



Social disinvestment and vulnerable groups in Europe in the aftermath of the financial crisis

The case of mental health care users in England

Joe Greener & Michael Lavalette



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Executive summary

Summary of key findings

- This project applies a capabilities approach to explore the social damage caused by austerity to people suffering with mental distress.
- Those coping and managing with severe, lasting and ongoing mental health problems find themselves devoting considerable attention, time and effort to staying well. Surviving and handling day-to-day symptoms were at the front of people's minds and were more pressing than other goals such as employment or education.
- The group work uncovered three major areas within which austerity affected people's mental health. These were:
 - reducing benefit entitlements, lack of access to employment, under investment in already deprived communities and the flexibilisation of employment were all implicated in recent experiences of personal economic hardship. In certain cases, this entrenched experiences of social isolation;
 - the rolling back of provision in both mental health and social care services due to central and local government spending reductions had a direct influence on resources available for managing mental distress;
 - increasing conditionality through the use of assessment of eligibility reinforced feelings of shame and inadequacy and fear of not being seen as genuinely ill. Welfare transformation also negatively impacted on the relationship between service users and professionals, with welfare workers being seemingly more likely to treat people with suspicion.
- A range of capabilities was talked about by the group as important for managing levels of mental distress. These included both welfare services, provided through the social care and benefits system as well as mental healthcare, and sources of more informal relational factors such as family, friends and volunteering. Such was the diversity of examples given that data analysis drew four major principles which were seen as beneficial for improving the capabilities of those experiencing mental distress. It could be argued that day centre care best brings together these different principles under one roof:
 - *recognition of illness*. Having their mental health problems taken seriously by qualified professionals but also the wider community.
 - *opportunities to engage in therapeutic activities*. The research group felt that there were a whole range of activities, delivered by both formal mental health services and other informal resources existent in their communities, which they considered to be of therapeutic worth.
 - *empowered participation and resistance*. Contexts where people felt empowered to exercise real decision-making were valued. People also resisted the dominant politics of welfare by both actively constructing narratives which challenged welfare users as disingenuous and, in some cases, actively engaging in campaigning.
 - *security and safety*. People felt as though they needed spaces and places in their lives where they felt protected and sheltered from wider pressures. This was crucial during times of severe deterioration in their mental health.

Policy recommendations

- In overcoming the stigma and social seclusion often accompanying mental distress there is a need to challenge hegemonic constructions of the welfare user and revalue the contribution that people who are

out-of-work make to communities. This group of people fulfilled many social roles as carers, family members, activists, sports team members and volunteers, but still often felt inadequate.

- Dealing with mental health issues is a demanding task in itself, the freedom to engage with a range of different services and activities should be encouraged, especially in long term community based services rather than medicalised or individualised forms of support. This would include being free to be 'unwell' indefinitely and consequently resist the current 'work first' approach of policies. A capabilities analysis, however, would suggest that this also involves material investment in an infrastructure of services.
- Ensuring financial security through higher benefit entitlements, easier access to benefits, better regulation of loan companies, and better support finding work could help people with ongoing emotional or psychological difficulties.

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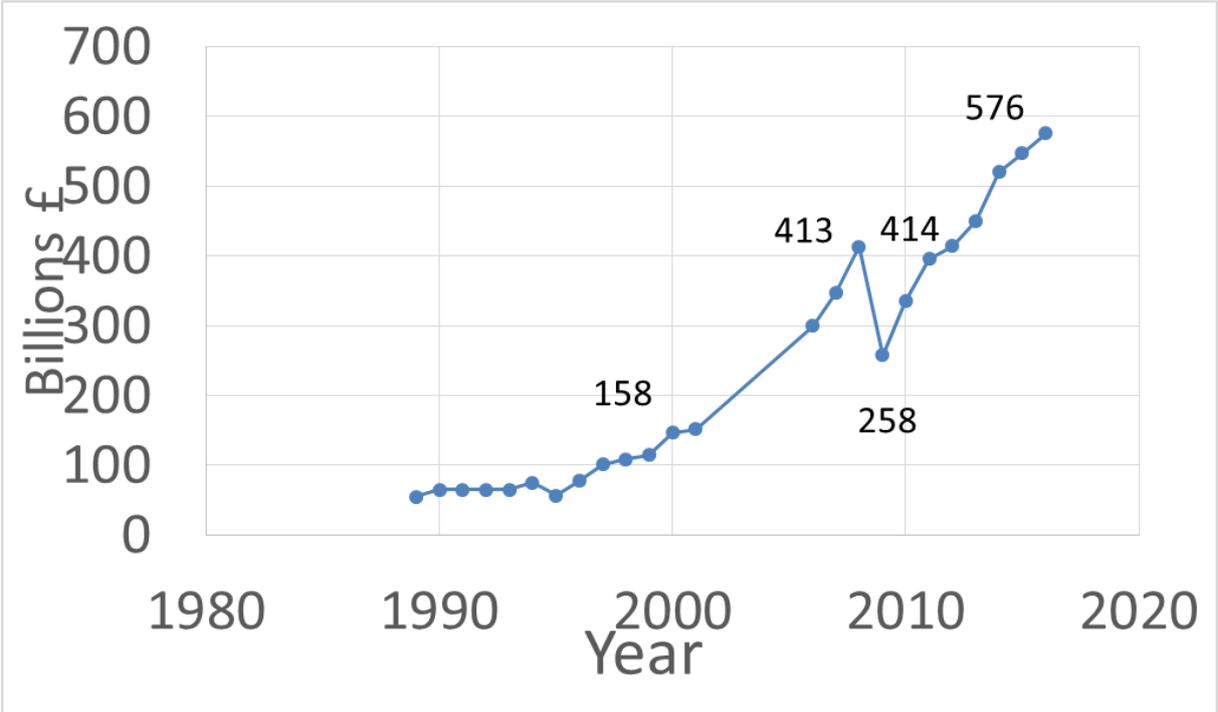
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Introduction

‘Austerity’, a political and economic project geared towards reducing government public sector social spending, was presented to many populations of Europe as inevitable. After the global financial crisis of 2008 the population of England, and in many other European countries, have been subjected to a mainstream political narrative that sees reductions in state social spending as necessary to re-establishing and securing economic growth and security. Spending on welfare services, some of which support disabled, unemployed and sick people, have been consistently presented as a luxury that society can no longer afford. However, austerity has not been bad for everyone. Whilst Harrop and Reed (2015) estimate that 2 million more children in England will be living in poverty by 2030, if current policy trajectories remain the same, other studies have shown that the richest 1000 families in the UK have seen their wealth grow exponentially during the recession (Garside, 2015). The Sunday Times produces an annual ‘Rich List’ which plots the wealth of the 1,000 wealthiest people in the UK. Figure 1.1 shows the growth in their wealth over the period the Rich List has been running (1989-present)

Figure 1.1 Increase in wealth of the 1000 Wealthiest people in UK (1989-2016)



Source Sunday Times Rich List ,1989-2016

The richest 10% of UK population now control 45% of wealth while the bottom half of the economic strata control a meagre 8.7% (Office for National Statistics, 2015). The financial assistance provided to banks resulted in the national debt in the UK rising to 850 billion, enough to pay for the now supposedly inflated National Health Service for more than 8 years (Mendoza, 2015).

A cornerstone in this economic transformation has been a symbolic, discursive and divisive politics attempting to propagate an ‘anti-welfare common sense’ (Jensen & Tyler, 2015). Pressures on public services and benefit payments and the scarcity of better job opportunities has been blamed on excessive immigration and freeloading welfare ‘dependents’ while the financial system has largely escaped any serious critique. Not surprisingly, growing inequality, reduction in public services and an often-divisive political narrative has been accompanied with a general decline in levels of trust in political institutions in the UK and across Europe. For example, in 2007 across the EU, 57% of people claimed that they generally trusted the European Institutions whilst in 2013 this had fallen to only 31% (Eurobarometer 2013). In the UK, trust in the EU was only 19% in 2013. Distrust in both EU institutions and in national political processes has also arguably set the context for potentially the biggest political event to happen in the UK for decades: when the British public voted to leave the EU.

It is in this context of political crisis, rising inequality, reductions in spending on public sector services, mass welfare transformation and an insidious political discourse that this research takes place. The theoretical vehicles for understanding the impact of spending reductions and welfare reform on people with mental health problems is broadly a human rights perspective but pays special attention to the resources available to people to realise their objectives and life-plans (Sen, 2001). This report adds weight to other studies revealing how recent economic and social policy transformations have created a toxic environment for mental health in England (Barr *et al.*, 2015). The report sits within a broader body of literature focusing on mental distress as an experience which is clearly rooted to particular social, economic and political contexts (Psychologists Against Austerity 2016; Wilkinson & Pickett, 2010).

Based on qualitative research involving biographical interviews and focus groups the report explains some of the complex social and policy processes that have resulted in deteriorating experiences for mental health service users in Liverpool. The report will explore the major transformations that have intensified mental distress and diminished the potentialities for accessing assistance to resolve, cope with and overcome persistent mental health problems and shorter-term crises.

