence, responsibility and integrity (Thompson and Russo, 2012), the guidelines include detailed advice on the following areas of ethical concern:

Informed consent

This is crucial to respecting the autonomy of the research participant and allowing for their self-determination (Thompson and Chambers, 2012). In the case of this research project, each potential interviewee was presented with an information sheet providing details of the research, outlining what would be expected of them, and how the information they provided at the interview would be used. It included the examples of the kind of questions they might be expected to answer or issues they would be invited to talk about, and asked for specific agreement to record the conversations and to the use of anonymised quotes in this thesis and any

published work (see Appendices). The information provided was sufficient for people to make an informed judgment about whether to participate. If they agreed, then as recommended by the BPS, at each interview a consent form was used which restated this core information and emphasised in particular the right of any interviewee to halt the interview or to withdraw from the research at any time.

Whilst potential interviewees would be persons who experience mental health problems they specifically did not include those who lacked the capacity to consent. The consent procedures used were designed to be as unambiguous as possible about the nature of the research, and prior to some interviews a simple coherency and lucidity test was used if I judged it necessary to ensure that true consent was properly being given.

Privacy and confidentiality

Privacy relates to the desire to keep private certain information about oneself and one's life (Thompson and Chambers, 2012). Interviewing someone about these things necessarily involves an element of intrusiveness into the private realm. Confidentiality is the mechanism used by the researcher to minimise the impact of this intrusion. In this case, all interviewees' data were closely protected. The identity of individuals with mental health problems was anonymised, they were given a pseudonym, and their actual residential locations disguised. Professional interviewees were described in terms of their general role (i.e. benefits advisor). Any additional information gained as part of my engagements with the drop in centres was used only for the identification of suitable interviewees, as background during the analysis, or as field observations to explicate my own positionality within the research and was not done in a way that could lead to individuals or particular events being identified.

The interview material (including audio recording transcripts) and interviewee contact details and communications were available only to me and were stored in secure password-protected electronic files.

Harm minimisation

“In relating personal experiences about the self, it is sometimes possible (for me as a researcher) to reject the doctor-patient, researcher-researched opposition ... The use of the body in the interview to reassure, to express emotion and to reaffirm support can also be useful, if problematic, and perhaps is significantly different to the situation of a doctor’s body distanced from the patient behind a desk” (Parr, 1998, p349).

Asking research participants to engage with us in ‘sensitive personalised dialogues’ (Pinfold, 1999) involves a risk of potential harm being caused to them. Whilst any potential harm in a study of this sort cannot be eradicated, it can certainly be *minimised*. As with the supposed innate vulnerability of particular demographic groups, individuals are not necessarily averse to discussing painful experiences if they believe the research to be worthwhile and, therefore, “it is important to be mindful that experiencing *distress* is not necessarily experienced as *harmful*” (Thompson and Chambers, 2012, p30, emphasis added). The onus is thus on researchers to minimise any risk of harm to their participants. For the present research study, this was partly attempted through the management of interviewees’ expectations, for example by outlining the sorts of topics they would be asked to talk about, or recall, and through the aforementioned consent procedure in which the right to skip particular questions or to withdraw entirely was made paramount. Importantly, it was also about establishing the right interview environment. I endeavoured to conduct the interviews with reference to the practices of more formal therapeutic encounters. These revolve around qualities such as empathy, genuineness and ‘unconditional positive regard’, and can be expressed by the use of techniques including attentive listening, paraphrasing interview content, reflecting feelings, summarising, and using open questions (Coyle, 1998, p58).

In practice, this meant that if interviewees exhibited signs of distress when talking about difficult or upsetting memories I tried where appropriate to offer comfort and support and, if necessary, suspended or terminated the interview. I offered the opportunity for a debrief or period of reflection post-interview (Coyle, 1998;

Thompson and Chambers, 2012) and if I judged it necessary used a stress test to determine interviewees' level of comfort or contentment prior to the interview and again at its conclusion. If levels of stress or discomfort were found to have increased during the course of the interview appropriate mood repair exercises were undertaken.

4.4.3. Research framework and tools

The research project utilised two specific field instruments:

1. A standardised survey questionnaire used at the initial interview with each respondent and designed to capture their personal details.
2. A semi-structured framework for the open ended conversational interviews with respondents. This was used primarily at the initial interview to retrospectively construct each respondents' residential mobility patterns, mental health status, and degree of dependence on welfare benefit payments over the preceding eighteen months, and was used again as necessary in slightly modified form to appraise any changes in the intervening period at the subsequent six-monthly interviews with each respondent. The framework was intended to be just that: a common framework for guiding each interview and not a blunt instrument through which each interviewee was forced regardless of the relevance of particular sections or questions. In other words, it was designed to mirror the reflexivity of methodological approach outlined below. In practice, this meant that the framework was adapted as necessary during the course of the interviews, with much less reliance on it as a tool during subsequent encounters than had been necessary at the initial interview.

Copies of each are in the Appendices.

The interview questions were intended to focus on why individuals move residence or not, whether the decision to move (or not) is intended by them and desired as part of a strategy to protect their mental health, whether these decision are made

for them by someone else or otherwise forced upon them by circumstances beyond their control, how moving intersects with financial resources from welfare benefit payments (and other coping mechanisms) and how or whether this is related to the state of their mental health, and how moving and benefit dependency effects their overall quality of life.

Each interview was audio recorded and transcripts produced, excerpts of which are used throughout the analytical chapters. A discussion of how these transcripts were processed and interpreted following next in section 4.4.4.

4.4.4. Analytical strategies

“[I]t is important that you collect data that map onto your research questions; sufficiently warrant the kind of claims you wish to make; and match the epistemological assumptions of your method of analysis” (Harper, 2012, p83).

The successful shepherding of a research project from conceptual aims, via detailed research questions and the design and implementation of a data collection strategy, count for little if progress comes to a juddering halt at the stage of analysis. One of the main stumbling blocks to negotiating the path from conception to conclusion is the adoption of an overly rigid methodological framework that sends the researcher up an analytical cul-de-sac and stifles creativity. Instead, a ‘moving methodology’ (Pinfold, 1999) is preferred. This should be sufficiently flexible so as to anticipate and adapt to problems during data collection, and which is also capable of capturing (or at least not foreclosing on) unanticipated findings or data sources (Snow and Anderson, 1993, p30). The main ingredient for success, therefore, is the ability to operate ‘reflexively’ throughout the research process (Bailey et al, 1999). Indeed,

“Research design is a creative and iterative process ... designs grow over time, developing as a function of the growing body of knowledge and the increasing skill and confidence of the researcher. This is perhaps why

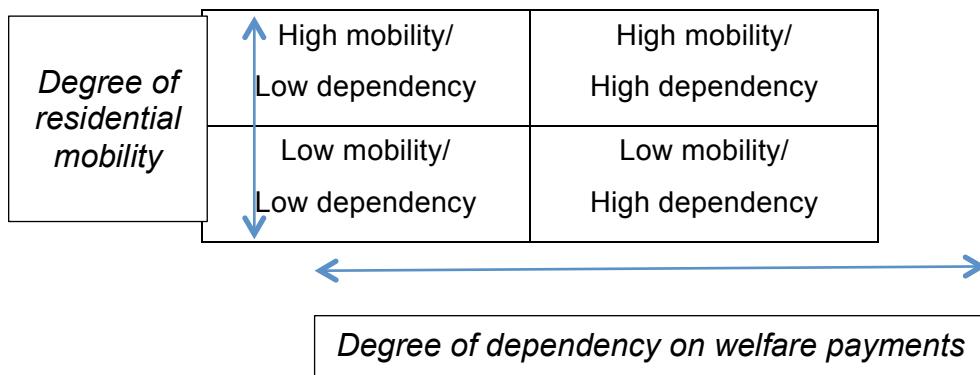
reflexivity is the crucial tool for the qualitative researcher" (Frith and Gleeson, 2012, p56)"

Nonetheless, reflexivity itself demands a degree of rigor (something that qualitative research has frequently been criticised for lacking; see Baxter and Eyles, 1997). Accordingly, the different pieces of the research jigsaw must be properly cut if they are to be fitted together to reveal the bigger picture. The quality of the picture that emerges is dependent on the analytical strategy employed, itself dependent on clarity in research purpose.

The overall research strategy had three points of analytical focus, each of which reflected the tripartite nature of the research objects – residential mobility, state of mental health, and degree of dependency on welfare benefits. The first focus, which is presented across chapter 5 (residential mobility) and chapter 6 (processes of welfare reform) relates to the *degree of mobility* and the *degree of dependency* on benefit payments evinced by individual service users. This was gauged by assigning individuals within a fourfold typology, embedded in which are the core conceptual components considered earlier – circulation, displacement and entrapment. A typology is a simplifying mechanism used to represent multifaceted realities. As an analytical procedure, the typographical approach is widely used by researchers across the social sciences to categorise and compare similarity and difference within a social group. Typologies are most useful when limited to a few crucial elements of intra-group variation and, though dependent upon the time and place specifics of the research setting, are nonetheless particularly helpful where research subjects are individuals who have too often been lumped together and treated as a homogenous group (see DeVerteuil, 2003; Snow and Anderson, 1993; Wiseman, 1970; for examples of the same approach with homeless individuals).

The typology used here delineated (1) those demonstrating high mobility and high dependency, (2) individuals evincing high mobility but low dependency, (3) persons with low mobility but high dependency, and (4) those showing low mobility and low dependency and are presented in the table below:

Table 4.1. Typology of residential mobility and welfare dependency



Based on the results of the initial retrospective interview, individuals were assigned as low or high according to where they sat in relation to the sample average for benefit dependency and degree of mobility. Their position in the typology was reassessed following the analysis of each subsequent interview and they were reassigned as necessary.

The second focus of the analysis is concerned with how individual residential patterns and associated benefit dependency were *experienced*. This was the analytical focus in which individuals' feelings about their residential, institutional, and welfare entanglements were drawn out. Thus, with reference to the 'politics of mobility' outlined in the literature review, it attempts to illuminate the ways in which the sequence and mix of residential accommodation, the circumstances under which these settings were encountered, the degree of force involved, and individuals' perceptions of each, were experienced and understood. It also sought to illustrate the role that both welfare payments and differing residential circumstances play in giving individuals a degree of 'ontological' security (Mifflin and Wilton, 2005; Padgett, 2007): that is, the extent to which the receipt of welfare payments and different forms of residential (im)mobility contribute towards individuals' having a sense of identity, meaning and belonging in relation to their home - and how this may have changed during the period of reform covered by

this study. This focus also structures chapters 5 and 6 and provides the basis for chapter 7 (how experiences of 'home' impact service users' mental health).

4.5. Summary

The following three chapters present and analyse the results of the research. The first focuses on residential mobility. The second will relate individuals' experiences of the process of welfare reform, and the impact this has had on their mental health and residential circumstances. The third assesses the role that 'home' – as both physical entity and emotional construction – plays in service users' efforts to manage their mental health.

Part Two: Empirical chapters

Chapter 5. Mental health service users and their experiences of residential mobility

“We don’t call it care in the community, we don’t even call it neglect in the community, we call it neglect in a bedsit” (Liam, mid 40s, mental health service user, central London)

5.1. Introduction to research findings

This chapter, the first of three that present and analyse the results of the research, focuses on residential mobility, with the second and third looking at closely interlinked questions surrounding welfare reform and the meaning of ‘home’ respectively. The specific research questions this chapter aims to answer are:

- How do persons with serious and enduring mental health problems account for their residential mobility (or lack thereof)?
- Have fluctuations in their mental health influenced decisions to change residence (or not)? What impact (if any) has a decision to change residence had on their mental health?
- Have decisions to move or stay put been made voluntarily, or have they been forced upon them?
- How do these experiences compare to the existing body of literature?

The literature reviewed in Chapter 2 set the backdrop against which the current research is situated: namely, the ways in which mental health service users had become residentially mobile (or not) in the post-deinstitutionalised mental health landscape, and the interactions and connections to their mental health. In presenting its findings this chapter draws on important points from that literature, and compares and contrasts the experience of service users interviewed for this research with those portrayed in previous studies. It tests this evidence against the attempts by scholars to create an analytical framework of mobility with which to better understand its relational aspects, primarily with reference to the theoretical structure offered by Cresswell’s (2009) ‘politics’ of mobility, especially the

elements of ‘force’, ‘feeling’ and ‘friction’ to which he refers, but also ‘rhythm’ and ‘routes’. Also helpful in the task of elucidating the relationship between mental health service users’ contemporary residential mobility experiences and the broader social, economic, and policy environment in which they occur, is Sheller’s (2008) discussion of the spatial freedoms, power imbalances and injustices that are indivisible from the practices of (im)mobility. Central, too, are those research papers which found the residential mobility patterns of mental health service users to be characterised by drift (DeVerteuil et al, 2007; Lix et al, 2006; McNaught et al, 1997), residential instability and repeated hospital admissions (Lamont et al, 2000; Tulloch et al, 2011), circulation, hypermobility and the effects of institutional factors and policy (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000a). Equally relevant are those studies that investigated the careful interplay between mobility and its counterpart, immobility, or entrapment (Drukker et al, 2005; Ross et al, 2000; Smith and Easterlow, 2005).

This chapter is formed of four parts: the first looks at those interviewees who were residentially mobile during the timescale of the research; the second presents three illustrative cases studies of the ways in which mental health service users’ (im)mobility and the degree of control they exercise over it can be central to their self-management of their mental health; the third compares and contrasts these findings with those of previous studies; and the fourth provides biographical details of the participants discussed in this and subsequent chapters.

5.2. Evidence of residential mobility within the research timescale

Residential mobility here was defined as a person having experienced a residential move of at least one nights’ duration in the eighteen month ‘retrospective’ period preceding the date of first interview and/or in the time which elapsed between the initial and final interviews (that being six months for those interviewed twice or twelve months for those interviewed on three occasions). A minority, or nine interviewees, met the criteria. This lower than anticipated number is probably related to the sampling/methods of recruitment difficulties commented upon in the preceding chapter. As the table below shows, three primary reasons

for the mobility could be discerned: hospitalisation, precarious housing, and extenuating home circumstance. These scenarios, and the particular events allied to them in respect of each interviewee, are explored in more detail in the section that follows.

Table 5.1. Participants' residential mobility

Reason given for residential mobility	Participant(s)	Predominately a voluntary or involuntary form of mobility?
Hospitalisation	Harry Jessica Ruth Yann	Involuntary Voluntary Involuntary Involuntary
Precarious housing situation	David Donna Stephen	Involuntary Involuntary Voluntary and Involuntary
Home circumstances	Laura Liam	Voluntary Voluntary

5.2.1. Mobility as a result of precarious housing situations

In the cases of three interviewees - David, Donna, and Stephen – the insecure nature of their accommodation presaged residential changes. For two, these changes can be seen as largely involuntary, having been foisted upon them in different circumstances outwith their direct control. The third, Stephen, had been sleeping rough in the months prior to the first interview, and the necessity of daily seeking new places of shelter and safety rested entirely on his own initiative, knowledge, and expedient use of local amenities. These actions could perhaps be considered to represent examples of the *practice* of voluntary mobility, yet Stephen's homelessness must ultimately render them the outcomes of an all too pernicious form of *involuntary* mobility.

Though only three in number, and therefore fewer than the study set out expecting to find (though another two interviewees had experienced significantly disruptive

involuntary mobility in the months immediately prior to the eighteen month retrospective period, and four other interviewees had experienced similar movement just prior to that), these examples nonetheless provide a richly textured illustration of contemporary residential mobility as practised by mental health service users. They are also important because, as Padgett (2007, p1926) notes, “the tendency in previous research has been to make static comparisons [between house and unhoused] thereby failing to capture the dynamic experience of housing deprivation”.

Donna, mental health service user, 45, east London

For over a decade Donna lived on the top floor of Victorian house in east London, in which she shared a common entrance and laundry facilities with her downstairs neighbours. During the first interview, she described her experience over the course of the 2000s of fighting against a slowly deepening descent into depression, of ‘trying hard not to go under’ but which, ultimately, resulted in two hospital admissions.

“It was difficult for the neighbours as I wasn’t mentally ill when I moved there, and then I became seriously mentally ill ... They cared about the vibes kind of thing, is how they put it to me, of somebody just being so sad, and there was kind of somebody imprisoned up there. I would sometimes become very nocturnal, sometimes I’d pace around a lot, sometimes I’d talk to myself and laugh quite loudly, so they were – one time I flooded, I left the bath running and fell asleep, and flooded downstairs, a couple of times I burnt food very badly forgetting I’d left the cooker on. So, it was difficult for the people living downstairs from me. Also, I think they told the landlord that the place was in a really bad way and he came round when I was in hospital I got quite a stern letter. He was trying to be sympathetic, but he was very disappointed that I had let the place become so squalid.

“In autumn 2012 my landlord asked me to leave. But he was very understanding, because he knew that I had mental health problems, so he gave me six months to find somewhere else. As it was, I didn’t even know

he had written to me as I was just too ill even to open letters. I hadn't been answering the phone, or been in contact with anyone, for a few months"

Thus, in late winter 2013, Donna found herself being prepared for eviction. She had been put in touch with a homeless support project and, despite the severity of her condition, had succeeded in getting herself accepted by the project and being allocated a support worker. Gaining some confidence, though still unwell, Donna had attempted to find an alternative place to live but repeatedly ran into a refusal to accept tenants in receipt of housing benefit. Eventually,

"[o]ne place was advertised as accepting DSS so without actually seeing it I rung up – I wasn't actually well enough to be doing this but I was just trying – and said I'll take it, but I hadn't realised it was more than the housing benefit cap – by a significant amount – which would have been seriously problematic. I asked my father, and said 'this is the situation, will you help?'. And he said 'no, I won't help'. And I was really upset, he said 'why can't you go into a homeless hostel?', which I was really amazed by, I was like 'My God, what do you think homeless hostels are like?'"

Fortunately, as the prospective landlord was changing his mind and deciding against accepting a tenant reliant on housing benefits, her support worker found her an appropriately priced alternative:

"She said 'where do you want to live' and I said '[name of neighbourhood from which the local psychiatric unit takes its name]', because it was close to the hospital [laughs]! I kind of had no higher aspiration at the time. I thought 'that's my life', so I may as well be close to the hospital".

Donna's specific role in the process of actually moving residence was limited to her desire for co-location with medical facilities (the only such instance of behaviour akin to active 'drift' to emerge in this study, though another interviewee, Susan, had for some time resisted moving home due to the proximity of her psychiatric support network). For her, the homeless support project "were really instrumental in my recovery". They,

“essentially moved me, as I was still too ill to engage with the process particularly, they did all my packing and my unpacking at the other end ... So all I had to do was get in a taxi and go from one place to another. I went from sitting on the bed in [name of neighbourhood] to setting on the bed in [name of neighbourhood] ... and this home was kind of taking place around me and at the time there was a tree outside my bedroom window, right outside the window and it was like a tree house, it was still snowing, and I sat, pretty much for a month and half, watching this tree come to life and come spring, listening to birdsong and looking at the birds in the trees. And not really going out, but leaving bed – which I didn’t used to do in the old place, I’d just stay in bed – I started going into the living room ... I suppose expanding my territory [laughs] and then it became the whole flat, and then it became the local area”.

Donna's feelings about her actual experience of residential mobility are largely positive ones – including her apparent sense of wonderment at seeing life begin anew, one of the many touchingly apt metaphors she was to use over the course of the interviews - and, unlike David, whose case is discussed next, involved essentially a uninterrupted and greatly assisted transition from one home to another, thus emphasising the centrality of the part that 'street-level bureaucracies' have in helping – as in this case – or in hindering outcomes for mental health service users (Hopper et al, 1997). The circumstances that led up to her eviction and move were, however, far from smooth. Her experiences – four years of effective bed-bound isolation, a psychotic breakdown, hospitalisation, and abandonment – are explored in detail in the final analytical chapter, which focuses on interviewees' sense of 'home' - as both physical abode *and* emotional construction – and its increasingly important and multifaceted role in service users' daily management and negotiation of their wellness, illness, stability, distress, and recovery.

David, 44, mental health service user, west London

A little over two years before first making contact in July 2014, his life having been “taken over by drug use”, and having endured a breakdown, three serious suicide attempts and three periods of hospital admission, David, a former trader in the City of London, found himself sleeping rough (a pattern of experience and circumstance all too familiar from the literature, i.e. DeVerteuil, 2003; Knowles, 2000a). At the time of our first interview that September, supported by housing benefit he had, for sixteen months, been living in a one-bedroom private rented flat in inner west London. When we spoke next, at the end of March 2015, him by telephone from a B&B in the Home Counties in which he had sought refuge, David was facing the prospect of imminent eviction. His particular trajectory through the mental health and homeless systems provides a revealing insight into the pathways that service users in David’s position are compelled to follow.

After two months of living on and around the streets of central London, wandering the city at night for safety reasons and instead sleeping in parks during the day, David was taken into hospital:

“I was sectioned whilst they helped me get off the drugs, I was in hospital for thirty odd days. The hospital didn’t really assist me in any shape or form in regards to getting accommodation and in the end they paid, the hospital paid, to put me in a bed and breakfast to actually get me out of the hospital. I went to the Council, and the Council put me up in [name of outer London borough], and I was there for just about a week – less than a week, I think – but the problem was when I was discharged from hospital, I was discharged with my medication and also someone else’s medication. So I was taking the wrong medication so during that period all the medication was mixed together which meant I had another melt down ... I was supposed to go and have a check-up with my GP, like a weekly check-up on the Monday, didn’t make it and on the Monday morning – I was in a terrible state – eventually got there on the Monday afternoon the GP refused to see me, even though I was suicidal this that and the other, and he said I had to come back tomorrow. So, I actually walked to A&E, went into A&E and they put me

back into hospital, I was there for about a week and half and the ward manager pushed and pushed and pushed the Council and they agreed to put me into a hostel in the borough so that I was near my support network”.

The hostel, a privately run 164 bed hostel in central London, provided David with the minimum of a roof over his head, but little more, his descriptions confirming previous studies which have noted that hostel dwellers tend to be “isolated from mainstream care and hostels to be places where disorder is ‘contained’ but not alleviated” (Craig and Timms, 2000, p208). It was ‘horrendous’, a ‘hell-hole’ in which neglectful owners, eager to minimise running costs in advance of an imminent sale and conversion into luxury flats, routinely ignored basic maintenance and cleanliness. Loathing the communal parts of the hostel – “I laid in bed for days at a time, like a hermit. I would go to the pub to use the toilet, it was much better than the hostel facilities, and I used to go to the local swimming pool to shower” - and finding the box-like atmosphere of his room further constricting his impoverished senses of wellbeing and dignity, David was delighted when, after seven months, he was moved on to supported accommodation in central London; and from there, three months hence, to his private flat.

At the close of the September conversation David, whilst relishing the vibrancy of the area in which he lived, and the “friendly locals who now know me and who I chat to”, explained that he was in an already protracted dispute over the failure of his landlady to ensure the proper upkeep of the property, and was being menaced with an eviction notice. As a consequence of this, his advancement away from shaky residential settings into more stable accommodation and toward longer-term stability of mental health, was threatening to stall. When we spoke the following March, matters had come to a head when, in November, “she served me with a notice to quit. That actually expired and I have just received about a week ago a court order saying I’ve got to vacate the property”. David surmises that the eviction rests on two issues: one, that owner wants a trouble free tenant “who isn’t demanding and makes her do what she’s supposed to do within the terms of the contract”; and two, she wishes to increase the rent. For David, a rent increase would place his flat outside the maximum housing allowance permitted under the housing benefit reforms. In conversation he picked up this point:

[F]rom conversations I've had with other people in the area it seems to me that people who are on housing benefit are being slowly squeezed out of the borough. Because obviously [this] is a place where people want to live but the allowance is not enough ... because there is obviously more and more demand on rental accommodation. But also, I'm finding it very difficult to get someone who's prepared to rent to me, in my situation, even though they get the rent direct from the council, a lot of landlords would not touch me.

I was supposed to be out last week but I am trying to extend it at the moment but she's not being very helpful. [The] housing department were trying to help me move out to [name of the home county in which David has friends and family] but they are really struggling to find someone who will accept me so they are basically now looking for a studio apartment in the borough, they're calling in some favours so hopefully they'll get something sorted out."

As a result of the anxiety engendered by his situation, David has been spending time away from his home, mostly with friends in the Home Counties. Asked how he was, David explained that "I was supposed to come home last night but I actually didn't bother coming home because the thought of going there at the moment really upsets me". Further,

"If this had been two years ago I would probably have ended up back in hospital, but because I've got a support network now, and I've got a partner, you know, I have reconnected with my family and so it has been a lot easier this time. But you know, there have been dark days. You know, my partner doesn't know that I'm not in London and that I'm staying in a cheap bed and breakfast because I don't want to go to my apartment. I don't like keeping things from her, but the thought of going there at the moment fills me with dread."

He is also crystal clear about his potential predicament:

“Well I am essentially going to be made homeless, yeah. That means going into a hostel or bed and breakfast and sort of going back to the beginning again.”

In concluding our conversation, David struck a note of defiance amid the resignation, echoing the sentiments expressed by service users in other, similar studies (DeVerteuil, 2003; Herbert, 2010; Knowles, 2000a). For him, as for other service users interviewed through this research, in situations similar and not, his current quandary represented merely another obstruction on the tortuous path to recovery and around which he would have to find an alternative route:

“But at the end of the day, you know, if I have to go into a hostel to start again the positive thing about that is once you go back into a B&B I know the system now, so I’d be knocking on doors to get from a B&B into sheltered accommodation and back into private. I mean you get a lot more help, and they will actually speak to estate agents and guarantee the rent and all this sort of stuff and there is much more help.”

Stephen, 41, mental health service user, Home Counties market town

Like David, Stephen had also embarked on a similar journey of hypermobility and circulation (DeVerteuil, 2003, 2004a; Hopper et al, 1997; Knowles, 2000a), though he was at a much earlier stage in the process when we met in early March 2014. Stephen had been residing in the town’s homeless persons hostel since September 2013. Previously he had been sleeping rough and, prior to that, had been lodging for some months with various family members until a family dispute resulted in him being turfed “out on the street ... he [family member] made me leave”. Thus began Stephen’s month long odyssey through makeshift encampments in the town and its surrounding villages, interspersed by one brief period back lodging with a relative. His residential movements are summarised in the following table.

