A qualitative study of the transition from unemployment and benefits to working whilst carrying the label of depression in England

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Impact of COVID-19

COVID-19 impacted on the recruitment phase resulting in a lower-than-expected sample size. In addition, due to home-working and periodic home-schooling the completion of the thesis required a one-term extension.

1. Abstract

Introduction: Mental health problems have been the single biggest cause for disability benefit claims in the UK for a decade. Welfare reforms have been increasingly focused on supporting disabled people into employment, with questionable outcomes.

Aim: To qualitatively explore how people who have the label of depression experience the transition back to the labour market from being unemployed and receiving social security benefits.

Method: Recruitment involved non-statutory disability and claimant networks and used a convenience and snowball sampling method. Reflexive thematic analysis (Braun & Clarke, 2006) was employed to analyse semi-structured interviews.

Participants: Eight interviewed (5 males, 3 females; age range: 25–51); heterogeneous sample. All participants had worked in paid jobs (length of employment: 4–35 years) and most had had several periods of unemployment. All had experience of the new and/or old social security benefits. All had tried medication and had received at least one psychologically informed intervention.

Results: Six main themes were constructed: (1) *Communicating confusion*, (2) *Managing in hardship*, (3) *Managing mental health*, (4) *Considering the consequences of working*, (5) *Questioning volunteering*, and (6) *Facing discrimination*. Two overarching themes were developed to highlight the interconnectedness of the six main themes, namely, (1) *Interacting barriers* and (2) *Counteracting the barriers*. In total, 16 subthemes were created.

Discussion: Participants' experiences of navigating the welfare systems (i.e., benefits and health care) is considered in a comparison to a VUCA environment (i.e., volatility, uncertainty, complexity, and ambiguity). Findings are considered within the social model of disability.

Dissemination: In line with participatory and emancipatory approaches and a pragmatist philosophy, dissemination hopes to reach a wider network of disabled people's organisations to contribute to their work in addition to submitting for a peer-reviewed journal.

2. Acknowledgements

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3. Common and Frequently Used Acronyms

Common and frequently used acronyms are listed in Table 1 to aid the reader.

Table 1

Common and Frequently Used Acronyms

Acronym	Phrase or word related to abbreviation
CBT	cognitive behaviour therapy
DSM	Diagnostic and statistical manual of mental disorders
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GP	General Practitioner
HB	Housing Benefit
IAPT	Improving Access to Psychological Therapies
IB	Incapacity Benefit
ICD	International statistical classification of diseases and related health problems
IT	information technology
JSA	Jobseeker's Allowance
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
PIP	Personal Independence Payment
UC	Universal Credit
UK	United Kingdom
US	United States
WCA	Work Capability Assessment

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4. Introduction Chapter

4.1. Chapter Summary

The chapter details the legal, clinical, theoretical, and socio-political and economic frameworks relevant to depression before discussing the key aspects of the lived experience of disadvantaged groups. It concludes with an overview of relevant literature and outlines the research aims and objectives.

4.2. Legal Framework of Disability and Depression

This section provides a brief historical context and critical views of the legal framework of disability. Following this, the current definition of disability with reference to depression is outlined. The estimated prevalence of disability and depression is discussed at the end of this section.

By the 1990s, the British disability movement had gained strength and facilitated the development of anti-discrimination legislation (Clifford, 2020), namely the Disability Discrimination Act 1995 (1995). The Disability Discrimination Act 1995 was criticised for being a weaker version of the "civil rights legislation disabled people campaigned for" (Clifford, 2020, pp. 248–250). The United Nations showed their commitment to promote, protect, and ensure that all human rights are enjoyed by all persons with disabilities when the Convention on the Rights of Persons with Disabilities (2006) came into force in 2008. The United Kingdom (UK) was "pressured into ratification in 2009" (Clifford, 2020, p. 60) by disabled campaigners. To fulfil this commitment, the Equality Act 2010 (2010) replaced over a hundred pieces of legislation with the aim of protecting the rights of individuals and advancing equality of opportunity for all (Equality and Human Rights Commission, 2019), although critics argued that this was a weaker version of the Disability Discrimination Act 1995 (Clifford, 2020, p. 59). By focusing on the legal rights of those with protected

characteristics, we are compelled to direct our attention to identifying these characteristics, which, it has been argued, hides the inadequacies of society (Clifford, 2020; Finkelstein, 2007). Despite its individualistic focus, both Acts helped raise awareness of disability and the variety of forms it can take (Clifford, 2020).

The current legal definition of disability is outlined in the Equality Act 2010 (2010). This Act covers everyone in Britain who has one or more of the nine protective characteristics, including disability. It protects people from direct and indirect discrimination, harassment, and victimisation. The Act also provides guidance on "adjustments on disabled persons" (Equality Act 2010, 2010, p. 12) and reasonable adjustments according to settings, such as work, education, and transport. According to the Act, a "person (P) has a disability if (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities" (Equality Act 2010, 2010, p. 6). *Substantial* is defined as "more than minor or trivial" (Equality Act 2010, 2010, p. 159). The impairment is deemed to have a *long-term effect* if it has lasted or is likely to last "for at least 12 months" (Equality Act 2010, 2010, p. 163), which includes impairments that are "likely to recur" (Equality Act 2010, 2010, p. 163). The ultimate decision on whether a person has a disability lies with "adjudicating bodies" (Equality Act 2010, 2010, p. 166), such as courts or tribunals. Psychiatric diagnoses, such as depression, or even undiagnosed mental health conditions are classed as disabilities if they meet the above criteria. Thus, the Equality Act 2010 provides the legal framework for depression constituting a disability.

4.2.1. Prevalence of Disability in the UK

In addition to the difficulties in conceptualising the term disability, bias can also arise from subjective self-report data collection methods that make it problematic to calculate its prevalence; thus, data is best interpreted as an estimate. According to the 2011 Census (Office for National Statistics, 2013), 11.4 million (18%) of UK residents reported a

disability or a limiting long-term health problem in the United Kingdom. The figure for England alone was 9.3 million, also 18%. The 2019/20 Family Resources Survey (Department for Work and Pensions, 2021) found that 19% of working-age adults reported a disability. Amongst the surveyed working-age adults (n = 5071), mobility and mental health were the most prevalent types of impairment (around 40%).

4.2.2. Prevalence of Common Mental Health Disorders in England

Since 1993, every seven years, a large representative survey assesses the nation's mental health in England. The last Adult Psychiatric Morbidity Survey in 2014 (N = 7500) was commissioned by NHS Digital and funded by the Department of Health (McManus et al., 2016). The survey was carried out by clinically–trained research interviewers and was based on the Clinical Interview Schedule (CIS-R), which identifies possible and severe levels of common mental disorders (i.e., depression and/or anxiety). Common mental disorders (CMD) were defined as difficulties that "cause marked emotional distress and interfere with daily functioning, but do not usually affect insight or cognition" (McManus et al., 2016, p. 38). Although the survey does not report on depression separately, it provides the best available evidence about its prevalence. Figures showed that one in six (17%) of adults over the age of 16 had CMD with higher rates for women compared to men (20.7% and 13.2% respectively). The longer-term trends indicated a steady increase in the prevalence of severe CMD symptoms[1] (6.9% in 1993, 7.9% in 2000, 8.5 % in 2007, and 9.3% in 2014[2]). The prevalence was higher for "Black women, adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked cigarettes" (McManus et al., 2016, p. 38). This supported the supposition that social disadvantage and poverty are "associated with higher risk of CMD" (McManus et al., 2016,

[1] The increases were driven by rises in women who reported and/or were able to report on more self-harming behaviour across age groups.
[2] For age group 16–64, as measured in each of the four surveys.

p. 38). The rate of those who accessed mental health treatment for CMD increased from one in four (in 2000 and 2007) to one in three in 2014, although this was partly due to "steep increases in reported use of psychotropic medication" (McManus et al., 2016, p. 8). Access rates were higher for those who were White British, female, or in mid-life, and lower for people in Black ethnic groups. These figures are likely to be underestimations due to the fact that they only included those living in private households and excluded vulnerable segments of the population, such as those in care homes, prisons, temporary housing, and rough sleepers.

4.3. Clinical Framework for Depression

This section outlines the historical context of the clinical framework for depression treatment and the current treatment guidelines, before giving voice to its critique.