1. Mental distress and Austerity

Recent research has already begun to map out the direct effect that austerity, and the social policies associated with it, has on worsening or deteriorating mental health. In 2007, a World Health Organization report predicted that the economic crisis would have a serious impact on mental wellbeing across Europe (Wahlbeck *et al.*, 2007). Rising personal debt and poverty have been associated with rising mental distress across the literature (Gunnell *et al.*, 2015; O'Hara, 2007; Wahlbeck *et al.*, 2007). Mental health charity Mind published data indicating that half of the people who have called their helpline feeling suicidal because of money, housing or benefits issues (Mind, 2016). As well as an increasing risk of suicide, evidence shows that there has been a huge increase in the prescription of antidepressants. Donnelly (2014) reported information from the Health and Social Care Information Centre which showed that prescriptions for antidepressants rose by over 33% from 2013 to 2014.

It would be erroneous to conceptualise the current problem of mental distress at a societal level as something especially novel or as exclusively emerging from developments over the last few years. Nevertheless the reforms implemented by this and the previous government are clearly aimed at further entrenching, deepening and intensifying the attack on welfare systems and living standards further intensifying the pressures on people living with mental distress (Barr *et al.*, 2015; Psychologists Against Austerity, 2016). The aim of this brief literature review is to highlight the manner in which the political and economic context for living with psychological distress has changed under austerity. This review will highlight the following ways in which austerity and welfare transformations in the UK are influencing mental wellbeing through three main developments:

- *deteriorating access to material security*: precarious work, unemployment and deteriorating benefit payments are deepening and extending poverty and financial vulnerability;
- *declining opportunities to access mental health support*: the rolling back of formal mental health service provision, cuts to more local social care budgets and the wider disinvestment in often already materially deprived areas is constraining the capabilities available in communities to seek support for mental distress;
- *the strengthening of workfare principles across the welfare system*: various policy developments are reimagining what the welfare state 'is for'. These are not only imposing new forms of poverty but are also creating new social psychological pressures as people are expected to conform to narrower policy definitions of who is entitled to welfare support through new conditionality structures.

1.1 Deteriorating access to material security

Recent work done by Fitzpatrick *et al* (2016) for the Joseph Rowntree Foundation found that about 1.252 million people in the UK are currently living in destitution where they are unable to buy the essentials needed to eat, remain warm and ensure personal hygiene. This can be seen as indicative of worsening experiences of poverty since the global financial crisis. To understand the context of declining living standards in the UK, three mutually reinforcing sets of changes need to be analysed including the labour market, welfare state reform and rising costs of basic goods, such as housing.

Deteriorating pay is part of a longer term downward pressure on wages and working conditions associated with successive attempts to realise 'flexible' labour markets (Lansley & Mack, 2015; Mendoza, 2015). However, this process has consolidated further under austerity. The Enterprise and Regulatory Reform Act passed in 2013 is a prime example of the buttressing of insecure and precarious working patterns through amendments to current employment legislation (Mendoza, 2015: 126-7). Amongst other developments, the

Act also means that an individual who wishes to lodge an appeal after losing their job at Tribunal now incur much greater costs (as much as £1,200 to lodge a complaint). If employees have wages withheld, are dismissed without good reason or are subject to other injustices, they risk losing a considerable amount of money if appeals are unsuccessful. Part of this deregulation in the labour market has been the huge rise in the number of employees working in what are informally known as ‘zero hour contracts’. The possibility for employment relations to be organised along this line has existed for decades but the sharp rise under austerity reveals some of the coordinated ways in which other policies are imposing precarity. The Resolution Foundation (2013) found that people on zero hour contracts have a lower gross weekly pay of £236 compared to those not on zero hours which is £482 per week. The Office for National Statistics (2014) reported that some 1.4 million workers were in contractual arrangements which had no guaranteed hours.

Other changes to the labour market which are emblematic of the normalising of casualised, temporary and insecure work include the rise in low paid self-employment (Lansley and Mack 2014), relatively low skill apprentice schemes with no guaranteed end job (Ofsted 2015), cuts in public sector pay (O’Hara 2015) and the return of totally unpaid employment through Mandatory Work Placements. The impact of this collection of reforms is increasing financial insecurity. John Hills’ (2015) recent research aimed to break down the pervasive myth of a workless, unemployed and welfare-dependent population, and presents evidence of the extent to which those at the bottom of the income structure have to juggle a number of different work commitments and require (insufficient) welfare support to plug gaps in periods of unemployment, lack of access to satisfactory hours and changing caring responsibilities and family structure.

Economic insecurity has also been organised through transformations in the forms of support available from the welfare state. Mary O’Hara described the support available to people with longer term needs as ‘a complex package of discriminatory reforms’ (2015: 145). A more detailed analysis of these changes is discussed later but it is worth drawing out here that two pillars of this assemblage of reforms are producing a decline in living standards. Firstly, disentitling strategies embodying new forms of means testing are attempting to strip people of existing benefit payments. Secondly, there is a more generalised programme of cuts to direct financial benefits including reductions in Jobseekers Allowance, the removal of the Independent Living Fund and Disability Living Allowance and the movement to Universal Credit (O’Hara 2015: 158).

Housing has also become a topic mired in controversy and is central to understanding rising living costs in England. Through long term and tandem processes of disinvestment in state-driven social housing programmes (Mendoza, 2015: 58-59) and the financialisation of the housing market in England (New Economics Foundation, 2016) problems of rising rent and limited supply of housing define the current market. In 2015, house prices rose by 4.5% while average pay only increased 2% (Meyer & Stuart 2015). Coupled with this generalised crisis in costs and supply, there has been the introduction of the ‘under occupancy charge’, more commonly known as the ‘bedroom tax’, for households where there are ‘extra’ bedrooms in social housing. This has forced many households in social housing to give back part of their benefit derived income to the state if there are more bedrooms than occupants in a given property.

Under the guise of austerity, the last two governments have deliberately orchestrated a set of labour market and welfare reforms which impose new forms of financial insecurity and deprivation onto households and individuals. As a result, people are being forced to turn to the debt and personal financing industry based on exorbitant interest rates and catering for the needs of low income individuals who have insecure, fluctuating and unpredictable pay packets. Indebtedness has been shown to have a complex interrelationship with anxiety and depression (Davies *et al* 2015).

1.2 Declining opportunities to access mental health support

As well as rising financial insecurity, mental health problems are being exacerbated by direct cuts to mental health treatment and more generic social care services. Recent research by Community Care and the BBC obtained freedom of information requests from 43 of the 56 Mental Health Trusts in England revealing a reduction in funding of 8.25% in real terms (McNicol 2015). In cash terms, the amount has diminished from £6.7bn in 2010-11 to an estimated £6.6bn in 2014-15. The same research has shown that community

mental health teams have seen a funding decrease of 5%. The numbers of beds in mental health hospitals has also diminished. Care Quality Commission recently warned that Approved Mental Health Practitioners (AHMPs) are being put under extreme pressure due to a lack of beds. Andy McNicoll reported that the total number of beds in mental health hospitals that has been closed since April 2011 and 2014 is 2,100 (McNicoll, 2014). Mental health hospitals in some trusts are running at 120% capacity, despite the Royal College of Psychiatrists recommending an occupancy rate of 85% (RCPsych 2011). There have even been seven suicides and one homicide directly linked to a lack of beds in hospital facilities (McNicoll, 2014a). Under the Mental Health Act in England, people can be detained in hospitals against their will if they are deemed to be a risk to themselves or others. Data from the Health and Social Care Information Centre (quoted by McNicoll, 2014b) showed that in 2015 these detentions were up by 10% from the previous year, with some suggesting that professionals were resorting to enforced detentions in order to find patients hospital beds (BBC, 2015).

Pressures on treatment services have meant that a breakdown in a person's mental health has become a more frightening and traumatic experience. Not only have hospitals become overcrowded but Trusts are increasingly resorting to out-of-area treatment options (Buchanan, 2014). This involves transporting people experiencing a downward spiralling situation in their mental health, sometimes hundreds of miles, to other facilities. The experience of transport during the initial crisis can be extremely disturbing, but can also make visiting by family and friends more problematic in the months and weeks after.

In England and the rest of the UK, social care and health care are separate policy fields with distinct modes of operation, legislative frameworks and funding sources. Social care is geared towards catering for longer term illness or disability. Whilst healthcare is largely funded through central taxation, social care is financed through local councils who raise taxes within their region and receive a proportion of funding from central government. To map out the cuts which have affected mental health services, therefore, means including Local Authority budgets, as well as the NHS mental health provision. Since the start of austerity UK local council budgets have been seriously affected. Under the previous coalition government, whose term ended in May 2015, local councils saw a 40% decrease in their central government funding. But these cuts have not been applied uniformly, indeed, it has been the most economically deprived councils which have suffered the biggest cuts. A recent study found that social care spending from 2010 to 2015 in the most well off councils has actually risen by 8% whilst it has fallen by 14% in the most economically deprived (Hastings *et al* 2015). Liverpool, where this research took place, is in the list of top ten most deprived areas in England (Department for Communities and Local Government 2015) with the latest child poverty rates indicating 32.1% of children in the city live in poverty (the majority in working households). Yet Liverpool has experienced exceptional reductions in central government funding. By 2017 Liverpool City Council will have had to make £329 million in savings which represents a 58% cut in funding in real terms since 2010 (Brindle, 2015).