Table 5.2. Stephen's residential mobility

Type of place	Source of shelter	Length of stay	Reason for departure
Semi-wooded/semi-open public ground on the edge of the town centre	Tent	2.5 weeks during the period mid-August to 4 September	Robbed and threatened
Father's residence, in nearby small town		"Couple of days"	Not established
Field, six miles or so from the town	Tent	4 days	Eviction notice from owner of field
Town bus station	Partially covered bus shelter	3 days	Local authority secured a place in the homeless shelter

Stephen described the process by which each location was initially chosen and the events that led to him moving on:

"I was homeless for four weeks. I started staying in a tent at [name of location in the town] ... that was the ideal place to go and obviously pitch a tent. It's kind of a public area, but there's also a little wood that you can go into a corner and obviously pitch a tent and no-one could see you. I stayed there until I got robbed and threatened, I think it was the beginning of September. [Then my] Dad obviously took me in for about a couple of days, so I stayed over his place. But then I was obviously back homeless for another two more weeks. I needed to get out the way, after what had happened to me ... for our safety, [then] I went to [name of village] where there was a farm field. I didn't get the permission of the farmer and obviously we were given our 'if you did not remove your tent [notice]'."

Stephen talked about a long trudge from the distant farm field back to the town - a rural, as opposed to an urban, 'pathway', but trod for the same 'purposes of

survival' as the homeless psychiatric patients interviewed by Knowles (2000a) - and the stresses of keeping both possessions and sanity intact:

"When I was made homeless I was very vulnerable. It was a very, very horrible experience. You had to look over your shoulder the whole time, you had to obviously keep everything in your tent secure. Which, I didn't have a lot ... I had one shopping trolley which I borrowed from somebody from the church, I had another holdall thing, and I had the rucksack which I've got with me now. So I was carrying three items nearly everywhere I was going. And, literally, my hands were getting very blistered, my morale was getting very, very down, but at the end of the day I didn't give up, I just kept on fighting on."

For safety reasons Stephen ended up sleeping at the town's bus station, which offered a modicum of some shelter and where, after three days, people from a church with which he had been associated, recognised him and contacted the local authority emergency homeless line. As a result Stephen was given an emergency bed for the night in the town's homeless hostel where, as a non-resident, he would be permitted to stay for a maximum of only seven nights. Stephen stated that he had been contacting the hostel himself, seeking a bed by telephone, since having to move from living with one relative to another earlier in the summer. He explained that:

"[I]f you want a room you have to keep phoning. I started phoning way back in June, and they have a tick on there of all the [times you phone]. Even when I was homeless I was phoning up! Because I wanted a room. I think they look at how many ticks, but at my situation, because of what happened to me, being attacked and robbed, my saucepan and everything were [stolen], I went in to the council pleading with them 'What has happened to me now, I cannot carry on as [I am]', if you know what I mean.

"You could stay there for a week. But luckily for me, on the last day which was the Wednesday, someone looked at me, put a hand on my shoulder and said, keep your phone handy mate 'cos you might have some good

news. When they turned round and said, you know, I was going to be given a room, I just... it was just like cloud nine! You looked at it, and it was like, there was a wash basin, there was a kettle, and ... it was just hard, I was just speechless, I mean I signed the contract, I'm there for about two years, but I am officially looking for one bedroom bedsit to get my life back on track".

Stephen ended the interview by talking about his desire to find a permanent dwelling place and rebuild his life, and of his frustrations with living in the hostel and with the long-drawn out process of having to use the local authorities online search system to locate a home for which he might be eligible to bid, frustrations which denote the continuing relevance of Hopper et al's (1997) observations on the 'inertial forces' of agencies such as housing and social service departments that end up sustaining homelessness. Plans were in place for a follow up interview with Stephen in September 2014 but it sadly proved impossible to make contact with him directly, nor via the local service users' charity where we had first met. Stephen was one of four interviewees who fell out of touch during the course of the research, but the only one who was not living in a stable home of his own and who had so recently been displaced into street homelessness.

5.2.2 'I'll be back in an hour'. And I wasn't'. Residential mobility as a result of hospitalisation

Of 26 interviewees, 17 had experienced at least one period of hospitalisation, four during the timescale for the study. In these latter cases, each instance of hospitalisation occurred during the eighteen month retrospective period and not following the commencement of interviews. Three interviewees (Jessica, Ruth, and Yann) underwent extended stays in hospital, two of whom (Ruth and Yann) were held under section and whose cases will be discussed shortly. Jessica, who first interviewed in January 2014, had spent eight days in November, and thirty days in December, 2012, as a voluntary patient at a local psychiatric hospital, after recognising her deteriorating condition and asking for voluntary admission. By contrast, Harry's experiences are typically of short, but involuntary and unpleasant periods of hospitalisation, as a result of chronic overdosing and self-harming:

“Most of my self-harming has been happening when I’ve been drunk ... I know how much it upsets her [Harry’s mother] when she’s seen me [rolls up sleeves to show scars from cutting] – these are quite old ‘cos these are all healed now. But it’s over here [pointing to arms], all over my chest. She’s been to hospital and seen me when they are all cut to ribbons and I’m off my head puking up soot because they make you drink soot when you overdose ‘cos it sucks up all the crap out of your liver. And the thing is, with personality disorder, you won’t get sectioned ... they only hold you long enough to patch you up.” (Harry, 48, mental health service users, Home Counties county town)

Having been ‘patched-up’ nearly thirty times in total, the most recent incident, in August 2013, saw Harry overdosing and subsequently stabbing himself through the chest with a meat skewer:

“I don’t have much memory of it, all I remember was I came to in a hospital ... I thought it was Saturday morning as it had happened on the Friday night but it turned out it was Sunday evening, so I’d been out of it for over a day and a half.”

Conversely, for Yann, whilst hospitalisation entails fewer emergency patch-ups, it is of a longer, and more uncertain, duration. Her most recent hospitalisation occurred on 26 September 2013, or precisely one year to the day before the first interview, and lasted until 16 December 2013. Yann, who in the course of her interviews explained the troubled and largely estranged relationship with one of her children and the role this relationship has had in her bouts of illness, and who has been hospitalised several occasions previously, explained:

“I signed off the mental health system to go onto alternative medicine. [Name of Yann’s child] wanted to contact me that day but I just wanted to be left alone. But [name of child] rung the police. Now, I have a problem with the police because they [have always previously] diagnosed me with having a relapse when they’ve been called ... What they tried to say is that I

came off the medication to go on homeopathic medicine and I became ill again which isn't the case, it's because [name of child] interfered with the police. I would have been quite fine staying at home and minding my own business by taking alternative medicine. You can function on them, you can have a laugh, you want to go out, you want to go for a drink with friends.

[But] these doctors they've got a habit of sectioning people and they've got nothing left in their lives after they've done that, they can't function. I don't know how doctors can see people deteriorating and carry on doing it. How can doctors say the drugs keep them well when they're looking like that? It's doing something to block out some actions when they're unwell but it's not giving them a better quality of life. I've been admitted quite a few times because I never had an outlet, but now I've found some other drugs which will keep me going if they listen to me." (Yann, 52, mental health service user, west Midlands)

Thus for Yann, the ability to remain residentially immobile, at home, quietly 'minding her own business', is prone to aggressive disruption by forces – the psychiatric profession, the police, the familial – outside her control, and which carry consequences that endure beyond the direct period of residential change.

Similarly, Ruth's experience of residential mobility during the timescale of the study was as a consequence of four periods of in-patient admission under section:

- 4 September – 16 December 2013
- 28 December 2013 – 30 January 2014
- 7 February – mid March 2014
- late March – 16 May 2014

She, too, refers to the part that medication played in her deteriorating situation during the summer of 2013:

“They say it was because of the medication I was on in 2009 came out of my system fully over the course of the summer ... [I started to] skip work, which is always a sign that I’m unwell, if I kind of dip out of work for any reason. I would kind of go in, and the meetings wouldn’t be making sense, and I would be looking for clues and suggestions and things from the meeting. So I had a couple of those, on the day before I was sectioned I just went into town, and walked around town, looking for clues and suggestions and things, and then climbed some scaffolding to, um, to kind of, it was like, um, I had an idea if I climbed the scaffolding and jumped off I would be... transmuted into a different kind of person, and that’s what I was looking for. And that would allow me then to connect better with the person that I wanted to connect with. But, thankfully, there was some people and builders on the scaffolding and they pulled me back and wouldn’t let me jump. And then they called the police and the police found me wandering round the streets and started to investigate me and I got taken to the 136 suite and I was in there overnight and they kept me in there until they decided what to do with me. I was there from about 4pm I got taken in, something like that, I must have moved sometime in the middle of the night. And I had two doctors section me and I was taken to [name of hospital].”

(Ruth, 50, mental health service user, south of England)

Ruth’s reference to her work is important here, because her status as a full-time employee in a sympathetic corner of the public sector meant that, despite spending the best part of nine months in hospital, she received full pay for four months and half pay for the rest, thus ensuring she did not lose her tenancy. Earlier, Jessica had expressed relief that her benefits, and thus her tenancy in her rental flat, were uninterrupted because of the relative brevity of her stays in hospital. This finding is particularly noteworthy as, unlike previous studies which found clear evidence of hospitalisation resulting in evictions, lost tenancies and a permanent residential move after release (Caton and Goldstein, 1984; Lamont et al, 2000; Tulloch et al, 2011), the evidence from this study (albeit from a much smaller sample) is that such moves were of only temporary duration and users returned to their own homes upon discharge. Nonetheless, Ruth described the disruptions an abrupt departure to hospital might entail, including her relief at

having power supplied through a key card rather than billing arrangement, so that during her second admission that winter her heating remained switched on only until the card credit ran out and not until she returned to an unmanageably large bill. Her admission in March was slightly more problematic as her house keys were mislaid and “it was a bit of a pain to come out and sit outside in the cold and not be able to get in”.

Ruth confessed to a sense frustration and a degree of ambivalence in her feelings about her experiences of being repeatedly discharged for a few days only to be taken back into hospital again:

“It was kind of frustrating to be taken back in. I mean, I was thinking bizarre things still, so I needed to be back in, I suppose. But, um, I tended to take things in my stride. But I had only just come back out and settled back into having my daily life here and picking up where I left off and there’s always so much to do in terms of answering the post, and getting things back into working order. So there was that to do. It was frustrating to have that ripped away from me and being taken back in and knowing it was unlikely you’d get out for another two months or whatever. And literally, in the March one, I had gone down to the doctors and had my tea ready for the evening – which was Mackerel – which was not the best thing to leave in the fridge for several months... so that was in the fridge and everything was on and ready to go as I’ll be back in an hour... and I wasn’t. That was really frustrating.”

When we met for a second interview, in March 2015, Ruth discussed her December 2014 decision, agreed with her psychiatrist, to discontinue her medication. She had “thought long and hard” and decided she would risk another psychotic breakdown to “find out whether I really need medication or not” even though she believes that everything – “my work, my home, my ability to drive – it all hinges on me maintaining a stable mental health outlook”. For Ruth, the ability to live a meaningful life free of medication, mindful of the fragilities of her mental health, will, she hopes, ensure her absence from further hospital admissions, though a temporary displacement from home is an event she is ready to countenance.

5.2.3. Voluntary residential mobility as result of home circumstances

Rather different to the cases discussed so far, two interviewees, Laura and Liam, experienced voluntary residential mobility as a result of their particular home circumstances. Each was able to take advantage of offers of temporary accommodation from friends as an alternative to remaining amongst the stresses of their respective home environments. This example of residential mobility, while likely to prove unsuited to longer-term welfare needs, nonetheless represents a self-determined response to particular daily circumstances (DeVerteuil, 2003) and shows the importance of a nuanced understanding of its practice. In Liam's case, over the course of a month preceding the second interview, he had spent several nights each week house sitting for a friend. The opportunity arose in the midst of an extended period of harassment and intimidation from his neighbours caused, he avers, by their prejudice against his status as a "psychiatric patient":

"I still have problems with my neighbours and, six months on, in the eyes of the environmental health officer, I am a 'health hazard', because I am not functioning. I have stopped functioning. Because of the harassment of my neighbours I am reluctant to go out my front door and be in the vicinity of my block of flats, so I don't take my rubbish out and my rubbish has built up and built up and built up. The environmental health officer visited and he declared it as a health hazard." (Liam, 48, mental health service user, central London)

Liam's housing association threatened him with eviction, citing the environmental health issues and what he called "a series of false allegations" by his downstairs neighbours over nighttime noise nuisance he was purported to have been creating:

"I understood that they were 'imminently' going to issue proceedings. It's been two months and every time I come back and I open the door I'm anxious if there is going to be a letter from my landlord saying they're going to issue court proceedings. You've got that sword hanging over you, you know, it's just hanging by a thread and..."

Accordingly, the temporary absence of his friend allowed Liam both to escape his oppressive home atmosphere and to find some pleasure in being able to engage in extended periods of writing, his primary hobby:

“It was actually quite productive for me in terms of writing as he has Wi-Fi at home. I don’t have the TV or the internet at home. The environment at home was not conducive to writing, so being at his place I have been away from the stresses of my neighbours so I think that liberated me.”

Laura, too, sought relief from difficult home circumstances, again involving burdensome neighbours:

“They [the housing association] moved this woman in ... and within a few weeks she was consorting with the Class A drug users next door even though we told her not to. She’s the kind of person who, as soon as she gets drunk, she loses the ability to make any sensible decisions and she just lets people swarm all over her. This went on for months and months and months. Things got nicked out of the hallway, we were feeling – well I wasn’t, but I think [name of another neighbour] was feeling really threatened by their presence – I was just feeling really, really annoyed because there was noise downstairs at night and people having arguments in the hallway and all this kind of stuff. About five months ago there was a major disruption – her drinking got completely out of control. She ended up knocking on my door at night, and knocking on my door first thing in the morning, so I took refuge with a friend because I had to get some sleep before I could cope with anything.” (Laura, late 60s, mental health service user, west Midlands)

Laura was keen to emphasise her view of her own relative privilege vis a vis the situation, noting that she lodged with a close friend nearby and that it “was just for one night. Because I have good connections it was ok, but if it had been someone else who didn’t have good connections I don’t know what would have happened”. Asked about any impacts on her mental health, Laura said:

“I think in my case it is actually helpful, because I’m that sort of person, you know? I’m not timid, I will go and confront people, I do take things on and I think having a role like this has helped me in some ways [earlier in the conversation Laura had described herself being regarded as “House Mother-cum-Rottweiler” by her fellow housing association tenants]. But there have been times when I’ve thought ‘Oh, I want to move, I don’t like this, I want to move out because of this’”

Nine interviewees met the criteria for having been residentially mobile during the research period. Of these, six in particular have served to illustrate what is perhaps the dominant feature of their experiences – namely the *involuntary* nature of their mobility: a form of movement which involved compulsion, or *force*, in which individuals were channeled through particular *routes*, encountering significant *friction* on the way (Cresswell, 2009), and which illuminates how geographies of power are bound up with practices of mobility (Merriman, 2009). Strictly speaking, though, one could argue that a voluntary admission to hospital, such as experienced by Jessica, is only voluntary to the degree that the alternative was a further deterioration of her mental health followed by a likely section; similarly, Laura and Liam took advantage of the opportunity to spend nights away from their homes largely as a consequence of their experiences in and around those homes. Liam’s case is one that will be revisited below, and will be joined by two others in an examination of the extent to which individuals’ residential circumstances were determined by voluntary, or involuntary, forces.

5.3. Residential entrapment: (In)voluntary (Im)mobility

Three case studies are contrasted in this section. Each demonstrates the extent to which having a degree of personal control over residential circumstances is crucial for service users attempts to maintain stability in their mental health, and which underlines the extent to which questions of mobility or immobility cannot be divorced from questions of power/powerlessness (Jocoy and Del Casino, 2010). For Christine, who had, in short order, been evicted and abandoned in temporary accommodation, and Liam, who for over a decade been stuck in inadequate

accommodation, their enforced and unwanted housing situations ill-served their mental health needs; indeed, at their worst, they were a cause for active suicidal ideation. In comparison, Ruth had elected to be regularly temporarily residentially mobile precisely in order to maintain her relative mental stability.

5.3.1. Involuntary mobility begets involuntary immobility: Christine's story

"I was made homeless during the Olympics, the run up to the Olympics, when landlords were getting extortionate rents. I went to the council, you had to go through the eviction procedure. So the same day you are evicted you go to the council and they give you temporary accommodation which, before you even see it, you have to accept it, and this was the place. And I was under the impression it would only be for a few months – well I was actually told that by one of the housing officers." (Christine, 58, mental health service user, east London)

When I first travelled to the inner suburb of east London to which Christine had been displaced, her time in 'temporary' accommodation had topped the two and a half year mark. The two-bedroom private rental flat she had previously shared with her teenage daughter had become a one-bedroom flat in a converted Victorian house occupied by other temporarily housed families. Among the first remarks Christine made when asked to discuss her housing circumstances was to emphasise her powerlessness – "you get no choice" - over her situation and to describe the process of experiencing eviction and being relocated in temporary accommodation:

"It was a nightmare, an absolute nightmare. I became really, really ill, especially when I discovered that the council force you – the landlord has to take you through the court proceedings to formally evict you. I didn't realise, that on the day you're evicted I thought you had the whole day to get your stuff out, but you don't you have to go there and then. So there is stuff I left behind in the flat. And on the very same day you get an offer of another place, temporary accommodation, so everything happens on the same day; you have to move all your stuff out, and then move into a new place which

is already furnished so you're not really supposed to bring your own stuff in. So, I went from there to here whilst my stuff went to south London [to go into storage]. It was awful, awful, I cried for days, and when I saw this place, I absolutely hated it."

For Christine her dislodgment was doubly damaging, involving a displacement from both home *and* local area, as the local authority, pleading an acute shortage of appropriate housing, placed her into a different, but adjacent, borough (though one with which she was unfamiliar and where she knew no-one). This geographical shift in location has had quite particular ramifications, none of which were conducive to Christine being able to help stabilise her already fragile mental health.

Firstly, Christine's teenage daughter attended a good secondary school local to where she had been living and Christine was loathe to have to move her daughter closer to their new home, particularly as she had been led to believe that 'temporary' accommodation meant precisely that. Her daughter thus had to make a substantial unsupervised journey to and from the school each day and Christine's relative distance from her daughter during the day was a particular source of worry. She explained:

"One of the things I promised myself is that none of my children would ever be sexually abused the way I was. I know how devastating it is. Anyway, this [Christine's daughter had been sexually groomed] had happened, the police came and took a statement, and I began to look into it. There are gangs ... and part of the gang's culture and initiation is to get girls to do things. So, this image was passed from one to the other – and there are men behind this, it's not boys doing it – and then she was told 'if you don't come and provide oral sex for this boy then we're going to make this go viral, etc.' And she got frightened, when she knew she'd been caught with this, that she'd been set up, so she called the police. Apparently, one of the gangs meet up near her school... but the police were involved so I couldn't – I wanted to go down and punch their fucking heads in, the lot of them. I

wasn't scared, I'm still not scared. I wanted to go and bloody do something and still probably will.

So I'd rather be nearer to where her school is so that I can be around if she needs to get home quickly or if I need to get the school quickly ... That's one of the things I worry about that I am so far away, and the traffic is so bad, that it could take me a long time to get there. That's one of the issues for me, that does effect my mental health, because I really worry."

Secondly, the accommodation into which Christine and her daughter had been decanted was palpably failing to meet either of their needs. Christine was sleeping on a sofa bed in the sitting room, allowing her daughter the privacy afforded by the single bedroom. Consequently,

"I have no space for myself. So, for example, when I do become depressed or anxious, I can't bear stimulation – I can't bear lights, noise, stimulation, anything – so I need a space, if I had a space to just to be quiet for a couple of hours, a space of my own, it would make all the difference. But I don't. I have to sleep here in this room, everything I do is between here [sitting room] and there [pointing to the adjoining kitchen]."

Thirdly, the inadequacy of Christine's accommodation is compounded both by the refusal of her 'home' local authority to accept her need to be rehoused, and by the difficulties of being temporarily placed out of borough:

"I have been campaigning since I got here. They've basically told me that they don't accept my mental health issues. Yeah, they basically said that they don't accept that living here has an impact on my mental health. I've sent in letters from the psychiatrist on two occasions, I've also sent in letters from my psychotherapist, and my GP, but apparently living here doesn't have an impact on my mental health. They seem to have their own policies now – disregard everything and just carry on doing what they're doing. Despite the fact that I have been suicidal several times, went to see the psychiatrist several times – I was really, really down – and also physical

complaints because I have to sleep on the sofa. I have arthritis, and my back hurts, I suffer with insomnia. But I sent in all of this information – everything they requested – and they completely rejected it and said they don't accept that it effects my mental health.

It makes it difficult if you're in temporary accommodation in a different borough, because the services that are linked to the borough you're from you can't use them because you don't live there. You have to use the services in the borough in which you're living, but they often don't have any contacts with the borough you're from and they're not familiar with the protocols and how they operate, and the people they should be contacting they don't know who they are. So that takes even longer to get anywhere."

Christine was understandably angry – in fact bitter - about her treatment and the lack of acknowledgement by the local authority of her particular requirements, and worn down by the constant battle to try to make headway against a tide that seemed to be carrying her ever further from her goal of stability and security for her, and her daughter. When we met for the second time in early spring, 2015, Christine has been in her 'temporary' accommodation for over three years and believed that "I don't stand much of a chance of moving from here anytime soon. I've done everything I can to get some kind of priority but it hasn't made *any* difference *whatsoever ... I've kind of given up hope – it feels kind of pointless sometimes and what's the point of doing anything or trying anything [else]. [But] why should I accept that this is ok? I know this is better than the way some people live, I know there's whole families to one room, maybe I should think myself lucky, but why should I when it's just not good enough. It's just not good enough". Her case – and that of Liam, which follows - is illustrative of several important points from the literature. First, that residential entrapment serves to damage further already damaged people (Drukker et al, 2005; Ross et al, 2000; Whitley and Prince, 2005). Second, that entrapment can result from the active emplacement of people whose health has already been compromised into deeper deprivation and exclusion (Easterlow and Smith, 2005). Third, that a saturated, high cost housing market like the inner London borough from which Christine was displaced, almost ensures that future opportunities to move 'back' will be severely constrained. And*

fourth, that such displacement undermines “the degree to which the social geographic dimensions of people’s location allows them to build networks of relations that improve their life chances and their health chances … [and which] increases the likelihood that less affluent people may be ‘prisoners of space’, lacking connections to opportunities outside their immediate neighbourhood environment” (Dunn, 2000, p356).

5.3.2. Further involuntary immobility: Liam’s entrapment

“I can’t stand living there and I have no prospect of moving. For me, my flat is a prison. The only reason why I am not dead is that there are no ligature points in my flat. I am so unhappy there.”

Thus did Liam introduce me to his feelings about his domestic situation when we first met in January 2014. Like Christine, Liam had become seemingly marooned in inadequate accommodation, was involved in a long running dispute with his housing association over his predicament, and felt his mental health was being severely compromised by the ‘poky’ and ‘minute’ size of his flat which had rent asunder his ability to maintain a family life with his wife and young daughter having left to live overseas:

“No sane, rational person would say that my accommodation is suitable for a family of three because it’s just too small … [as] my property was renovated in 1998 so since there was no minimum size set out [in law], my housing association took advantage of that and made a property that would be suitable for an elderly couple but that’s not suitable for a family home. And that’s one of the consequences – my family don’t live with me – and that is a great source of personal anguish, that I am separated from my family.”

Liam had been resident in the flat since 1998 and despite over two hundred viewings from prospective tenants with whom he and his family could swap no offers had been made. In each of our three interviews, Liam said he had “no

prospect" of moving and was effectively resigned to remaining a "prisoner of [name of central London borough]". His dissatisfaction with his housing position, with residing in central London with its attendant noise, crowds and pollution, had led him to attempt suicide and he was filled with a distant longing to return to the rural Scotland of his childhood:

"I live in Zone 1 in central London, I have no choice but to be in crowds. I would love to be 'far from the madding crowd'. I would love to be back in Scotland where I grew up in a small village. I would love to be back there. This is why I call myself a prisoner. I don't have the economic means to change my life. I don't have the opportunities ... I've given up on life."

Liam's position was compounded by the long drawn out dispute between himself and his housing association, by whom he felt himself to be persecuted. As discussed earlier, allegations relating to noise nuisance had been made against Liam and the housing association had announced their intention to commence eviction proceedings against him. Liam considered himself to be a victim of 'harassment' by his neighbours. He explained:

"They said I was making noise in the middle of the night. As you know, I am trying to write a book and so – my first thought was that the typing on my keyboard must be disturbing my neighbours – err, someone said the environmental health people should put in a noise monitor to record the alleged incidents of noise – they said I was making noise at two o'clock in the morning, three o'clock in the morning, five o'clock in the morning. Well, how can I prove I was asleep? How can I prove I was not doing something at that time? So to gather evidence, someone said put a noise monitor and that was supposed to go into the flat of the people making the complaint. They said no. As an alternative they asked whether I would be prepared to accept the noise monitor in my property and I said yes.

Now, if you go to court you have to have evidence. My housing association are taking everything my neighbours say as gospel and everything I say as unreliable. [But] I have a bit of previous with my landlords. I have taken my

landlords to court over disrepair. I have a county court judgment against my landlords which they still haven't complied with, but I don't have the energy or the will to enforce it. But because – it's a phenomenon that's well recognised – that if you complain your landlord will take revenge and evict you. And that applies to social landlords as much as private landlords. There is no distinction between a social landlord and a private landlord in that regard.

We went through the complaints procedure, we went through the ombudsman, for mediation, my social landlords just ignored it. They refused to come to the table, after nine months of trying to get them to come to the mediation table, I pulled out, I asked for my MP – in an attempt to save public money – can they get my landlord to do their statutory duties as laid out by the Landlord and Tenant Act of 1985, that proved to be ineffective and my last resort was to go through the courts and I got a county court judgment. I got summary judgment – which means you don't even need to appear it's all done on the paper evidence ... It really is an Orwellian nightmare if you're in the public [housing] sector in the UK."

The situation Liam finds himself in was one that is unenviable in the extreme. Unlike Christine who is, ostensibly at least, still in temporary accommodation, and therefore *could* be moved to something more appropriate, Liam's housing tenure is permanent, his sense of entrapment complete. He found some relief from his unhappiness in his writing (in the course of our interviews he became a published author) and through his activities connected with the wider service user and anti-psychiatry movements. His trenchant opinions about his home circumstances will be returned to in chapter 7 on the assessment of the role that 'home' plays in sustaining (or not) good mental health.

5.4. Voluntary mobility to manage mental health: Ruth's experiences

In contrast to both Christine and Liam, Ruth had practised a regular form of residential mobility as a part of a coping strategy to manage her mental health.