The first accounts of using the label of depression were recorded at the end of the 19th century (Snaith, 1987). This early identification mentioned patients losing interest in their usual activities as its key feature (Snaith, 1987). Earlier versions of the *Diagnostic and Statistical Manual of Mental Disorders* (1st ed.; DSM-I; American Psychiatric Association, 1952; 2nd ed.; DSM-II; American Psychiatric Association, 1968) were influenced by psychoanalytic principles (McPherson, 2019). Since the development of the Kraepelinian approach, depression as a diagnostic label in later versions of the DSM has undergone many iterations, such as its separation from psychosis and later from bipolar presentations (Park & Kim, 2019). The National Institute for Health and Care Excellence (NICE) was established as a legal entity (i.e., as a special health authority) in 1999 with the aim of "creat[ing] consistent guidelines and end[ing] rationing of treatment by postcode across the UK" (National Institute for Health and Care Excellence, n.d., para. 1). Its first clinical guideline was published on schizophrenia in 2002 and its first depression guideline was developed by 2004 and updated by 2009 (Clarke, 2020; National Institute for Health and Care Excellence, n.d.). NICE was

re-established as a non-departmental public body in 2013 and was mandated to bring "evidence-based guidance and standards to the social care sector, as outlined in the Health and Social Care Act 2012" (National Institute for Health and Care Excellence, n.d., para. 22). The second edition of "The NICE Guideline on the treatment and management of depression in adults" is currently in operation (originally published in 2009, and updated in 2010; 2nd ed.; National Institute for Health and Care Excellence, 2010). It is based on the DSM-IV-RT (4th ed, text revised; American Psychiatric Association, 2000); however, it also provides information on its application for those who work within the *International statistical classification of diseases and related health problems* framework (10th ed.; ICD-10; World Health Organization, 2016). In the currently active guideline, depression is conceptualised as a "broad and heterogeneous diagnosis" (National Institute for Health and Care Excellence, 2010, p. 6), in which "depressed mood and/or loss of pleasure in most activities" (National Institute for Health and Care Excellence, 2010, p. 6) were the core ideas. The guideline outlines several general principles for the "care of all people with depression" (National Institute for Health and Care Excellence, 2010, p. 12). These include building "a trusting relationship;" exploring "treatment options in an atmosphere of hope and optimism;" providing "information about the nature of depression and the range of treatments available;" informing people "about self-help groups, support groups and other local and national resources;" and being "respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds" (National Institute for Health and Care Excellence, 2010, pp. 13–14). It also advocates for conducting a "comprehensive assessment" that considers symptoms, "associated functional impairment," experience of previous treatments, "quality of interpersonal relationships", and "living conditions and social isolation" (National Institute for Health and Care Excellence, 2010, pp. 13–14).

The NICE guideline for depression has been extensively criticised for several reasons. Recent draft versions of the guideline were critiqued on the grounds of methodological biases during stakeholder consultations in 2017 and 2018 in relation to the recommendations for psychodynamic psychotherapies for complex and persistent depression (McPherson et al., 2018). The authors argued that basing recommendations on short-term outcome data was reinforced by the assessment method employed to rate the quality of studies; thus, indirectly favouring short-term studies and excluding those with non-symptom-based quality of life outcomes. Concerns also included the reliance on arbitrary categorisations of depression—misaligned with United States (US) and European standards—and the overlooking of qualitative evidence and recent studies on service users' and carers' experiences. The latter point was pressed further in relation to the whole guideline for depression by McPherson & Beresford (2019) who argued that service user involvement, both via co-production and via incorporating existing research into the proposed guideline, was planned to be replaced by a "restricted" version of patient choice (McPherson & Beresford, 2019, p. 492). This would be influenced by factors such as limited options, geographical variations, and—often—the lack of assistance to help service users make informed decisions. The practice of discounting studies with long-term follow-up outcomes was—again—challenged further in 2019 by McPherson & Hengartner (2019). Moreover, McPherson (2019) illustrated the philosophical contradictions within the classification practices used by NICE in which treatment-resistant depression and chronic depression were treated as two separate types, thus resulting in too few research studies to be sufficient for analysis. The latest versions of the diagnostic manuals (5th ed.; DSM-V; American Psychiatric Association, 2013; 11th ed.; ICD-11; World Health Organization, 2019) use no subcategories for persistent depression, yet the guidelines continue to subclassify "multiple discreet forms of persistent depression" (McPherson, 2019, p. 1), which, as argued, is to the detriment of clinical utility. A group of academics, service

users, stakeholders, and clinicians addressed the Guideline Committee during the consultation period with a joint position statement requesting that their feedback be considered before the new guideline was published (Rost & McPherson, 2018). NICE agreed to produce yet another draft, currently under stakeholder consultation again.

Given these methodological concerns and the lack of comprehensive response to stakeholder feedback during the consultation period, McPherson & Sunkin (2020) examined the legal and scientific processes of accountability. The authors noted that NICE is operationally independent from government, which duly safeguards NICE from commercial lobbying, and helps to protect the National Health Service (NHS). However, in practice, this seemed to weaken its accountability towards the Department of Health and Social Care and the Secretary of State. In addition, a circular process was noted in which, if NICE was challenged via court proceedings, the court may defer to the expert appointed by parliament and thus, potentially "impede [its] scientific accountability" (McPherson & Sunkin, 2020, p. 233). Furthermore, both the peer-review process and its stakeholder consultations were appraised to be less vigorous than traditional scientific publishing—though they noted a positive shift in improving stakeholder consultation (McPherson & Sunkin, 2020).

In the UK, state support, whether financial in the form of benefits or mental health treatment, is contingent on a diagnosis or the detection of a diagnosable condition, which—by and large—determines the treatment pathway. The positions taken by NICE impact on the construct of depression, its definition, treatment options, management, and—more widely—influence the welfare system and the ways in which claimants are supported back to work, which is discussed further in Section 4.5. Building on information provided in this section, models applicable to depression are outlined next.

4.4. Theoretical Frameworks of Mental Distress

This section consists of two parts. The first part discusses different models applied to mental distress providing a short historical overview. The second section highlights the social model of disability and its application to mental distress, which provides a theoretical foundation for this research.

4.4.1. Overview of Models Applied to Mental Distress

In this section, I attempt to bring together different models that address mental ill-health or psychological phenomena. The first systematic observation-based attempt to describe, group, and explain the origins and outcomes of mental illnesses was developed by Kraepelin in 1883 (as cited in Hoff, 2015), though attempts at psychiatric classification reach back to 2600 BC (Mack, 1994, as cited in McPherson, 2019). Kraepelin's work via "Neo-Kraepelinianism" (Hoff, 2015, p. 38) had influence on both classification systems and their iterations (3rd ed.; DSM-III; American Psychiatric Association, 1980; Hoff, 2015; McPherson, 2019; 10th ed.; ICD-10; World Health Organization, 2016). Coupled with the wide-spread use of somatic therapies (e.g., electroconvulsive therapy and lobotomy) and the psychopharmacological revolution of the 1950s, they cemented the *biomedical* approach in the field of mental diseases (Deacon, 2013). The biomedical model assumes that mental disorders—psychological and/or behavioural deviances from the norm—have an organic or physical cause, such as "biochemical or neurophysiological" (Deacon, 2013, p. 848). Simply put, "mental disorders are brain diseases" (Deacon, 2013, p. 847). Depression, viewed as a brain disease, is explained by different hypotheses. These include: (1) the imbalance of neurotransmitters (e.g., Amine hypothesis describing low levels of serotonin and noradrenaline); (2) genetic predisposition (e.g., endogenous depression in the ICD-10); (3) changes in brain structure (e.g., neurotransmitter path damage post-stroke); or (4) function (e.g., neuroendocrine factors, such as stress raising cortisol levels; Deacon, 2013; McLeod,

2018). Despite decades of research, there is no credible evidence of a "reliable biomarker" (Deacon, 2013, p. 847) or a biological cause, only correlation. Moreover, in spite of best efforts to reduce stigma by educating the public about the biology-based nature of mental diseases, it has not been successful (Deacon, 2013; Read & Harper, 2020). The biomedical model does not make a distinction between mental diseases and physical diseases and supports a biological treatment (Deacon, 2013). This model is also called the "disease model" (Kiesler, 1999, p. xiv) that is part of the wider medical model, which favours biological theories and treatments over psychosocial approaches (Deacon, 2013; Engel, 1977). Disabled people described the medical model as follows:

> The 'medical model' sees the disabled person as the problem. We are to be adapted to fit into the world as it is. … The power to change us seems to lie within the medical and associated professions, with their talk of cures, normalisation and science. Often our lives are handed over to them. Other people's assessments of us, usually non-disabled professionals, are used to determine where we go to school, what support we get and what type of education; where we live; whether or not we can work and what type of work we can do and indeed whether or not we are born at all, or are even allowed to procreate. Similar control is exercised over us by the design of the built environment presenting us with many barriers, thereby making it difficult or impossible for our needs to be met and curtailing our life chances. (UK Disability History Month, n.d.-a, para. 3)

The conflict between biological psychiatrists, Freudian psychiatrists, and drivers of the anti-psychiatry movement coupled with slow and questionable advances in the development of remedies reduced psychiatry's credibility as a medical profession (Deacon, 2013). Consequently, the DSM-III (American Psychiatric Association, 1980), published in 1980, shifted from a psychoanalytic approach to the biomedical model (McPherson, 2019). This was followed by a targeted campaign launched by the American Psychiatric Association hoping to re-establish the faith in psychiatry as a valid, evidence-based scientific profession (Deacon, 2013). Nevertheless, critiques of the biomedical model continued to challenge its

basic assumptions and offered alternative approaches. One of these alternatives was the *biopsychosocial* model of illness proposed by Engel in the 1970s (1977). Engel, arguing that the medical model is a reductive natural science, placed an emphasis on considering the psychosocial environments of his patients (Deacon, 2013) and the "individual experience and expression of […] illnesses" (Engel, 1977, p. 132)—though he maintained the view that mental illness was a disease with biological causes (Hogan, 2019). The biopsychosocial model was embraced by the World Health Organisation (WHO) in the 1980s (Hogan, 2019). In the UK, national clinical guidelines that are systematically developed to support the decision making of clinicians and patients have also been influenced by the biopsychosocial model of illness—for example, by considering the "experience of depression" (National Institute for Health and Care Excellence, 2010, p. 72).