Yet the cuts in mental health funding is running in tandem with transformations in how the nature of mental health support is viewed in terms of its aims, scope and foundational principles. Austerity has proved to be a convenient economic cover for promoting ideological changes. For instance, reductions in funding for community care can be neatly accompanied with more individualised interventions. Previous services have often delivered ongoing support in day centres, day hospitals and other community settings which could last months and even years. This sort of service created opportunities for long term care for those with persistent mental health problems (Bell, 2013). Yet many of these services are being replaced with alternative short-term provision with an emphasis on 'recovery'. In the Liverpool area some services previously geared towards the long term community support have been transformed into 'reablement' focused services, aimed at delivering six week intensive recovery (Carter 2016). Hospitals and day centres are moving services towards short-term recuperation models where patients are asked to resolve, often long term mental health problems, in very small periods of time.

There is also an individualising undercurrent to these transformations, where self-recovery and independence are valued above other possible views on how mental health services should be delivered. This 'responsibilisation' agenda seems to fit neatly with the context of declining funding (Brown and Baker 2012).

A model of mental health where full recovery is not only possible, but is also best achieved by the individual taking responsibility for their own health legitimates reducing or even eliminating the network of community based professionals and services.

1.3 The strengthening of workfare principles across the welfare system

As we have seen the infrastructure for mental wellbeing has been significantly dismantled and there has been a rise in levels of poverty. Lastly we consider how changes to the driving principles of the welfare state are placing new stresses, strains and anxieties on people with persistent mental health issues. This is discussed separately to cuts in living standards and mental health services in order to capture how people who use public services are increasingly treated with more suspicion and subjected to greater scrutiny regarding their entitlement to support.

Stigma, although a contested concept in social sciences, conceptualises the way that an individual's identity can be called into question, devalued and undermined with that person being seen by those around them as less than human in some way. Stigma is an inherently social concept as it is concerned with the ways that a person or a community of people are treated by others as a result of having a tarnished character. What characteristics, traits and groups of people are stigmatised can change between time and place and is therefore relational in that it is determined by specific social, cultural and political contexts. Pescosolido and Martin (2007), in their in-depth review of stigma and mental health, argue that the concept is best seen as working at a variety of different ontological levels. This means that analysing the concept requires an analysis of the full range of social, cultural, political and psychological processes at play in the lived experience of stigma. For this study, we suggest that the experience of stigma needs to be understood in a changing political climate whereby people who use certain public services or benefits, such as those relating to being out of work due to disability or infirmity, are being understood and treated differently, in turn shaping, not only how they are viewed by others around them, but also how they understand themselves.

The data presented in the following sections shows how recent welfare reform has intensified a longer term transformation in how citizenship and rights are understood. The changes implemented through the Welfare Reform Act 2012 are complex but have initiated new forms of assessing eligibility to benefits. The Act introduced, amongst other things, the Work Capability Assessment (WCA) which means that people who have been unemployed due to illness or disability are now required to undergo a test, delivered by private sector organisation, to determine whether they have entitlement to long term financial assistance. This Act also brought in a whole new system of sanctions for people who are claiming Jobseekers Allowance if they fail to meet the requirements imposed on them, such as if they are late for meetings or training or if they fail to apply for the number of jobs that is expected.

Existing research has shown how changes to the ways welfare is delivered can impact on those with mental distress and how they understand themselves. Henderson *et al* (2012) found widespread evidence that discrimination was a common experience amongst people with mental health problems in the UK. They also found a sharp rise in experiences of discrimination in 2012, which they attributed to austerity. Hansen *et al's* (2014) ethnographic study explored the effects of the 1996 welfare reforms in America and found that stigma was experienced in new ways as a result of the changing context of welfare delivery. The 1996 changes to welfare in the US are very similar to those pushed through in the Welfare Reform Act 2012 in the UK. These 'disentitling strategies' (Wacquant 2009: 91) in which those claiming benefits are consistently required to prove their 'sick' status represents a change in the experience of stigma. Hansen *et al* (2014) claimed recently that people who are in receipt of benefit payments may find themselves in a contradictory situation where on the one hand adopting a label of mental pathology entitles them to services, but on the other, this label itself is often felt to be a stigmatising social role to adopt.

As Link and Phelan (2014) argued, social and economic power are crucial for understanding how stigma-related practices are played out in daily life. As discussed in the introduction, austerity is both a political and economic project that has located the blame for Britain's debt and deficit crisis with particular marginalised groups. Whilst the logic which underpins policy reform has been the need to realise the fiscally lean and

globally competitive economy, there are indications that recent welfare reforms have actually cost the state more money than it has saved. Barr *et al* (2015), using data from the National Labour Force survey, found there to be no evidence that reassessing people who had been out of work for long periods actually increased the likelihood of finding employment. Similarly, Wright (2016) reporting findings from the National Audit Office in *The Independent*, showed that the Department for Work and Pensions had plans to hand over £1.6bn to private contractors to carry out the controversial WCA whilst the savings in benefit payments are only expected to be around £1bn.

Deeming (2015) argues that social policy in many states has moved towards an ‘active’ stance involving a reformulation of citizenship. Policy and practices no longer emphasise the rights of individuals and instead obligation and responsibility now drive welfare programmes. Poverty and unemployment are constructed differently and re-‘problematized’ (Deeming 2015) as the result of individual failure, rather than systemic processes to do with job availability and inadequate welfare. Part of this neoliberal trajectory has been to visualise the welfare state as actually reproducing deprivation through dependency, rather than as a form of protection from the ills of market society. Policy makers are increasingly concerned with coercing individuals into employment, and into accepting low paid, insecure and unrewarding work. It bolsters a more pervasive political and cultural project attempting to gain public support for an ‘anti-welfare common sense’ (Jensen and Tyler 2015). Through insidiously crafting a welfare state guided by the idea that many people may indeed be disingenuous scroungers living a lavish lifestyle from the hard earned coffers of the taxpayer, governments manufacture support for ‘innovations’ in social policy aiming to dispossess vulnerable people of the resources they rely on. This simultaneously fortifies the idea that welfare claimants might be culpable for the financial crisis whilst maintaining impunity from scrutiny for late financialised capitalism.

Psychological and emotional states are fundamentally relational in that they develop in congruence with how individuals are treated, reacted to and engage with the communities they live in. Putting the dynamics of power and inequality central in an analysis of social policy and daily life is critical for understanding current experiences of mental distress.

2. The participatory research approach

2.1 Human Rights and Capability Approach

RE-InVEST aims at investigating the philosophical, institutional and empirical foundations of an inclusive Europe of solidarity and trust. To this end it draws on capability and human rights based participatory approaches.

Human Rights are universally agreed basic standards that aim to ensure that every person is treated with dignity and respect; they are interdependent and indivisible, they belong to all people without discrimination. Usually set out in law, through international or regional treaties, or national legislation, they form a legal statement of universally accepted principles of how the state should treat its citizens and other people living within its jurisdiction. In this project, however, we aim to widen the notion of rights beyond those which are formally prescribed in international treaties and national and supranational legal frameworks. As Ted Benton (2006) notes, scepticism of conventional liberal rights has arisen because it tends to emphasise ‘formal’ rights. In other words the fact that in theory different individuals are permitted to follow their aims. In practice, consideration of how social structures deny people access to opportunities is also required, and a legalistic view of human rights is unable to achieve this. Analysis needs to focus on what people are actually able to do and to be in their everyday lives, rather than what the official sanctioned choices are. As Benton expands:

‘The life-plans we are able to devise are constrained and shaped both by our cultural horizons and by our actual placing in society, with its current pattern of fulfilments and frustrations. But in each case our ability to live out whatever plan we might devise will be conditioned by our access or lack of access to resources.’ (2006: 25)

As a solution to this problem with rights-based approaches this study employs a capabilities approach. The capabilities approach, developed by Amartya Sen (2001), argues that thinking through human development requires consideration of what resources are available to people. What are people actually able to do and to be in given social, political and economic context? This tends to open up analysis to whole range of different aspects of the social and political system to explore the full range of institutions present in a given society or locale. For Sen then, a ‘capability’ is the presence of a particular opportunity such as the existence of a local education system or the fact that homosexuality is permitted and tolerated. A ‘functioning’, on the other hand, in Sen’s language, is where a person achieves a particular state of being or activity (Burchardt, 2004). So that would be the emotional, psychological and technical capacities developed in the course of attending a educational institution. Analysis of capabilities requires exploring the full range of potentials and possibilities available to a person, while a functioning is what they actually manage to achieve and become in the course of accessing capabilities.