Ruth stood out more generally from the bulk of interviewees both for the extent to which she had been residentially mobile in the period prior to the study and the number of hospitalisations she endured, as well as for her (relative) financial security which gave her a degree of choice about her residential surroundings. Ruth has moved house quite regularly within the city in which she resides, and where she had been an undergraduate student. In the period immediately prior to the study she had begun to study for a postgraduate qualification at a university in London and, reluctant to move to what for her amounted to a more challenging urban environment, Ruth elected to travel up to London on the days when she had lectures and to sleep overnight in her car which she parked in the university car park. I asked her how others had reacted to her choice of accommodation:

“People were quite horrified that I was sleeping in the car, and couldn’t understand why I didn’t just book into a B&B. I was living off an inheritance that came from my grandmother, and that was paying for the course and my living expenses and I was working part time as a support worker, and so was managing fine with money, but I just thought for the one night it’s supposed to be it was manageable but then I joined one of the [University social] clubs and so I then I was staying over three nights.

I used the main student car park that I felt particularly secure in. I had an incident the first night when I was sleeping in a different car park. I put the seats down and I was sleeping in the back. Cars drove into the car park about midnight or so and I thought it sounded like gunfire. I remember pressing my nose to the window to try to look out and see what was happening and then I phoned the University security and they said I shouldn’t be staying overnight in the car park, but I never had any problems and they [the security people] used to do a walk around. In November I got the camper van and so I had some pretty cold and chilling nights in the car.

People would look at me and think that to be an irrational choice maybe, but to me it was perfectly rational, I was perfectly safe, I locked the doors and, yeah, I felt secure.”

Ruth explained that during the course of her undergraduate degree she had begun to reduce her medication until by the end she was on the minimum dosage. On her doctor's advice had stopped taking it completely:

“But that [the minimum dosage] was keeping me a little bit stable and so when I started my masters, and the effect of [the urban environment in London] I had some difficulty in adjusting to that ... that kind of led me to go down a path of fears and sort of beliefs that kind of played on my mind and led me to do irrational things. So it was quite beneficial that I wasn’t living there as I think I would have found that quite hard, if I’d actually been living there.”

Thus Ruth felt able to practice a quite particular form of mobility in order to help her manage her own mental health. When we spoke she was quite matter of fact about the apparent strangeness of the situation in which a person who could have afforded to sleep in proper accommodation would instead choose to bunk down in a vehicle. Yet, to Ruth, this was a perfectly sensible way of accommodating her mental health needs with the day-to- day requirements of her life.

5.5. Discussion and summary of findings

This chapter focused firstly on those nine service users who had been residentially mobile within the timescale of the study, either as a result of hospitalisation (four instances), unstable housing situations (three), or problematic home circumstances (two). It then presented two illustrative case studies of individuals who had unwillingly and unwittingly become residentially immobilised, and contrasted those with the very different circumstances of a service user who had elected to undertake a quite particular form of residential mobility in order to better manage her fears over her mental health condition. An array of experience - current, incipient, previous, or feared homelessness; eviction and displacement; circulation; repeated hospitalisations; entrapment; voluntary itinerancy - is evident in these accounts, yet what they share is the degree to which the lives of most service users featured here are governed by feared or actual residential instability.

This is a volatility mediated by potent forces internal (including poor mental health and prior experience) and external (such as a dominant policy environment of welfare and service retrenchment), which exist in spaces, both real and imagined, beyond the purview of service users' control. Thus, it is through the extent of these involuntary influences that individual residential circumstances are determined, felt and experienced. This is probably the most important finding in relation to residential mobility to have emerged from this study, and one which has implications both for geographical scholarship and policy makers in the field of mental health. The purpose of this concluding section, then, is to test and interpret these findings against previous studies that have trod the same ground, and to establish the extent to which the framework offered by Cresswell's politics of mobility is a valuable one with which to view and understand the contemporary residential mobility patterns of mental health service users presented in this chapter.

The results presented here find common ground with much of the existing research, especially in relation to instances of circulation, instability and hospitalisation, entrapment, and the role that institutional bodies and policies play in sustaining these scenarios. They have less in common with those studies that found that hospitalisation resulted in homelessness upon discharge, rather than a more general change in residential location. They also raise a question about the continued applicability of the notion of 'drift' when applied to the service user mobility patterns uncovered by this research. More specifically, this research can show the following:

- That contemporary residential mobility patterns of mental health service users are most easily understood with reference to questions of power and control, in particular the *ultimately involuntary nature* of most of the patterns described herein. While not an entirely novel finding it remains an extremely valuable one, especially when set against the broader policy environment of welfare retrenchment and the potential dislocations to individual lives that this portends. It also confirms the value of applying the political framework of mobility offered by Cresswell (2009) – in this case the element of 'force' – in comprehending the complexity of these patterns.

- Fluctuations in mental health are clearly implicated in examples of instability ('feeling' in Cresswell's formulation) in residential circumstances, leading to circulation and hypermobility ('rhythm' and 'routes') and/or hospitalisation ('friction'). This too is an important finding, raising questions as to whether deteriorations in health of the kind that have in the past presaged large scale residential mobility – with all the personal distresses and costs these entail – may go unnoticed by overstretched and under-resourced services.
- Mental health service users practice particular forms of mobility to attempt to maintain stability in their mental health, once more demonstrating the desirability of allowing them to help judge which residential circumstances are in the best interests of their own health and wellbeing, and emphasising the extent to which the actual impact of broader policy and political processes can, in some circumstances, be very much contingent upon individual agency, itself mediated by individual characteristics and experience.
- By contrast, entrapment is a punishing phenomenon, which causes great and unenviable distress to those unfortunate to experience it, which can often be deepened rather than alleviated by those statutory bodies charged with providing care and support, and which underscores that policy outcomes can, in other circumstances, trump individual agency rather than be contingent upon them.

The most extreme cases – Stephen, David, Harry – variously represent the hard edge of mental health service users' experiences of hospitalisation, eviction, rough sleeping, hostel dwelling, substance addiction, and self harm, and they recall the tales presented by Knowles (2000a) in her investigations of the (lack of) community mental health service provision in Montreal and the manner in which homeless individuals become displaced across the landscape, formulating makeshift routines of survival. Stephen and David could certainly be seen as examples of those who, as in previous studies, (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000a) 'circulate' through a variety of residential settings and are buffeted by structural and institutional forces beyond their control; a journey that

David, facing imminent eviction at the close of the study, appeared to be ready to embark upon once again.

Christine and Donna had also experienced the indignity of having been evicted from their homes, though unlike David and Stephen, their dislodgment did not presage periods of rough sleeping and circulation through various settings formal and informal. There, though, the two of them part company as their cases are marked by decidedly different outcomes, each of which illustrates the degree to which institutions, statutory agencies and other public bodies can play a crucial role in determining the aftermath of such events (Hopper et al, 1997). In Donna's case, her eviction could be presented, in the end, as allowing the emergence of a more optimistic residential scenario in which the newly found (for now, at least) stability of residential situation – and growing sense of ontological security - was reflected in her improving mental health. By contrast, Christine's emplacement into, and subsequent entrapment in, temporary accommodation could reflect various structural impediments to the permanent rehousing by local authorities of needy populations in ultra-high cost housing markets like inner London (Kearns and Parkes, 2003). It could also reflect the difficulty of relocating families as opposed to single people, or it could, perhaps, be an example of what Smith and Easterlow (2005) perceived as being a tendency on the part of statutory authorities to place people whose health had already been compromised into (further) material deprivation. Regardless of explanation, the negative impact that feelings of seemingly permanent residential entrapment has had on the mental health of participants in this study echoes the findings of other studies (DeVerteuil et al 2007; Drukker et al, 2005; Lix et al, 2006; Ross et al 2000; Whitley and Prince, 2005) and also help to confirm "how the intimate and personal spaces of home – and their loss – are closely bound up with, rather than separate from, wider power relations" (Brickell, 2012, p229).

The cases of Christine and Liam in particular also reveal the ways in which institutional factors – the local authority housing department and housing association respectively – can provide a seemingly all-encompassing foil to service users' self-identified pathways to recovery. Other service users interviewed experienced similar frustrations, though to a lesser degree, whilst some – Donna

here, Simon in a later chapter – spoke very highly of help and assistance rendered, particularly as part of a carefully prepared transition toward independent living.

Periods of enforced in-patient care – as experienced by 17 out of 25 interviewees, and four during the period of the study – disrupted individuals' day to day residential existence but did not, unlike other studies (Lamont et al, 2000; Tulloch et al, 2011), result in an immediate change of address upon discharge. In the four instances cited here the admission was of short enough duration for there to be no detrimental impacts on tenancies or housing benefits (Harry, Jessica), because the individual concerned was fortunate enough to reside in an area with fewer pressures on social housing (Yann), or because, in the case of Ruth, she was insulated from the most disruptive impacts of hospitalisation by dint of being in long term employment with appropriate sick absence pay.

It was more difficult to determine specific evidence of 'drift', with only Donna and Susan specifically connecting their choice of residential location to ease of access to medical facilities, and Harry speaking of how the general purpose social housing building in which he resided had become unofficially designated as the location in which other service users would be placed. While other service users, particularly in London, were plugged into formal and informal networks of care and service provision which meant they wanted for as long as they were able to remain residing within easy reach of such services, the research findings raise the question of whether the idea of 'drift' versus 'causation' as models for explaining the residential mobility patterns of service users might need to be reconceptualised, with greater emphasis being placed upon both individual agency and the wider policy and socio-economic environment as explanatory factors.

Overall, in each instance the determining factor in the multi-layered interaction between mobility and mental health outcomes appears to rest on the extent to which each individual is able – or perhaps equally as important, *feels* able - to exercise some say over their residential circumstances (Herbert, 2010; Jocoy and Del Casino, 2010. That is, the extent to which the respective mobilities discussed here were expressions of internal free will or were undertaken as a result of

external compulsion. This is the chief contribution of this research to the wider literature on mental health and residential mobility, and, as noted, can be seen as analogous to the first element of Cresswell's politics of mobility, *force*. As the literature makes clear, mobility and immobility do not represent extremes on a good-bad continuum. For some, (im)mobility can enhance health outcomes; for others, restrict it. Overall, though, for the service users interviewed here, their experiences of becoming residentially mobile were predicated on instability in factors outside their direct control (primarily health relapses and evictions) and their experiences of residential immobility were of enforced stays in inhospitable places. Clearly, freedoms of (im)mobility reflect broader social, cultural and policy environments that privilege some over others, and therefore it is unsurprising that service users largely dependent on welfare benefits for what tenuous residential stability they have should find themselves on the underprivileged side of the ledger. Yet, different mobilities freedoms have their "own forms of resistance, subversion and countertactics" (Sheller, 2008, p30), some of which, particularly those around entrapment, come more clearly into view in the chapter 7 on the role of 'home' in service users lives, but which are also applicable to the analysis chapter which follows and looks at the service users' experiences of welfare reform and their entanglements with the processes determining existing and future benefit entitlement, and upon which both their residential and mental stability depend.

5.6. Interviewee profiles

Service users

Alistair Date of first interview: 26 September 2014

Alistair is a 66-year-old, white, British man. Originally from the south west of England, he has lived in the west midlands city where we met since the late 1980s, and since the early 1990s has resided in supported accommodation in an inner suburb. With a diagnosis of schizophrenia, Alistair's first experience of mental ill-health was as a result of nervous breakdown. He was hospitalised three times in the 1970s, twice in the 1980s, and once, briefly, in the 1990s. Alistair underwent an enforced course of ECT during the 1970s, a searing experience that he recounted with great dignity when we spoke forty years later. He undertakes voluntary work on behalf of the service users organisation who facilitated our meeting and subsequent interview. Alistair was a gentle, kindly man, with whom it was a pleasure to converse.

Anthony Date of first interview: 26 September 2014

Anthony is a 49-year-old white, British man. He lives, with his partner, in an owner occupied ex-local authority flat in the same part of the west midlands city in which he was born. Although he does not think of himself as a service user, and has not received a formal diagnosis, he nonetheless describes himself as having been "depressed for thirty years". He has a degree level qualification, practices art, undertakes voluntary work as a trustee of local NHS mental health trust, and survives on Job Seeker's Allowance. His last period of long-term paid employment – from which he left as a result of his nervous breakdown – was in 2013. He said of his participation in the research, "[j]ust having someone to listen to me – like this thing [the interview] - is like a counselling session, that you're able to be there for 45 minutes and that's great, to get things off your chest. Everyone's become isolated"

Benedict Date of first interview: 24 April 2014

Benedict is a 67-year-old white, British, man. He recalled first starting to feel unwell in the 1990s before receiving a diagnosis of bi-polar disorder. He had been a teacher before his nervous breakdown caused him to leave his job, and was now

involved in voluntary work for a number of mental health service user-led organisations, and was chair of the body that facilitated our meetings. Ben resided in central London in his privately-owned house and was in receipt of full occupational and state pensions and so was unscathed by welfare reform. He was softly spoken, private man who tolerated my invasive questioning and, when asked about his mental health during our first interview, explained that he was “depressed at the moment, quite energetically so. It often doesn’t appear to others, but those who know me well it does”.

Christine. Date of first interview: 30 September 2014

Christine is a 58-year-old white, Scottish woman, who had lived in London since childhood. She was diagnosed in 2002 with severe depression and anxiety. She had enjoyed a professional career in the field of social welfare before her breakdown caused her to leave. She now survived on benefits in inadequate accommodation in east London, and had recently withdrawn from her volunteer work over disagreements with what she perceived to be as an increasingly ‘corporate’ view of service users. Christine, who invited me to her home for the interviews, was a forceful personality, whose ‘strong’ character had forced her to ‘keep going’ and which had been to her detriment in the past. Christine challenged me both over my personal qualification to undertake the research and on its purpose, asking me to explain what it was I thought I contributing to, and what the end result was intended to be.

David. Date of first interview: 5 September 2014

David is a 44-year-old white British man, born and brought up in the Home Counties and who had lived and forged a successful career in financial services in the City of London. He has been diagnosed with borderline personality disorder and was residing in a private rental flat in inner west London. David has experienced serious drug and alcohol addiction and has both slept rough and been hospitalised. Currently on benefits, David spent a considerable amount of time engaged in service user activities as a volunteer. He spoke with me on two occasions, once in person, and once by telephone, in the latter instance whilst preparing for eviction. I lost contact with David shortly thereafter.

Donna. Date of first interview: 7 August 2014

Donna is a 45-year-old white British woman, originally from the north of England, who now lives in east London. Donna had been diagnosed with depression, anxiety, and borderline personality disorder. She had experienced a nervous breakdown that had caused her to fall out of her professional career in the media. She now relied on benefits and resided in a private-rental flat. Donna spoke very frankly, and freely, during our interviews, was extremely articulate, and we corresponded by email after the conclusion of our interviews. Her final message read: "Thank you so much for your kind and, as always, sensitive words, and apologies for my laggard response. I've struggled after the [2015] election result: usually my anger about the persecution of the vulnerable is on behalf of those others I know to be in worse situations than myself, but this affected me personally, to my surprise. I certainly don't view myself as a benefit scrounger but the perception that the majority of people do and actually chose to increase the hardship, suffering and even deaths of the poor and disabled was a real shock"

Emily. Date of first interview: 26 September 2014

Emily is a 65-year-old white, British woman, who lives in her own house in an inner suburb of a west midlands city. She has lived in the same house for forty years. Emily endured a nervous breakdown at the age of 16, and has suffered from major spells of depression ever since. She attributes her breakdown and depression to the physical disabilities she has had from birth, over which she was bullied as a child and which have, in her view, hindered her ability to pursue the artistic career for which she was qualified. Emily explained that, as a consequence, she has struggled to cope "with all the setbacks I've had in my life ... there's disappointment and frustration really". Emily was an incredibly kind, seemingly talented individual, for whom life had dealt an unfortunate hand, and for whom the question 'what if?' loomed large.

Faisal. Date of first interview: 25 September 2014

Faisal is a 54-year-old man, born in Pakistan but resident in a west midlands city since the 1970s. He was diagnosed with schizophrenia and depression, and has experienced two periods of in-patient admission. He has lived in his council maisonette since the mid-1980s, has been educated to degree level but, as a

consequence of his illness, has been unemployed since the age of 25. He spoke to me about difficulties he has experienced as a result of his illness but also of the ways in which he has been able to bring some stability to bear on his circumstances with the imposition of a rigid daily routine – a routine which was disrupted by our interview but during the course of which Faisal talked with clarity, honesty, and poise about his circumstances.

Hannah. Date of first interview: 26 September 2014

Hannah is a 36-year-old mixed-race, British woman. She was born in London but has lived most of her life in the Midlands. Currently resident in a housing association flat of an inner suburb of a west midlands city, Hannah has been diagnosed with borderline personality disorder and low-level bi-polar disorder. Hannah also experienced serious eating disorders as a result of which she had a gastric bypass operation and lost 14st. She works as a mental health awareness trainer for the public sector. Hannah was very open and forthcoming in our interview, describing her fears and anxieties about her experiences of assessment for disability benefits, and over which she spoke intimately and with great emotion. I was sorry not to have had the opportunity to speak with her on a second occasion.

Harry. Date of first interview: 27 August 2014

Harry is a 48-year-old white, British man. Born and brought up in south London he now resided in the main settlement (and county town) of one of the Home Counties. Harry has been diagnosed with several kinds of personality disorder, and depression. He is a (currently) sober alcoholic with a history of self-harm, for which he has been hospitalised twenty to thirty times. He attributes his problems to extreme abuse experienced in childhood and to difficult familial relationships. Harry has never really been engaged in routine employment and survives on benefits. He talked in great depth about extremely sensitive and painful subjects that were hard to hear. We met, twice, at an art gallery in London, and Harry, who created artworks which had been exhibited at the Tate, said that the visits to the gallery gave him “a sense of serenity, there’s something about the colour, and the order, and the quality of light and the finishes are quite smooth, and it makes me feel something inside my body when I’m in these environments”.

This, he explained, gave him temporary respite from the everyday, whereby “I feel like I’m treading water. The years go by and you kind of fill in the days to kill time. It’s not a real way to experience existence, is it? You’re kind of trying to think what can I do so that I don’t get that desperate that I think I can’t carry on. But sometimes the despair will just bubble up and I’ll be like doing something and I will start crying – and I can feel it’s coming up a bit now – but you think what is my life for? Why am I alive? What’s the fucking point? I’ve got talents [describes his art work being exhibited in the Tate and elsewhere]. If I didn’t have this condition I’d probably have a better life, but it feels like, I have to say this to you, that adoption and that abuse in my childhood has ruined my life. It has ruined it. My emotions are all over the place. I haven’t been able to have a single fulfilling relationship. My physical body is damaged. I am knocking on fifty’s door and I think what is the fucking point, do you know what I mean?”

Helen. Date of first interview: 9 April 2014

Helen is an 85-year-old white British woman. Born in west London, raised in east London, she has lived in central London for sixty years, and in her council-owned bedsitter for thirty-two.

Her residence predates her engagement with the mental health system, which came about as a result of severe depression and a suicide attempt, in 1993. She has been stable for the last 20 years. She has worked most of her life and enjoys a small private pension in addition to the state pension. She receives no other forms of social security and pays her rent out of her pension. Helen described how her engagement with the service user movement had allowed her to regain the confidence and ‘spark’ that she had lost after her breakdown. She was generally ‘positive’ about life and seemed to take most things in her stride. Helen, who had lived her life to the full through some tumultuous times, was a fascinating woman, with whom it was a pleasure to converse. At the conclusion to our interviews she said she had “opened my soul, I’ve never done that before ... I’m glad I’ve helped you in some way, and it’s helped me – you don’t get a chance to talk about your experiences, you know, because you know that people don’t want to hear, unless it’s another service user where we compare notes!”

Jessica. Date of first interview: 31 January 2014.

Jessica is a 45-year-old British woman of mixed Caribbean and Middle Eastern decent. She is single, with a daughter and granddaughter who occasionally stay with her. She was born in south London, raised in the midlands, she now lives in north-west London. At the time of the first interview she had been residing at her present home, a privately rented basement flat, for twenty-three months. She has bi-polar disorder and depression, for which she takes medication. Though only formally diagnosed in 2007 she said she has “always” been ill. She has had multiple admissions to hospital, most recently in November and December 2012 for a period of eight days and one month respectively. Janet left school at sixteen and has three CSEs. She was last in employment in 2007. Latterly, she was engaged in an arts degree at a London university. Jessica was a very engaging person to spend time with.

Jonathan. Date of first interview: 24 October 2014

Jonathan is a 48-year-old British man of mixed race. He has lives with family members in an owner-occupied house in an inner suburb of the west midlands city in which he was born. Jonathan experiences Asperger’s Syndrome, and depression, a combination of which forced him from work in the late 1990s. Jonathan talked very openly and often amusingly about how his Asperger’s governed his daily geographies and the ways in which it resulted in manic and obsessive, routines.

Katherine. Date of first interview: 26 September 2014

Katherine is a 56-year-old white, Irish woman, who lives in a housing association flat in an inner city part of a west midlands city. She first became unwell in her early-20s and has been diagnosed with schizophrenia and bi-polar disorder. She also suffers from MS that impedes her mobility. She has been hospitalised on approximately fifteen occasions, only rarely since the early-2000s but “almost yearly before that”. Katherine has worked on and off over the years but not since 2005/6. She has a beautiful cat, to which she is devoted, and about whose behaviour she repeatedly referred and at which we both laughed and joked.

Laura. Date of first interview: 29 January 2014

Laura is a white, Jewish woman of American birth and parentage in her late 60s who has lived in the UK since the late 1960s. Since 2000, she has lived in a housing association flat in the inner city of the west midlands city to which she first moved in 1980. She has been diagnosed with depression and anxiety and also with personality disorder – the latter being a diagnosis she does not accept. She first became unwell in the 1970s. Educated to degree level, Laura historically worked in social services and in the mental health field. She currently does both paid and voluntary work for various statutory and voluntary organisations in the mental health field. Laura was a great source of support and encouragement during the fieldwork, and assisted enormously in the recruitment of other participants. It is not for nothing that, in the context of the housing association building in which she resides, she described herself as the “house-mother-cum-Rottweiler”.

Liam. Date of first interview: 31 January 2014

Liam is a 48-year-old man of white Scottish decent. He was born in Glasgow, grew up in rural Scotland and presently lives in central London. He is separated from his wife who lives abroad with their son. He does not have any contact with family members, and this is not through choice. He describes himself as being “very isolated”. He has resided at his present address, a housing association flat, since 1998, where he feels a “prisoner”. He preferred to be referred to as a patient, and he very much sees himself as someone who is at the mercy of his mental illness and the wider mental health system. He has had numerous diagnoses since experiencing a nervous breakdown in 1993 – the primary ones are paranoid schizophrenia and depression, for which he is on medication. He has had several periods of hospital admission, both formal and informal, the last of which was in 2012 where he spent 28 days and three and a half weeks respectively under section. Liam left school at sixteen having passed several exams. He has not worked since 1993.

Paula Date of first interview: 3 March 2014

Paula is a white-British woman in her late 40s. She lives in a part-ownership housing association house in a market town of 40,000 people in a primarily rural

part of the Home Counties. She “lost” ten years of her life – from her late 20s to her late 30s - to severe depression. She currently works part time for a mental health charity and she sits on the resident-involvement board of her housing association provider. Paula was very kind and solicitous when I travelled to see her and facilitated my introduction to other service users. I unfortunately lost touch with her when the mental health charity for which she worked shuttered its doors having been unable to find additional sources of funding in order to keep operating.

Richard. Date of first interview: 21 January 2014

Richard is a 57-year-old white British man, originally from the central belt of Scotland. He has lived in central London since returning from abroad in 1989, and in his present housing trust flat since 1999. He has demonstrated significant levels of residential mobility in the past, including social housing, hostels and as a hospital in-patient. He is single though has a sister in the north of England with whom he is in contact and has started visiting. Richard first became unwell in 1984 whilst living abroad and has been diagnosed with paranoid personality disorder. He also receives treatment for depression and believes he has low-level autism, including medication. His last period of hospital admission was in 1999. He left school at 16 having gained 'O' Levels. Apart from a temporary cleaning job in the late 1990s Richard has not worked since 1989. Richard was my first interviewee and helped me enormously in seeing where I was going and how I might get there.

Ruth. Date of first interview: 26 August 2014

Ruth is a 50 year old, white British woman, born in the west of England and living in central southern England. She remembered starting to feel unwell in the mid-1990s but was not formally diagnosed – with schizophrenia - until 2008. Ruth had experienced multiple hospital admissions. She now worked full-time in the field of statutory mental health services. Ruth was extremely open and patient in her interviews, and talked candidly about her experiences, including her suicide attempt. At our last interview she explained that she was withdrawing from her medication, saying: “I always struggled with feeling that I had a diagnosis of schizophrenia – when I have talked to others I just have never felt that I shared their experiences – and being sectioned for all that time I was able to explore my

thoughts quite well, and I prefer to deal with my thoughts as they come up – which is what they are, I don't get voices – but I do get thoughts. So I had the opportunity to explore those with thoughts and not with medication. I thought about it long and hard and decided that I would risk another supposed psychotic breakdown to find out whether I really need medication or not. I suspect that I don't. I am quite scared that I might have an episode, but the last injection was 24th November but I've been stable – more stable I think – than I was on the injections ... I have to be quite careful now because anything I do that's a little bit irrational, a little bit out of the ordinary, would be seen as psychotic behaviour by other people, and that's what led to my readmissions last year".

Simon. First interviewed on 22 January 2014

Simon is a 51-year-old white British man, originally from the Home Counties and now residing in a housing association flat in east London, where he has lived for just under five years. He is single and has regular contact with his mother. He first became unwell in the mid-1980s whilst at University and has had a diagnosis of schizophrenia since 1986 for which he takes medication. He has had three periods of hospital admission: from 1986-87, 1989-91, and most recently for three months in 2002. Simon has both undergraduate and postgraduate qualifications (a masters awarded in 2012) and is currently searching for PhD opportunities. He last full time employment was in 1990 and he has been unemployed since with the exception of a period of part time cleaning work from 2004-08. Simon is actively looking for work and quite hopeful about his prospects.

Stephen. Date of first interview 3 March 2014

Stephen is a 41-year-old white British man. He lives in a homeless persons hostel in the same Home Counties market town as Paula. He was born and grew up nearby. He is separated from his wife, has no contact with siblings and ex-in laws who live nearby but is in contact with his father who lives in a village some ten miles distant. He was diagnosed with anxiety and depression in 2013, for which he takes medication. He ascribes his poor mental health to recent experiences in his family life, including separation from his wife and disagreements with his siblings. This has been exacerbated by his having become homeless and having to sleep rough, in a tent and latterly in a bus shelter. He has been in his hostel

accommodation since the autumn of 2013. Stephen left school at sixteen. He has had periods of gainful employment in recent years and was in temporary paid employment as recently as the early summer of 2013. Sadly I lost contact with Stephen shortly after our first interview.

Susan. Date of first interview: 1 September 2014

Susan was a 48-year-old white, British woman, who resided in the south of England. She had been a teacher and was now a post-graduate student. She recalled feeling unwell from the mid-1990s before being diagnosed with depression and anxiety. Susan's post-graduate work was around her experiences as a service user and she worked alongside service user organisations. She stated that while her mental health now was more settled "I have to work hard. I manage it through using tools and using the therapy that I have gone through. It's always a work in progress"

Terence. Date of first interview: 2 February 2014.