Other critiques of the disease model advocated for a different approach—namely, that some fields, such as mental health and disability, should be removed from the medical model (Hogan, 2019). Proponents of this exclusionist strand of the medical model, such as Szasz (1956), believed that medical interventions for certain fields are "stigmatizing and oppressive" (Hogan, 2019, p. E16).

This idea was further developed by clinical psychologists Wolfensberger and Albee who called for a reform of "social institutions to be more supportive of individual differences" (Hogan, 2019, p. E17)—though their efforts were largely ignored by their colleagues.

The Emotions aRe Not Illnesses (ERNI) movement is an example of service users and professionals in the mental health field joining forces in an attempt to de-medicalise distress and emotions (ernimovement, 2021). Embraced by the Mad in the UK community (part of Mad in America Foundation), ERNI "is based on the idea that distress does not equate to disease, dysfunction, dysregulation, or chemical imbalance" (ernimovement, 2021, para. 1). Professionals and mental health service users/survivors who call for a paradigm shift away

from the disease model developed an alternative—in line with the ERNI movement—called the Power Threat Meaning Framework (PTMF; Harper & Cromby, 2020; Johnstone et al., 2018). This new framework was endorsed by the British Psychological Society (Harper & Cromby, 2020). Although the model continues to develop, the fundamental premise is based on the idea that, instead of asking "What's wrong with you?," we need to ask "What's happened to you?" (Harper & Cromby, 2020, p. 1). By inviting people to examine the ways in which power has operated—and continues to operate—in their lives[3], the threats they have encountered and the meaning they have made of it all; they are helped to see beyond the disease model, to which many in the West have become socialised (Engel, 1977; Harper & Cromby, 2020). Critiques suggested that the framework does not offer enough for a paradigm shift as it still closely maps with diagnostic categories (Salkovskis & Sutcliffe, 2018). I would argue, that given that one of its central features is meaning making, it continues to stay close to the philosophical roots of cognitive behaviour therapy (CBT)— namely, Stoicism.[4] This said, I believe it offers a framework for those who work within the biopsychosocial model and want to do more than "pay a lip service" (Deacon, 2013, p. 848) to the psychological and social components.

In part, the development of the PTMF is underpinned by concepts of trauma as a primary driver of mental distress. The trauma-related research in the field of war veterans intensified after the Vietnam War (C. Wilson et al., 2013). Simultaneously, trauma-informed approaches developed in other areas influenced by survivors of interpersonal trauma and domestic violence (C. Wilson et al., 2013). A seminal study of adverse childhood experiences (Felitti et al., 1998) helped to extend the trauma-informed approaches to wider mental health communities (Fenney, 2019). Over the decades, trauma-informed care developed and is now

[3] Power: "coercive; legal; economic and material; biological/embodied; interpersonal; and ideological" (Read & Harper, 2020, p. 3)

[4] "idea that 'men's suffering comes not from events, but from their opinion about events', as Epictetus put it" (Evans, 2012a, as cited in Evans, 2018, p. 32)

incorporated into some parts of the NHS (Fenney, 2019). It advocates for a "cultural shift" (Fenney, 2019, para. 7) by taking into account traumatic experiences of service users and working from a strengths-based approach (C. Wilson et al., 2013). Although it does not fundamentally challenge the individual-focused models, it trains professionals to pay more attention to the psychological and social elements of care along with systemic issues (C. Wilson et al., 2013). In contrast, the social security system has been described as trauma-blind (Scullion & Curchin, 2021). The social model of disability and its application to mental distress are discussed next.

4.4.2. The Social Model of Disability

In the UK, the challenge to the dominant medical model came from activists of the disability rights movement from around the 1970s. People under the Union of the Physically Impaired Against Segregation (UPIAS) theorised that "disability was caused by the way society was organised" (Hunt, 2019, pp. 219–220). In their view, impairment "was a personal attribute whilst disability was imposed by society" (Hunt, 2019, p. 125). Thus, they favoured the terms "disabled people" and "people with impairments" instead of "people with disabilities" (Hunt, 2019, p. 125). This idea was later termed the social interpretation, or social definition, of disability (Hunt, 2019). Building on this, Mike Oliver, a British sociologist and disability rights activist, introduced the social model of disability to professionals (Oliver, 2013). He argued that this model offers a radically different alternative to individual models of disability (e.g., the medical model; Clifford, 2020). It does so, by challenging the fundamental flaw of the individualistic perspective, which underpins neoliberalism and capitalism (Clifford, 2020; see Section 4.5.1.). The social model of disability is a pan-impairment model that encompasses not only physical impairments but mobility and sensory impairments, neurodiversity, learning difficulties and disability, mental distress, and mental health conditions (UK Disability History Month, n.d.-a).

The social model of disability was extensively criticised for two main reasons: underplaying the role of impairments, and treating disabled people as a homogenous group (Oliver, 2013). However, even critiques agreed that it facilitated far-reaching changes in public policy and disability politics, increasing access to transportation, education and housing, and improving "disabled people's own understandings of their positions in society" (Beresford et al., 2010, para. 5).

The social model of disability also offered an additional alternative to the medical model for those with mental distress. In this, disability includes "mental distress," which often exists as a "hidden impairment" (UK Disability History Month, n.d.-a, para. 2). However, a user-controlled national study (Beresford et al., 2010) found that there was controversy amongst mental health service user/survivors about the relevance of the social model of disability, some contesting the idea of *impairment*. Nevertheless, the study showed that there was agreement about the harmful manifestations of the medical model. The authors also called for further exploration of conceptual frameworks (e.g., social model of madness and distress) that could bridge the gap between different groups of service users.

In reaction to the social model of disability, which was beset by constant attacks from both non-disabled and disabled groups, a "contemporary biopsychosocial model" (Waddell & Aylward, 2010, p. 23) of disability was developed to provide a theoretical basis for welfare reforms (Clifford, 2020). The Waddell-Aylward biopsychosocial model of disability "combines and balances the medical and social models, and introduces the personal/psychological dimension" (Waddell & Aylward, 2010, p. 24). It was also positioned as a continuation of the original biopsychosocial model of illness by Engel (Engel, 1977; Waddell & Aylward, 2010). It was introduced to be applicable to common health problems, such as common mental health problems, and featured a strong focus on vocational rehabilitation (Waddell & Aylward, 2010). This said, the Waddell-Aylward model has been

criticised for lacking scientific credibility (Shakespeare et al., 2017). Crucially, despite the intended balance, it overemphasised the "individual and psychological factors" (Shakespeare et al., 2017, p. 34) to the detriment of biological and social factors. Consequently, as it has continued to be widely influential in the field of social policy, the model exacerbated the oppression against disabled people (Clifford, 2020; Shakespeare et al., 2017). In response to this, another disabled people's organisation—namely, Disabled People Against Cuts (DPAC)—offered a "reinvigorated" (Clifford, 2020, p. 279) version of the social model of disability. They suggested that it is used as an emancipatory tool to tackle austerity and welfare reforms—in line with its original aim—rather than as an all-encompassing theory of disability (Clifford, 2020; Oliver, 2013). Furthermore, they emphasised the focus on the social approach, in contrast to other individual-centred models, and hoped to further develop the idea of the social model of impairment, which was originally proposed by Oliver to complement the social model of disability (Clifford, 2020). In the social model of impairment, impairment is conceptualised as a material deficit that is not necessarily linked to physical or mental deficit. Clifford explained the concept of material deficit as one that "could be experienced as pain or distress but equally as lack of income or autonomy resulting from discrimination against people with mental or physical differences" (Clifford, 2020, p. 284). Thus, the combination of the social model of disability, a tool to challenge oppression in unity, and the social model of impairment could offer practical tools and an approach for those who experience oppression and disabling barriers, including those with mental distress.