For assessing the capabilities of vulnerable people RE-InVEST aims to place their voices centrally within the research process. Their participation is fostered by relying on participatory action research that directly results in policy recommendations. Participatory action research views participants as co-researchers who have special knowledge about their own situation. Hence they are not only asked or interviewed on their views but take part in research by engaging in, examining, interpreting, and reflecting on their own social world, shaping their sense of identity.

Accordingly, the approach attempts to encourage the coming together of different forms of knowledge. Crucial for this kind of knowledge generation is the ‘merging’ or ‘crossing of knowledge’ that comes from

three parts: scientific knowledge as gained by researchers; knowledge which those who have suffered injustice have, from their first-hand experience; and the knowledge of those who work among and with these victims (Figure 2.1).

These are the core elements of the Participatory Action Human Rights and Capability Approach (PAHRCA) developed in RE-InVEST. PAHRCA entails seven steps (Toolkit, 44-45):

1. Identify and meet partner NGO/gatekeeper,
2. Preliminary ‘meet ups’ (for trust building if necessary),
3. First meeting with participants – trust building,
4. Developmental: implement developmental human rights & capability approach,
5. Inquiry/data gathering,
6. Identifying patterns (key issues and themes of concern to the group) and
7. Undertake action/outcome using one or combination of approaches.

Figure 2.1 Merging of Knowledge



2.2 Methods and Methodology

In recruiting respondents we exploited existing links between a university department that the researchers were based in and a local non-profit welfare providing organisation, Person Shaped Support (PSS). In conjunction with PSS the department had an existing service user group who help to deliver training, select candidates for degrees and inform the design of courses. Many of the members of the existing service user group self-identify as having a mental health problem and are in regular contact with mental health services. Two extra participants were also recruited in order to increase the size of the group. The current PSS group does have an overrepresentation of women members but some males were included. There were 13 members of the group with a reasonable age spread, although ethnically there was little diversity with all respondents being white British or Irish. There was also a gender bias in favour of women with 9 females and 4 men. One worker from PSS also participated in the meetings who is a fully qualified and registered social worker. This was partly to ensure that there was support available if any difficult issues arose for individuals in the group and to foster the merging of knowledge.

There were six research meetings altogether and the table below gives a synopsis of the first four meetings. The sixth meeting is not discussed as this was largely a planning meeting to discuss the public event that took place which was one of the outcomes of the research. The research meetings were an attempt to operationalise the different strands of the methodology discussed above and in particular intended to promote a merging of professional, academic and lay knowledge.

As well as the six research meetings there were two more in-depth biographical interviews conducted with two of the participants. The two individuals were selected mainly because their stories spoke directly to two austerity-related policies: WCAs and the under-occupancy charge.

<p>Session one – introduction and ‘austerity snakes’</p>	<p>In this session the researchers explained the aims of WP3 and the wider RE-InVEST project. Each member of the group was asked to briefly introduce themselves and then blank ‘snakes’, essentially timelines, were handed to each participant. Group members were asked to fill in the snake by noting major life events since 2007. We asked them to include both personal changes in family life, changes in employment, welfare services and benefits they had received or lost and also major changes in their mental health, including periods of crisis and periods where they felt they were improving. After the snakes had been completed, a group discussion was had regarding what they felt about the exercise of reflecting on their lives since the financial crisis.</p>
<p>Session two – human rights</p>	<p>This meeting kicked off with an overview of what human rights are and, in particular, a summary of the UK Human Rights Act 1998. After this the group were asked to fill in a worksheet in which they highlighted what rights they felt were most important and whether they thought that they had experienced specific instances of human rights abuses. After this a group discussion was had where we collectively worked through the Human Rights Act 1998 to explore which rights were relevant to people experiencing mental distress and welfare service users.</p>
<p>Session three – capabilities</p>	<p>This meeting kicked off with an overview the capabilities approach. In operationalising the capabilities approach we focused on two issues. Firstly, we asked respondents to fill a worksheet reflecting on the full range of factors in their life, both in terms of informal support networks, welfare services and hobbies, which helped them in managing mental distress. Secondly, we asked them to think about what their current life plans were, how these could be achieved and what barriers they faced.</p>
<p>Session four – the politics of austerity</p>	<p>Given that in the first 4 sessions so much conversation had orientated around the ways that interactions with welfare professionals and other people in the community were often harsh, stigmatising and degrading, the group felt it was important to look further at the ways others depicted welfare users. For this session the researchers chose a selection of newspaper headings which reported negatively on disabled people and benefit recipients. These were shown to provoke a general debate about social policy reform and the political dimensions of austerity.</p>
<p>Session five – taking action</p>	<p>The action component of the research had been discussed at various points in previous meetings but in this session it was agreed that we would develop, as a group, a photo exhibition. The group were given cameras and then took photos which they felt spoke to two main themes. Firstly, what experiences in their everyday life result in deteriorating mental health and, secondly, what are the resources in their communities which allow them to survive in spite of mental distress and other forms of marginalisation.</p>

3. Biographies of austerity social policy and mental distress

3.1 Ian's Story: Enforced Isolation and the 'Bedroom Tax'

One policy implemented through the Government's austerity agenda known to have had a socially damaging impact has been the under occupancy charge, more commonly known as the 'bedroom tax.' One of the participant's of this study, given the name Ian here, had been gravely affected by this policy change.

Ian has a long history of dealing with mental health problems. Serious problems first seemed to set in in around his mid-to-late 20s. Growing up in a deprived area of Liverpool in a large family, Ian felt that this upbringing set the context for later onset of more gravely deteriorating mental and emotional state. In one incident, when Ian was only a teenager, he was assaulted badly by a stranger who wrongly believed he had stolen a bicycle.

Ian had been relatively successful in finding work in his early life and had enjoyed being able to help his Mum out with extra cash. He also felt, however, that he could have had a better start in life, and had wished that his father had played a more significant role in his life by encouraging him to think about his long term employability.

Yet, Ian experienced a number of more traumatic events in later life which shaped the emergence of more severe forms of mental distress. Ian's mother, whom he had had a very close relationship with, died from cancer. Ian lived only a few doors away from his mother. This seemed to have brought many emotional and psychological issues to the fore for him. In the years leading up to his mother's death and in the period after, Ian had developed severe problems with agoraphobia, anxiety and panic attacks.

'To be honest with you, I wouldn't say I was depressed years ago, it was more the anxiety and the panic attacks I had, everything just happened and I ended up getting a house next door but one to my Mum. But I think it was seeing what my Mum went through that really affected me. Then, because I was next door but one to my Mum, it was like everything got left to me. 'Oh Ian's there, he'll do it'. I would do it all again if I could now. But everything got on top of me and I just broke down. Started having bad anxiety, really really bad, severe panic attacks.'

Ian also developed agoraphobia around this time and developed an inability to leave his house. After Ian's mother's death he remained in the same property but around 2011 he became subject to the Government's under occupancy charge. This disorienting strategy imposes a charge onto people who are considered to be under-occupying social housing. For example, if a person is on their own, as Ian was, then there is a charge for every extra bedroom in the property. This extra payment is to be paid, in many cases, directly out of people's already meagre benefits. This forced Ian out of his home and out of his community.

'Because of the bedroom tax I had to move my home and it was like a safe house and that's really affected me. I'm in a one bed flat now and its out of my area, for starters. I'm already stressed out to death. It's just little things, like you don't see your family and your friends. Just little things like you've got to change your GP where your GP knows all your history. It's like starting again.'

The bedroom tax had resulted in a direct and severe deterioration in his mental health by both increasing his general anxiety and removing some of the strategies he had available to him for coping with agoraphobia. For example, in his previous property he had been able to stand outside his house and see people he knew, which he felt limited the isolation he experienced.

Despite Ian's ongoing psychological problems he still shows considerable capacity to seek various forms of support, engage in the community and support others in a similar situation. Attending a local football scheme for people with mental health problems was clearly an excellent source of socialising for Ian and had a therapeutic impact:

I've got six or seven people going to this now (community football initiative) who are suffering with mental health and they'd never heard through services, they heard through me, no psychiatrists, no doctors nothing referred them ... see when I play, I give everything, that's why I am one of the best there at the time, but my head, everything just clears in my head for that hour or 2 hours ... you can go there with 150 things going in your head once you start but as soon as you finish its back.'

In the past Ian had also relied heavily on a day centre for care and support and is currently visited weekly by a psychiatric nurse, both of these help him. Yet, in many ways Ian feels the forms of support he is offered relied on were lacking in intensity and failed to really engage with his issues seriously. He had been waiting 18 months for Cognitive Behavioural Therapy at the time of the research. On another occasion he waited over 3 months for an appointment with a psychiatrist which lasted 10 minutes.