Terence is a 70-year-old white British man who was born in central London and has since 1996 lived in a housing association flat in north-west London. He has some contact with surviving family members. Terence received a diagnosis of schizophrenia in the early 1990s, having first received treatment in 1991. His last period of hospital admission was in 1993. He has a BA from a very high-ranking university in London and enjoyed a career in the private sector. He is now retired. As such, he was relatively protected from the welfare reforms.

Trevor. Date of first interview: 4 February 2014

Trevor is a 51-year-old Black-British man who was born and grew up west London. He lives in central London in a housing association basement flat. He is single and has caring responsibilities for his disabled mother who, along with his sister, lives nearby in north-west London. Trevor has been in his present flat for ten years. He has been unwell since 1979/80 and has a diagnosis of schizophrenia, for which he takes medication. His last period of hospital admission was in 1990. He could not recall how long this was for. Trevor has various vocational qualifications gained since leaving school at seventeen. He has been unemployed since 1990. He went

to great efforts to think of ways to assist with my research, including writing me detailed letters that documented his struggles to keep his head above water

Yann. Date of first interview: 24 October 2014

Yann is a 52 year old woman, born in Jamaica and raised in the west midlands city in which she continues to reside. Initially diagnosed with schizophrenia she received six years ago a diagnosis of bi-polar disorder. Her mental health has resulted in several hospitalisations. Despite leaving school with a full suite of O' Levels, Yann's mental health has ensured that she has largely spent the last twenty years out of work and is reliant on benefits. The housing association flat in which she lives is where she raised her children. She has been there for thirty years. At the time we first spoke, Yann had been engaged in an ongoing battle with her medical team to move away from psychiatric medication and toward homeopathic remedies. She said, "I want to come away from the mental health system because you've got no life. It destroys your livelihood. It destroys your mental capacity. It destroys your everyday function and your everyday life. Most people can't keep up a relationship when they're on those drugs, they're all single and they all end up in nursing homes because their brain cells have died by the medication. Taking everything in your body day after day, the same thing, it gives you brain damage, especially those kinds of medication. It's blocking your life. I've been through this loads of times with them – up and down, up and down. I don't want to be put out. I haven't enjoyed my life anyway and I don't want to be put out, brain-wise, it's not fair. Can't the doctor see you've got no life like that – you feel as if you've committed a crime, as if 'you've committed a crime now here's your punishment: take the injections'.

Service providers

1. Welfare rights' advisor working for a mental health service users' organisation in south London.
2. Mental health service provider, home counties market town
3. Policy officer, national mental health charity

Chapter 6. Re-employment, re-assessment, relapse? Initial findings on the impacts of welfare reform on mental health service users

6.1 Introduction

Chapter three set out the context against which this research was being undertaken. It investigated the background to the government's programme of welfare reform and probed the potential implications of the detailed reforms for people with mental health problems. This chapter presents the lived experiences of service users to examine the benefits landscape in an age of welfare reform as it impacts on the lives and daily geographies of the individuals depicted herein. It is divided into three sections: the first explores service users' relationship to, feelings about, and distance from paid employment – the (re-)employment of those in receipt of benefits being one of the guiding principles behind the government's reforms; the second looks into day-to-day financial management and asks what strategies – if any – individuals are deploying or planning in relation to the new welfare landscape, in particular the threat of benefit cessation; and the third comprises an analysis of the reassessment processes involved in welfare reform, primarily through looking at the Work Capability Assessment (WCA), the tool used by the government to assess individuals' entitlement to ongoing support through the Employment and Support Allowance (ESA) benefit.

Core *geographical* concepts – space, place and mobility – emerge from the interviews. These are crucial in understanding how the carefully constructed daily geographical practices that service users employ in attempting to maintain stability and hang on to a sense of ontological security are *emplaced*, particularly in and around the home (a point revisited in detail in Chapter 7), and how these sometimes precarious constructions are threatened by government attempts to impose a normative understanding of daily life – 'going to work' – onto service users. The key themes to arise from the analysis of the interviews and which are developed in this chapter include:

1. The imaginative (as opposed to physical) *remoteness* of the world of work, and the attendant difficulty of *accessing* it – or even knowing how to. For many service users, the workplace represents a space that is at best unfamiliar (or at least no longer familiar) and, at worst, a potentially hostile environment which poses an active threat to the often fragile sense of stability they have tried to bring to bear on their lives
2. The importance of *boundedness*, whereby those ‘safe’ spaces, places, experiences and people that contributed to a sense of ontological security were separated off from those which were unsafe or threatened instability
3. The careful practice of elements of *(im)mobility* (especially ‘force’ and ‘routes’) to ensure the above balance is held in check
4. The *inflexibility* of the tools used to consider service users’ entitlement to ongoing support through the benefits system, and modes of employment unsuited to the fluctuating nature of many service users’ mental health conditions.

6.2. Service users’ relationship to paid employment

“It’s not that I don’t want to work, it’s just that I have been out of work for so long, and if they start to put me under pressure it might make me ill again. I’m not ready yet” (Jessica, 45, mental health service user, inner London)

“That [paid work] is what I’m working towards now. It’s a hard one though. How do you go back into paid work when you know you have periods of depression that can last up to a fortnight? What employer would employ someone when maybe every couple of months they take two weeks out?” (Christine, 58, mental health service user, east London)

“[Welfare reform] will create a new world for benefit claimants. No more sitting at home on benefits doing nothing. No more excuses about it all being too difficult” (Employment Minister, Chris Grayling, 2010)

Four of the 25 service users interviewed were in paid employment (probably not coincidentally all in the field of mental health) at the time of the first interview, one was in full time education, and five were of retirement age and in receipt of state (and, in some cases, private) pensions. The remaining sixteen were unemployed and claiming welfare benefits⁷. Each had experienced paid employment in the past, with the most recent instances ranging from under a year to over three decades prior to the first interviews in 2014. The table below summarises the employment history of the 20 service users who were either in work or who were below retirement age at the time of first interview.

Table 6.1. Participants' employment histories

Interviewee	Time of last paid employment	Field/type of employment
Anthony	2013	Local authority driver
Christine	2002	Social worker
David	2011	Financial services
Donna	2007	TV production
Faisal	1985	Not recorded
Hannah	In work	MH services trainer
Harry	1980s	Prostitution
Jessica	2007	Admin assistant
Jonathan	1996	IT technician
Katherine	2006	Factory worker
Liam	1994	Financial sector
Laura	In work	MH services trainer
Paula	In work	MH charity worker
Richard	Late 1990s	Cleaner
Ruth	In work	MH services user involvement
Simon	2005	Cleaner
Stephen	2013	Cleaner
Susan	In full time education	

⁷ Despite not being in paid employment many of the sixteen nevertheless undertook unpaid voluntary work which provided them with some of the 'benefits' propounded by supporters of reform (activity, structure, routines, taking 'responsibility', putting 'something back') and which they were able to manage alongside their health needs.

Trevor	1990	Kitchen porter
Yann	Late 1990s	Cleaner

Interviewees expressed a range of feelings about the prospect of re-entering the world of paid employment, and the circumstances under which they may do so. These varied from the suggestion by one interviewee that, owing to the nature of his mental illness, it would be impossible for him ever to regain employment, through scepticism or ambivalence about both the probability and desirability of getting into and sustaining work without potentially serious repercussions for individuals' health and finances, a wary hopefulness about future prospects in relation to achieving meaningful employment, to a latent desire to (re)enter the world of work as soon as practicable.

Without exception, all seventeen interviewees currently unemployed related both their original loss of employment and their present status as being primarily a consequence of their poor mental health. For Donna and Christine, who had excelled in their previous professional careers, the lengthy process of dropping out of work went hand in hand with their mental and emotional collapse:

“There was this very slow disintegration of falling out of being able to work. In the end I was just sitting at the computer crying, day in, day out, just unable to work.” (Donna)

“None of my colleagues who I used to work with are aware of what happened to me, and I’ve not kept in contact with them and I do feel a sense of... I suppose, um, I used to be a manager, and I used to manage people... I was very well known and very good at my job, um, and well respected, and I do feel a sense of perhaps shame that, if they knew, what they would think? But then I was ill for quite a long time before I left, I actually left cos I knew I was getting more and more ill, and nobody picked up on it, but they must have known, my managers must have known ... I took six weeks off work. It got worse and worse and worse I couldn’t go out the front door. It was so bad that the ground was actually moving, it was so bad that I couldn’t actually see a level ground to walk on. Six weeks later I

went back to work, but I was a shadow of my former self, and I was never right. That was 18 months before I left in the end with my final breakdown. They must have noticed it in me. I notice it in other people. I feel quite bitter about that.” (Christine)

For others, their inability to cope with the dynamics of the working environment, particularly changes of staff or routine, were at the root of their fears:

“[M]y boss, Nick – he was really good – all the staff were really nice to me – he left, and I didn’t want to... I couldn’t cope with the idea of a new boss, ‘cos he knew me really well, y’know? We were very honest with each other, all the staff, y’know? I thought a new person... I just left.” (Richard, 57, mental health service user, central London)

“One of the problems with mentally ill people is that they don’t like doing anything out of the ordinary.” (Liam)

The precarious state of individuals’ mental health rendered them at a particular disadvantage in respect of gaining and retaining employment. Nonetheless, there was a distinction amongst those who were hopeful of gaining employment before too long and those who felt it was unlikely they would ever work again. The difference could not be starker between Liam who stated firmly and matter-of-factly that,

“I am unemployable. I am unemployable because my first diagnosis was paranoid schizophrenia. If I went to any company with that diagnosis during the hiring process I would have to disclose it to them. I have to disclose it because they have to run your employment prospects by their insurers. If you went to your insurance company and said ‘we have a man here with this diagnosis, are you prepared to underwrite this person until retirement age?’ No insurance company would underwrite me with my diagnosis. Therefore that makes me unemployable.”

and Simon, who is actively seeking work,

“I feel at the moment that it is quite likely I will go back into paid employment ... For the last three or four months I’ve been having, um, appointments with [inner London borough] Mind’s education and employment service, and going to a job club on a Wednesday. I use the computer there, and talk to the employment and education people there. And I know, the, um, err, the disability employment advice person at the job centre in [inner London borough] and I know they’re very good. They actually helped me.” (Simon, 51, mental health service user, inner London)

and for whom the emphasis placed on work incentivisation as part of the welfare reforms could be argued to have had a positive effect (or at the least a neutral one)⁸. Nonetheless, there is a sense of caution in Simon’s incremental approach to the prospect of employment: gaining trust and confidence in the process of finding work before actually embarking upon its undertaking.

Simon was very much an outlier amongst the service users, in that he had access to private funds (in the form of a trust fund) that meant any re-engagement with the labour market and consequent withdrawal of benefits would not necessarily have a detrimental impact on his finances. Conversely, others were distinctly worried about a loss of income connected with re-entering the labour market:

“I don’t think I have an understanding of how to get back into it [work]. You know, I can make a general attempt, but I doubt if I could afford the rent. I’d be out on the streets, probably, because I know the rent will go sky high ... I can probably make an attempt, but I doubt I’ll get back into it.” (Trevor, 51, mental health service user, central London)

⁸None of the interviewees thought it likely that the reforms would produce positive outcomes for them or for other people with mental health problems who were unemployed; they felt that any positive change in their readiness for employment would occur *despite* and not *because* of the reforms.

The fatalism expressed by Liam finds a faint echo in others' remarks, though here it is tinged with a certain defiance about the kind of employment opportunities likely to be made available to people with mental health problems:

"I know people with mental health problems who've got a job, things like photocopying and filing for the next twenty years, y'know, [but] I'm not really interested in that. I am interested in me being reasonably content most of the time ... In the huge scheme of the universe, if I got a job again, or if I don't get a job again, it's no... I mean, in a hundred years time, who'll give a shit, you know? I don't necessarily buy the bullshit." (Richard)

This defiance can also be seen as reflecting not so much a fear of the impact of interviewees' mental health status on employability, as in the case of Liam, but rather the potential impact of employment on mental health status:

"It's not that I don't want to work, it's just that I have been out of work for so long, and if they start to put me under pressure it might make me ill again. I'm not ready yet." (Jessica)

"[M]y ability to mix with people would be difficult due to the Asperger's... I may start to have disturbing thoughts about anybody I work with, or any set of people I work with. Essentially I'm plagued by disturbing thoughts and the only way to stop the disturbing thoughts is to not do certain things like becoming involved in work." (Jonathan, 48, mental health service user, west Midlands)

"I am a bit sceptical... I am not sure that having a job is necessarily the ultimate goal, y'know, for me. If I was encouraged, and I could go somewhere that had some kind of relevance, where if I needed a day off I could have a day off - because that's the reality of it, every day you're not necessarily going to be up to it. If they make it accessible to people with mental health problems - one of the main things is you're not going to be good every day, you may have a week where you're not good. So [to] take a week off and not have that against you, that kind of thing." (Richard)

“Well, my aim is to get a job, yes, but at the moment, obviously, I’ve got to get my health sorted first.” (Stephen)

The emphasis placed by interviewees on their *remoteness* from the world of work, and the difficulty this lack of familiarity would pose in relation to successfully gaining and retaining a job, might appear to lend support to government policy rhetoric about the centrality of employment as a panacea for poverty, benefit dependence and ill-health. In reality it does not do so. For these service users, their personal priority was the maintenance of relative stability in their mental health as opposed to the government’s one of spurring entry into the labour market. Indeed, forced entry into the labour market would for these service users represent not an escape route from benefit dependence – as government policy purportedly intends - but rather a threat to both their stability of health and their finances.

That this represents a form of involuntary mobility – from the relative security of the familiar and the ‘safe’, to the unfamiliar and the dangerous - is clear, as is the extent to which this conflicts not just with service users wishes but with the *strategies* they devise and practices they deploy to preserve their stability as they seek a greater sense of wellness. There are strong comparisons here with Pinfold’s examination of the ways in which the ‘safe havens’ built up by service users were potentially threatened by the community rehabilitation service’s aim of ‘normalisation’:

“Service users are not passive players in the rehabilitation landscape, moreover: they are active participants in shaping, as well as being shaped by, socio-medical pathways that are negotiated using personal coping mechanisms to sustain everyday equilibrium. Instead of absolute positions, individuals often occupy a (preferred) middle-ground between isolation and integration, between states of dependency and ones of independence.”
(Pinfold, 2000, p210)

And also with the work of Hester Parr, who notes that:

“For many people who experience mental health problems the disruptions to both their senses of self and their everyday routines, including their feeling of control over time and space, are extremely distressing realities which prompt varied strategies of coping.” (Parr, 1999b, p189)

Aspects of Cresswell’s politics of mobility are also reflected: service users have drawn connections between the *friction* involved in contemplating a potentially *forced* change – such as coercion into employment at a pace (*velocity*) or time not of their choosing – and the disruption to their coping *routines* and the everyday *rhythms* of their “lived geographies” (Parr and Davidson, 2010, p263).

The extent to which stability versus ‘normalisation’ (enforced entry into the normative world of the labour market) is inter-dependent in both service users minds and in their experience is the subject of the following parts of this chapter.

6.3. Welfare benefits, financial management, and survival

6.3.1. Service users’ benefits

The table below summarises the principle benefits received by the twenty interviewees who were either working or below pensionable age at the time of first interview.

Table 6.2. Participants' benefits

	Paid employment	Inc incapacity Benefit or Employment Support Allowance	Job Seekers Allowance	Disability Living Allowance or Personal Independence Payment	Housing Benefit
Anthony			✓		*
Christine		✓		✓	✓
David		✓		✓	✓
Donna		✓		✓	✓
Faisal		✓		✓	✓
Hannah	✓			✓	✓
Harry		✓		✓	✓
Jessica		✓		✓	✓
Jonathan		✓		✓	✓
Katherine		✓		✓	✓
Laura	✓			✓	**
Liam		✓		✓	✓
Paula	✓			✓	**
Richard		✓		✓	✓
Ruth	✓			✓	**
Simon			✓	✓	✓
Stephen		✓			✓
Susan	***			✓	*
Trevor		✓		✓	✓
Yann		✓		✓	✓
Total	5	13	2	18	15

* Anthony and Susan owned their own homes

**Laura, Paula and Ruth paid their rent out of their salaries

***Susan was in full time education and in receipt of a grant to cover living costs.

What is striking here is the extent to which almost all those interviewed rely on a series of interlinked benefits in order to meet their daily living, health and housing needs. Fully twelve out of the thirteen recipients of IB/ESA also qualified for the entire suite of sickness, disability, and housing benefits. Even for those in

employment, benefits either as a top up to income (i.e. housing benefit for Hannah) or as assistance to the maintenance of employment or education (DLA/PIP for Hannah, Laura, Paula, Ruth, Susan), formed a core part of their finances. Noteworthy, too, is that the only two interviewees not to receive DLA or PIP – Anthony and Stephen - were also the only two service users who had not engaged with statutory mental health services and had not received a formal health diagnosis. With the exception of the five interviewees in employment or education, and Simon, who has access to additional financial support via a trust fund established by his mother, none of the service users had any sources of regular income outside of their benefits.

6.3.2. Service users' income and day-to-day financial management

There was considerable variation in what service users reported about their ability to manage their finances over both the shorter and longer terms. For most, their benefits gave them a fiscal platform on which to get by, though those interviewees who lived in London were most likely to make reference to how tight money could be. Conversely some, like Richard, felt they received a sufficient amount in benefits to be able to put some aside, both as savings for the proverbial rainy day and also as a way of offering some protection against any future reduction in benefits or some other, unanticipated, event:

“Basically I am doing ok, money wise. I can well see David Cameron or... who’s the Labour guy? – whoever it is anyway... er Miliband - I can see them thinking I’m getting a huge amount of money. I am getting a lot of money, but it brings me peace of mind. And I’m not apologetic, I’m not apologetic about that at all. I didn’t ask for the money they’ve given me. I didn’t go bleating, saying oh you should give me my DLA back – they [the DWP] came to me [to say they had mistakenly stopped it] – now I’ve got a lot of money. What I do with that is – I don’t drink, I’ve never smoked, drugs have never been my thing, I don’t attend ladies of the night or gentlemen of the night, and I don’t gamble.

“My £1,700 is a sinking fund. I am not apologetic that I am having a decent standard of life. I know what it’s like to walk around London in the rain with holes in my shoes. People say ‘oh, you shouldn’t be able to save when you’re on benefits’. Well, why the hell not?” (Richard)

Richard spoke with some feeling about the ways in which he and other people with mental health problems perceived themselves as being stigmatised for their reliance on benefits. In addition to noting the important role that a secure income played in maintaining stable mental health, he drew a rather different morality tale than that painted by the government. He believed he was getting what he was entitled to and, in return, considers that he exercised responsible and respectable – perhaps even ‘moral’ – fiscal discipline as *part of* his everyday geographies of coping, a point other service users also made when discussing their everyday spending habits and how these were orientated around meeting their health needs:

“I’m eating very healthily and doing internet shopping which is probably more expensive than going to the supermarket but it means I can eat well. I have started going to the spa once a week, and that has really helped with the stress, but that’s £10 per week ... I have had lots of anti-skin allergy ointments and things that aren’t available on the NHS and that’s proved quite expensive. And I also do charity mindfulness courses or low cost therapies that are reduced in price, so I have to use my budget for that. And I pay to go to the local leisure centre to do yoga and exercise and things like that” (Donna)

Others, for whom bullishness and financial fall-back in the form of savings did not apply, were significantly less secure in comparison to Richard. Anthony, by dint of his sole reliance on JSA, was something of an exception among the wider group of interviewees. He did not formally define himself as a mental health service user, despite experiencing a work-related breakdown that produced a debilitating depression and caused him to leave this job, preferring instead to think of himself as “just a member of the public who’s trying to get some help”. Accordingly, he had elected not to go down the path of engagement with statutory mental health

services, a decision that, not just in hindsight, appeared a costly one. Instead, he had approached local voluntary mental health services where, in a twist in geographical fate, he found that he lived on the ‘wrong’ side of the boundary between two local authorities, one (relatively) service rich, the other service poor. As he explained,

“If I was lying in the middle of the road, having a crisis, I’d be able to qualify for both sides. But I don’t, I come under [name of local authority] who only deal with [people in] crisis. I have a house and so they can’t help me. So I can’t even get into the system as I’m not vulnerable enough. You have to be really, really, really, really critical [to get any help].” (Anthony, 49, mental health service user, west Midlands)

Thus, with entry to informal mental health services closed off, and having chosen not to engage with statutory services, Anthony had inadvertently denied himself access to medical advice and assistance which might otherwise have questioned the suitability, in the circumstances, of his relying upon JSA of £56 per week to meet both living costs and broader mental health needs. His enervating condition, which had caused him to fail on several occasions to complete the requisite number of job applications expected by JSA, for which he had been sanctioned, and to miss job readiness appointments, for which he had also been sanctioned, was closely entwined with the financial predicament in which he and his girlfriend found themselves:

“We don’t get paid till next Friday now and I think we’ve got £20 in the account left. My landline’s been cut off and so it costs a lot more from my mobile phone to call these numbers [the DWP JSA helpline]. If I’m not coping well, and if I’ve got low mood, I’m not able to do things, like the pay the bills, and dealing with stuff. So it’s really tricky if someone says can you do this or sort this out. It just gets worse and one thing spirals to another. For example, the landline, we changed to a different contract with broadband, so instead of £145 for a quarter we changed it to about £90, but we missed three payments and they’ve terminated the contract, even though I phoned them the day after. They stick another £190 on top for

terminating it, cos it's an early end of the contract, so a bill of £163 is now £345 which... it's just going to go on the end of creditors debtors."

Despite binding recipients to mandatory work related activities, JSA does not offer any additional financial support to meet the associated transport costs. While being obliged to subsist on his weekly JSA (and the occasional £10 handout his mother gave him for food or petrol), Anthony had not wanted to spend £2 per day on bus travel and had intended to continue to operate his car. However,

"There's now £50 coming out for the car insurance because it's gone up from £28 because I didn't get back to them so they have automatically stuck another charge on top which just coincidentally just happens to be what they do when you're unemployed. So the insurance has gone up from £320 to £550 because I'm unemployed. What's the difference between someone who is employed or unemployed? Nothing! The day before you get unemployed you're just the same person as you were afterwards, but the emotional and the mental effects are so dramatic that everybody starts looking at that person in a different way – it's really stereotyping. So I've had on occasion to drive with my car untaxed [because I couldn't pay that and the insurance]. Mental health isn't a crime – neither is depression – it just seems to get you into that situation."

Anthony struggled to reconcile his recognition that he would ultimately need to try to stay on top of his finances with his inability to do so. Even where he had negotiated a reduced payment schedule, as happened with the water company, he ended up missing the revised payments. And, as with the car insurance example, he felt aggrieved that the more difficult his personal circumstances, or the deeper that he descended into debt, the greater the cost to his financials and his health:

"Where's the sense in making it harder as it gets tougher? It just seems to be... it's just the scenario I suppose, means people hit the bottom quicker. But you get to a certain point... a tipping point, and once you go through it all the debts pile up and it's too much. You can just about make it but someone sticks another thing on the end, another straw, it's the last one."

When we met next, six months later, I asked Anthony if there had been any improvement in his situation, whether he had been about to surmount his difficulties and take advantage of the grace period he had been offered to organise a longer-term repayment schedule. His response was not encouraging:

“When I panic I don’t act. I retreat. I’ve basically buried my head in the sand. I haven’t paid the electricity bill for over a year – I’m smiling when I say that but it’s not a good thing. It just keeps adding up, it’s like £1,500. The phone bill is now £400 and something. I can’t deal with this stuff, and that’s the whole point of depression, it’s avoidance.”

He continued with an anecdote that I think he intended to be, and I took to be, illustrative of how, at the time we spoke, he was feeling:

“There’s a story: if you put a frog in boiling water, it’ll jump out. If you put it in cold water and just turn the heat up slightly it’ll boil to death. So we’re in a country in which people are boiling to death. Nobody notices it.”

Having previously referred to a ‘tipping point’, I asked Anthony whether he had reached this point, and received the reply that he had gone past it. He was not confident of being able to get the assistance that he clearly needed to help straighten out not just his finances but also his mental health, and there seemed no indication that such assistance would be forthcoming any time soon.

Others similarly alluded to the struggles they had in trying to meet their most basic of needs out of their meagre incomes:

“I was on JSA, and that made it really, really hard. I managed – there is a place here called [name of homeless support service] – I went for my breakfasts there, I went for my dinners there, so that was fine, it was trying to survive on your own, which I did. I had a camping stove, a little mini camping stove, which cost me about £25, and about £8.50 for the little gas

thing. So, it was... I tried to manage, I tried to... you know... to survive as well as I could. But it was just horrific.” (Stephen)

In Stephen’s case, he had only to support himself. Other interviewees are having to use their own incomes to supplement those of relations who have even less:

“I send money abroad to support my family, so I actually live fairly frugally. I had a period of where I had no money or next to no money because I’d went into... because I had no hot water I went into an hotel for one night. That cost me £80 so that took all my disposable income till I got paid. (Liam)

“My daughter, who is on JSA, has so little money that I have to help her out a lot. It’s hard to make ends meet.” (Jessica, 45, mental health service user, north-west London)

It is entirely possible to see Liam and Jessica, dependent upon benefits as they are, as nonetheless taking *responsibility* for themselves and their dependents as government rhetoric demands. Thus, as with Richard, service users’ *lived geographies* expose the shallowness of the more simplistic moral reasoning used to promote the wider welfare reforms, and stress the importance attending to service users’ *voices* (Parr and Davidson, 2010).