In the next section, I will expand on the socio-political context in which current mental health related policies are formed.

4.5. Socio-Political and Economic Frameworks of Mental Ill-Health

The first part of this section details the wider socio-political background of the UK before discussing the context in which the welfare provision was developed. This section then expands on the challenges arising from inequalities.

4.5.1. Wellbeing in Welfare, Work, and Workfare

The context in which welfare support continued to evolve was influenced by varying forms of capitalism, socialism, liberalism, democracy, ideas of Social Darwinism, and the medical model of disease (see Section 4.4.; Clifford, 2020; Webb, 2014). These are discussed next.

Britain started to gradually move away from an absolute monarchy towards democracy around the 11th century. Parliament gained supremacy over the monarchy in the 17th century and "laid the foundations for the democratic representation" (Bill, 2022d, p. 21) in the 19th century. Democracy continues to evolve, and its application brings many challenges (Bill, 2022d). For instance, the UK system of democracy requires the participation of citizens in politics, at least to the extent that they vote at elections. However, the participate rate has shown a decline over the last century. Similarly, party membership, which is needed to disseminate information about party policies for example, has shrunk over the decades, and has given way to undue influencing through the funding of political parties. Participation is linked to the assumption that voters and politicians possess sufficient knowledge about the issues they vote on; another factor that determines the efficacy of democracy. Knowledge, however, can be contaminated by misinformation and disinformation from both within and outside the parties or country. In the modern form of democracy, the media is used as a central apparatus of democratic politics. Post-elections, the power returns to those elected, leaving little scope for the voters to influence the government. In the UK, only one part of the Parliament is democratically elected (i.e., the Commons, and not the Lords or the Queen;

Bill, 2022d, p. 21). Whilst democratic thinkers agree that ‘freedom from’ a tyrannical regime is paramount, there are opposing views regarding the ways in which people are enabled or not to achieve the best version of themselves (i.e., the question of ‘freedom to’; Bill, 2022d, p. 24). On the one hand, some argue that if citizens are “prevented by their circumstances—birth, education, poverty—from having the chance to realise their potential as human beings” (Bill, 2022d, p. 24), they are not truly free. On the other hand, if people are given assistance, it could reduce the incentive to improve, which could be damaging to the economy, and—at worst—would make way to a different kind of “servitude” (Bill, 2022d, p. 24). A related and much-debated principle of democracy is equality. Similarly to the idea of freedom, ‘equality of opportunity’ and ‘equality of outcome’ are topics of ongoing debate (Bill, 2022d). Advocates of the latter generally promote progressive taxation, wealth redistribution, and welfare provisions, whilst critiques warn that such interventions would pose the risk of removing the incentive of hard work.

The ideology of liberalism took hold between the mid-17th and mid-19th century in Great Britain (Bill, 2022a). Liberalism supports individual liberty (such as equality before the law; freedom of assembly, thought, and expression; right to buy and sell) as long as it does not impose on the freedom of others. Similarly to democracy, representation is also a core idea in liberalism. Furthermore, liberalism advocates for toleration; thus, attempting to separate government from religious debates. Classical liberalism, which was developed by different philosophers in the 17th and 18th centuries, was embraced by the Liberal Party in the 19th century promoting the idea of “independent, rational and self-governing citizens as the basic unit of society” (Bill, 2022a, p. 95). Classical liberalism opposes the absolute power of any monarchy; thus, it favours a minimal government. Social Darwinism, a popular concept at the time, centred around the idea of the “survival of the fittest” (Spencer, 1864, as cited in Webb, 2014, pp. 33–34) based on which Spencer argued that welfare support would wrongly shelter

the poor and that misery was a useful consequence of "misconduct" (Bill, 2022a, p. 96) Whilst liberalism is primarily a political concept, capitalism, on the other hand, is foremost a collection of economic principles; though, they evolved hand in hand in the UK and are intertwined. Classical liberalism embraced "laissez-fair economics" (Bill, 2022a, p. 97), in which one has the freedom to buy, sell, own property, and to take profit resulting from successful economic activities. It, however, stood in opposition to inherited financial advantages, such as those linked to aristocratic privileges. This form of laissez-fair capitalism fostered the idea of a self-regulating market alongside minimal state regulations or trade protection; hence, supporting a market free of political restrictions. By the end of the 19th century, some liberal thinkers noted that this form of a capitalist society created a "complex and repressive" (Bill, 2022a, p. 98) system that significantly restricted the chances of those living in poverty. This gave way to 'new liberalism' in the 20th century that seeks to provide more protection to citizens than classical liberalism prescribed. This opened the road for a welfare state and a mixed economy (Bill, 2022a, p. 97).

Similarly to new liberalism, socialism took issue with the exploitative application of capitalism (Bill, 2022b). Socialism developed as an anti-capitalist position. As capitalism was embodied by the Conservative Party in the early 20th century, the Labour Party took the place of the opposition once the popularity of the Liberal Party faded. Advancing a socialist approach, the post-war Labour government—with the consent of the Conservative opposition—championed the development of a welfare state, nationalisation of some of the major utilities, and a managed economy. However, global economic challenges and those experienced by the UK from the 1960s onwards gave rise to a reinvigorated form of classical liberalism delivered by the Conservative Party following the elections in 1979 (Bill, 2022b). This period later became known as Thatcherism and was also dubbed as neo-liberalism, featuring the promotion of a free-enterprise economy (aka. enterprise capitalism; neo-liberals

are also called economic liberals; Hickson & Williams, 2022, p. 76). The notion of a self-regulating market was embraced again. To achieve a "dynamic economy" (Bill, 2022b, p. 109), there was a shift from nationalisation to the privatisation of state-controlled industries, from supporting to weakening trade unions hoping to benefit from the budding globalisation. The welfare state was reduced in order to promote the "self-reliance" of citizens (Bill, 2022b, p. 110). Consequently, it accepted functional inequality (believed to create an incentive needed to escape poverty), letting go of the 'one nation' idea that promotes liberal inclusivity and reducing the division between the rich and the poor (i.e., the "two nations in Britain"; Bill, 2022b, p. 109).

When the Labour Party regained power in 1997, it had already made a full circle from socialism (in 1979) to diluted forms of socialism and continued to advance many ideas started during Thatcherism (Bill, 2022b). The New Labour approach included further reductions of the power of the trade unions; the promotion of tax cuts and low inflation; the prioritisation of growth, productivity, and a competitive market economy, this time, with the additional challenges of globalisation (Bill, 2022b). During this period, a social democratic approach prevailed with a Keynesian economic strategy of injecting fiscal (state) stimulus into the market. Supporters suggest that this period aimed to "follow a Scandinavian social democrat model" (Hickson & Williams, 2022, p. 75). Although it did not endorse Thatcher's denial of a society, it emphasised people's responsibilities in return for their rights (Bill, 2022b). That said, the motion to help the "less well-off majority" (Bill, 2022b, p. 120) had an influence on subsequent Conservative-led governments. Since 2010, the Conservative-led governments (including during the coalition period) continued on a broadly similar road to their predecessors, which they badged as "Liberal Conservatism" (Foster & Daddow, 2022, p. 44).

In general, the forms of capitalism and economic policies are influenced by government priorities and strategies (e.g., the neo-Keynesian phase of 1945-79, from the Thatcher

government to New Labour, aimed to keep unemployment low and control inflation; Bill, 2022c). The new objective of the recent Conservative governments was to reduce the deficit of public finances, which they prioritised over economic growth (Bill, 2022b). National and global circumstances have also impacted on the types of liberalism, capitalism, and socialism governments favoured. These included—amongst many others—the faltering of the British economy in the 1960s; the oil crisis and high inflation in the 1970s; the global recession of the 1970s and 1980s; wars including the Cold War, the Falkland Islands, Afghanistan, and Iraq; the break-up of the British Empire; globalisation of markets and technological extension; and the challenges of global warming (Bill, 2022c; Foster & Daddow, 2022; Hickson & Williams, 2022). Three major events impacted on the recent Conservative-led governments, namely, (1) the banking crisis in 2007-9 and the following recession, also known as the Global Financial Crisis (GFC); (2) Brexit and the uncertainties around it; and (3) the Covid-19 pandemic (Hickson & Williams, 2022). The ways in which governments responded to the national and international challenges of their times was also influenced by the tools that were available to them and the level of intervention they approved of. For example, the "manipulation of the interest rate" (Grant, 2022a, p. 664) worked during the 1990s and 2000s until the GFC. However, following the banking crisis, the novel method of quantitative easing[5] (i.e., injecting money into the economy) was chosen to deal with the crisis accompanied by austerity measures to reduce public spending (Grant, 2022a). In terms of governments favouring or opposing interventionist approaches, the level of intervention also changed over time. For instance, the corporatist phase[6], in which unions, business leaders, and the governments worked in tandem, gave way to more interventionist policies first under Conservative and then Labour governments in the 1960s and 1970s (Hickson &

[5] Quantitative easing means "printing electronic money and using it to buy up assets such as gilt-edged stock (government bonds that pay an interest rate) and corporate bonds" (Grant, 2022a, p. 670).
[6] "Corporatism, in one sense, was a means of bridging the gap between a capitalist economy and the socialist notions of planning and democratic consultation" (Grant, 2022b, p. 283)

Williams, 2022). Following this, in the era of economic liberalism (Thatcherism), a move towards a free-market form of capitalism meant less state intervention using principals proposed by political economists Hayek and Friedman (Hickson & Williams, 2022). New Labour embraced a mixed strategy following some economic liberal policies with a number of interventions, such as the introduction of the minimum wage and a higher degree of interventions following the GFC (Foster & Daddow, 2022). Although, in general, the Conservative approach promotes a less interventionist government, to address the implications of the COVID-19 pandemic, breaking with their traditions, a "highly interventionist emergency budget" was put in motion in 2020 (Hickson & Williams, 2022, p. 79), which was a step towards the direction of "One Nation Conservativism" (Bill, 2022b, p. 130).