Ian's story uncovers the brutality of Government austerity agenda in relation to social housing. *Psychologists Against Austerity* (PAA 2016: 1) have argued that a key defining 'ailment' of austerity has been 'isolation and loneliness.' Ian, as just discussed, was able to resist and challenge some aspects of the mental health system, contesting certain pharmaceutical prescriptions and making use of opportunities in the community. However, social dislocation caused by the move out of his area reinforced feelings of shame, abjection and remoteness. Ian's experiences shows just how damaging the bedroom tax has been for some individuals:

Where I've moved to I'm really isolated, I feel like going worse now and I'm taking a backwards step, I'm starting to go ill again ... Since I have moved and I'm totally isolated and all I can do is sit in my little kitchen for 9 or 10 hours and I have to admit that suicidal thoughts have come into my head more in the last year than in the last 10 years of being ill. And I still think it's because I don't see a face, I don't see anyone. Without the day centres I wouldn't be here. I know for a fact that I would not be here ... you try and sit in that corner over there for 10 hours, you're going to start thinking and thinking and thinking. I mean I don't see anyone. At least when I was in the house and I did start getting down I could go and stand by the front door and you would see someone walk past and have a chat. But where I am now, there's nothing.'

3.2 Agnes's story: Work Capability Assessments and deepening distress

A further controversial developments in English social policy in recent years has been the 'work capability test' undertaken, initially, by the French company ATOS. ATOS obtained a government contract to assess people's suitability for work or whether their physical and/or mental health was such that they were incapable of holding down regular employment and would, therefore, qualify for various out of work benefits. Agnes's story reveals how deeply distressing it can be to go through the 'ATOS test' (as it has become more commonly known by service users).

Agnes is, by profession, a qualified teacher. Initially a PE teacher, she moved into 'informal education' through Youth and Community Work in the 1980s. In 1989 her husband died leaving her on her own to support two young children. At that stage she retrained as a primary teacher as the hours could be combined with her caring responsibilities.

However, after she completed her re-training she developed a medical problem (associated with her voice) which meant she was unable to work as a teacher any longer. She looked at possibly working part-time but this was also ruled out. So by the late 1990s she retired through ill-health and got a small work pension. She also qualified for incapacity benefit. The small pension and the incapacity benefit together didn't provide much but she was able to manage. But she would rather be working: 'I just felt as though I was thrown on the scrap heap'

Over the next few years Agnes developed some other medical conditions: she had bowel problems and suffered from incontinence, she had a hysterectomy, appendicitis and the removal of her appendix, she had a shoulder operation and spinal problems. As a result she was on strong medication and suffered with

depression. Her mental health problems were to become more sustained, however, as a result of the emotional turmoil and stress brought on by her experience of the 'ATOS test'.

As Agnes says, things weren't too bad 'until 2011 when ESA [Employment Support Allowance] came along.' With ESA Agnes found herself having to undergo a work capability test. 'Dear old Atos healthcare. They send you a letter, a questionnaire, so you fill that in and then they call you up for a medical'

Agnes went for her first medical assessment in 2011. She was unused to such tests and, like many people, wanted to 'put on a good show'. She wanted to show that she was trying to manage her life and her difficulties and took supporting medical evidence that explained the extent of her physical problems. As she said: 'you go to the medical and you try and do your best ... but [as she noted ruefully] that's the wrong thing to do.' She described her experience:

'Well you're sitting with a lady behind a desk and she is asking questions about what you do each day and at the time my mum had been diagnosed with dementia so she was my focus. ... So you say what you do and blab-de-blah and I took with me letters from consultants, from the spinal unit, from gastroenterology and other places. [But] they didn't ask for any supportive information. They then said they would like to do a physical examination, move you, this type of thing [raises arms]. They said get on the couch, so she said 'would you like help?' So I said 'no, just leave me, I can get on myself in my own way.' You know, I've got disc problems, I needed a new replacement so I had to put my bad leg first you know, so when I came off [I would lead] with my good leg.'

And then she got the report:

'Needed no assistance', could do this with no problem. 'Answered questions directly', 'looked at the person who is asking the questions', that's only manners isn't it? I was marked down because I was smart appearance. ... They twist your words and when I got the letter to say there's nothing wrong with you I was distraught. For many reasons, the first reason was that my income went down by £300 a month.'

Agnes lost all her benefits. She was forced to live on her small occupational pension. She quickly went through her savings and her mental health deteriorated dramatically.

She went to the voluntary sector organization the Citizen's Advice Bureau for help. But, because she was a home owner (and the value of her property was more than £100,000) she did not qualify for any support from them.

Eventually she was directed to Merseyside Welfare Rights office. They helped her appeal the ATOS decision. The Welfare Rights office said 'appeal on physical grounds, not mental health grounds, they said, because they told me 'you've got enough physical things wrong with you, so you should be OK'

Over 50% of appeals against ESA decisions are successful in England (Stone 2016). Agnes told us that, this time, she was more careful about how she answered the questions.

'I had all the paper work [from the initial test] so I knew I was marked down for being of smart appearance, so at the appeal I didn't go of smart appearance. I took my cousin with me, and in the meantime my mum had died and she died like three weeks before so I went in and there was a legal guy and a doctor, in this big room, he was there and this woman about 15 yards away, right down the other end of the room. And you're behind a desk, you have to stand up, and I said well 'I can't stand up', I said 'do you mind if I lean on the table?' 'No that's ok'. So she started asking me all these questions and I told her. She accused me of being my mum's fulltime career, but ... I wasn't able to care for my mum, I had to put my mum in a care home and that's one of the worst things that anybody's got to do. Your mum looks after you and when it's time for her to be looked after you can't do it. ... She talked about other things that I had wrong with me. Well do you go to this clinic, I said "no, I go and see the consultant." I have bowel problems and I have incontinence and she asked "do you go to the incontinence clinic?" and I said "no I don't, I go and see Mr. G--- the consultant and I see the stoma nurse." "Oh so you don't go there, so you're not incontinent then", you know and she was just horrible.'

They rejected her appeal.

Distraught Agnes went back to Welfare Rights who persuaded her to make a fresh claim. This time Agnes knew she had to emphasise her difficulties in the assessment.

I filled the form in. Then I had to go for a medical, another atos assessment. So I didn't wash my hair for a week, I went in the clothes that I do my gardening in, I took somebody with me and I hired a wheelchair from the red cross, so I got her to push me in the wheelchair. So we went in and this was a completely different thing, whether the wheelchair did it, I don't know. The lady took a chair from behind her desk and placed it there, and said right can you tell me, and I said I applied once, so I told her the story and she was horrified, she said I can't believe that you've been treated like that, I said 'well I've no reason to lie'. So the next thing is the, oh I've qualified.'

At last Agnes thought she would get her benefit support back. But the changing nature of benefit provision meant that she was in for another shock. Because she didn't have enough national insurance payments (because she had been retired early from work) she was now assessed under the means tested benefit rules. She submitted two years of bank statements but her savings (though now largely spent), her home and the fact that she had supported her son financially for a few months were used to rule out any support.

Nobody tells you when you start off that the actual benefit is, at the end of the day, means tested. Well where is the logic in that. You know it is a health benefit. You're either ill or you're not ill. And that process made me more ill. [It made my mental health much worse] Emotionally I was a wreck, because all these things were traumatic, they were traumatic events. ... I didn't know, you know, if my savings went, if I could pay my bills; luckily the savings lasted until I was 62 and a half and I got my old age pension [State pension].'

Agnes's story reveals the vindictive nature of the work capability assessment tests. Their aim, as Agnes states, 'is to save money and get vulnerable people off benefits'. But worse than this, the process makes vulnerable people more ill, it undermines their social rights of citizenship and puts barriers in place which undermine people's capabilities and ability to engage, even in limited ways, in the social life of the community.

4. Analysis

4.1 Goals, hopes and aims: What is it that people experiencing mental distress want to do and be?

Part of the uniqueness of the capabilities approach, arguably, is it puts life plans, aims and objectives first and foremost in any analysis of the power or failure of social systems to promote social justice (Brunner and Watson; Burchardt 2004; Sen 2001). Capabilities are seen to be those opportunities that are available to people in a given context, while functionings are the actual achievements that result as a consequence.

One of the tasks given to the group was to identify what they felt were their long and short term aspirations. However, this can be conceptually difficult in relation to mental distress for a number of reasons. Firstly, mental distress is often intertwined with people's life, in its entirety, so any step forward in terms of personal relationships, educational or employment experiences, improvements in physical health and so on, can all potentially, by consequence, improve the experience of mental health. Secondly mental distress is both enigmatic and deep-rooted. Any individual's psychological and emotional wellbeing is constantly shifting but exactly what leads to improvements and what to deterioration is not stable or predictable. Lastly, what professionals feel is beneficial and positive might not actually be what service users feel is most supportive. This sort of problem is embodied in the notion of 'recovery' (Anthony, 1993). The term is widely thought by service user movements to have some traction when it first appeared as a potential concept for driving positive change (Wallcraft 2005). However, there is a tension between conceptions of recovery developed by service user/survivor movements and clinical models utilised by mental health professionals (Secker et al, 2002). The latter tend to biomedicalise mental health, promoting simplistic ideas that distress is an easily categorised illness that can then be 'treated' through pharmaceutical and psychological intervention. Alongside this, there has been a tendency to use models of recovery which emphasise forms of individual responsibility (Harper and Speed, 2012). A recent service user led activist movement, Recovery in the Bin (Recovery in the Bin 2016), have argued that 'recovery' became colonised by various nefarious interests and reshaped to meet the aims of punitive welfare agencies.