Trevor’s comments suggest a sort of resigned acceptance of the reality of having to struggle, though tempered by the knowledge that circumstances had been significantly worse in the past:

“I think a lot of people like myself are struggling with the way we’re having to manage things. I get about, um, I was getting quite a bit, I was getting about £200 a week and it dropped to a £100-and-something a week, I think it’s £150-something. I then got another payment at the end of the month, which is DLA, but I can still manage cos if I can manage [as he had previously done when working] on £10 a week, £28 a week, £40 a week, that’s big money for me so I’m not too worried, you know?” (Trevor)

Again, we see service users attempting to orientate themselves within their worlds, bringing past experience to bear on an uncertain future. Simon finds that while his benefits are sufficient to cover the basics, they don't allow for the kinds of *social* activities that he and other service users identified as being crucial in their efforts to achieve wellness over illness:

"I've got, I think, sufficient to get by from the benefits, but not for anything else. [Thankfully] I do have other sources of income, and I do declare it when I apply for benefits. But... it's my mother put some money into a trust for me, which I can't access myself, I have to apply through my mother, and a trustee who's a solicitor, for funds for specific things that I want to do. They then decide whether it's something that I should be doing, that's good for my, you know, my wellbeing. And then they decide whether they are going to give me funds for that specific – it's made quite a lot of difference to my life having a trust fund actually, because, erm, on benefits I would not be able to do [language] classes at the institute, for example. So, I am accessing some trust money to be able to do that. I think life would be pretty tough without it." (Simon)

6.3.3. The relationship between service users' income and their mental health.

Unsurprisingly, all service users felt that there existed a strong connection between having an income sufficient to exceed basic needs, the maintenance of stable mental health, and a broader sense of security – indeed that an income at a level above basic needs provided them with a form of *social security*:

"One of the things that does effect your standard of living – or your attitude towards life, rather, is if you've no money in the bank, y'know? ... It complements my mental health as well. You're not worried about where the next tin of beans is coming from ... When they stopped my money [DLA] I found it very difficult socially, y'know, to go out with friends." (Richard)

“Yes, absolutely. My kind of social circle revolves around my musical interests and my [language] interests and, you know, it’s kind of that’s where my friends are really. Keep myself stimulated. Enjoy London life. And meet people.” (Simon)

“[Benefits] help me very much indeed, because erm, if I was working, I’d be getting about £40 a week, I don’t know if I’d be getting more than that, because the minimum wage is in, but I used to get, like £10 a week, £28 a week, £40 a week, and obviously I’d struggle ... With the DLA and the Income Support it gives you a sense of well-being, you know? You don’t necessarily have to worry about where your money comes from, all you have to do is sign your name and that’s how simple it can get, you know? So sometimes I don’t even have to go into the bank cos it’s like a direct payment.” (Trevor)

“Knowing that you’ve got money. Knowing that you’ve got somewhere secure and comfortable to live, and you’ve got enough money to survive on, helps keep you well.” (Paula, late-40s, mental health service user, Home Counties market town)

The alternative – the alarming prospect of having even less money coming in than at present – was scarcely imaginable for some interviewees, Jessica stating that such a scenario would be:

“... a nightmare. If I didn’t get them [benefits] I don’t know what I’d do. I would probably spent more time in hospital ... literally have no money.”

And:

“I can’t imagine an alternative. I mean, not having benefits would be really difficult, wouldn’t it?” (Simon)

“Not having enough money, or not having somewhere secure to live, or being worried about your money, adds to the difficulties which people are trying to manage.” (Paula)

These comments have a distinct geographical impression: spaces that are secure, or through which to be voluntarily mobile, or as a bulwark against hospitalisation. For example, the income from Simon’s trust fund money allows him not only to participate in specific places of social interaction but also to circulate in and through the wider spaces of the urban environment, both of which are key components in his attempts to manage his mental health. Conversely, for Jessica, her benefits provide the space that separate her from further periods of hospitalisation, and it is her almost total reliance on them both to meet her needs and to attempt to remain stable that makes the prospect of losing them almost unthinkable.

However, this unimaginable world was, for several interviewees, about to become all too real, as they prepared to negotiate the reassessment process to determine their ongoing entitlement to existing benefits. The third section of this chapter looks at how interviewees are preparing for, and coping with, the changes to the benefits system, and what impacts these have had, or threaten to have.

6.4. Reassessment

Chapter 3, on welfare reform, examined the detail of the proposed reforms. It posited that the reassessment process for continued eligibility to benefits was flawed in both conception and design, and that the effects of reassessment were likely to be particularly pernicious for people with mental health problems. It argued that if hostile political rhetoric represented the leading edge of reform then reassessment could be seen as its hard edge, in which the unpleasant and stigmatising rhetoric was set to take concrete form. It was hoped that this part of the chapter would be able to present a less alarming picture of reassessment than the bruising process that was envisaged in chapter 3 but, regrettably, the evidence from these interviews lends credence almost solely to the initial hypothesis and to

findings from other recent studies (Barr et al, 2015; Garthwaite, 2014; Garthwaite et al, 2014; Moffatt et al, 2015; Patrick, 2014; Power, 2016; Roulstone, 2015; Warren et al, 2013): namely that the reassessment process is not just flawed for people with mental health problems but is actively damaging to them. This part of the chapter is divided into two parts, the first looks at how mental health service users' are coping with the *anticipation* of being reassessed for ongoing entitlement to their respective benefits, and the second looks at the actual experience.

6.4.1. What effect is the anticipation of reassessment having on service users' mental health?

For those service users' who had not yet experienced it, reassessment hung like a pall over their lives. Anticipation of what the process involved, and fears over the outcome and the potential impact on their mental health, had caused service users acute worry. Indeed, in several cases it was implicated in significant deteriorations in users' mental health. Despite the uniformity of expectation, individual service users nonetheless approached their individual reassessments in a number of ways, with some appearing resigned to the expected outcome (a loss of, or reduction in, benefits), others expressing alternately antagonism, fear, and frustration.

Richard, who was preparing to be reassessed from IB to ESA, and Paula, who was anticipating reassessment from DLA to PIP, both expressed a combination of anger and resignation over what they anticipate will happen to them, with Paula stressing the point made earlier that DLA serves an enabling function, in this case helping to keep her in work and out of hospital:

“At some point, they'll cut my benefits, ‘cos I’m doing this Atos [company which then conducted the reassessment] thing just now ... If they cut my money next week I wouldn’t be happy about it but at least I know I’ve got that £1,700 in the bank if needs must. A lot of people don’t have 1,700 quid in the bank. So what do they do?” (Richard)

“I am currently getting DLA. I am aware that at some point, when I’m assessed for PIP, I’m going to lose it, because I am the sort of person they are going to take it away from ... I actually feel that what I get in DLA is actually damn good value for money, ‘cos apart from the fact that last time I got ill, seriously ill, I ended up in hospital for about six weeks. £400 a night for six weeks. Um, also, actually, by paying me a small amount of DLA I am able to do work here [at the mental health service user charity] ... actually I think the state gets damn good value for money for what they get from me”.
(Paula)

For others, being engaged in or thinking about the reassessment process has been a source of deep upset and worry.

“It was distressing. I was nervous, on tenterhooks after I left hospital. I felt vulnerable coming out of hospital and got completely worked up about the medical [assessment]. It exacerbated everything. I was in such a state and [the two month wait] was agonising. I didn’t know what was going to happen. I felt really bad mentally. (Jessica)

“Everyone is worried. Cos’ if they cut your benefits, what do you do? What do you fall back on?” (Trevor)

“I was really, really worried about. Went through that process and it was months and months and months and months went by without hearing anything and that really plays on the paranoia as you’re thinking ‘why aren’t I hearing anything?’” (Harry)

The climate of fear and uncertainty surrounding reassessment is compelling service users to contemplate that which, for Jessica and Trevor, remains unthinkable – the possibility of finding themselves adrift in a world without benefits, cut off from the often rudimentary spaces of safety these provide. As Yann succinctly expressed it, “benefits are my security”.

Service users expounded at length on their expectations that the assessment procedure, and the assessors, would be judgmental and unfair, seeking to use tricks to catch them out in order to put them at an immediate disadvantage.

“Apparently, if you make a lot of eye contact they’ll say ‘he’s not nervous’. Well, I make a lot of eye contact. They must be reading the idiots guide to psychology or something like that. I come across as quite secure, which is a defensive thing, y’know? It’s not very nice being called into a place where you don’t know the person and all of a sudden they’re making all kinds of judgements about you. When they don’t know the facts, y’know? Or maybe not even asking for the facts, which is even worse. They [Atos] have been given quotas, so many people a day they have to cut off their benefit or else they get drawn in front of their boss. It’s a wholly insidious process but that’s the way we’re living.” (Richard)

“I had heard horror stories of Atos... that they disregard what you said and make their own decision. If they’re not going to listen what’s the point in going?” (Jessica)

“People have tactics on this. With me it [the ESA50 application form to assess eligibility] arrived and I was about to go out but I thought I might as well start filling in the basics. I think it took me about two and a half hours to fill the whole thing in and then, after waiting a day to get a photocopy, I sent it back. People said to me, ‘Oh! You don’t want to send it back immediately, they’ll say that proves you can work’. There’s this mythology that’s built around. But I thought, well, I’ve sent it back let them pick the bones out of it. I had another friend, and he received it the same week, and he waited until the very last moment and he sent it back by recorded delivery.” (Liam)

Liam said he had heard how the Atos assessors use subterfuge and various ruses to try to catch claimants out – leaving coins on floor to see whether individuals picked them up, thus allowing them to question claims of immobility, or by pretending to be asking for directions as the claimant approaches the assessment centre, so that if the claimant is coherent, lucid and has logical recall the assessor

will use the information against him or her in an attempt to ‘catch them out’ and deny their dues. What matters here is not so much whether these allegations are true, but rather the extent to which they hold fast in service users’ minds, the degree to which they do indeed form a ‘myth’, and the impact these myths have on individuals’ health and stability – and the spaces and places in which this stability is practised - as they approach an assessment that is intended to judge their ‘fitness’ to work and which, given the importance of employment in the moral discourse surrounding the reforms, is implicitly judging their fitness to be seen as morally deserving citizens.

6.4.2. How are service users experiencing the actual reassessment?

Reflecting the evidence presented in chapter 3, there was substantial reflection on the part of service users that the assessment processes simply did not appear to regard them as people with quite particular needs, ones that perhaps could not always be ‘seen’. This could be demonstrated in relation to the bedroom tax, whereby,

“[The DWP] say I’m under-occupying, but actually I’m not. I’ve got a spare bedroom which, if I ever become ill again – hopefully I won’t – but if I do, members of my family can come and stay to look after me. I’ve got a room which is theoretically a spare bedroom but in actual fact is office space. And I am sure that applies to lots of other people. And I think it applies to a lot of people with mental health issues, you know thinking back to times when I’ve been ill, I spent quite long periods of time when I have not been able to get out of the front door. And actually, it’s far pleasanter to be trapped in a larger house than in a small flat.” (Paula)

The feelings of bewilderment and worry that surround the apparent inability of the assessment processes to comprehend the distinctive requirements of people with mental health problems, or which render them invisible, is a picture mental health

service providers, who were on occasion also spoken with as part of the research encounter⁹, recognise too:

[For] the ones who have been dragged through it, it has been incredibly stressful. Um, I mean, one of our members here [at a mental health drop in centre] that I support, I mean she actually went for an ESA assessment without any support, got bumped off it, put onto job seekers, um and just seeing somebody who has borderline learning disabilities, has mental health issues, got physical health issues, being, you know, forced to jump through these hoops, and being threatened with being penalised because she couldn't prove that she'd done the necessary number of [job] applications that week, and somebody who actually despite all their issues and problems, was doing a lot of work here as a member, supporting other members, doing a lot of practical things here, also doing a lot of support at [name of homeless support organisation], you know, she's actually contributing, and being told that she is not doing enough 'cos you haven't got the paperwork to prove that you've done the necessary number of applications, you're not trying hard enough. This is a person who has been stable for quite a period of time, coming back from each interview at the job centre more stressed and more destabilised, um, and did eventually... I managed to help her get back on ESA, and went with her for the assessment for ESA, and I did a fair bit of prompting in the interview as I knew that otherwise she'd just sit there and be flummoxed by the whole thing and be bumped back on to job seekers.

[Also, service users] have to travel to [name of county town] ... but I do get the impression that possibly if you manage to turn up at your assessment in [name of town] on your own that's a mark against you because you can manage to travel to get there in the first place." (mental health service provider, Home Counties market town)

⁹ These were the service providers who had assisted in the recruitment of participants and who were themselves keen to contribute by setting their experiences of reassessment processes alongside those of participants

“One particular work programme in this borough have no understanding of mental health whatsoever. So, around about September or October last year, I had to put in six formal complaints to the DWP and to this work programme because these six clients had all been sanctioned for non-attendance at their work programme. Now, that in itself was causing their mental health to deteriorate significantly, so it’s not only when people are being reassessed and turned down it’s even when they’ve passed the assessment and they are actually getting an acknowledgement that they’re unfit for work the impact of the work programme is then also making them more unwell. And, you know, it became Kafka-esque in that I just couldn’t resolve the situation, because half of the six people I complained about had actually attended the appointments, so the work programme had made the error. They then acknowledged they’d make the error, told the DWP, but the DWP didn’t know about it, they weren’t communicating, and it went on literally – one of them is still outstanding, he’s actually got to attend a tribunal on Monday to have his sanction lifted even though the work programme acknowledged that they’d made an error. It is incredible. Kafka-esque, it really is.” (welfare rights advisor, mental health service users organisation, south London)

“I go to [name of] psychiatric hospital every week … people often say I got these DWP letters and it tipped me over the edge. That’s often the phrase they use. They say ‘I was having difficulties in my life anyway’, from life circumstances, or whatever had been happening to them, but they say ‘I just kept getting these DWP letters, then my money stopped, you know, I’m in here, I attempted suicide’, or whatever it may be. Yeah, I regularly see people where their mental health has deteriorated as a result of what has happened with their benefits.” (welfare rights advisor, south London)

The geographical concepts of space, place and mobility are as crucial in understanding the impacts of reassessments as they are in comprehending service users’ relationship to the prospect of employment: service users occupy *too much* residential space; they are ‘dragged’ through the WCA process; the suggestion that service users’ competent use of public space through accurate

way-finding is potentially suspect and will likely count against them in any assessment of their 'capabilities'; even in the flesh they are unseen and uncounted.

As part of the transition from Incapacity Benefit, several service users were assessed for Employment Support Allowance and found themselves instead in the unenviable position of being deemed eligible only for Job Seekers' Allowance. Donna explained her incredulity at what had happened:

"It was inconceivable to me! I have become seriously mentally ill in the interim period and now you're saying I am well enough to work?! I was increasingly mad, was on really heavy medication, in hospital for months and then had to go for reassessment. So I went along, I was sort of straightforward, told them what had happened and everything, and I got kicked off! Not, like, put into the work focused group, but scored zero points! It was very stressful and it took me a long time to get over the shock of losing my benefits when I was so severely mentally ill. I found that completely destabilising. You know, I became much more seriously mentally ill as a result of that happening... you know, dealing with reality was obviously just very, very problematic. But it became completely impossible after that for quite a long time."

Like Donna, Christine had also been rejected for ESA, and the impact was equally shattering:

"They made me go on JSA and I began to get psychotic again, got really, really ill. When they changed from IB to ESA I went to the interview and they denied it so I had to go on JSA. So I went to sign on every week and you have to keep a record of all the jobs you're looking for and apply for anything and take it back to the interview once a week. So I was doing that and the stress was building up and I started hearing things, and seeing things. When I get very depressed and stressed I start hearing things and seeing things."

The delay- and backlog-prone reassessment schedule was felt to operate against people by ensuring the process was a drawn out affair: hardly had it been dispensed with when service users were required to start preparing all over again for another assessment:

“Then, just before Christmas, I had another [letter] to say I was to be reassessed for ESA only nine months after being told I had been accepted for it. I rung up about it and asked if it was a mistake. She said no it’s not a mistake and you’ve got to do it all again. I said ‘surely, if you read my form, you’ll see I have a long-standing condition and I’ve been on the thing for years and years, and I’ve been awarded a life award for DLA, and it shows you the things I struggle with’, but she wasn’t interested.” (Harry)

“I went down to the Job Centre to get my ESA reactivated. The first thing I received in the post was a letter to say my case would be reviewed again. So before I even got a letter saying ‘we are going to renew your benefit’ I got a letter saying ‘we’re going to review your case again’, which I thought was very hostile.” (Donna)

This seemed also to penalise service users for the fact that certain health conditions do not remain unchanged over time:

“I applied for DLA and then it was refused, and then I had to appeal it – which took ages and ages and ages – and in between that I’d had my gastric bypass and I’d lost loads of weight. So I was going into the appeal with the form saying I was 24 and a half stone but, of course, I am bloomin’ size twelve and so straight away it looks as if I am a lying fraud! Some of the most embarrassing things I’d had to put on the form, like toilet needs and stuff - when you weigh so much you’re more likely to be incontinent - things like that. And I was mortified that I’d put in things that I hadn’t even told the doctor. So, they’re asking me about that and I just felt like a fraud. And I think the other trouble with personality disorder is that whole polarised, black and white thing, so if you’re having a day where you’re feeling good it’s actually very difficult to even be reminded that a week ago,

or two weeks ago, you were feeling [so much worse] ... I was almost desperately wanting – this will sound bizarre – to show them how well I was. When you actually feel good, you feel that you want to shout about it.” (Hannah)

Hannah also damned the process for its inconsistency, noting that when later she applied for the replacement PIP, “I was in a better place – bear in mind I was rejected for DLA – and I was awarded it for four years! It makes me angry, really, because part of [the reason for] me not being able to get Disability Living Allowance was *because of my disability!*”

Both Christine and Donna talked about the way they had been advised to behave at their next hearings, with the recommendation that they answer every question as if it was their ‘worst day’. Christine talked about feeling obliged to put on an act in order to maximise her chances of being found eligible for ESA:

“This time I was primed, kind of coached, that you have to behave in a certain way. I was really against it, I had to basically perform, because I don’t understand why they don’t believe what you say. I know I present articulately, I look well and all the rest of it, but they should know well enough that you know people have to perform when they meet somebody, so I can present as fine but, in the evenings, I might just have to lay in a darkened room until the next day because the stimulation has been too much. I find it demeaning and humiliating that I have to present in a way that makes me seem worse than I really am, or that it’s my absolute worst day when it’s not my worst day. I just find the whole thing absolutely humiliating, but I did what he said and I got it. I didn’t make eye contact, didn’t speak very much, took an advocate with me, um, all the things that they expect to see so that you tick the boxes.” (Christine)

Christine and Donna’s experiences are supported by mental health service providers who have sufficient experience of shepherding fearful clients through the assessment process to be able to confirm the extent to which the WCA is a hopelessly inadequate tool, poorly administered:

“Time after time people were coming to me to say that I went to the assessment, and that the assessor said to me ‘can I go to the shops?’, and I might say ‘most days I can’t even get out of bed’ but, when I do feel well enough, I do go to my local shop, but I don’t go to the supermarket because there’s too many people there, but I go down to my local shop. And then you see the assessment and it says ‘goes to the shops alone’, and makes no mention of all the other problems. And I can kind of repeat that for lots of tasks that come under assessment within the WCA.” (welfare rights advisor, mental health service users organisation, south London)

[People] go to their Work Programme appointment and they say they’re in a big room full of lots of people, who often have their own mental health issues - you know someone gave an example of someone who had a major panic attack in there because they couldn’t be around lots of people, and they were trying to tell the WP worker, ‘I need to leave this building and stand outside for a moment, I’m gonna have a panic attack’, and they said to them ‘if you leave this building you’re going to be sanctioned’. That in itself caused that individual lots of lots of mental health problems and made it worse. But, when all the other people in the room are seeing that happening, you can imagine the stress that causes them.” (welfare rights’ advisor, south London)

“There is a lack of understanding at the DWP about mental health issues. There is much more pressure on people to ‘get back to work’ … the process of putting people into work through the use of sanctions and conditionality is making people feel threatened and that they are being demonised … and the WCA is a crude tool and wholly counterproductive – how can it measure fitness to work when the whole process renders lots of people unfit to work?” (policy officer, national mental health charity, London)

The WCA is therefore viewed as a device in which the quotidian rhythms of mobility – such as the occasional ability to visit the local shops – are seen not as practices anchored in individuals’ finely honed methods of stability and safety, but

are rather decontextualised, up-scaled, and presented as evidence of individuals' capability to begin preparations for re-entry to the labour market.

The involuntary mobility imposed on service users by the WCA - “*...being called into a place where they don't know the person and all of a sudden they're making all kinds of judgments about you*”, “*If they're not going to listen, what's the point?*” – and compelling them into unsafe places - “*...a big room full of lots of people...*” – is mirrored in official decision-making over the ‘bedroom’ tax. These too are perceived to be based on an inability to understand the different life worlds inhabited by people with mental health problems, especially the ways through which practices of stability and security are strongly *emplaced*:

“I know a lady who did make the decision she had to move [as a result of the bedroom tax], and did get support to move and did move. And she survived the move but it was... an incredibly traumatic experience, and she is very, very angry about it. That... the place where she had lived, that was her home, the place where the spare bedroom was extremely small anyway, and she's got a daughter with children who lives some distance away so its now far harder for her family to visit her.

“There is a member here who is being hit by the bedroom tax but who does not feel in a place – she does not feel robust enough to move. And, yet, she's being hit with a financial debt that she can't afford to meet. And she is far less well than she was a year ago. And potentially she's going to get ill, and she's going to end up in hospital, which costs £400 a night, so where's the saving? And not just in financial terms, but actually somebody who's been stable for quite some time has, actually, been destabilised by this.”
(mental health service provider, Home Counties market town)

Again, the mobility here is experienced as a form of ‘trauma’, in which people are either uprooted, their practices of stability and safety not just disrupted but destroyed, or remain in place but are destabilised to the point where the prospect – and cost – of hospitalisation looms menacingly once more.

In addition to the perceived inadequacy of the WCA, service providers also spoke about its incompetent administration whereby even when people had been found unfit to work the 'system' ensured that any respite was of short duration:

"Once someone's passed their assessment they should be left to try and get well and get the support from the CMHT [community mental health team], and support workers etc., to try and get well to be able to actually get back to work, whereas what I am actually seeing is that people are reassessed so regularly that it actually impacts on their mental health so they become more unwell because of what is happening to them."

"The fact that people are being reassessed so regularly means they may have passed their assessment, they then try and get well - which they may have waited eighteen months for, because if they have to go to a tribunal the average wait is about a year, to actually even get it to a tribunal. So, they've waited about eighteen months, they are then awarded their ESA if they get through the tribunal, they then get all their arrears paid, they're then left to get on with their lives. Then, three months later, they get another form through the post. And then they fill in the form as best they can, they're called in for an assessment, they're then found fit for work again. And they have to go through the whole process. And it's terrible, because, you know, I see it with my own eyes, how people have had some improvement, breath a sigh of relief having had to go through the appeal, they start to focus on getting well, but then they go back down again. And, literally, because I see people repeatedly over the years I can see what it's doing to them." (welfare rights advisor, mental health service users organisation, south London)

Individuals are presented here as being entrapped within a seemingly never ending and dizzying circuit of assessment, appeal, and reassessment, in which the time and space for them to (re)locate their stability becomes ever more fleeting. Service users (and providers) have been at pains to stress the extent to which they are precariously balanced at all times between 'wellness' and 'illness'. They are acutely aware that one false move by them or, increasingly, by the state apparatus responsible for administering to their needs, could have them fall back

into places darker and more troubling than the twilight world of the reassessment process. And so with varying ability to manage – hope, determination, defiance, anger, pain, bewilderment – individual service users can be seen re-orientating their practices of stability in order to cope as best they can in circumstances which are largely outwith their control.

6.5. Summary

Chapter 3 sketched out the broad ideological canvas of the welfare state under neoliberalism, upon which the key tenants of unsustainable fiscal burden and immorality of welfare dependence and worklessness had been inscribed. It examined suggestions that the ways in which the government's preferred method of imposing 'morality' onto the welfare state – the reassessment of continued eligibility to individual benefits – required instruments that had been fashioned in such a way so to ensure that those who had been damned in policy rhetoric as undeserving were indeed confirmed as such. Thus, the primary tool used for existing assessments – the Work Capability Assessment – found disproportionately high numbers of those assessed as 'fit to work'. That this tool was predicated firmly on a medical model of (dis)ability and was structurally incapable of recognising social barriers to employment (Hawkes, 2011; Patrick, 2011a), let alone detecting the variation in mental health conditions that make obtaining and sustaining employment so difficult for people with mental health problems (Grover and Pigott, 2010; Patrick, 2011b, 2014; Warren et al, 2014), is, these critics allege, hardly coincidence. It was *politically* necessary for joblessness to be rescaled to the level of individual failings amidst a culture of dependency (Slater, 2014), rather than being viewed as a structural consequence of a distorted and unbalanced economy. That people with mental health problems would find themselves caught up as collateral in this calculation was an unfortunate – and presumably unintended – consequence (Barr et al, 2015).

This chapter set out to see how mental health service users have fared under welfare reform and to test the propositions outlined above. It aimed to do this by investigating the personal and structural relationships between service users' and

the benefits system, and to assess the impact of wider welfare reforms. In doing so it has focused on three particular areas: first, service-users' relationship to and feelings about employment; second, their relationship to welfare benefits in the context of the day to day management of their lives and their mental health; and third, their experiences and views about the reassessment process for ongoing eligibility to benefits. In each, core geographical principles – space, place and mobility - were invoked through the ways in which service users' discussed their engagements with, and experiences of, the processes and procedures of welfare reform. Service users' mechanisms for upholding wellness and stability in their mental health – the tools by which they orientate themselves in the world – are heavily *emplaced*, *bounded*, and subject to strategies and practices of *(im)mobility*. These tactical devices have been disrupted, dislodged and displaced by welfare reform. This can be witnessed most significantly through two particular variants of *mobility* – first, the threat of enforced entry into the labour market, and second, the spectre of enforced home moves - and by two forms of *entrapment* – one, an invisibility in which 'mental health' is in the decision making processes of reassessment seemingly discounted as being valid grounds for continued protection and support, and two, the apparently never-ending loop of assessment, appeal, and reassessment. The overall outcome of which has been to jeopardise the already shaky ground upon which service users position themselves. Welfare reform has thus had an impact that is experienced by service users as profoundly *spatial* and this is the distinctive contribution of this research to the wider literature. It has found that service users are propelled through the work capability assessment; their ability to navigate public space effectively in order to acquire basic groceries, or to attend medical assessments, or interviews, or 'work-related' activities, is viewed with suspicion and as being evidence of readiness or fitness to work rather than as an often fraught task involving significant amounts of distress and that may be more frequently abandoned than successfully completed; such distresses – and the needs that attend to them - are not necessarily physically present or observable and are therefore unseen and go unheeded; thus, when service users *are seen*, it is in the context of occupying too much residential space, or being caught on the hamster-wheel of reassessment. In each of these instances the boundaries that service users have erected to protect their practices

of wellness, stability and recovery have been breached, and they have been forced to confront the unfamiliar and forbidding spaces that lie beyond.