Before moving onto a more detailed discussion of the development of welfare provisions in the UK, general definitions of capitalism, socialism, liberalism, and neo-liberalism are noted here. This is with the caution that these concepts continuously evolve and the degree to which each government applied these concepts in a pure manner or as a combination of several—sometimes contradictory—ideologies also fluctuated, as described in the previous section. Capitalism aims to keep markets free of regulation, emphasise growth, and to minimise the role of the state, with the later addition of globalisation (Heywood, 2002). Socialism is associated with the values of community, fraternity, social equality, and the satisfaction of basic need (Heywood, 2002). *Liberalism* advocates for individual freedom, individualism, no or minimal state interventions, equal opportunity, and equal rights[7] (Heywood, 2002). Neo-liberalism, is a highly controversial concept with no agreed definition, which reduces its power as an analytic frame (Bell & Green, 2016; Springer et al.,

[7] In this sense, liberalism promotes a "plurality of different ways of life" (Girvetz et al., n.d., para. 3) by protecting the rights of marginalised groups; though, not with equal effort.

2020). This study adopts the definition by Martinez and Garcia (2000; Parker Harris et al., 2012) who noted five principles of neoliberalism: (1) the rule of the free market; (2) reduced state involvement and funding to social services; (3) deregulation; (4) privatisation; and (5) emphasising individuals' responsibilities as citizens. This is coupled with the trend of neglecting the social and economic side of the labour market (Parker Harris et al., 2012).

From the psychological perspective, socialism assumes human nature to be inherently good and believes that it is "only the selfish competitive economic system of capitalism that distorts man's innate qualities" (Bill, 2022b, p. 116). On the other hand, conservatism, the political expression of capitalism, implies that "human nature is imperfect and corruptible" (Bill, 2022b, p. 108). It thus advocates for a strong but minimal government to provide discipline.

From the 18th century onwards, the Industrial Revolution transformed society in Britain as a new hierarchy developed based on one's ability and willingness to work (Webb, 2014). In Europe, the longest, "continuously surviving legal system" (Charlesworth, 2009, p. 1) of welfare support, the social assistance of the poor, is the one in England and Wales, which can be backdated to the Elizabethan Poor Law (1601, as cited in Charlesworth, 2009). The right to relief from poverty did not include everyone equally (Charlesworth, 2009). Unmarried women, foreigners, and unsettled paupers (i.e., the poor residing outside of their parish) were excluded, whilst the mentally ill (i.e., settled lunatics) were "legally differentiated under the law" (Charlesworth, 2009, p. 168). County Asylums were created under the old poor law (though small and few in numbers) and proliferated following the New Poor Law (1834, as cited in Bartlett, 1993) as the result of changed administration processes. The "poor law system was structured to induce the pauper to choose a life of morality and wage labour" (Bartlett, 1993, p. 22). Similarly, the idea that "work had a therapeutic value" influenced the

treatment of the pauper insane who were "to be taught a trade" in the asylum (Bartlett, 1993, p. 22).

Right from the onset of the ideological conception of a welfare state in the early 20th century, the values of *equity* and *efficiency* were present and inseparable (Klein, 1984). Simply put, early social engineers believed that healthier citizens made a more productive population (Klein, 1984). The idea that the state has an obligation to support its citizens matured in the era of the Second World War and was cemented by the Beveridge Report (Beveridge, 1942; Klein, 1984; Karen Scott & Masselot, 2018). The report suggested that such an investment would "pay for itself" (Klein, 1984, p. 85) by gradually reducing the need for the service. The modern version of the welfare state was established in Britain when many of the recommendations of the Beveridge Report were implemented by the Attlee government following the Second World War (Klein, 1984). For instance, delivering on its promise of improving the health of UK citizens and following the equity and efficiency principles, the National Health Service (NHS) was established in 1946 (Klein, 1984). The aim was to rationally deploy the knowledge of the experts through the NHS and to allocate resources according to need, thereby serving the population equally and "maximis[ing] the impact of medical science" (Klein, 1984, p. 86). In addition, it aimed to remove the "financial anxiety" (Bevan, 1946, as cited in Klein, 1984, p. 85) from health care.

Along with the changing socio-political-economic environment, the welfare state has been a constantly shifting system with ever increasing complexity due to its often-conflicting aims (Baumberg, 2014; Timmins, 2016). Since the 1970s, the welfare state has undergone significant changes leading to an increasingly punitive and more stringent system that emphasises citizens' *responsibilities* over their *rights*, coupled with a diminishing effort by the state to remove barriers (Daguerre & Etherington, 2014; Dwyer et al., 2020). These reforms had significant impact on people with mental health conditions who have been one of

the targeted groups of work-activation policies amongst others (e.g., lone parents, young people, and disabled people; Dwyer et al., 2020). In an international comparison by Geiger (2017), the UK was classed as a "compliance-based system" with "high conditionality" and "weak rehabilitation link" (Geiger, 2017, p. 115).

The current welfare system has several overlapping and interdependent parts, such as health care, education, housing, personal social services, and cash benefits (Faher, n.d.).[8] This study focuses on the health part of the welfare state along with the unemployment and in-work related benefits of the social security net. At the time of the interviews, the old legacy benefits and the new Universal Credit were both in use as social security cash benefits, which are summarised in Table 2. Regarding the terminology, 'welfare' can refer to the social security part of the welfare system, often called welfare benefits, which is the default meaning in this text. Welfare is also used to indicate the whole welfare system (the use of this meaning is indicated separately in the text). In recent years, the 'welfare state' phrase is being replaced by 'welfare system' to include the non-statutory sector (D. Green & Department for Work and Pensions, 2016).

Table 2

Overview of the Currently Available Legacy Benefits and Universal Credit

Benefit type	Key features
JSA*	Taxable benefit for those who work less than 16 hours and who can work and seek employment

[8] In 2017/18 the benefit expenditure included Armed Forces Independence Payment, Attendance Allowance, Bereavement benefits, Carer's Allowance, Christmas Bonus, Cold Weather Payments, Disability Living Allowance, Employment and Support Allowance, Financial Assistance Scheme, Incapacity Benefit, Income Support, Industrial injuries benefits, In Work Credit, Job Grant, Jobseeker's Allowance, Maternity Allowance, Over 75 TV Licences, Pension Credit, Personal Independence Payment, Return to Work Credit, Severe Disablement Allowance, State Pension, State Pension transfers, Universal Credit, and Winter Fuel Payments (Department for Work and Pensions, 2020).