It cannot be assumed that people with mental health problems have overcoming their diagnosis at the forefront of their minds when considering their life plans and options. For some in the group getting well, staying well and surviving was put before many other life goals and aims. As Peter described when the group were reflecting on where they would be in 5 years, he wanted to put most of focus onto staying 'well':

'The last 5 years since those three admissions (to psychiatric hospitals) I have just been trying to rebuild and give myself enough support and care from people around me from people who love me and recognise those things ...In 5 years time I hope I'm still alive, I hope have a decent standard of living, I hope I haven't had any more episodes in the next 5 years, I hope I can be involved with people whether that's a job I can cope with or just having friends and family around me, or volunteering that would be great, whatever it is, that's all I want, that would be great.'

Furthermore some in the group felt that true recovery was not possible. As Rob said, 'I don't think you can ever recover ...You might think you're getting better but then you just hit rock bottom again, out of the blue.' All told a story of how their wellbeing had continually revolved between periods where it was significantly better and other periods when their emotional state deteriorated dramatically, often with the onset of intense and frightening symptoms.

As a result of the periodic, fluctuating nature of mental wellbeing, analysing the capabilities of people with mental distress and how these have been damaged under austerity requires a nuanced analysis of the full range of dynamics helping and hindering mental wellbeing. The rest of the report focuses on the full range

of life-world factors that the group felt were important for coping and managing with mental health, and is not intended to be a crass claim that offers solutions to the current mental health crisis through a collection of neat and tidy policy recommendations. Our more tentative claim is that some policy manifestations of the austerity project are directly impacting on people's mental wellbeing but also that it is possible to identify the forms of assistance that are most useful for enhancing people's capabilities.

4.2 Austerity and mental health: Enforcing poverty, eroding possibilities for recuperation and entrenching conditionality

Unjust outcomes for people with ongoing mental health difficulties emerge from a range of structural configurations of discrimination, many of which unambiguously predate the current austerity phase of social policy. From this research, however, there was a clear indication that recent changes seem to have had a direct impact on people's capacity to manage their mental health problems, sometimes creating new sources of distress. There are three main dimensions to this. First, the rolling back of sources of assistance, including day centre provision and greater difficulty accessing other mental health services. Second, increased problems with financial and material poverty including difficulties with access to and conditions within the labour market. Last, heightened experiences of stigma as people were required to go through new hurdles to remain eligible for support.

The group described growing financial hardship under austerity, which often placed growing strains on both people's emotional state and their family life more generally. Kay described how brutal the benefit system had become in recent years and the pressure of paying the under occupancy charge:

*I went to the bank to get my money out and all I had was 8 pounds. I rang them (**the DWP**) and they told me that they had stopped payments because I owed them money from 7 years ago. It turned out that they couldn't change it for six weeks ... When I told the benefits officer that I have a disabled son and asked her how I was supposed to live for the next weeks she said "you can always go to the foodbank.". I said "pardon" ... And it was like, I am in a situation now, I've got bedroom tax bounding me, and it's mounting up. So I am going to have to apply to the water board to have any money left squashed off, at that point I owed 3000 pound to the water board and they squashed 2000 pound off, that was two years ago. I applied to the gas board for EON to squash anything off that bill. I applied for a bus pass ... So I've had to go through all this rigmarole to get things wiped off to keep my home. They (**the DWP**) sent me letter saying I owed them £105 for bedroom tax and they're going to take me to court ... How does it feel when you write a letter saying you're going to take my home away for £105? How many people have lost their homes through the bedroom tax? Do they realise how vulnerable people are?'*

As well as increased material disadvantage being imposed through benefit cuts and new charges, Sophie here describes the pressures emanating from her husband's precarious employment situation on a zero-hours contract.

The only work my husband has now is ... agency work. You can't live on agency work, you can't live on zero hours, you've got to know what you've got coming in. You've got to know that you can pay your mortgage, you're main debt, you're main priorities ... One day my husband was out shopping with me and he got a phone call saying "can he come in at three?" "No, I can't I am out in town, I'll be in tomorrow", he said. They replied "I can't tell you that you can work tomorrow, you'll have to wait for a phone call." So I went through all that with him where he was getting up at 4 in the morning to see if he was going to be in at 6. So up at 4, no phone call at six, go back to bed to see if get your afternoon shift. "No, you may as well stay up now." So you're watching that man, my husband, walking round from room to room, checking his phone, not going outside the door to see if the afternoon call comes to see if he has the afternoon shift. That call doesn't come. You're not allowed to phone them by the way, they won't tell you if you're in the next day, you've got to wait for the call. Then he waits to see if he gets the night shift. He's been up since 4 in the morning. And then he's on his knees, there is no work that day, he'll get up tomorrow and he'll do the same thing all over again. In the end he had to stop. As I say these zero hour contracts are no good ...'

Others in the group also thought that austerity had brought increased deprivation to their wider community. A number of the respondents were from one particular part of Liverpool, Speke, known to be economically and socially disadvantaged. In the years leading up to the financial crash the city council undertook some building projects in the area including a new school, with sports facilities and a football field. Work had ceased on these projects and the group argued this reinforced the socially deprived status of the community:

Rob: *'We've got full sized pitches in Speke, we used to have a park, then they put up a shopping centre and built football pitches but it is all sealed off, you can't use it.'*

Sophie: *'I would like to know how many people live in Speke and we haven't even got a bank, we haven't had a bank for years ... Our Doctor's surgery is a portacabin, we got told 6 years ago that we're getting a surgery built, but it's still a portacabin.'*

Jacky argued that, due to its low socio-economic position, the whole community had long term problems with mental distress:

'I think ... so many people are finding it difficult, it's touching everybody in one way or another, breakdowns, my mother had three nervous breakdowns when I was a child and the doctor used to have the prescription pad written out when she walked through the door ... You know in Speke alone ... I would say at least 70% of people are on some sort of antidepressant.'

The group argued that austerity had impacted on them and many people they know as a result of the downward pressure it had placed on material living standards. Other factors cited was the movement to Universal Credit, the introduction of new charges for community services and the difficulty in finding work. Yet, improving their personal economic situation was not always recognised as that significant in terms of improving their capabilities. For instance, many emphasised the fact that their health and family life was more significant than increasing wealth, although when bills could not be paid or homes came under threat then the impact on levels of distress was severe:

Emma: *'You need enough to live on and pay the bills.'*

Rob: *'My independence, and to be where I want to be, which isn't here. It involves getting my health back to normal, I suppose my health is most important, but also I would like to be working ... you can have money and not be happy, and that's been myself most of my life, I always said I have money and I am still not happy.'*

Sophie: *'My priorities are my health and the health of my family. Without your health, I don't think you have anything, no matter how much money you have in the bank. As long as we can get by, as long as we can pay the mortgage, keeping a roof over our heads, pay the bills, food, anything else is a luxury really, it's just about getting by and staying well.'*

This was further reflected in the fact that those who wanted to work wanted to do so because of the social status and personal gratification of work, rather than monetary gain. Three of the respondents revealed that work related stresses had featured prominently in the onset of initial mental health crises but a number in the group still felt that their ultimate goal was to re-enter the paid labour market.

Ian: *'I would love to work myself, I love being round people me, I love people, but I just find would someone take me on having been out of work for so long. I worked loads when I was younger. I would love to work again.'*

Two in the group also described instances of rejection from potential job posts after admitting they suffered with mental health problems, Rob's example was very recent:

'I went for a job interview last week for a company, ... as soon as I mentioned that I have mental health problems and I suffer from Asperger's syndrome they literally switched off and didn't want to know. And that really upset me, and I walked out of the interview and I knew I hadn't got the job. As soon as I mentioned that [my mental health situation] they were just like they didn't want to know ... This raises the question of whether you do risk it in job interviews. The problem I find now is that I have been away from work for a year and half and they ask question 'why did you leave your employer?' What do I say now?'

Since the financial crash the group exposed instances where personal finances had deteriorated and some indicated that finding work had become more challenging. However, the group were probably more concerned about the dwindling mental health services available to them. This seems to fit with some of the claims made within the capabilities approach, that it is not only an individual's personal finances and wealth that are important. Analysis should be widened to include what a society provides in terms of opportunities to flourish, prosper and grow. For the research group, the most talked about concern regarding the impact of austerity on their mental distress was the reduction in services intended to support people with mental health problems in the Liverpool area. People described many different forms of reductions to both whole services and to certain cherished aspects of services.

However, the struggle to access forms of support clearly preceded the latest phase of austerity and the group frequently told stories about not being taken seriously or being unable to contact better forms of support. Here Sophie remembers her discharge from hospital following a suicide attempt, noting the total absence of support:

I've never had a social worker, I left hospital without a social worker, no after care, basically I got told 'you've got a husband, you've got 2 daughters at home, you've got somebody there for you – get on with.' As you start to improve your psychiatrist says you don't need to come here anymore. And when you do need to go back, you've got to go through the whole system again. They tell you that they don't keep records – I think that is a load of rubbish. And then also I have had my psychiatrist in the past changed for almost every appointment, I've never really got to see the same one.'