This chapter has also established that employment as both a concept - 'the world of work' - and a practice - 'getting a job' – is remote from the daily lived experiences and expectations of the majority of the service users interviewed. Far from supporting the government's view of employment as *the* solution to the curing of their ills, service users view it in more stark terms, as an activity and/or experience that is at present sufficiently unfamiliar so as to represent a *potential* threat to their carefully constructed methods of managing their health. This confirms the findings of similarly-themed research on the chasm between state interpretations of individuals' readiness for work and their actual health and lived experiences (Garthwaite et al, 2014; Patrick, 2014), and on the ways in which their fear and suspicion of welfare reform impacts upon their daily lives (Garthwaite, 2014). Furthermore, it is one that could become an *active* threat were employment to be imposed on them at a time, in a place, or in a manner that did not take into account their status as people with mental health problems (a status found here to be frequently unseen or unheralded, and which mirrors Roulstone's (2015) findings that DLA recipients were frequently considered as being 'insufficiently' disabled to merit additional financial support), and for whom certain normative behaviours and practices are at times impossible to contemplate let alone implement. The results presented here thus also reflect the findings of Barr et al (2015), and Wilton (2003) and Mifflin and Wilton (2005) before them, whereby, perversely, welfare reform policies ended up contributing to a deepening of poverty, an increase in mental health problems and social exclusion, and an *increased* rather than *reduced* reliance on benefits and social support.

It is precisely these nuances – that with good reason service users can view their distance from supposed 'norms' rather differently - that are cast aside by the nature of reforms to the welfare state and their method of introduction, a finding that has echoes of the ways in which the service users interviewed by Pinfold (2000) found that attempts at encouraging their normalisation through engagement in particular social activities operated in ways that threatened, and did not necessarily enhance, their own sense of social inclusion.

In the context of reform and reassessment, therefore, this chapter has demonstrated how interviewees have tried to develop personal coping strategies for managing the gap between the government's expectation of an easy and supposedly 'supported' passage into work, and their own excruciating fears of a bruising transition into something they feel ill-equipped and unable to endure. These fears are evident whether they are actively involved at a particular stage of the reassessment process or are continuing claimants caught up in an atmosphere mediated by harsh political rhetoric and service user alarm. As such, these strategies take the form of protective tactics that are predicated on upholding their own 'everyday equilibrium' (Pinfold, 2000), and which allude to the ways in which service users can be seen as active agents working in a multiplicity of ways at a series of different scales to determine and have control over their own pasts, presents and futures (Parr 2006, 2008). Yet, as this chapter has tried to show, they are inherently geographical too, and involve a strong element of practised boundedness, in which the familiar and the unfamiliar, the safe and the unsafe, are, so far as possible, kept apart spatially, temporally, and emotionally. Yet, this judicious balancing act is threatened with disruption in which (relative) stability is upended by enforced movement – to an assessment, to a job centre, to a tribunal, back to an assessment, and so on - or through the menace of a 'brown envelope' dropping through the letter box (Garthwaite, 2014). Either way, new spaces of stability have to be sought or eked out of potentially unforgiving terrain.

The sensitive nature of the personal geographies revealed here is the result of a research design that prioritised individual cases, detailed knowledge and in-depth understanding over a more controlled research framework, and as such reflects recent similar work (Garthwaite et al, 2014; Patrick, 2014). Yet, in the context of this particular research, individual stories are not enough in and of themselves. In order to justify my fleeting appropriation of others' lives, such stories must be set against a broader social tableau, in this case the current policy context of reforms to the welfare state in England and Wales. The literature review demonstrated that large scale social policies are central to the individual and collective geographies of people with mental health problems: decanted from asylums into communities that sought their spatial filtering into particular parts of the urban realm; as actors

in a deinstitutionalised landscape of homelessness and precarious and circulatory living; as recipients of a re-stigmatisation that sought pushback against 'care in the community' and which posited various forms of reinstitutionalisation as a solution; as users of a large but unequal and fragmentary set of services provided by public, private and voluntary sector organisations; and now, as benefit reliant individuals experiencing the rough edges of welfare reform.

Chapters 2 and 5 discussed how people with mental health problems had been residentially mobile, and the ways in which this mobility had been represented and experienced. The conceptual idea of mobility proposed by Tim Cresswell – that is, a person or thing being engaged in *relationally important movement or stasis* and which involves force, feeling, friction, rhythm, routes and velocity – has been also been shown here to be similarly important in helping to understand the complex and multifaceted ways in which mental health service users have experienced welfare reform. Again, as with residential mobility, this revolves primarily around instances of *involuntary mobility* and *entrapment*, where the feelings and frictions surrounding each have led to deteriorations in mental health, feelings of trauma and debility, and which have caused a compression of time and space that is choking off prospects for wellness, stability and recovery. Many of the strategies that service users adopt in seeking to maintain wellbeing, and which have been discussed in this chapter, are emplaced in, or operate in relation to their feelings about, their own homes, and it is the role that the distinct place of the 'home' – and any sense of ontological security that it does or does not help to engender - in service users' mental health to which the next chapter turns.

Chapter 7. A long way from home? The role of the ‘home’ in service users’ daily management and negotiation of their mental health

“[H]omes are ‘places’ that hold considerable social, psychological and emotive meaning ... In understanding a person’s connection with their home, then, we go some way towards understanding their social relations, their psychology, and their emotions and we can begin to understand their lived experiences” (Easthope, 2004, p135)

“The thing about home – a lot of people with mental health problems don’t really have a ‘home’ – if you don’t have somewhere you call home, and it feels like home, the chances of your mental health getting better are very limited. If you’re not happy where you live that’s a huge part of your life” (Richard, mental health service user)

7.1. Introduction

In the preceding two chapters, the thesis has used the broad framework offered by mobilities and mental health geographies scholarship to analyse service users’ countervailing experiences of residential mobility and/or immobility, and has examined how service users’ were positioned to cope with reforms to the welfare state that threatened stability of both health and residence. This, the final of the three analytical and discussion chapters, moves the thesis on from questions that relate primarily to *housing* (and other forms of accommodation) and the ways in which transitions between different residences are felt and experienced, to those of the *home*, a largely fixed place of abode created in the close and personal intermingling between its occupants and the broader social relations that flow in and around it. It is particularly concerned by questions of ‘ontological security’, or the extent to which a place of residence offers a level of security beyond merely providing a roof over one’s head (hugely important though that is) - a distinction Somerville (1992) refers to as ‘rooflessness’ versus ‘rootlessness’, in which questions can be asked “not only about the unhoused and the ill-housed, but also

about the well-being of the relatively well-housed who do not experience a sense of being at home" (Kearns and Smith, 1994, p420). Ontological security can be discerned by: permanence and stability; privacy and control; a base for the practice of daily routines and activities; and scope for personal development. A 'home' thus comprise both 'hard' (i.e. material) and 'soft' (i.e. imaginative) aspects (Shaw, 2004) and, as the literature review noted, it should be viewed as being a verb as much as a noun (Mallett, 2004), and as representing the outcome of embodied practices that occur within and around this specific place. It is therefore also best understood at an emotional level, and the ways in which it is created, used, experienced, and felt, reveal a "powerful domestic geography" (Gurney, 2000, p34, quoted in Easthope, 2004, p134). An understanding of these home-based geographies is made all the more important in the light of the previously discussed welfare restructuring, which has seen the scaling back of the quotidian spaces that service users have frequently incorporated into their inchoate daily practices, and benefit squeezes that make the possession of a home an ever more precious, or possibly even unlikely, commodity. Thus, service users' emotional constructions of home, and the roles these play in sustaining wellbeing or distress, become ever more significant in the post-deinstitutionalised – and possibly post-welfare - world.

In the literature, the home is seen as a hazy synthesis, a place that is simultaneously open and closed (Massey, 1992), physical and abstract, felt and imagined (Blunt and Dowling, 2006), protective and repressive (Schroder, 2003; Somerville, 1992). These ideas are fitting in the context of the experiences of mental health service users in the present study. Indeed, the shifting and hybrid nature of home in this reading could be seen as reflecting service users' own perceptions and feelings about the fluid nature of their health and social worlds. For service users, the home, as both physical abode *and* emotional construction, plays an increasingly important and multifaceted role in their daily management and negotiation of their wellness, illness, stability, distress, and recovery. Thus,

"it makes much more sense to view home as a site of and for ambiguity since its protective functions are interconnected with its limiting characteristics. Feelings of solidarity, safety, and protection are often

achieved by severe acts of exclusion and regulation, which are in turn oppressive" (Schroder, 2006, p33, quoted in Brickell, 2012, p226).

This notion of the hybrid home – specifically one that can simultaneously be both protective and exclusionary - accords more readily with the experiences of service users than a reading of it as solely or even primarily a place of residence.

Accordingly, the spaces of the home, and the position it occupies in service users' emotional firmament, are understood differently depending on their affective state at particular times. For some, their homes can represent a private sanctuary, in which retreat from the burdensome stressors of shared, social spaces, is possible; for others, they are experienced as constricting places in which service users are either entrapped or that they feel daily obliged to shun. Yet, in each scenario, the dominant feelings about the home are constructed in relation to *external* factors, two crucial ones being their own previous experiences of being or becoming residentially mobile and the degree to which they are, or feel themselves to be, appropriately supported by the relevant services and/or insulated from repressive welfare changes.

This chapter will explore the different ways in which service users view the(ir) home(s). It starts with an examination of it as a space or place for retreat, separation or even isolation from the world, in which service users locate instances and experiences of recovery, stability or wellness, in which they believe their homes to have an ameliorative effect or about which they have expressed broadly positive views. That is, those examples in which a degree of ontological security could be said to be evident. It then turns to the alternative, in which the home is a space or place of negative impacts, in which distress or illness has flourished, in which people have become entrapped or from which they seek relief, in which a sense of ontological security is notable only through its absence, and concludes with a case study looking at the hoarding of goods and possessions, a behavioural act in which a number of the service users interviewed had been or were involved. The division of material between these two sections is necessarily somewhat arbitrary and indeed often overlaps - individual experience rarely being a simple choice between binary opposites of good and bad – and therefore it is probably most helpful to consider the accounts presented here as demonstrating

gradations of personal feeling and experience, from roughly the most positive to the most negative.

7.2. Respite, refuge, and retreat: Home as a (half way) haven?

“Domestic space offers protection from other peoples’ presence, judgments and disorderliness, and allows the self to re-establish its boundaries and coherence” (Seagrott and Doel, 2004)

“People who have never spent time in institutions or other environments controlled by externally imposed routine, or people who have been without housing, probably cannot understand the joy and relief that having personal control of a living situation brings. It comes from controlling access to personal space, from being able to alter one’s environment and select one’s daily routine, and from having personal space that reflects and upholds one’s identity and interests” (Ridgway et al, 1994)

“On the 8th of February I will have been in my flat for sixteen years. I was saying to someone the other day, that it’s the best thing that’s happened to me, that flat. I feel completely at ease in my flat” (Richard, mental health service user)

Echoing other studies (Alaazi et al, 2015; Bretherton and Pleace, 2015; Marcheschi et al, 2015; Padgett, 2007; Smith et al, 2015), those aspects of home about which service users expressed at least some upbeat feelings were, almost without exception, reported with reference to concomitant improvements in mental and emotional welfare. Equally, these feelings were always relayed vis a vis previous experiences of residential accommodation – hospital, hostel, private dwelling, makeshift encampment for rough sleeping - which had in their view either caused harm, sustained ill-health or which had otherwise operated to hamper pathways to recovery. As Ridgway et al (1994, p412) noted of those service users who have resided in more institutional settings, “[psychiatric patients] are often expected to live in close proximity to people whom they have not chosen to live with and to have their personal idiosyncrasies under continual surveillance by

staff'. These experiences of constricting spaces, of uncomfortable co-existence with or nearness to others whose behavioural oddities they feared, of unpleasant or frustrating encounters with operatives of the medical, homeless, and housing bureaucracies, were those from which they were mightily relieved to have, finally, become free.

Richard, who had for sixteen years been residing in the same flat, rented from a social housing landlord, was clear in attributing an improvement in his mental health over that time period to three factors: first, the stability of his residential situation; second, the physical properties of the flat; and three, the opportunities it afforded him to engage in activities that were ameliorative in nature. Taken as a whole, these three elements imbued Richard with a broader sense of safety and security – *ontological security* – with which he felt better able to face an external environment that he perceived as remaining frequently inhospitable.

"I think safe is a crucial word. A friend mentioned the other day 'oh, you're safe in your flat', which I think is very astute. I didn't feel safe at any point in the hostel, I didn't feel safe living in [name of high rise council block]. I was on the fifth floor and I had a balcony and I thought 'I can see me diving off this at some point'".

Here we see the ways in which Richard's current home environment is very much viewed through the lens of previous 'unhomely' experiences, and which supports Somerville's (1992) contention that the notion of 'home' has an especially strong symbolic resonance when contrasted with its absence. He continued:

"The neighbours upstairs were crazy ... I couldn't cope. So, one day, I just packed up all my belongings and I went to [name of psychiatric hospital] and I said 'look, I don't care what you do with me but I'm not going back there'. So they put me in the hostel. I spent eight years living there which, if you've got paranoia, is bad because people knock at your door at four o'clock in the morning and wake you up, try to sell you drugs, or you come to the door and they say 'oh sorry I've got the wrong door' and if you're paranoid you're not going to go back to sleep again ... [the] trouble with

paranoia is it snowballs very quickly. If you're paranoid and you can put two things together you can put a hundred things together."

Richard was clear in his mind that the key to him making a successful transition from long term hostel dweller to social housing tenant was the need to provide respite from his paranoia: "I didn't want the ground floor as I'd be paranoid about people breaking in, or looking in, and I insisted I needed a phone before I moved in". Once ensconced, Richard explained the gradual period of adjustment that ensued:

"I slept on the living room floor for the first three months, because the phone was in that room and I thought 'what if somebody breaks in and they're between me and the phone, how do I get help?' ... if I was walking past the door I used to check 'is this door locked?' Before I went to bed I'd check it three or four times. I'd wake up in the middle of the night and think 'did I lock it or did I inadvertently unlock it?' In the past four or five years that's gone and sometimes I go to bed without checking it. That's a huge step forward ... I'm also [now] sleeping with the windows open because it's hot. Even four or five years ago I couldn't have done that, I would have been too paranoid."

Richard's paranoia, to which he referred throughout the three interviews, caused him to remain guarded and somewhat aloof when out and about in public places. He thus spent considerable amounts of time in his home, listening to music, watching art house films, reading and, particularly important for his mental health (as it would turn out to be for other service users interviewed as part of this research), writing. His home, its sense of constancy, and the absence of anxiety-inducing neighbours, allowed him the space and freedom to create a place – "characterised by a calm tempo" (Olin et al, 2011, p142) - in which he could increasingly "come to terms with the limitations in my life. Just to be, just to be quite happy – I feel a bit emotional now – just to feel content, it's the word I keep coming back to again. And to be left alone". For Richard, there is a tangible – though perhaps fragile - sense of ontological security having developed since his years dwelling in a hostel, evidenced by the longevity of his current tenancy, the

scope for control and privacy it offers him, the opportunities to enact daily routines and practices and, perhaps most importantly, in the final remarks quoted, the possibility of a changing sense of self-acceptance and self-reliance that had not always been evident. This final element of ontological security – that of self actualisation - would seem necessarily to rest upon the presence of the former three and to be the hardest to obtain, the first to be lost, and the most difficult to recover.

The sense of being 'left alone' - that is, having a private space in which to be alone with, or to be able to manage, one's thoughts or feelings - figured heavily in the responses given by service users when asked to talk about their feelings about their homes. Like Richard, Katherine experienced significant levels of paranoia, chiefly in relation to other people's thoughts or feelings about her – "you can think everyone's talking about you which isn't helpful at all. You see, if you were sitting there and looked at me, I would think '*you're looking at me which means you're talking about me*'. But it's hard to think that you aren't. If you said 'I'm not talking about you' I'd think 'he *is*', you know?" This paranoia manifested itself in her hearing voices and it was in the self-management of the effect of these voices that Katherine spoke about her home. She explained the difficulties involved in judging when the voices presaged a possible downturn in her condition, and in being able to manage them:

"Sometimes you get voices and you think 'have you heard that, or have you just thought it? Is it true or not? I've had ones where I thought I'd killed someone. Well, you can't ask someone if you've killed someone! So I try to think about what I was doing, you know, 'what was I doing that day, then? Would I have the time?' cos I can't ask someone that! I find that it's best to try to work it out. I write it down, for my own peace of mind." (Katherine, 56, mental health service user, west Midlands)

She continued by talking about how she used her home as a place of distraction from the voices and to which she would withdraw should they become particularly persistent or pernicious:

"If it happens when I'm out, if it's just for five or ten minutes I can manage it. But if it carries on and carries on, what I do is [get home] and I'll talk to them [the voices] to try to distract myself from it. Or I just go and sit down and listen to some music or I just sit, sit back with the cat and that and relax. I don't know why it happens. It might be something small sometimes that, you know, the man over the road is staring at me through the window. And I think to myself 'he wouldn't be able to see me from right over there, with all the bushes [getting in the way], but if he came over to the bus stop and stood where the lamp post is he could see me, but I've got blinds so he can't see right in!'"

As Katherine used the privacy of her home and the routines therein – music, her pet cat to whom she was devoted - to try to distract herself and ultimately seek respite from her voices, so other service users used the privacy afforded by their own homes to create space between them and more physically present others. For example, the additional space afforded to Susan by her ownership of a relatively large house allowed her to tactically 'shut doors' between herself and her family to give her the necessary space to cope with "what's going on in my head". Equally, Faisal, found the possession of his own socially rented flat preferable to his previous position of having been living with his parents. In addition to giving him a sense of independence and "of having a go at doing things myself", it also helped him to maintain stability by providing a degree of separation from occasionally overbearing siblings: "there isn't anyone to shout at me or tell me to do this or that... because of my illness I might get cross or have a row with someone". It also allowed him the development of his own very specific daily routine, one that would be disrupted by the continual presence of others:

"I just take one day at a time. I can't plan for the future or anything like that. I get all confused and start to have negative thoughts that things might go wrong, and criticise myself and then get into a rut or something like that. So, I take one day at a time. I look after myself. I get up in the morning. I take my medication, brush my teeth, sit downstairs for about half an hour at, say, 08:30 – I have problems staying awake, I feel sleepy, my thinking isn't very good, I get very drowsy about half past eight. Make myself some breakfast."

Then I sit for another half an hour. Then I am myself. An hour after that I go out ... This is my daily life." (Faisal, 54, mental health social worker, west Midlands)

Jonathan's management of his mental health also involved the careful and tactical use of his own home. Depressed, having had to leave his job at a school, and experiencing the yet to be diagnosed symptoms of Asperger's Syndrome, Jonathan isolated himself at home:

"When I became depressed I didn't go out the house very much – for about three and a half years. So, I stayed in the house all the time. It got to the point where some days I was only up for three or four hours and [then I would] go back to bed. [Then] I was on anti-depressants and that got me moving about the house, and sometimes going into the garden. [Eventually] I thought this isn't good, really, and I need to go out and do things, so I decided on a Monday I would go out and buy a lottery ticket. And then I'll find something to else to do on a Tuesday – just a little thing. And the same on Wednesday. So that's how I got turned around, just doing one thing each day each week."

Despite a graduated move towards spending a greater proportion of time outside his home, it nonetheless remained the fulcrum around which Jonathan's daily mobility revolved. He described his Asperger's manifesting itself in an inability to socialise and in an overwhelming need to avoid proximity to children. It is worth quoting our exchange at length for the revealing insight into way in which Jonathan's daily geographies were structured by his distinctive experiences of mental distress:

"Because the Asperger's makes me tend to have fairly extreme views I can be fairly extreme in my feelings toward things. When I was working at the secondary school I was obviously mixing with children a lot. When I lost the job there I sort of turned against children so I never really talk to them now... and as a result of that I sort of got into the habit of not being outside

when they were about. So I go out during the day and come back by about three o'clock.

They're such a nuisance, children, they really are. I won't go out on Saturday. But on a Sunday morning children don't come out – they're all watching TV or something. So I can come out on Sundays until about half past two and I go back to the house then. They're not normally out and about. One of the things that's changed in the last twenty years is that children used to be playing outside but now there's not so many, they're at home with their play stations.

[I try to avoid] Where schools are. And Parks. So if you avoid parks and schools. You can just walk along the road and they'll be coming the other way and you're thinking "oh, God" don't really like dealing with them. So...

JL: Do you ever do anything like go into a shop, or go the other way, or go round a corner or something, or do you just manage it now?

Jonathan: It's not, it used to be as extreme as that, but not really in recent years, no. Obviously we had a problem with August but over the years that's become less of a problem as televisions and play stations and whatever. But, yeah, there's been a time when you'd see them coming the other way and go back into the house, oh yeah."

Jonathan's experiences would certainly fall within Schroder's description of the 'ambiguous' home, in which the provision of a perhaps positively viewed sense of security or safety can be obtained only with a concomitant reliance on more negative actions of self-exclusion and self-regulation. The fluid nature of feelings about home - that is, the way in which service users' feelings change depending upon their affective state – is another aspect of this ambiguity. The case of Helen is illustrative. During our interviews she elaborated on the ways in which her studio-sized flat had, at different times, been both an avatar of her disappearance into an all-consuming fog of depression, as well as her current 'home' and place of safety from the more general disorder prevalent on her inner London council

estate. She described feeling as if she “was being crushed in a box because it’s so small. I couldn’t bear to be in there... I felt so alone and I couldn’t sleep”.

Discouraged by her psychiatrist in her attempts to gain admission to a local psychiatric hospital, she was instead sent to a retreat in a large residential home in the country. Feeling worse rather than better she,

“came home. It was the end of ’93, I remember it was 31st December. I said goodbye to [name of partner] and then I lined up all my Temazepam, all my tablets, thought I’m not going to take them with alcohol because I’ll be sick, so I took them with water. About sixty or seventy tablets. I threw the rubbish away, I locked the door, made myself look nice, and then [I] just lay down. The next thing I knew I woke up in a terrible kind of half coma.” (Helen, 85, mental health service user, central London)

Despite the trauma of it being the site of her suicide attempt, Helen emphasised the sense of safety her flat now gave her and how important was her security of tenure - “I am safe. I am safe in my flat because it’s council and its protected. I’m in the same flat and as far as I’m concerned I couldn’t do better”. This was despite the “terrible problem with drugs. We had people lining up in the morning. The flat below me... We’ve had murders, stabbings. I came home last night and I got in the lift – body wrapped in a quilt! I thought, God in heaven, what is the world coming to?”

Asked whether, if the choice to move was offered she would take it, Helen firmly swotted the question away: “No, no! I take everything in my stride: the language, the school children, the fights. Of course we’ve had a couple of murders. Dreadful! But, that’s life today. No, I’ll be there as long as I possibly can be there”. Part of this determination to stay put reflected the fact that, in addition to the aforementioned security of tenure, Helen had, over a number of years there, found a sense of well-being and been able to fashion a home of which she was proud and was happy to share with others: “Everybody that comes in says it’s so comfortable and pretty and so I’d never be able to get anything like that again”.

The ability to engage in the creation of a home had assisted several service users in the process of salvaging a more positive sense of self from periods of distress. For Donna, her conceptions of her home were intricately bound up with her changing mental health, and manifested themselves in complex ways, not least in those aspects of experience which conventionally might be thought of as negative but which, to her, nevertheless presented some benefit. Reflecting on her experiences in her current flat to which she had moved eighteen months previously, she emphasised that:

“It made a huge difference to my recovery, I think. That I was in a positive environment. I’d never had my own totally self-contained accommodation and so I hadn’t realised what a difference it makes. I couldn’t house share or flat share with other people in an ordinary way because of my mental health problems. I love it. I love the fact that it’s my place. I realise that, in the last place, because it wasn’t entirely self-contained, I always felt slightly on edge. I don’t have that here. It was a big part of my recovery, in fact. I actually love where I am. It’s brilliant. I think I am realising more and more how important it was to my recovery to have good housing.”

Prior to this present period of recovery Donna had, in her previous flat, segregated herself almost entirely. Claiming “I didn’t want to leave the place and the safety” it offered, she dismissed what she viewed as my somewhat gauche suggestion that a self-enforced five years of isolation must have been a ‘hideous’ experience, suggesting instead that it provided her with a certain respite, particularly from having to overly think about her own anxiety-ridden interior world:

“It wasn’t entirely. In some ways I feel... to a certain extent it was quite a healing experience. Because when it stopped being depression and when I started making up stories – it gradually became psychosis but it was making up stories for a long time – that was such a gift because it was eighteen hours a day being creative purely for myself, and I really loved that. I didn’t want to see anyone else. When it was psychosis sometimes it was really good and really exhilarating but sometimes it was really terrifying because some of the characters I made up could torture me, because I

could hallucinate physically, in all ways, sensory ways, and it was really extreme.

I feel like the five years I was in bed - to some extent I was liberated from self in a literal way, in terms of thinking about myself, which I'd always done far too much ... I haven't dared go there [the origins of her mental distress] yet. I mean, sometimes I have insights, but a lot of it is still quite mysterious to me, but I can kind of see, like, some of the characters I can see what was going on and why I might have made them up so. So I think I was dealing with my own issues but in a less literal way than I had attempted in the past."

In Simon's case, his possession of his own socially rented flat can be seen as the culmination of a long period of slow progress, from multiple periods of lengthy hospital admissions under section in the late 1980s and early 1990s, through assisted living into the 2000s, toward the ultimate goal of independent living which, at the time of our first interview in January 2014, he had successfully sustained for five years. He shared an article he had written for a service user organisation newsletter in which he made parallels between his trajectory toward his own home and the concept of recovery, and in which a clear sense of personal development is evident:

"Like 'recovery', I suspect that 'move-on' means different things to different people. I was encouraged to develop independent living skills. For example, looking after the flat and garden and managing my tenancy, communicating with benefits' and health agencies, and engaging with the local community. Eventually I was offered a 1 bedroom flat in a new part of London that I accepted. So, a snowy February day found me at a 1st floor 1 bed flat in a new part of London. My address had changed and I had the spacious flat I wanted. I was in a new area and finding my feet. The move-on had gone well and things were falling into place. I accessed local floating support after the move, and enjoyed discovering and exploring the local area, including shops and libraries, green spaces and cafes. Along with more

independence have come responsibilities, both financial, in organising things, and personally, which I have enjoyed. I feel at home here."

If these accounts are characterised by the emergence of at least some of the markers of ontological security some of the time, other service users' circumstances were, sadly, far bleaker. Christine and Liam daily navigated social housing environments as inhospitable as Helen's yet, unlike her, were desperate for the chance to up sticks and create a proper home away from the disturbances and mayhem they had to contend with. These two users' experiences are featured in the following section.

7.3. The harmful 'home' I: "I just have to get out of the house"

Liam and Christine's stories featured in Chapter 5 on residential mobility, which outlined how their mental health suffered as they became increasingly entrapped in undersized and inappropriately located accommodation. In that chapter, their experiences of residential immobility were brought to the fore. Here, the closely entwined issue of the impact this immobility has on their feelings about, and their interactions with, their own homes is examined. The trauma wrought from being immobilised in sub-standard housing unsurprisingly colours their accounts with an intensely negative hue. As such, the sentiments that service users have thus far in this chapter associated with the home – a place of sanctuary, safety, and, in some cases, a growing fondness for their personal surroundings - were entirely absent from these two tales. Their experiences have begot particular forms of daily mobility practices – quite literally a desperation to get out of, and stay out of, their homes for as long as possible each day – that act as a way to relieve the pain of the lack of a proper 'home' of the type some other service users examined so far enjoy, or as a distraction from larger and more profound absences in their lives. In these cases, the lack of any sense of ontological security is chilling.