Benefit type	Key features
	Two types: (1) income-based and means-tested and (2) contributory/New Style JSA (non-means-tested) Conditions and sanctions operate Included in the Benefit Cap [a]
ESA*	Support for those who have limited capacity to work due to sickness or disability Two types: (1) income-related ESA (means-tested and not taxable) and (2) contributory/ New Style ESA (non-means-tested and taxable) Eligibility is assessed by the Work Capability Assessment (questionnaire and medical assessment) Subgroups: a) Work-related activity group (mandatory work-preparational activities, such as Work Focused Interviews with Jobcentre staff) b) Support group (no mandated activities)
IS*	Support for those not on ESA, JSA or with a full-time job Can be paid on its own for those with no other income or can top up other benefits or part-time earnings
HB*	Help with housing cost for those on low income whether working or not Paid directly to landlord (mortgage support is managed separately) Included in the Benefit Cap [a]
WTC*	Means-tested salary supplement for those on low income working at least a minimum of 16 hours
CTC*	Independent of working status and means-tested Help with the cost of bringing up a child
UC	Introduced in 2013, nationally available since 2018

Benefit type	Key features
	Migration from legacy benefits is ongoing
	Means-tested benefit for people of working-age who are on a low income
	Providing a single claim; integration of in-work and out-of-work experiences (risk of losing all income if sanctioned) [b]
	Designed to dynamically follow the natural fluctuation of income [c]
	Fully digitised service resting on 'real-time' earnings information (requires IT skills) [d]
	Conditional on claimant accepting claimant commitment (contract)
	Increasing claimant 'responsibility': less frequent payments to mimic work salary; built-in 5-week delay for first payment (optional advance load is paid back over 12 months); and housing payment does not go directly to landlord [e]
	Increased conditionality and sanctions (applied to part-time workers too) [f]
	Included in the Benefit Cap [a]
	Three groups depending on health and caring responsibilities:
	a) all work-related requirements
	b) work preparation (e.g., update CV, training, and/or liaise with work coach)
	c) no work-related requirements (no work coach)
	'Limited capability for work' assessment applies for groups 'b' and 'c'
	Additional step introduced in the appeals process (mandatory reconsideration)
	Not replacing contributory ESA, contributory JSA
	Can be in addition to DLA or PIP acknowledging that having a disability will incur additional costs [g]

Note. JSA = Jobseeker's Allowance; ESA = Employment Support Allowance; IS = Income Support; HB = Housing Benefit; WTC = Working Tax Credit; CTC = Child Tax Credit; CV = Curriculum Vitae; DLA = Disability Living Allowance; PIP = Personal Independence Payment.

Descriptions are based on information presented on the Turn2us website with the marked exceptions (Turn2us, n.d.).

[*] Legacy benefit

[a] Benefit Cap defines the maximum benefit families can receive per year, which is set at the average of net earnings of a family in work (Hood & Keiller, 2016, p. 8)

[b, d, e] (Gardiner, 2019)

[c, f , g] (Timmins, 2016)

One of the most challenging aspects of any social security system is to provide support for people with wide-ranging needs including those who cannot work, those with considerable working capacity, and everyone else with their varying—and sometimes fluctuating—levels of need (Baumberg, 2014). Another puzzle for policy makers and professionals is the paradox of the improving general health of the population and the rising number of sickness benefit claims (Baumberg, 2014). Moreover, by 2010, mental health problems were "the biggest single cause for a disability benefit claim" (OECD, 2010, p. 11) in most Organisation for Economic Co-operation and Development (OECD) member countries, such as the UK. Data provided by the Health and Safety Executive (2018) found that over half of working days lost can be attributed to workplace stress, anxiety, or depression (57% in 2017/18). According to an OECD report (2009) less than half of working-age people with a disability were employed (UK rate around 45%), and this was likely to be a part-time position, to be employed with low income level, and live in or near poverty.

As the link between wellbeing and work was recognised, there was also a rising interest in measuring wellbeing (Bache & Scott, 2018). GDP growth alone was no longer considered sufficient to measure progress (Bache & Scott, 2018). The policy solutions targeting wellbeing came in several forms (Bache & Scott, 2018). These measures included (1) labour-focused strategies, such as activation, incentives, support, conditionality, and sanctions; (2) psychology-focused strategies, such as the national roll-out of short psychological and psychosocial interventions; and (3) their combination (Frayne, 2019a; Watts, 2019). The latter included, for example, employment status being instated as an outcome measure for wellbeing, placing employment advisers in mental health services (as they are in UK IAPT services for example), supporting people with severe mental illness into open competitive jobs via the Individual Placement and Support service, and encouraging workplace wellness

initiatives (Frayne, 2019a; HM Government, 2011b; Mental Health Taskforce Strategy, 2016; NHS England, 2016; NHS England et al., 2014; Watts, 2019). The first two types of strategies are discussed next.

Labour-focused strategies aimed to support disabled people into employment, initially under the New Deal programmes (Welfare Reform and Pensions Act 1999, 1999), which was rolled out nationally in 2001 (Daguerre & Etherington, 2014). Engagement in work-related activity was voluntary and there was an emphasis on removal of structural barriers (Daguerre & Etherington, 2014). Conditionality can be defined as "the principle that entitlement to benefits should be dependent on satisfying certain conditions" (Daguerre & Etherington, 2014, p. 27). Conditionality was extended to most people, including the majority of disabled people via the "Pathways to work" programme (Welfare Reform Act 2007, 2007), which included financial incentives for a return to work (Daguerre & Etherington, 2014). The subsequent "Work for your benefit" schemes (Welfare Reform Act 2009, 2009) and the workfare schemes (Employment, Skills and Enterprise Scheme Regulations, 2011 and Mandatory Work Activity 2011 Regs, 2011, as cited in Daguerre & Etherington, 2014) targeted the long-term unemployed (Daguerre & Etherington, 2014). Conditions mandated claimants' engagement in work-focused interviews and tasks agreed in the claimant commitment (i.e., contract between claimant and benefit officer; Daguerre & Etherington, 2014). Failing to meet conditions results in being sanctioned, which means the withdrawal of one's benefit for a period of time (Daguerre & Etherington, 2014). Although sanctions were introduced in 1996 with Jobseeker's Allowance (JSA), they received increasing emphasis with subsequent legislations (Daguerre & Etherington, 2014; Welfare Reform Act 2007, 2007; 2009; 2012), similarly to conditionality (Daguerre & Etherington, 2014). Sanctions are thought to "incentivise claimants to meet their responsibilities" (Daguerre & Etherington, 2014, p. 38). Eligibility assessments were also in line with work-activation initiatives and

became more stringent with each iteration (i.e., All Work Test, Personal Capability Assessment, and Work Capability Assessment; Daguerre & Etherington, 2014). In response to work-activation policies and other measures, disabled activists triggered an inquiry "into the impacts of welfare reform and austerity measures" (Clifford, 2020, p. 66) by the United Nations Disability Committee. The report concluded that "the UK government is responsible for grave and systematic violations of disabled people's rights" (Clifford, 2020, p. 266).

The central idea underpinning psychology-focused strategies arose from a conversation at a British Academy tea party (Evans, 2018). Layard, an "economist who specialises in employment economics" (Evans, 2018, p. 31), met one of the leading British practitioners of CBT, David Clark, and together they envisaged a new wing of the NHS (Evans, 2018). This instrument was hoped to bridge the gap between the recommendations of the NICE guideline for depression (and anxiety; see Section 4.3.) and its delivery and, in so doing, reduce the economic burden of depression (Evans, 2018). The first plans were presented in 2005 at 10 Downing street[9] and included doubling the NHS psychological therapy budget (i.e., from £80 to £160 million a year) to train 6000 CBT practitioners (Evans, 2018). Similarly to the original plans for the NHS, the new programme was hoped to "pay for itself" (Evans, 2018, p. 32) by reducing the economic and social implications of mental ill-health. Under the name of Improving Access to Psychological Therapies (IAPT), the service launched in 2008 (Evans, 2018). IAPT was positioned at the forefront of fighting the "epidemic of mental illness" (Evans, 2018, p. 33) through offering initially mainly CBT-based interventions predominantly for mild to moderate depression and anxiety.

Clark (2018), one of the founders of IAPT, examined the achievements of the programme in his review of the first decade of IAPT. These included, increasing access to—not only psychological therapies but—evidence-based therapies, improved outcome

[9] The address of the British Prime Minister

monitoring compared to pre-IAPT norms, transparency of data, and compliance with NICE guidance. Clark called for funding to systematically research longer-term outcomes and the expansion of the service "as it is still only meeting approximately 16% of the prevalence of depression and anxiety in the community" (Clark, 2018, p. 176). In addition to concerns regarding NICE guidelines (see Section 4.3.), critiques included its focus on symptom-based outcome measures and the consequent overlooking of wider outcome indicators, the patient experience and perspective of recovery, adherence to a positivist paradigm, and being driven by the medical model (McPherson et al., 2009; Williams, 2015).

Furthermore, within the (neo)liberal framework, the individual is at the centre of psychological and welfare interventions. Rimke and Brock (2012) termed this psychocentrism and called attention to its issues (Watts, 2019). For instance, making psychological interventions a condition of eligibility for social security and professionals being mandated to turn "deviant" (Grover & Piggott, 2010, p. 274) citizens into economically productive ones, can be harmful and unethical in many ways (Grover & Piggott, 2010). The simplistic and pervasive idea that work is good for you ignores several conundrums (Frayne, 2019a)—namely, work is reduced to the definition of economically viable activities[10] (Watts, 2019) and evidence suggesting that poor work is worse than no work (Houston & Lindsay, 2010; Watts, 2019). Moreover, studies showed that claimants were keen to return to work and felt ashamed about their situation (e.g., Beatty et al., 2010); and that the pressure to return to work, sanctions (Watts, 2019), conditionality (Mehta et al., 2021), surveillance[11] (Grover & Piggott, 2010), and financial insecurity (Wickham et al., 2020) can be detrimental to mental health.