This was interlinked with the predominant medical model of delivering mental health services. Whilst those in the group were frequently denied or had to wait a great deal of time for talking therapies, the prescribing of anti-depressants and anti-psychotics was the main form of support offered:

Rob: *'When I go to the GP and ask for help they always start looking at my drugs and saying they want to change my prescriptions. I don't need drugs, I just need someone to talk to ... Do you know the side effects? Loss of sex drive, weight gain.'*

Some had been unable to access forms of talking therapy or when they had, the periods of engagement had been so short they were not deemed to be useful:

Emma: *'Things that could be provided, it's all this supposed improved this LAPT [NHS Programme Improved Access to Psychological Therapies] thing bollocks ... I've not seen this on the ground at all, this improved access to psychotherapy? My partner has still been waiting 18 months, that's not happening for him. Maybe counselling through the doctor or whatever but even that's not enough.'*

Agnes had also been attending, at the time of the meetings, a group therapy session which attempted to deliver mental health support through lectures:

'There's like 25 of us in a hall, two women who couldn't organise a piss up in a brewery, they've got a computer going onto the big screen and they're just reading it out. It takes them ten minutes to set the computer up. We don't get a cup of tea, the place is really really hot and we're all falling asleep. One man in the first session said 'this is no good to me, aren't we allowed to talk about our feelings, and how we're feeling, have we just got to sit here and listen to you.' And at the end of the session they gave us a 69 page booklet to read.'

Here we see principles of responsabilisation at work – service users effectively being told to sit through a lecture, read a booklet and resolve their own mental distress.

What concerned the group more than anything were changes to day centre support. This topic was mentioned more than anything else by the group and was identified as something of great value. Cuts to local authority budgets had resulted in day centre closures and the trimming down of the activities available.

As Peter explained, he felt that day centre provision across the city had been declining for some while:

'The support I've had in the day centres has been incredible, places where I listen and talk to other people. That's being cut, there used to be 20 odd centres in Liverpool, and now it's 2 or 3. Of those left, spaces are limited, it's going to be a short term contract for the services. The staff have had their hours cut.'

And Jacky described how the full range of services at the day centre she used had diminished:

'They were talking about funding acupuncture, massage, relaxation, colour therapy, counselling. A big pool table for the men, a little kitchen if you wanted to make a coffee, art, music, days out ... and all different things and then of course everything went. The massage went, used to love that, and the colour therapy and all that, and creative writing and all kinds of stuff. Slowly and surely things went.'

The day centre used by Jacky has now been forced to rent out half of the building to a private sector company – which raised issues of privacy and security as both employees of the tenant business and day centre users shared the same kitchen.

The struggles to access forms of support for their mental health had been taking place prior to austerity: in the UK welfare retrenchment has a longer history than that since the post-2008 financial crisis of these longer term welfare transformations the group were most concerned about changes in the intensity of community forms of support, first and foremost, and secondly in the reduction in talking therapies. In this sense austerity has been used as a mechanism to entrench further notions of individualised responsibility and medicalised modes of mental health support, limiting more community and collective forms of service.

Budgetary pressures on locally and centrally funded public services, have increasingly been coupled with a more generalised policy project which attempts to narrow who is defined as entitled to services in the first place (Roulstone 2015). A recent article in *The Independent* showed WCAs, as Agnes experienced, are costing more than they are saving (Wright 2016). The current and previous UK Government has rolled out a system of welfare based on stricter conditionality often requiring greater expenditure than the money saved, seemingly contradicting its own rhetoric of austerity as a rational economic logic concerned with bringing down the deficit as quickly as possible.

The last identifiable way in which the group felt that austerity was worsening the experiences of mental health is through rising experiences of stigma. The general politics of the day and some important social policy changes have reinforced feelings of shame associated with mental health difficulties. Increasing conditionality throughout the welfare system in tandem with a generalised political narrative which attempts to locate the underlying causes of austerity as a result of 'worklessness', 'scrounging' and 'welfare dependency' (Wiggan 2012), are promoting a perspective which suggests that people who are out of work should be held individually culpable and responsible for their own 'failure' to access employment. Crucially policy changes and political narrative are crafting pervasive anti-welfarist ideas, in turn shaping relations between actors.

Most of the participants in this study were subject to new forms of assessment and evaluation by different parts of the welfare system. Even in day centre care a new mandatory payment scheme had been established. As noted earlier, because Liverpool City Council has received massive reductions in the amount of central Government funding it has been forced to find extra savings in the social care services it offers. In trying to achieve this the Council instigated the Benefits Maximisation Team (BMT). Part of the BMT's role has been to assist people to ensure that they are claiming all the central government benefits that they are entitled to (an arguably positive development). But in addition, the BMT was assessing whether certain individuals are able to contribute payments for social care services they receive. Two people in this study were subject to assessment led by the BMT over whether they should make payments in order to access certain therapies and activities offered in day centres. These were intrusive evaluations of their spending and had required them to submit bank statements for scrutiny. Sophie stated that she stopped attending the day centre service after the introduction of charges, as she felt that other people probably needed the service more.

In this study many of the respondents made it clear they wanted to work. However, they felt unable to as employers were unable to accommodate their needs, and in some cases due to outright discrimination. This seemed to add an extra pressure to our group to make a case that they fell into the 'deserving' category. Reflecting the current dominant discourse about claimants, some in the group felt that there was a problem of 'others' dishonestly cheating the welfare system and that, as a result, the new system of conditionality may be justified; though none of them thought anyone in the group – or amongst their immediate friends and families – was anything other than 'deserving' of support. The invisible nature of mental health difficulties and other health problems was seen as socially problematic because others in their community might

not be sympathetic or accept that their entitlement to benefits and services was credible. So for instance, Jacky described how her conditions were imperceptible to others: 'You can't see them so I'd have to walk round with a placard on saying these are my illnesses'. She went on to recount how she was fearful, at times, about whether other people felt she deserved the help she received from public sources.

I mean I get in the taxi here and you get worried that your neighbours are watching you getting taxis because I get a taxi to the places, to my church café and they must think where she's going. If she's able to go out, but when you're on DLA it's for helping you get around. If you can't get around, drive and what have you, your DLA helps with taxis and can't remember anyone carrying five bags of shopping from Morrisons and not paying 2.20 for a taxi round the corner, do you know what I mean. It's that on the bus now if you haven't got a bus pass. But it's just suspicion.'

Rob also reflected similar anxieties when he stated that 'everybody judges you, why aren't you working, what's wrong with you. You don't want to go into it, you don't want to tell everyone why you're not working.'

The shame associated with having to seek support from the state was compounded in various interactions the group had with welfare professionals. When Agnes appealed the decision she received from the fitness-to-work assessment the lawyer asked a colleague at the beginning of the tribunal 'have we got another mental?' A GP laughed at Sophie when he had mistakenly thought she had spent time at Broadmoor, a renowned high security unit known for having incarcerated infamous serial murderers.

The increasing importance of evaluating assessment, constant checks on credibility and a political and media campaign which has constantly constructed people in receipt of welfare as feckless, workshy 'benefit scroungers' is, at heart, why our respondents constantly felt the need to justify their own entitlement to services (Jenson and Tyler 2016). While some, especially those with a clearer connection to service user political movements, were able to actively resist some of the dominant binary constructions of deserving/undeserving, others were compelled to engage in accounts which was geared towards displaying their status as an ill person who warranted help and support and was excusably out-of-work. The politics of austerity is deeply insidious in promoting certain social stereotypes and caricatures of welfare users, which in turn frame interactions with others in their community. People with mental health problems, as we will go on to see, are faced with a difficult conundrum: that welfare and mental health services, which are often a source of deteriorating mental health for people, are also often one of the few options available for those seeking support. So whilst they are profoundly critical of much of the assistance that they have received they also often argue for easier access and more services.

In a nutshell, the role of austerity has deepened the longer term neoliberal project which attempts to individualise and stigmatise the experience of being a welfare user. This has resulted in new forms of isolation and deepened previously existing modes of exclusion.

4.3 Improving the capabilities of people experiencing mental distress

The capabilities approach asks us to focus on the resources that are available to individuals in order to achieve their goals, aspirations and hopes. It also requires a transcendence of a conventional human rights approach which is inclined to focus only on what a state should resist from doing (Benton 2006), in other words negative freedoms, and that attention should be targeted at how societies can promote human development (Brunner and Watson 2016; Sen 2001). This section examines what the current capabilities are available to people when they are seeking to improve their lives, and what conceivable developments people felt could be useful. Four main themes emerged from the discussions around what was seen to be beneficial, including comments concerning what they found particularly useful in surviving with mental distress. These included:

- having their illness recognised by others, including friends and family but also from trained professionals;
- opportunities to engage in constructive therapeutic activities;
- active participation in social locations defined by decision making and opportunities to resist dominant understandings that welfare users are disingenuous or workshy;

- places in people's life defined by security and safety.