As that previous chapter discussed, Liam had been on the receiving end of what he perceived to be a targeted campaign of harassment by his neighbours on the grounds of his status as a 'psychiatric patient'. He was also intensely pained to be

separated from his family. His home had become what he referred to a prison in which suicidal thoughts ranged free. He was thus daily engaged in a form of almost hypermobility that saw him circulating through spaces public and private in the city, seeking to maximise opportunities for engagement with others and especially with services or facilities available to him as a mental health service user. Before reaching such places, though, Liam was obliged to negotiate an exit from the council estate onto which he had been domiciled:

“Instinctively now I know the areas to avoid. Areas where the crack addicts are. I naturally avoid the bad areas. I will plan my routes, navigate through the nicer areas. When you come out of my flat, don’t turn right, turn left. Always go left. Never go right. It’s like New York. I live ninety seconds from a block of flats where there are crack houses and murders. You go ninety seconds the other way, there’s another block and you’ll see beautiful blondes driving open top Porches into an underground car park.”

The contrast between Liam’s daily mobility and what we can make an educated guess to be those of the beautiful Porsche-driving blondes emerged most starkly when he offered a daily journal in which he had recorded his day to day activities and his struggles to survive financially. The (lengthy) edited extracts that follow grant a unique insight into the quotidian practices of a mental health service user, immobilised residentially yet engaged in daily mobility practices that reflect his despairing need to be absent from his home, which are centred largely around his dependence on – largely informal – services, and which echo similar cases of daily hypermobility reported on in the literature (DeVerteuil, 2003; Knowles, 2000a).

FRIDAY 20 JUNE

Picked up free newspaper. No lunch due to insufficient funds. Sat in park. Afternoon went to the office of [name of mental health charity] as a surrogate day centre... Travelled by bus to [name of inner London area]. Went to public house alone. Watched 15 minutes of World Cup game. Did not purchase drink. Went to [name of charitable foundation] which on Fridays provides a meal and entertainment in the facilities of a church/community building. Travelled home on tube.

SATURDAY 21 JUNE

Meeting of support group for those affected by abuses within psychiatric services. Informal gathering of members in public house – coffee purchased for me by another member.

TUESDAY 24 JUNE

Read 'Time Out'. Free. Travel on bus to attend Working Men's college. In cafe of college use Wi-Fi for free. Attend class. Take bus to premises of [name of charitable organisation]. Meet friend by chance and take friend to Starbucks. 2 drinks. My treat. £5.20. Take tube to attend class at [name of mental health charity].

WEDNESDAY 25 JUNE

Tube journey to attend class at [name of arts club in south London]. Free tea and apple (small). Lunch: free sandwich and muffin donated to arts club by Pret a Manger. Tube to Hampstead. Supermarket cafe to read newspapers. Wrote letter to actor/comedian Lenny Henry. Go to library to view Who's Who. Move to cafe to use free Wi-Fi.

THURSDAY 26 JUNE

Travel by bus to office of [name of charitable organisation]. Use printer and given envelope. Walk to offices of Lenny Henry's agent to deliver letter. Retire to public house to reflect on letter. Pint of ale £4.10. Read papers. Travel to Hampstead. Use free Wi-Fi in shopping centre.

SATURDAY 28 JUNE

Did not go out. Wake late and stayed in bed as consequence of 'hangover' from anti-psychotic [medication]. Listened to radio for entertainment.

SUNDAY 29 JUNE

Did not eat breakfast or lunch. Stayed in until 4pm then went to shopping mall. Went to bookmakers to watch World Cup game. Went to friend's after game.

Drunk tea. Ate Sainsbury's Basic Rich Tea biscuits. Went to another friend's. Talked late. Night bus home.

TUESDAY 1 JULY

Travel by bus to Working Men's College. Lunch provided. Pot of tea in restaurant as part of [name of] internet writers' group. Supper: four fruit scones purchased from Tesco: £1.

WEDNESDAY 2 JULY

Tube to south London. Free lunch at arts club. Bus to Hampstead. Tea at supermarket. Read papers. Shopping mall cafe to use Wi-Fi. Tube home.

THURSDAY 3 JULY

Bus to Welcome Library. Tube to Hampstead. £1 cup of tea at supermarket cafe to read papers. Tube home. Tea, apples, peanuts and raisins for dinner.

FRIDAY 4 JULY

Bus to University College Hospital to visit friend. Bus to [name of inner London area] for meeting of health service providers' group. Bus to Welcome Library. Use free Wi-Fi. Bus to [name of charitable foundation] for free evening meal. Tube home.

Liam's daily movements through the city were in large part facilitated by his ownership of a 'Freedom Pass', the eligibility for which for people with mental health problems depended upon the type and level of welfare benefits being received, the loss of which would have a devastating, perhaps fatal, impact on the ability of an individual like Liam to maintain even a rudimentary existence of daily non-housebound activities.

Christine, too, used the Pass to escape from the confines of her 'home'. As will be recalled from Chapter 5, she and her daughter had been placed by their home local authority into temporary, out-of-borough accommodation. The supposedly transient nature of her accommodation had made it extremely difficult for Christine

to either envisage it as a 'home' (which she had previously had and had been evicted from) or to begin the tentative steps toward making it one. As she said:

"The furniture that was in here was awful [Christine's own possessions had, upon her eviction, been removed into storage]. I got rid of that. The garden – he said he had tenants here who didn't take care of it so he put all that black plastic [sheeting] down to stop anything growing. If I'd known I was going to be here for two and a half years I would have painted and decorated and all kinds... The bathroom is disgusting. It gets damp and mouldy but the landlord's got no intention of changing that anytime soon. So I just keep fighting the mould."

The temporary accommodation into which Christine has been displaced was of insufficient size to realistically accommodate her and her teenage daughter. Christine elaborated on the relationship between the cramped nature of her accommodation and her exceedingly fragile mental health:

"It gets into a cycle where I get really depressed about things. I've got a sofa bed – I could pull it out and show you – and it comes right out to there [pointing] so I can't really use it weekdays because [daughter] gets up at six thirty to go to school and she has to come in here – the kitchen – so she'd have to roll over the bed or something. Just being so cramped and having no space to myself – there is no space for me which, when I get stressed out, leads to not sleeping, when I'm not sleeping I get more depressed. The flat upstairs, three different people have lived there since I've been here. One of them was a young man who'd come out of care and he used to have all his friends up there. The noise was absolutely awful. They'd have girls up there screaming – I'm sure the girls were being raped by the boys. I used to phone the police. It was horrendous."

Accordingly, she took advantage of the opportunity for respite offered by her Freedom Pass. "I have to get out of the house ... go on bus rides, to the furthest reaches of the suburbs, where it's nice, and leafy, and green. Just to sit somewhere quietly for a while." Unfortunately for Christine, her invidious position

of existing in enforced exile from her home borough caused even this minor pleasure to be denied her. The issuing of Freedom Passes is the responsibility of an eligible person's home local authority and, somewhat ironically, Christine's home authority had, in advance of its expiry, issued the replacement form to the prior address from which they had assisted in her eviction. As the forms never found their way to her, Christine's pass was cancelled and the daily mobility from which she sought relief from her home circumstances was severely curtailed. At the time of our second conversation she was battling the local authorities to have it re-instated and, in the interim, had turned her attention to the hitherto black plastic clad garden where she was growing her own fruit and vegetables and attempting to find some solace.

One could see Christine's actions, in particular the efforts in her garden, as being reflective of an acceptance that, for the foreseeable future, her life would be based in this supposedly temporary place, and she was accordingly taking tentative steps to make it as homely as possible within the constraints within which she was obliged to operate.

The gaping absence of any sense of ontological security in Liam and Christine's lives, and the negative stranglehold their places of residence have over their mental health, forced them to fashion external routines – which in Liam's case were an almost hyperactive form of daily mobility – to give them some sense, however fleeting, that there were some aspects of their lives over which they could exercise a degree of control, even if their respective homes were not amongst them. The important point to make here is the extent to which, once again, the service users who participated in this research can be found in even the most trying of circumstances to be exercising their own power and judgment to create some space in which to more easily be able to manage their complex mental health needs.

7.4. The harmful home II. “Like an earthquake in a jumble sale”: home, hoarding, and health

“Hoarding is deemed a mental disorder, poorly understood, that stirs people to incoherent acts; sufferers may buy products simply to have them. Amid the mess were half a dozen unopened ironing board covers, multiple packages of unused Christmas lights, four new tyre-pressure gauges” (Kleinfeld, 2015)

“Compulsions are forms of behaviour – such as washing, cleaning, checking, counting, touching, hoarding, arranging and ruminating – that a person is driven to perform … and which are highly geographical in that they involve using space in particular ways” (Seagrott and Doel, 2004, p599)

“There’s crap everywhere. Piles and piles of clothes, and books, and crap. I sleep in the lounge, the bedroom is so full of junk you can’t even get in there” (Harry, mental health service user)

One - unanticipated - aspect that arose from the interviews with service users was the number for whom the hoarding of possessions was a prominent factor in their complex relationship with their homes. For some, hoarding was a practice they were grateful to have been able to jettison; for others it remained the dominant force through which feelings about their homes were mediated. Four individual experiences are highlighted in this section: two in which home lives are dominated by – or indeed, even subservient to - a voluminous quantity of possessions; one who reflects on past hoarding and how this related to her mental health and financial circumstances at the time; and the fourth who appeared to have tacked in the opposite direction and was, during the series of our interview, in the process of seemingly discarding the majority of his household goods. Each of which reflects the observation made by Smith (2004, p89) that “some people are more engaged by or enmeshed within their relationships with domestic space – with the fabric, layout and contents of their home - than they are with their human relations.”

The most extreme experiences to emerge were those relayed by Harry, whose chaotic lifestyle and emotional traumas appeared to have become effectively

imprinted into the very fabric of his home. It is worth discussing the example of Harry at relative length as his overall experiences with mental ill-health, homelessness, abandonment, addiction, and suicide, paint a vividly coloured portrait of what life at the far edge of the continuum between good and bad mental health can be like.

At his request, our interviews were conducted in the cafe of a London art gallery. He remarked upon the contrast between the environment in which we found ourselves and his home circumstances:

“I said to you about coming here and how it gave me a sense of serenity. There’s something about the colour, and the order, and the quality of light, and the finishes are quite smooth, and it makes me feel something inside my body when I’m in these environments. But in my flat, it just looks as if someone’s got a skip and emptied it through the roof.”

Harry had ended up in his present accommodation via a series of residential situations over the previous two decades, including periods spent sleeping rough, a room in a half way house, and in supported accommodation dedicated for people with mental health problems, before landing up in his current housing association flat. This chapter has previously touched on the value that service users have placed on a sense of being able to exercise some degree of choice of, or control over, their transitions toward independent living, and in the creation of a home. Harry felt he had been denied these opportunities, noting his experience was that:

“In these situations you never have a choice. Your home – the decision about where you live – is made for you, and that does have an impact. Most people who’ve got a bit of money they’ll go and look around at a number of places, find somewhere they like, but for most people from my background it’s kind of like a lottery. I am very grateful that I’ve got somewhere to live, but it’s something about which you don’t have any choice; you get given a flat and that’s where you’re going to live. And I think that does have an effect on whether you can put down roots. In the block, most of the people

have got mental health problems. They don't say that, but when they make a decision about where people get allocated to, that block is kind of underwritten as where all the mad people get put. There are pros and cons of it. Perhaps people could reach out to one another, but they don't, because they suffer from the same kinds of social phobias that I do, so you just get a lot of isolated people in the same block of flats."

Harry's terror of being isolated, allied to (and quite possibly closely connected with) the 'squalid' condition of his flat, appeared largely to drive his existence. Explaining the ways in which his obsessive compulsive disorders had rendered his occupation of the flat almost intolerable, he emphasised that he had previously been "ultra, ultra, ultra tidy, and that perfectionism drives you to a point – like an elastic band that gets pulled and pulled and pulled – and you have to be more and more and more perfect and in the end the elastic band breaks". With one exception, at no other point in our lengthy conversations did Harry refer to his home, preferring always to use the term flat. It brought out in him feelings of deep shame and anguish at his inability to live a meaningful life in the conditions he had created but about which he felt powerless to act.

"I can't accept good enough, I can only accept perfection. So if it's not absolutely perfect I just leave it. I can't clean it, I can't finish the decorating. Every room in that flat is half decorated but I've never been able to reach the end. The bathroom's the worst of the lot. It's shameful to say this but I haven't cleaned the toilet for so long ... I have to go in there, hold my nose and have a bath in the dark so I don't see. I've got washing up in my flat that's now, like, ten months old, just sitting there with mould on it. It's almost uninhabitable. It's gone from liveable if you're insane enough to live in all that fucking chaos to almost unbearable."

The situation impacted on Harry in two ways: first, an understandable, and negative, impact on his mental health – "it makes me mad when I'm in a mad environment'; and second, a desire – like Liam and Christine before him - to absent himself from his 'mad' home environment as much as possible. Harry described his near daily routine as follows:

[When I come back to my flat] I try not to turn the lights on because I don't want to see it, get into bed, wake up, get up straight away, put my clothes on and get out the door because I really don't want to be there."

And this routine was predicated in large part on an almost overwhelming horror of being alone:

"To keep mentally health you need a structured day and some sort of social interaction every day. That isolation and nothing to do will make you go right downhill very quickly. I constantly have to invent things otherwise I'll go crazy. If I look at my diary and there's an empty week I think what the fuck am I going to do, how am I going to fill my day? It's like ten o'clock in the morning and you're tearing your hair out, you somehow get through the day into the evening, go to sleep, wake up the next day and have to go through it all again. It absolutely drives me mad. I was saying to my Mum last night that I feel suicidal, I can't cope with this, it's making me feel like a want to die."

I asked Harry whether there was an opportunity for him to gain some assistance from the housing association, perhaps in helping to bring some order to the chaos in the flat, but he denied he was able to, saying that he was too fearful of asking because what they might think – or do – were the state of the place to be revealed to them. Harry – like other service users interviewed – spoke with raw emotion about the circumstances of his life, of a sense of it having been ruined by events or incidents over which he had no control and from which people seldom recover. Talking to Harry on those two occasions was an intense experience in which barely suppressed, heart-breaking emotions simmered just below the surface, and his grievances threatened more than once during our interviews to boil over.

Emily and Yann were two service users whose experiences of home were closely entwined with their mental health, and for whom hoarding had also played significant role. Emily told me that:

“My depression has played a part in that I was – still am – a compulsive hoarder. So my house is a dreadful mess. There’s clutter everywhere, the garden is overgrown. The whole house is cluttered: I could be a candidate for the television programme, easily. There’s, there’s just loads of everything. I can’t have one of something I’ve got to have half a dozen. It’s on the floor, it’s precariously balanced, it’s just a mess. I feel slightly ashamed. I do feel slightly ashamed of myself, really. I have a friend – she’s a bit eccentric herself – and she’ll come in and she’ll say the first thing that comes into her head and she’ll say ‘Oh, Emily! Your house is a mess, you’ll have to do some cleaning up!’ She doesn’t understand and I’ll end up shouting at her... I’m very much out and about to avoid the clutter, but still in this coat of depression.” (Emily, 65, mental health service user, west Midlands)

During the interviews she, like Harry, referred repeatedly to what she perceived to be the sources of her depression, and to her anger and upset over the limitations these had placed upon her life:

“I started having a nervous breakdown when I was sixteen ... I had a congenitally dislocated hip as a baby and I was subsequently bullied terribly at school and felt I never fitted in. And I think all my mental health problems came from that. I had a hip replacement at the age of twenty-seven but it never stopped the limping. And I was never able to have a successful singing career because of it. I was very depressed. I think it’s coping with all the setbacks I’ve had in my life and the disappointment and frustration.”

I asked Emily if she thought she would be able to come to terms with the difficulties and the disappointments to which she referred.

“I am, basically, a very self-pitying individual [laughs]. I was always brought up by my Mother, you know, ‘don’t go around feeling sorry for yourself’ ... but it’s like major flashbacks, it’s like you’re going through post-stress disorder symptoms. And I think ‘oh, if only this, if only that’, you know? It’s

too difficult. So, no, I haven't come to terms with things and, at this stage, I don't think I ever will."

Conversely, Yann had moved away from her fetish for hoarding brass and copper ornaments and nick-naks – “When I sit in that room now at home I think ‘how could I have done that? The place must have looked like a junk shop!” – and had instead decorated her home to make “it look like a new built place. It’s like a new function for me – once I’ve got that I feel more uplifted in my mind”. She compared it favourably with her hoarding experiences, which she related to “an abnormality of your mental state. You’ve got nothing else to do. You think: that’s nice, I’ll have that, but it’s not normal”.

“Because I didn’t go out much when I had my son I really became like a hoarder, hoarding things in the flat. But now I like to be out more. I was going round charity shops buying this and buying that because you’ve not got much money and the stuff is quite cheap so I ended up with all this stuff around me. I thought ‘there’s something going on in the head, I’m not getting enough socialisation. I’m hoarding things because there’s something missing in my life’. You can’t do much when you’re on medications and you’re stuck indoors and you’re sort of trying to create a paradise, like an escapism, something to compensate for the loss of life outside.”

It is hard to know how – or indeed where in this narrative – to present Trevor’s story, it having been somewhat difficult to get to the bottom of it. Like Yann, Trevor had embarked upon what he called a ‘decluttering’; unlike her, however, he appeared not to have stopped at the clutter but had continued until the majority of his household goods had also been dispensed with. Trevor’s basement flat – which he rented from a housing association – had been flooded on several occasions, and whilst this certainly explained his decision to dispose of the damaged items of furniture, he didn’t elucidate on why he hadn’t stopped there.

“I’m clearing out the flat. I’ve cleaned out the sofa, the settee, two arm chairs, the refrigerator, the bed, the TV. The washing machine caught fire

three times so I flung out the washing machine. I flung out the tumble drier because that broke down. I haven't got new stuff to replace it yet.

JL: Have you got a bed?

No, no, I am hoping to get a bed soon.

What are you sleeping on?

Two cushions on the floor. I had a sofa bed, but my sister flung that out, said it was rubbish, so I'm sleeping on the floor. I'm hoping to get a bed.

Do you know where you'll get one from? Will you get assistance to pay for it or will you have to pay for it yourself?

I'll have to pay for it myself. There's a shop down the road and they deliver so I could probably go there and get a bed.

What about stuff in the kitchen. Is your cooker working?

I had to throw out the cooker, because it was right near the curtains, and the heat from the gas cooker melted the extractor. I thought 'that's a bit dangerous' as it was right near the curtains so it could have easily caught fire. So I had to get rid of the gas cooker, plus they had smoke alarms in the flat, so [I] turn on the gas cooker [and] 'boom' the smoke alarms went off as it was too hot in there."

Nor could Trevor suggest how he was going to replace all of these items or who was going to pay. He doubted the housing association would foot the bill, stating that despite the several instances of flooding – from both burst pipes in the walls and backed-up sewage – he had been offered £200 compensation “which only covered the cost of the curtains”. Trevor’s view of his home circumstances - that of a place to live rather than a home – seemed matter of fact and was understandably coloured by his experiences since living there. He explained that,

in addition to the aforementioned flooding, he had endured an infestation of rats, six attempted burglaries, and had initially been unable to move in during the first six months of his tenancy as a consequence of its occupation by a gang of squatters. After our first interview, he wrote me a note detailing his residential history – the familiar litany of often temporary and transitory forms of accommodation – and how he ended up being ‘decantered’ into his present flat. Unlike some of the other service users whose cases have featured here, Trevor – whilst residentially stable – appeared not to have enjoyed the kind of ‘home’ outcomes that these others had succeeded in achieving, despite him feeling that he had made repeated efforts to do so – “I’m still there. Still working at it. Still seeing if I can make good”. The strong impression I was left with was of Trevor being both residentially emplaced and unanchored and adrift in the seas of housing bureaucracy inertia: “At the moment I’m on the floor writing this article and still can’t get the help I need from the housing association. I began to think is there a way out of this without me losing all that hard work”.

7.5. Summary. Do service users’ homes assist in the creation of a sense of ontological security?

Trevor’s reference to hard work and the danger of it being undone is instructive. One thing that unites all the participants in this study – and is shown in this and the preceding two chapters – is the strenuous efforts – physical, mental, emotional – they go to in an attempt to find and preserve some semblance of stability in their mental health. That is: they serve to emphasise the importance of a relational perspective on individual agency when considering their residential and socio-economic circumstances. Given the ways in which their mental health difficulties manifest themselves, the low levels of involvement in the labour market and consequent heavy reliance on welfare benefits amongst study participants, it is unsurprising that their social worlds are, in most cases, relatively circumscribed and that, as a consequence, their individual homes should loom large in any assessment of their daily lived experiences. That, at least, is the rationale for having focused on ‘home’ in this, the final analysis chapter of the thesis, which lends further credence to the fears about welfare reform expressed in Chapters 3 and 6.

This chapter has leaned heavily on the concept of 'ontological security' in its attempt to present and interpret individuals' experience to ascertain the extent to which their home environments do, or do not, assist in the aforementioned efforts to locate and maintain a sense stability and wellbeing. What is evident is that while a(ny) sense of ontological security develops slowly, its essential fragility means it can be dashed instantly, and with many participants precariously balanced amid the large structural reforms to the welfare system, it is not difficult to see how the carefully concocted sense of ontological security that some have managed to obtain could – notwithstanding the powers of agency and tenacity employed in its construction - easily be swept aside.

Ontological security denotes a general sense of well-being and stability that the presence of a 'home' can help to impart. It rests upon four conditions being met:

1. A feeling of constancy and stability in ones residential surroundings.
2. The ability to exert control over one's domestic space and guard one's privacy.
3. The enactment of the everyday routines and rhythms of life.
4. The opportunity for personal development and self-actualisation.

These conditions build one upon the other in cumulative fashion – i.e. constancy is a necessary condition for a sense of control to emerge, which must be in place for the enactment of routines, which can then generate opportunities for personal development and self-actualisation – to collectively provide the sense of ontological security which, it is argued, people strive for in their domestic arrangements. We would expect to find that the service users experiencing all individual elements of ontological security would be fewer in number than those experiencing only one or two. And, indeed, the experiences of the service users presented here suggest that, Richard, Faisal and Simon excepted, for most there is some considerable distance to go before they could be said to be fully ontologically secure (though with the important caveats addressed below). Nonetheless, this research substantiates existing findings on the ways in which home circumstances typified by the various markers of ontological security

produce better health outcomes for mental health service users than those marked by its absence (Alaazi et al, 2015; Bretherton and Pleace, 2015; Olin et al, 2011; Marcheschi et al, 2015; Padgett, 2007; Smith et al, 2015). Furthermore, it adds to this body of research by emphasising that, for those service users who were unfortunate enough to find themselves in the latter situation, daily mobility away from the home, as an imperfect but short term strategy, is important if service users are to grasp some sense of wellness despite their less than advantageous home circumstances.

As the previous chapter on residential mobility has shown, the first marker of ontological security - constancy or stability in residential accommodation - is the central pre-requisite for the construction of a 'home'. Thus the individual service user experiences that have been presented in this chapter demonstrate those *additional* three elements of ontological security that have either been referenced by interviewees or where their presence can be easily inferred. The most frequently occurring of which was the second, i.e. service users feeling they were able to exercise an element of control over their personal space and privacy. This is evident in the accounts of Richard, Katherine, Susan, Faisal, Jonathan, Helen, Donna and Simon that have been quoted throughout this section. This marker of ontological security represents the second essential building block in the emergence of a 'home', and its importance is especially noteworthy when viewed in the context of past experiences of more institutional forms of living, and thus the results presented here confirm those previous studies in which the invasions and infringements of others were found to compromise feelings of control and privacy, and impacted negatively upon individuals' mental health (Padgett, 2007; Ridgway et al, 1994; Seagrott and Doel, 2004).

Like all subjective personal experiences, however, the individual elements of ontological security discussed here have an intrinsic ambiguity that do not map precisely onto a particular positive interpretation over an alternative less rosy one. Indeed, for several service users, Helen, Katherine and Susan among them, the sense of having control over their home life was gained only through carefully honed tactics of exclusion and seclusion; for Donna and Jonathan such tactics led to the deployment of acute, prolonged and ultimately quite damaging forms of self-

exclusion and isolation. Even Richard, who might, on the surface at least, appear to be one of the interviewees most able to enjoy a sense of ontological security, gained a sense of control only with obsessive attention to the maintenance of the protective functions of his home. As Seagrott and Doel (2004, p606) remind us, “[w]hilst certain inherent facets of domestic space offer feelings of safety (e.g. being bounded by its walls), other aspects of ‘ontological security’ experienced at home only exist as a result of *effort* (e.g. keeping doors, windows ... closed”. It is in this sense, then, that Schroder (2006) emphasised the ‘interconnectedness’ between the ‘positive’, protective aspects of a home, and the ‘negative’, exclusionary ones, in which the former can exist only as a result of the latter.

Like Olin et al (2011), there was some evidence of service users having the ability to calmly enact everyday routines and rhythms within the home – most evident for Richard with his writing, music and films, Faisal with his very specific and uninterrupted morning rituals, and Katherine with the attention she was able to pay to her much loved pet cat. More significant, though, were those service users whose specific daily rhythmic patterns took place outside the home as a direct consequence of a desire to spend as much time away from their homes as possible, whether for reasons of hoarding and general disorder (Emily, Harry), to escape from harassment and invasions of privacy (Liam), or because of a profound sense of dislocation as a result of having lost a ‘real’ home and being marooned in a substandard, temporary one (Christine). These latter two cases are also instructive for the ways in which they reveal some of the limitations of the concept of ontological security, and its applicability to all service users in the current study. In particular, the emphasis on constancy and stability in residential circumstances as the founding stone upon which the edifice of a home can then be built does not apply to Liam - whose home whilst being very much permanent was compromised by physical limitations (its small size) and external social forces (neighbourly harassment) – or Christine – whose ‘temporary’ home had the effect of immobilising her in a spatial and temporal vacuum. In which two cases the political framework of mobility offered by Cresswell once again comes to our aid whereby the elements of ‘feeling’, ‘routes’ and ‘rhythms’ reveal more about these experiences than do the dimensions of ontological security. There is also the intrinsic difficulty of delineating precisely where positive experiences end and

negative ones begin (examples here would be the cases of Donna or Jonathan), or in trying to see these as separate entities when in fact they are most likely to be coexistent. Last, and not least, there are problems of definition and interpretation that make pinning down and categorising actual experiences using conceptually 'fuzzy' concepts such as ontological security and self-actualisation a fraught business. Nonetheless, the interview material presented here would seem to agree confirm Padgett's contention that:

"Having a secure base after years of struggle affords the 'freedom to' reflect on past losses, ongoing dependencies and future prospects ... Having a home may not guarantee recovery in future, but it does afford a stable platform for recreating a less stigmatized, normalized life in the present" (Padgett, 2007, p1933-4).