[10] The idea that work is good for mental health in its earlier understanding in the first half of the 20th century included other activities, such as play, creativity, activism, volunteering, and activities for their own sake (Watts, 2019).

[11] In the form of work-focused interviews, job search logs, and eligibility and capability assessments

Those who look beyond the failing of the individual and/or faults of the welfare system (e.g., assuming a dependency culture) have pointed towards several other factors that might contribute to the rising exclusion of disabled people from the labour market. Baumberg (2014) theorised that multi-dimensional changes in job characteristics[12] play an important role. Similarly, Houston and Lindsay (2010) emphasised the possibility that post-industrial labour market restructuring led to the "marginalisation of certain groups"[13] (Houston & Lindsay, 2010, p. 137) with increasing barriers to employment, whilst Parker Harris et al. (2012) highlighted the detrimental impact of the unregulated markets on already disadvantaged groups. Furthermore, Grover and Piggott (2010) named the widely accepted expectation that the sick and/or disabled need to be as productive as their non-disabled peers once adjustments are in place as guided by the Equality Act 2010 (2010) and highlighted the questionable assumption that the labour market is well placed to employ those with impairments. Without detailing these theories further, they show that alternative explanations exist that challenge the dominant individualist discourse.

The welfare state was underpinned by the ideology of social liberalism that advocated for a "'positive' view of freedom" (Heywood, 2002, p. 46). In contrast to negative liberty that favours the non-interference of the state but could leave its citizens free to "starve" (Heywood, 2002, p. 46), a positive approach to liberty steps beyond protecting its citizens by helping them to "achieve self-realization" (Heywood, 2002, p. 46). Both Berlin[14] and Nozick[15] (1958, 2002; 1974, 2001, as cited in Evans, 2018) warned that governments that do not restrict themselves to the matters of enabling the "negative liberty" (Berlin, 1958, as cited

[12] For example, low job control and high physicality.
[13] Those with low skills and qualifications, and those with poor health and disability as they might not be as flexible and compete in a saturated labour market (e.g., Anyadike-Danes, 2010; A. E. Green & Shuttleworth, 2010; Houston & Lindsay, 2010).
[14] Latvian-born British social and political theorist and philosopher and the author of *Two Concepts of Liberty* (1958, as cited in Evans, 2018).
[15] Robert Nozick was an American liberal philosopher and the author of *Anarchy, State, and Utopia* (1974, as cited in Evans, 2018).

in Evans, 2018, p. 27) of its citizens (i.e., enable access to basic public services) and attempt to impose *one* conception of "the good life onto the messy diversity of human temperaments" (Nozick, 1974, as cited in Evans, 2018, p. 27), would be oppressive and illiberal and could risk repeating history (i.e., the tragedies of fascism and totalitarianism). The current integration of wellbeing into workfare and welfare facilitates a cultivation of "positive liberty" (Berlin, 2002, as cited in Evans, 2018, p. 27). This version of wellbeing is based on the inherently discriminatory Aristotelian concept of flourishing with the modification that *all* citizens should be enabled to flourish (Evans, 2018). However, the neo-Aristotelian idea of wellbeing has been criticised for perpetuating discrimination (Ahmed, 2010; Bache & Scott, 2018). Thus, the warning of Berlin and Nozick (1958, 2002; 1974, 2001, as cited in Evans, 2018) continue to be relevant today (Evans, 2018).

4.5.2. Inequalities

Income inequality is usually understood as the extent of the uneven distribution of income (Bullock, 2010). There are contradictory views regarding the methodology of its calculation, the historical and current levels of economic inequality, and the reasons behind the fluctuation (Atkinson, 2020; Brewer, 2008; Magness, 2019). Notwithstanding, it is surely safe to state that there was and is a wide gap between the wealthier and poorer segments of the population in the UK.

Another aspect of inequality described by Miller (2017) in his book, "The Alternative: Most of what you believe about poverty is wrong," highlighted the difference between the poorest and the wealthiest in terms of financial support. Miller called this the "benefit gap" (Miller, 2017, p. 33), though it is also referred to as the squeezed middle or squeezed middle class both in the US and UK (OECD, 2019; Parker, 2013). The squeezed middle can be defined as those who are "living in households below middle (median) income, but above the bottom 10%, and not heavily reliant on means-tested benefits" (Parker, 2013, p. xii), thus

being too rich for state support yet too poor to "thrive independently in important private markets" (Parker, 2013, p. xii). State support reduces, tapers off then stops as people get closer to balancing on the poverty line. In contrast, after a certain income level, higher earners can benefit from preferential treatment in the forms of, for example, private market opportunities, tax breaks, and mortgage interest deductions (Lansley, 2013; Miller, 2017). This leaves a sizeable group of the population in the middle without either of these types of assistance. Moreover, the numbers vulnerable to poverty, which is the group sitting just above the poverty line, "have risen compared to thirty years ago" (Lansley, 2013, para. 8). This group was described as "neither comfortable nor secure" (Lansley, 2013, para. 8).

Layte and Whelan (2003) emphasised that neither poverty nor the poverty line are static phenomena. Studying longitudinal data for over 80,000 individuals across 11 European countries, they found that "poverty is experienced by a far higher number of individuals when viewed longitudinally rather than cross-sectionally" (Layte & Whelan, 2003, p. 188). This would suggest that the group under the poverty line is not a stable group of people, rather there is a fluctuation around the poverty line, which is in line with Miller's (2017) findings from US census data. Further analysis highlighted that polarisation of poverty (i.e., the unequal distribution of those in poverty for 1, 2, 3, or 4 years) varied depending on the country's welfare regime (Layte & Whelan, 2003). Compared to social democratic countries, such as Denmark, the UK showed more polarisation whereby the number in longer-term poverty was far greater than the number of those experiencing poverty for a shorter period (Denmark: 30% and 36%, UK: 12% and 46% for one and four years of poverty respectively). The authors theorised that poverty can "trap" (Layte & Whelan, 2003, p. 188) more individuals and households in countries that are further from a social democratic or employment-centred regime. Moreover, contrary to the idea that state benefits provide a good life, only 2.4% of people were able to transition out of poverty due to an increase in welfare

support, which was the second lowest figure from the 11 countries examined. Most people exited poverty due to an increase of income (40%) or rise of income and social welfare combined (24%). On the other hand, the reduction of welfare support seemed to play almost as important a role in the transition into poverty as a reduction in income or the combination of the two (13%, 21%, and 16% respectively). The data in Layte and Whelan's (2003) study was taken from the 1994-1997 period when the New Deal was rolled out in the UK, at which point the authors classified the UK as a liberal regime, positioned in between residual or sub-protective and social democratic types of regimes. Since then, the significant cuts to the welfare system (Mattheys et al., 2018) would indicate that the UK might be closer to a residual welfare state (Daguerre & Etherington, 2014), so I would argue that the UK could see both a growing polarisation and increasing poverty as the result of the reduction in welfare.

The far-reaching consequences of poverty or—more widely—socioeconomic deprivation has been the subject of much research. For instance, a Lancet study of global health concluded that "lower socioeconomic status and those who live in poor or marginalised communities have a higher risk of dying from non-communicable diseases than do more advantaged groups and communities" (Di Cesare et al., 2013, p. 585). Another UK study by Lancet Public Health (Bennett et al., 2018) showed that life expectancy increased between 2001 and 2016 except for females in the two most deprived deciles since 2011, where there was a decline. However, Bennett et al. (2018) found that the life expectancy gap between the most and least deprived groups grew from 6.1 to 7.9 for females and from 9 to 9.7 for males. Policy changes in the 1970s and 1980s likely fuelled rising health inequalities in subsequent decades (Bennett et al., 2018). Furthermore, evidence suggests that the wider determinants of health continue to play a role today. For instance, a different kind of job insecurity in the form of the gig economy, stagnating and low-wage incomes for the poorest, cuts to in-work

and out-of-work benefits, the substantial reduction of local authority budgets, and unequal provision and utilisation of health care are believed to contribute to 1.5 million people reaching the level of destitution "with particularly large effects in children and people of working age in already disadvantaged groups" (Bennett et al., 2018, p. e595). Therefore, given that policy stagnation and regression feature in all three key areas—namely, (1) economic and social determinants, (2) risk behaviours and environments, and (3) health and social care—the expectation is that health inequalities will continue to worsen unless coordinated and sustained action is taken across the three areas (Bennett et al., 2018).

The next section is centred around the lived experience of poverty, unemployment, benefit claiming, and mental ill-health.

4.6. Lived Experiences of Disadvantaged Groups

This section outlines some of the key features of the lived experiences of disadvantaged groups. Following on from the previous section, shame and stigma are discussed—first, in relation to poverty, then regarding unemployment and benefit claiming. The concepts of invisible disability and intersectionality are detailed last.