The first principle was that people needed to feel that they were taken seriously, that their status as mentally distressed was *recognised* both by professionals and others in their lives. For instance, Jacky felt that part of the stigma of having a mental illness was that other people did not realise you were sick. Peter explained the importance of receiving expert guidance from trained professionals:

'Acknowledgement of illness, an opportunity to talk to professionals, and for me that's my own way of looking at symptoms that I've got, fears that I've got, experiences that I've been through that play on my own mind a lot and helping me understand my own symptoms, what that means to be myself, what that means to other people, what that means to the rest of the world.'

Others linked the lack of recognition to the amount of pharmaceuticals they were taking. As noted earlier, most members of the research group complained at both the lack of support and the need to continuously skirmish with formal services, whether it be primary care or mental health services, in order to get assistance. The point being, that others recognising that they were ill and especially receiving support after having illness recognised, was important to the group. This has relevance for broader debates about the importance of recognition in understanding social justice and injustice (Garrett 2010). Recent changes have tended to promote ideas that those who are entitled to benefits are disingenuous or have become 'dependent' on welfare representing a misrecognition. Opportunities to have illness taken seriously can help people to overcome pervasive negative stereotypes but also represents entitlement to real beneficial forms of services.

Across the group there was a desire to have access to some form of talking therapy but the problems in accessing this form of support were continually discussed. Talking therapies were most valued when it was with a trained professional, they were longer lasting and they represented serious engagement with a therapist exploring the complex and lifelong biographies which underpinned mental distress.

On the whole the mental health system was not talked about positively although on many occasions people thought that it could help if it was designed differently. The system failed to provide any longer term service outside of a crisis or sectioning situation and this seemed to be its primary weakness. A number in the group described frustration at not being able to have regular contact with a psychiatrist. Others described the unhelpful support from community psychiatric nurses and especially not having sufficient time to talk through problems and symptoms. Emma summed up the importance of both internal and external acceptance and recognition of mental distress:

'Actually accepting that you need help is the biggest step because for years I blagged it, I'm fine, I'm fine, the more you do that the more you spectacularly crack at the end. But obviously you can't then get anywhere without access to services, day centres, day hospitals are brilliant. The biggy is talking to somebody who's got empathy, somebody who understands. Whether that be a fellow service user or a professional. Psychotherapy certainly helped me but you wait forever to get it.'

Secondly, the participants valued tangible opportunities in their lives to engage in various forms social, cultural, spiritual and physical activity. Sometimes these were therapeutic activities participated in through their engagement with mental health services and in other instances they were hobbies and interests engaged with in the course of their everyday lives. Two of the male respondents regularly played football in a programme specially set up for people with ongoing mental health problems. Many had engaged in arts and crafts through day centres and other support groups. A number were actively engaged in churches and one was a follower of paganism. Pet ownership, keeping an allotment, reading, popping bubble wrap, cycling, gym membership, amongst a range of other hobbies and interests, were seen as beneficial to coping with mental distress.

However, one service was repeatedly noted as being especially advantageous for improving people's lives. Day centre care had the potential to be transformative for some. This did not necessarily entail a complete overcoming of mental distress altogether but rather allowed them to find a sense of normality and routine in their life. Sophie, Jacky, Peter and Ian all described the way that day centres provided people with a place to meet and somewhere to go. The value of day centre care seemed to be double fold in that on the one hand, it provided a safe, secure and stigma-free space within which to develop social relationships with

other services users and staff, but on the other, it also provided social purpose and stimulation. Peter reflected on the importance of accessing day centre care for the first time some years ago:

I had always struggled to talk about my illness and events that took place. But the service, we did bee-keeping, we did gardening, we did eco-world projects, we did interior design projects, we did DIY, and it would be with like skilled workers and there'd be a small group of people that worked with them and did these activities. And it was just a joy, a quiet joy, it was really kind of under the surface all the good it was doing and you know it was stopped me from having that cycle of admissions to hospital, it helped me to have better relationships with my family again, it gave me security, it gave me a positive outlook on life, it gave me confidence, it gave me support, and it gave me an understanding of my mental health. And one of the key workers I had while I was there, you know I learned things about bee-keeping, I learned things about the allotment, plants and flowers, and I learned things about politics. You know it was just brilliant, it was like university all over again without the pressure and all the essays to hand in, just the social side, and I'm still supported by it now.'

Opportunities for political action and reflection on the biographical and systemic nature of mental health was the third area of capabilities for coping with distress. There were four major examples of this. Firstly, the engagement with a University's Service User Involvement Team (USUC), which the majority of the research group were active in and had been the major point of contact for recruitment in this study; secondly a recent local activist campaign challenging the proposed closure of a day centre (see Moth *et al* 2015); thirdly, the setting up of a service user organisation and; lastly, one member was participating in an anti-psychiatry campaign group. These four examples, it is contended here, were cherished because they assisted people to comprehend both their current mental health situation but also develop a political consciousness around the forms of injustices they had been subject to over the lifecourse: they were social and political spaces where 'conscientisation' took place (Friere 1970). In all these forms of engagement real empowered decision making also existed, although not always easily.

The involvement with USUC allowed people to contribute to teaching, assisting with course development and design, and, most frequently, making decisions on candidate selection for social work degree. So for instance, both Agnes and Rob were in agreement in one of the research meetings that involvement with the University gave them a social purpose:

Agnes: *I think the work at Hope has helped me, because you feel that you're of use, you know you're not thrown on the scrapheap.'*

Rob: *It makes you feel like there's purpose to life, your valued by someone, same with football now, you get to know that there's people out there like you, you're not different, you're normal. Just cause you've got mental health problems doesn't mean you're any different to anyone else.'*

Similarly, Sophie noted that one of the principle positive impacts of engaging with this scheme was that it gave the 'opportunity to give something back'. This reflects the fact that the opportunities where people felt empowered and valued combated both the pervasive stereotypes that mental illness was about personal or moral failure. Emma said 'So I think campaigning can do that, or the teaching, or doing the interviews [for entry to the social work programme], it's just not feeling a useless piece of shit but unfortunately that is what mental illness does and how others treat you'.

Opportunities such as USUC, local campaigning or participation in community groups also help the respondents to develop a critical understanding of their mental health. All valued the opportunity to learn from others, both those who had experienced similar experiences and professionals, which assisted them to understand that their mental illness was the result of systemic factors with class and gender both being mentioned. As noted in earlier sections, the group, on the whole, were aware and critical about how both the welfare system and the nature of mental health support could be frightening, counterproductive and unquestionably cruel.

The last major theme to emerge from the research activities was the notion of *safety and security*. This, again, undoubtedly emerged from the fact that previous experiences in mental health services were often frightening.

Peter: *'[The day centre] was real safe place, it was fantastic. That's the security element... And with a garden as well you feel like you've got your own sanctuary and you feel active and you're doing things and you're talking about things and feel good about yourself, being physically active and talking about things and doing things with friends, making friends as well, socially, it's a real sanctuary. From the liberty aspect my mental health felt liberated, I had the support, I felt so much better about myself, I just felt safe, that gave me freedom in its self, freedom in my mind, freedom in myself with my mental health.'*

This short discussion of the key capabilities feeds into some of the wider thinking about the approach. The emphasis on individual freedom appears to be backed up by the respondents apparent desire to access different forms.

5. Conclusion

This project has employed a participative methodology to explore the social damage that austerity has meted out on people with mental distress. Transformations that have occurred in the last seven years have not only placed greater demands on people's material access to finances, but has also identifiably promoted negative constructions of people who are out-of-work due to ill mental health. A number of policy recommendations emerge from our report which will also serve as concluding remarks.

1. The group revealed that their experiences were increasingly contextualised in a political context promoting an 'anti-welfare common sense' (Jensen and Tyler 2015). This framed interactions with welfare professionals but also how they saw themselves. Resisting these dominant constructions of people who use public services as disingenuous or workshy would negate feelings of shame about 'being on the scrapheap', potentially improving people's self-worth. Transforming the dominant political narratives could create a psychological and interactional environment more conducive with improvements in mental health. This would include the removal or decreasing importance of assessments and conditionality across the welfare system, including the WCA.
2. The group developed a strong critique of current mental health services, and especially those which were more individualised and medicalised in their approach. They believed that services which were most beneficial were those which allowed active participation, constructive therapeutic opportunities, offered security and shelter and also allowed for the development of critical thinking and direct challenges to their place in the world. Support from trained professionals, however, who recognised the severity of their distress was also important to them. All this points to the importance of community mental health services, and day centre support in particular, as a critical pillar of in the long term support for mental distress.
3. Rising household and personal financial precarity since austerity was clearly emanating from a range of sources including casualised employment contracts, decreasing benefits, under investment in communities and new charges such as the bedroom tax. Securing better material security would also free people to give better attention to managing and coping with their mental distress.

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