The desire to understand how mental health service users can acquire a 'secure base' in which to cope with their own individual health needs is not only the primary subject material of this and the preceding two analysis chapters, or the key thread that runs throughout this thesis, but is in essence the governing basis for the entire research project. And in this it is not unique. As the literature review has demonstrated, the bulk of scholarship upon which the present study is founded has, at heart, the same intentions: to bring the geographies of mental health service users into view, to help decipher them, to understand their connection with broader structural impediments to wellbeing and recovery, and to help chart a path towards the identification and safeguarding of the spaces necessary for such bases to develop. The final, and concluding, chapter to this thesis will assess how far this study has succeeded or failed in these aims.

Chapter 8. Conclusions

8.1. Research questions revisited

The stated aim of this thesis was to “*explore, in the context of ongoing welfare reform, the interactions between mental ill-health and residential mobility as reported by persons with serious and enduring mental health problems*”. To achieve this twenty-five mental health service users were asked to account for and describe:

1. Their experiences of residential mobility (or lack thereof) over a proscribed time period.
2. The extent to which these were the result of voluntary or involuntary actions.
3. Whether fluctuations in their mental health influenced or determined their residential mobility, and vice versa.
4. The role that their financial circumstances and in particular their receipt of welfare benefit payments played in these decisions.

It then sought to set these accounts against the broader social context of austerity and welfare reform, by exploring service users’ experiences of the process for reassessing eligibility for welfare benefits, and probing what the outcomes were in terms of financial security, residential mobility and their mental health status.

Has the research project met its stated purpose? And to what extent does this thesis offer a comprehensive reply to the questions previously posed? The in-depth and longitudinal aspects of the research methodology enabled service users to successfully report in detail their experiences of residential mobility and welfare reform. They were able to articulate their own histories and lives in ways that meshed closely with the underlying themes of the thesis, and these individual accounts were explored in detail in chapters 5, 6 and 7.

8.2. Summary of findings

This study found that the most commonly expressed feelings surrounding actual or even potential residential mobility were fear or trepidation of residential *instability*. For those who had experienced a move, either within the historical or contemporaneous periods of the research, or on a previous occasion outwith the timeframe of research, the most important factor in how the mobility was experienced and subsequently reported was the extent to which it was undertaken voluntarily or involuntarily, with the latter representing powerlessness and being associated with negative residential examples of displacement, homelessness, and circulation (including repeated hospitalisations) and with poor mental health. This sense of powerlessness was similarly implicated in instances of residential immobility in which feelings of abandonment, entrapment, and mental distress dominated. In both sets of circumstances, the cases featured in chapter 5 largely reflect the findings of earlier studies where service users were asked to describe and account for their residential mobility and associated experiences. In comparison, the study was less able to report specific evidence of 'drift' within the timescale and cohort examined here, with only two service users referencing their desire to co-locate with specific (medical) amenities. That said, service users were residing in predominantly inner urban areas that aided their connection to broader networks of facilities and services, both formal and informal, a theme to be returned to shortly when considering the relevance and importance of the findings relating to 'home'.

Service users' residential circumstances do not, of course, exist in isolation to other factors or influences. One of the key variables that impacts their residential mobility is entry into, and an ability to continue hold on to, stable, suitable accommodation; an ability that is closely dependent upon income. With the majority absent from the labour market, this means instead access to meaningful, regular and reliable welfare benefits. As chapters 3 and 6 showed, the ongoing reforms to the welfare state are predicated on 'normalising' the experience of paid employment, by reducing benefits and curbing entitlements in order to force entry into the work place. While reducing the monetary value of certain allowances might be seen as posing a more obvious threat to the residential stability of mental

health service users, equally important is the limitations placed upon the entitlement to a particular benefit upon which continued eligibility for another may rest. It had been anticipated that housing benefit reductions in particular could preface enforced residential mobility amongst those so affected and thus it was expected that the thesis would address the question of whether these had played any role in decisions relating to residential mobility. Unfortunately for the thesis, but fortunately for the service users, the interviews yielded no instances where loss of benefits was the direct cause of an enforced residential move, such moves being instead related to deteriorations in mental health, unstable tenure of accommodation, or which arose out of particular home circumstances. As a result of this, the thesis focused on individuals' relationship to, and thoughts about, the goal of employment 'normalisation', and their experiences of the reform processes which were intended to bring this about. It found service users remote from the workplace with in most cases no discernible desire to (re)turn to it *if* the circumstances of a theoretical job threatened health, well-being or income levels that were, generally, enough to get by on (but little more). It also found service users betwixt and between their expectations of wellbeing or recovery on the one hand and the demands of the welfare reassessment processes on the other. These demands, which intruded so frequently and were considered to be such an anathema to daily strategies for managing mental health that service users spoke of them as powerful instruments poised to tear down the fragile existences they had managed, against the odds, to carve out for themselves.

The absence of a daily routine of employment, and the state intrusions that so threatened individual boundaries of safety and stability, served to emphasise the extent to which the domestic sphere became the fulcrum around which many service users primarily operated, especially given the progressive withdrawal of informal services and facilities in the urban settings around which mental health service users have traditionally coalesced. Thus the 'home', and the sense of 'ontological security' that it can engender, became the focus of Chapter 7, in which it became apparent how closely entwined the markers of ontological security – permanence, control/privacy, routines, and self-actualisation - were with service users' feelings about their own emotional and mental stability, and the extent to which they provided a secure base from which to seek further improvements in

wellbeing and stability. Indeed, having a firm platform upon which to rest, recuperate and, perhaps, grow, seemed, as the last chapter indicated, to be the primary conclusion of the study. That this is not a novel insight does not invalidate it. Indeed, given the existential threats to the welfare spending that sustain people with mental health problems, and which in turn impacts on the places and spaces (physical, emotional, mental and imaginative) they use to protect their vulnerabilities, it serves as a timely reminder of the need to ensure that hard won gains for service users are not lost through negligence of policy or neglect of operation.

8.3. What this thesis contributes to the literature

The contributions of this thesis to the wider literature are threefold. First, in respect of residential mobility, it builds on the existing knowledge from similar qualitative inquiries (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000a) and shows that the processes found to be operating in north American cities – including circulation, hypermobility, entrapment, and the effects of institutional policy and practice - are also at work in the UK. The exception is examples of drift, for which this thesis can show little direct evidence. This answers the question of *how* mental health service users are residentially mobile. It then takes our understanding further by providing evidence of *why* mental health service users are residentially mobile, showing that their experiences and the impacts these have on their mental health are, to a large degree, determined by the extent to which they feel that they are able to exercise some power and control over the circumstances of their mobility. In particular, the thesis shows that it is the *involuntary* nature of residential (im)mobility that determines how negatively it is experienced, and which confirms existing research (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000a; Lamont et al, 2000; Tulloch et al, 2011) that residential instability damages mental health and that entrapment, in particular, is a punishing phenomenon (DeVerteuil et al, 2007; Drukker et al, 2005; Lix et al, 2006; Ross et al, 2000; Smith and Easterlow, 2005; Whitley and Prince, 2005). Accordingly, the findings on residential mobility call for a possible re-evaluation of theories of social causation versus social selection, with greater stress being laid upon the political

dimensions of mobility and the role that individual agency play in underpinning the experiences presented here. A reconceptualisation could explicate how 'freedoms' of residential mobility for mental health service users are contingent upon the delicate interplay between individual attributes, characteristics, and life histories on the one hand, and the wider socio-economic and policy environment in which such freedoms operate on the other.

Second, in relation to welfare reform, the thesis enhances our knowledge of mental health service users' relationship with both the welfare state generally, and the reform processes and procedures especially, by demonstrating that their experiences of each have taken on a particularly geographical – i.e. spatial – form, involving boundedness, emplacement, and practices of (im)mobility, and that these spatial effects exist as part of mental health service users' strategies for attempting to hold the more threatening aspects of reform at bay. This is important because in addition to providing fresh information about how mental health service users are coping under conditions of reform and austerity, it also serves to confirm earlier qualitative research (DeVerteuil, 2003; Knowles, 2000a; Parr 1997, 1999, 2002, 2006, 2007; Pinfold, 2000) that emphasises the importance of attending to the ways in which service users are active agents, shaping their own worlds and resisting so far as possible intrusive external forces. On a related theme, this thesis similarly confirms the importance of bringing service users lived experiences – which often go unseen – to the fore, not least for the ways in which they reveal the gulf between what services users say about their lived experiences and what the government and its agencies appear to feel they are capable of and should be responsible for. Thus, the research presented here builds on the emerging literature on the lived experiences of individuals touched by welfare reform and the demands of austerity (Garthwaite, 2014; Garthwaite et al, 2014; Patrick, 2014; Roulstone, 2015) and confirms too that revanchist welfare reforms create situations in which existing poverty and mental illness are deepened rather than alleviated (Barr et al, 2015b; Mifflin and Wilton, 2005; Wilton, 2003). Thirdly, the thesis adds to knowledge by demonstrating that an ontologically secure home can not only contribute to better mental health (as found by Alaazi et al, 2015; Bretherton and Pleace, 2015; Olin et al, 2011; Marcheschi et al, 2015; Padgett, 2007; Smith et al, 2015) but can play a key role in mitigating – albeit temporarily,

and imperfectly - some of the external threats posed by welfare reform, thus demonstrating the extent to which the nature of relationships between the policy environment, 'freedoms' of mobility and individual agency, can themselves be mediated through the role of the 'home' and questions of ontological security.

8.4. Limitations of the research

As Chapter 4 discussed, research with vulnerable populations can pose potential problems above and beyond those that would apply to more straightforward research. These dilemmas, which are ethical and methodological, are closely connected with the ability of the researcher to gain access to participants, and have contributed to two shortcomings with the research. One original intention was to aim for a breadth of residential experience among participants. The hope was to establish two broad cohorts of participants: the first would be those in relatively settled accommodation, who would be accessed via mental health support services; and second, a group from less secure settings such as homeless shelters or hostels, and who might be accessed via a homeless-orientated organisation. The former was largely achieved – and with a broader swathe of experience than was originally feared - whilst the latter, sadly, was not. The process of establishing the research did involve meeting with representatives of a large homeless services organisation who, while indicating a willingness to assist where they could were, in reality, so overwhelmed with the needs of their clients that understandably it proved impossible for them to devote time and effort to helping a single postgraduate student. This failure meant that the participant sample skewed toward the more settled end of the spectrum – the 'low mobility/high dependency' quadrant of the typology - than had been hoped. Even though it did contain participants who had extensive histories and experience of street homelessness, hostel-dwelling and other forms of temporary accommodation, it still had less to say about particular patterns of residential hypermobility – the 'high mobility/high dependency' corner - than perhaps it otherwise might. The second, and connected, shortcoming is the result of the same difficulties and delays in recruiting participants which rendered it impossible to meet the initial longitudinal objective of interviewing each participant three times

over eighteen months. Nonetheless, eight were interviewed three times, thirteen on two occasions, with four spoken to only once, and what proved most able to capture participants' actual residential mobility within the study timeframe was not the contemporaneous longitudinal period, but the historical one which asked participants to account for their mobility over the preceding eighteen months and which revealed a rich patterns of contrasting experiences.

Another potential inadequacy, also relating to the longitudinal aspect of the research, revolves around the question of whether it was sufficient to rely on three separate interviews – as opposed to other, additional methods - to capture the dynamic, fleeting feelings that entanglements with welfare reform invoked in participants. Other methods – written or spoken diaries, tweets, drawings – might have better reflected the intensity of emotions *as they occurred* rather than, potentially, being recalled six months after the event. There could have also been merit in asking participants to keep of record of their financial circumstances, requesting them to note their money management strategies, worries, cuts they had had to make, and so forth. Doubtless these would have been valuable additions but, on balance, the danger of making the project too unwieldy or in leading to a loss of focus meant that ideas around these were, in the end, not pursued.

Finally, the question of sampling needs to be reconsidered. As stated, the intention was to use purposive sampling as a way of getting a characteristic sample. Despite the missing homeless cohort, overall the participants reflected a swathe of experience. Demographically it was a little more unbalanced. Despite a roughly equal gender balance – twelve women, thirteen men – eighteen of the participants were white, and seven non-white or mixed race, which is not entirely reflective of a mental health system in which non-white people are over-represented. The age of participants also slanted upward, with the average participant being 54 years old. Perhaps younger service users, by dint of their being at an earlier stage in their journeys through a mental health landscape, might have different experiences? That is certainly one area that might be ripe for future research.

8.5. Policy implications

“Whose reality am I meant to comply with? Theirs or mine? I’m not doing any harm, and I’d like the politicians to see that.” (Richard, mental health service user, central London)

The primary policy implications of this research relate to the necessity of having the genuine needs of people with mental health problems taken into account and reflected in both the formulation and implementation of those policies that are ostensibly directed to their aid – and not, as is so often the case, relying on others' perceptions of what those needs may be. Too often such policies have been executed with little evidence of any assessment of how they might operate in practice. The end result has been ever familiar: service users left largely alone to pick up the pieces and cope as best they can. It is the policies and procedures of welfare reform that, at present, hover menacingly over the lives of mental health service users. These imperil the residential stability, sense of self-worth, health and financial viability that service users require if they are to retain or construct an ontologically secure 'home'. As such, they are inimical to health, happiness, comfort and security. Mental health service users believe that in the pell-mell of austerity-driven restructuring they are being deliberately targeted for cuts. They view the Work Capability Assessment as a pernicious, invasive instrument of reform that is antithetical to their lives and which betrays a fundamental lack of understanding about the quotidian realities of mental ill-health. They feel very strongly that the reality of their lives as they perceive it is far closer to the mark than those dreamt up and paraded by policy elites.

Accordingly, a thorough reappraisal of the way in which the welfare system and wider labour market engages with people with mental health problems is needed. Tinkering with a busted tool such as the WCA is insufficient: it needs to be scrapped and replaced with an assessment mechanism that is as much about health as it is about work, that emphasises support rather than compulsion, and that seeks creative ways in which employment opportunities can be appropriately matched to fluid realities of services users' mental health. The withdrawal of housing benefits and imposition of penalties such as the bedroom tax as a way of

reducing expenditure is a pointless exercise (as well as being ethically dubious) if it results of the kind of residential mobility patterns – circulation, homelessness, hospitalisation – that have so often been the previous costly outcome of the withdrawal of housing support. Thus, there needs to a recognition that stable and appropriate housing, which allows service users to orientate their lives domestically to aid wellness and promote health, would probably prove more cost effective in the long term than further benefit squeezes and upheavals. All of which is no easy feat, given the hold that neo-liberalism has over the electoral and parliamentary levers that ultimately determine policy. Nonetheless efforts can be made to if not overturn then at least seek to blunt the more pernicious effects of welfare reform – as witnessed in the spring of 2016 when further cuts to disability benefits were shelved by the government.

In terms of the potential policy impacts of this research, in addition to sharing a summary of findings with participants, the intention is to seek to align with those organisations with whom I worked during the recruitment of participants so that they themselves may draw upon its findings as part of their own strategies and campaigns to influence the policy agenda.

8.6. Implications for further research

There is a definite need for further research in this area. This study has enabled a largely characteristic sample of service users to present their lived and embodied experiences in the fields of residential mobility and welfare reform and the extent and ways in which these interact with mental health. With welfare reform a policy juggernaut that cannot easily be stopped there is a need for further studies that (a) focus specifically on the long-term impacts of reform on the health and material wellbeing of service users, (b) attempt a more quantitative assessment of the potential impact on residential mobility, and (c) that look at the impacts of austerity on the broader field of informal services and facilities more generally. There remains too a need for continued investigations into the lived experiences of mental health service users in residential settings more precarious than the majority of those presented here and who have largely been absent from this

study. Their accounts, in the welfare reform context of this research at least, are a gap that need filling.

Shortly after concluding my final interview with him in the spring of 2015, Liam, who described himself as one of the “mass medicated army of welfare recipients living impaired lives”, e-mailed me with the following subject heading: “Do the basics right and the complicated stuff will come too”. He wrote,

“Dear James,

On reflection at our interviews, I have come to the opinion that your approach has been textbook in terms of preparation and execution. I have given you more detail in our conversation in ten minutes than I have ever been allowed to give to any mental health professional. No mental health professional would let me carry on for this length of time without interrupting me, blocking me, and preventing me from entering this information into any consultation. I have the expectation that your end product will also be a textbook example.

Your humble subject,

Liam

A psychiatric patient of 22 years and counting”.

The heart of this research has been my halting attempts to enable mental health service users to bring their lived experiences to a wider, academic audience, experiences which have often engendered humbling and discomforting feelings on my part. I was not able to share service users’ acute distresses, nor to offer any soothing balm, but I did strive always to offer empathetic understanding of others’ predicaments and promised to represent their views and experiences as faithfully as I could. This thesis is the result.

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Appendix A. Fieldwork instrument

SURVEY QUESTIONNAIRE AND RETROSPECTIVE OPEN-ENDED INTERVIEW FRAMEWORK

The following survey questionnaire and interview framework was used at the initial interview with each respondent. They were designed to capture respondents' personal details and to retrospectively assemble a picture of their residential mobility patterns, mental health status, and the degree of dependence on welfare benefit payments.

STANDARDISED SURVEY QUESTIONNAIRE

This interview is to help me understand a little more about both you and your recent history, particularly where you have lived, how you have felt, and how you have managed financially. There are two parts to the interview. The first one is about your personal characteristics, so that is things like your age, place of birth, whether you have family, your health, education and employment status, and whether you get financial help in the form of welfare benefits. The second part of the interview is about where you have lived and how you have managed your mental health and finances over the last year.

DATE OF INTERVIEW:

RESPONDENT IDENTIFIER CODE:

PART 1. PERSONAL INFORMATION

During the first section of this interview I will ask some basic questions about you and your life, family, health, education and employment history, and how you support yourself financially. I will write down your answers I will let you know when we are about to move onto a new set of questions. Ok?

Basic personal information

1. How long have you used the drop in centre?
2. Date of birth/age
3. Place of birth
4. Current home address
5. How long have you lived in this [or that] area?
6. Ethnic origin [insert standardised categories – white, Afro-Caribbean, Asian, Other?]

7. Marital status [i.e. single, married/civil partnership, living with someone, separated/divorced]
8. Do you have contact with family members? If so, who, and do they live close to you?

Health

The next few questions are about your mental and physical health and whether you use medical or other health facilities or services.

9. When did you start to feel unwell?
10. Do you have a formal mental health diagnosis? If so, what is it?
11. Can you remember when you were first diagnosed?
12. How is your mental health now?
13. Do you have any physical health problems? If so, do you consider yourself to be physically disabled?
14. Are you currently taking any medication?
15. Have you ever been hospitalised as a result of your mental health?
16. If so, where was that, and for how long? If more than once, how many times, roughly?
17. Are you required to attend a mental health clinic? If so, where and how often?
18. Have you ever received treatment for drug or alcohol use?

Education and employment

These questions are about your education and employment history

19. How old were you when you were last in formal education? Did you receive any qualifications before you left?

20. Do you have any difficulty in reading or writing?

21. Have you ever had a paid job?

22. If so, what was this and when? Full time or part time?

23. If not in current employment, what do you think the likelihood is of you getting a job now (High likelihood/some likelihood/little chance/no chance)

Welfare benefits and financial support

The next questions are about whether you currently or have recently received any welfare or social security benefits or any other financial support from the government.

24. Thinking about the last eighteen months have you received any welfare or social security benefits? If so, which ones?

- a. Housing Benefit
- b. Disability Living Allowance/Personal Independence Payment
- c. Incapacity Benefit/Employment and Support Allowance. If the latter, are you in the Work Related Activity Group, or the Support Group?
- d. Jobseekers' Allowance.

25. Are you currently in receipt of any of these benefits? If so, which ones?

- a. Housing Benefit
- b. Disability Living Allowance/Personal Independence Payment
- c. Incapacity Benefit/Employment and Support Allowance. If the latter, are you in the Work Related Activity Group, or the Support Group?
- d. Jobseekers' Allowance.

26. Are there any other sources of financial support that you use to help you meet housing and other costs, including paying bills, buying groceries, paying transport fares? If so, what are they?

PART 2. RECENT HISTORY OF HOUSING, HEALTH AND BENEFIT PAYMENTS

This second part of the interview is about your housing, mental health and financial history over the last twelve [or eighteen] months. What I want to do is try to get a picture of how these things may fit together. I am going to ask you to help me to reconstruct the last twelve [or eighteen] months of your life, thinking about where you have lived during that time, for how long, what you felt about each one, how your health has been during this time, and how you have managed financially.

A. Residential History

First, I want to ask about each place you have lived or stayed for at least one night over the last twelve [or eighteen] months. If you haven't moved in that period then I will ask you to think only about your current accommodation.

- 1. Starting with the most recent and thinking backwards, can you tell me all the places you have lived or stayed for at least one night over the last twelve [or eighteen] months and how long you stayed there? I have prepared a timeline to help organise the information. Don't worry if you can't remember them all, but we will write down each that you can on the timeline and, when we have all the places that you can remember recorded, I am going to ask you to talk about each one in more detail.*
- 2. So, for each place can you talk about what it was like.*

Type of accommodation

What kind of place was it? For example:

- Was it private accommodation, for example your own flat for which you had to pay rent?*
- Was it more formal or institutional accommodation in which you had to share space and facilities, such as a hostel, a homeless shelter or a hospital, and which you didn't have to pay for?*
- Or was it more informal such as sleeping on someone's sofa, or even sleeping rough?*

Perception of place

How did you feel about staying there? For example, what about it did you like? What about it didn't you like?

How was your mental health while you were there? For example, was being there good for your mental health, or did it make it worse?

Mobility

What caused you to move to the next place? For example:

- Was it because of changes in your mental health?*
- Was it because of changes to your financial situation?*

Did you voluntarily decide to move? Or were you forced to do so by someone else?

How did moving make you feel?

Did moving affect your mental health? If so, did it make it better or worse?

B. Financial situation

Here I am going to ask you to talk about your financial situation over the last twelve [or eighteen] months to see how you have managed.

Welfare benefit payments

How important are your benefits to you? For example:

- *Does receiving regular payments make it easier to cope with managing your life?*
- *Do they make it easier to manage money on a day to day basis? Such as paying rent, bills or buying groceries?*
- *Can you tell me in more detail how you plan your money, for example whether you can make it last all month, or whether you run out before receiving the next month's payment?*
- *Does receiving regular payments have an impact on your mental health?*

Have your benefits been changed, reduced, or stopped at any point over the last twelve [or eighteen] months? Did this have an effect on your mental health?

Have you had to undergo any eligibility assessments, for example to test your fitness to work? Did these have an impact on your health?

Are you going to be reassessed (again) in the future? How does that make you feel?

Concluding remarks

1. Thank interviewee for time.
2. Ask them if they have any preference for a pseudonym? Would you like to choose one?
3. Ask interviewee how they are feeling after the interview. Perhaps ask them to say how they feel on a scale of 1 to 10 (10 being really happy and 1 being really unhappy).
4. Hand over gift card and explain how it is used.
5. Ask whether would be willing to keep a diary. If so, explain that it will be provided separately. Offer to buy a coffee and explain it over that.
6. Thank once again and **switch off the recorder**.

Appendix B. Participant paperwork

PARTICIPANT INFORMATION SHEET (Version number 2 – 20.01.2014)

(Individual respondents)

Study title: Mental health, residential mobility, and welfare reform

Researcher: James Lowe

Ethics number: 6128

Please read this information carefully before deciding whether to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is this research about?

This research forms the main part of my research degree at the University of Southampton. As part of this research, I want to know more about people's mental health and whether it effects where people live or have previously lived. I am also interested in how changes to the benefits system may affect people's mental health, where they choose to live, and how they manage financially.

Why am I asking you?

I am asking service users whether they are willing to help me complete this research by talking to me about their health, where they have lived, and how they manage their finances.

What would it involve?

I would arrange to meet with you on three separate occasions over the next 12 months or so. We would chat for about an hour at a place, date and time convenient to you. I would also ask you to consider keeping a brief one-week record of your personal expenditure in the form of a diary to help me understand the impact that benefit changes may have on your day to day life.

Are there any benefits to me taking part?

As a token of my thanks I would like to offer you a £10 voucher for Boots or Superdrug for each completed interview. More widely, I hope that the results of the research may in the future help other people experiencing mental health difficulties by emphasising how benefit payments can help people bring stability into people's lives.

Will my participation be confidential?

I will tape-record each interview so I can properly consider everything that you tell me. The recordings will only be made available to me and will not be shared with

anyone else. Your interview material will be stored securely on computer in compliance with the Data Protection Act and as required by my University. When I publish any material from the interviews – for example in the written report of my research – I will make sure that your identity is protected. I will use made-up names instead of your real one, and I will disguise your identity so that you could not easily be identified.

What happens if I change my mind?

I will ask you to sign a consent form before each interview which says that I can use the information you tell me in the written report of my research. However, if at any point you decide you don't want to continue, then you can withdraw and I will not use your interview up to the point of writing up the report and publishing it (about 18 months from the date of the first interview).

Where can I get more information?

If you have any questions about the research and your participation in it please contact me directly at JI20g11@soton.ac.uk or on 07966 349 935.

Alternatively, if you would prefer you can contact my supervisor at the University using the details below:

*Dr Geoff DeVerteuil
Department of Geography
University of Southampton
Southampton SO17 1BJ
02380 594580
G.P.DeVerteuil@soton.ac.uk*

In the unlikely case that you have any concerns or complaints about this study then please contact:

*Dr Martina Prude
Head of Governance
University of Southampton
Southampton SO17 1BJ
02380 595058
mad4@soton.ac.uk*

I can let you have a summary of the findings if you are interested.

CONSENT FORM

Study title: **Mental health, residential mobility, and welfare reform**

Researcher name: **James Lowe**

Ethics reference: **6128**

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (Version 2/ 20.01.2014) and have had the opportunity to ask questions about the study.

I agree to take part in this research project and for my interview to be audio recorded and that quotations can be used for the purpose of this study. I also agree to consider keeping a personal expenditure diary for a period of one week.

I understand that my identity will be disguised and my responses anonymised in reports of the research

I understand my participation is voluntary and I may withdraw at any time up until the point of writing up and publication without my legal rights being affected

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study.

**Name of participant (print
name).....**

**Signature of
participant.....**

Date.....

.....