In addition to the wider determinants of health, evidence shows that stigma and shame are "central features of poverty" (Sutton et al., 2014, p. 145). Many aspects of poverty that are stigmatising have been evidenced in the literature, and summarised with a thematic narrative analysis by Sutton et al. (2014). Based on Beresford's (1999, as cited in Sutton et al., 2014), Reutter et al.'s (2009), and Scheff's (2003) works, Sutton defined stigma as "an 'external' process through which the social 'contribution' or 'value' of those on low incomes is actively denigrated by the pejorative labels that are attached to specific aspects of life on a low income" (Sutton et al., 2014, p. 144). Shame was conceptualised as the "internalisation of stigmatising social labels that force an individual to view themselves" (Sutton et al., 2014, p. 145) "negatively in the eyes of the other" (Scheff, 2003, p. 254). Shame was linked to

other emotions, for example embarrassment, guilt, humiliation, and disgrace, which can fluctuate both in intensity and duration (Sutton et al., 2014). For instance, guilt might be linked to not being able to fulfil social roles, such as being the provider of the family, whilst humiliation might be experienced as the result of refusal of state support. Sutton argued that such events can have "damaging social psychological consequences" (Sutton et al., 2014, p. 148). Subcategories of stigmatised groups might be emphasised (e.g., mental health vs addiction) with the aim of "avoiding stronger forms of shame" (Sutton et al., 2014, p. 148), whilst others might withdraw from social interactions or may seek to "conceal aspects of their circumstances from others" (Sutton et al., 2014, p. 149) to manage shame. Sutton stressed that, beyond the deprivation of material living conditions, the social harm caused by poverty should be considered when developing plans to tackle poverty.

4.6.1. Stigma of Unemployment and Benefit Claimants

The public perception of unemployment and claimants of social assistance has undergone significant changes over the last few hundred years. There follows an overview of the pivotal points during that period of time.

The first legalised system that provided social assistance for the poor was established in 1601, and is now referred to as the Old Poor Law (1601, as cited in Charlesworth, 2009). Contrary to popular belief, in Charlesworth's view, the Old Poor Law was *not* a "model of exclusion, control and 'undeserving'" (Charlesworth, 2009, p. 3), rather it was a system "based upon rights" (Charlesworth, 2009, p. 3). Charlesworth emphasised that the denial of legal rights to relief and the associated notion of pathologizing and stigmatising poverty—as a problem that needed to be controlled and contained—strengthened around the time of the Poor Law Amendment Act 1834 (1834, as cited in Charlesworth, 2009) and with its subsequent amendments. By this time, even the settled poor (deserving of relief of poverty), when asking for aid, were increasingly subject to examination under the legal system (and

often found to be guilty of vagrancy and punished). "Active proofs" (Charlesworth, 2009, p. 175) were required to show they were genuinely in need and were expected to work to qualify for aid (i.e., indoor relief typically in workhouses). Refusal to work could lead to "criminal convictions of vagrancy or a prison sentence" (Charlesworth, 2009, p. 171).

The rights element of social assistance was further diluted before the creation of the modern welfare state around the mid-twentieth century, which helped to further obscure the right to relief (Charlesworth, 2009, p. 6). This said, the seminal work of Beveridge (1942) observed five collective, large-scale, and structural causes of societal challenge (National Archives, n.d.). Beveridge hypothesised that "want" is the "easiest to attack" of the "five giants" (Beveridge, 1942, p. 42). Beveridge conceptualised *want* as poverty, or the relief of, and identified structural and other causes that lead to poverty, such as "old age, illness, lack of work and lack of training" (Greener, 2021, p. 2). Beveridge considered the four other giants to be the contributing factors to *want*, which were (1) *disease*, or illness, which blocks "the path to a civilised society" (Greener, 2021, p. 9) due to inadequate health care provision; (2) *ignorance*, which stems from lack of education; (3) *squalor*, which referred to substandard living conditions, housing shortages, and inappropriate environment planning; and (4) *idleness*, which meant being temporarily unable to find work (Greener, 2021). The latter was in the context of wartime period and mass unemployment during the 1930s (Greener, 2021). To abolish poverty and achieve social security, Beveridge proposed national, comprehensive (i.e., covering all problems from pre-birth to death), universal, contributory, compulsory, and—largely—non-means tested strategies. These strategies consisted of a government policy of full employment[16], a national health service, and family allowances (BBC, n.d.; Greener, 2021). Over the next few decades, successive governments

[16] Full employment was defined as keeping unemployment rate below 8.5% (Greener, 2021)

battled with the challenges of the implementation of a modern welfare state using Beveridge's report as a starting point (Daguerre & Etherington, 2014).

By the 1970s and 1980s, the modern welfare state, its aim, feasibility, and structure became heavily criticised through a lens of individualism, a tenet of (neo)liberalism. The notions of *welfare dependency*, *workshy*, and *benefit fraud* were (re)injected into public discourses by Conservative governments in the hope that these ideas would legitimise the subsequent reduction of the social security system (Daguerre & Etherington, 2014). The "hard working majority" was positioned against the "workshy" (Daguerre & Etherington, 2014, p. 14), who needed to be "moved away from dependency and into independence" (Timmins, 1996, p. 448; Daguerre & Etherington, 2014, p. 14), a narrative that was also exploited by New Labour (Slater, 2012). Moreover, tackling welfare fraud and idleness (or worklessness) continued to be high on the agenda under the Labour governments at the end of the 1990s (Daguerre & Etherington, 2014). Idleness was no longer viewed as a structural issue but, rather, a characteristic of the individual which—under the disguise of the social model of disability and empowerment narratives—brought about an increasing scrutiny upon disadvantaged communities with regard to the labour market (e.g., disabled people and lone parents; Daguerre & Etherington, 2014). The so-called benefit dependency was further addressed by a raft of measures under the Coalition Government, not only to punish and exclude the undeserving from social security provisions but also to reduce the economically inactive group to an absolute minimum (Daguerre & Etherington, 2014). Daguerre and Etherington (2014) noted that policies since 2010 (under Conservative-led governments) reinvigorated the "moral underclass discourse which portrays poverty and unemployment as being caused by individual behaviour such as alcohol and drug addiction, chaotic lifestyles, and lack of purpose" (Daguerre & Etherington, 2014, p. 45). Moreover, they argued that a new element of stigmatisation entered the public discourse around fairness, or rather benefit

claimants enjoying an "unfair advantage" (Daguerre & Etherington, 2014, p. 50) over—and at the expense of—the taxpayer.

The Breakdown Britain report (Centre for Social Justice, 2006), 64 years after the Beveridge Report (Beveridge, 1942), also identified five "pathways to poverty" (Centre for Social Justice, 2006, p. 2). The unit of analysis, however, was no longer society but, rather the individual and the individual's immediate network, such as their family and family of origin (Daguerre & Etherington, 2014). This meant that individuals, unstable families, and intergenerational patterns were further problematised. Therefore, solutions proposed in the report "almost exclusively centred on the individual and family" (Daguerre & Etherington, 2014, p. 47). Slater's (2012) paper named the influence of the US in the creation of the paternalist 'workfare' approach effective from before 1997 to the present. For example, this discourse of familialism echoed concepts of Charles Murray who believed that a "dependency culture" is caused by "illegitimacy" (Murray, 1984, as cited in Slater, 2012, p. 956). Conservative governments strengthened the narrative of dysfunctional families with concepts such as living on benefits being considered to be a lifestyle choice, and dysfunctional families cultivating an intergenerational dependency culture, despite social scientific evidence suggesting the opposite (Slater, 2012; Turn2us, 2012).[17] Slater also drew attention to the wealth of research that suggested that punitive actions do not resolve poverty and instead have a detrimental impact on the non-working poor and further exaggerate "class, racial and gender fractures in society" (Slater, 2012, p. 960).

In Slater's view (2012), to balance the notion of individualism and familialism and to create a more "compassionate" (Slater, 2012, p. 964) image of the Conservative government, the word 'society' was reintroduced into the public discourse, albeit with a much lighter

[17] Only 0.3% of households have two generations that have never worker based on data from the Labour Force Survey (Turn2us, 2012).

meaning compared to the pre-Thatcher period. Society in its modern meaning refers to the third sector (e.g., charities) that support the welfare of others, which Cameron called "Big Society" (Cabinet Office et al., 2010, para. 45). It was suggested that strengthening philanthropy (e.g., volunteering and donations) would "fix a '*Broken Society*'" (Slater, 2012, p. 963). Interestingly, volunteering is heavily regulated for those who are receiving some form of in-work or out-of-work benefit (NCVO, 2020). For example, all volunteering or other economic activities must be declared (Department for Work and Pensions, 2019b). Moreover, volunteering as a pre-agreed reasonable action to find a job cannot replace more than 50% of the time expected to be spent on job searching (Department for Work and Pensions, 2019b; NCVO, 2020). It is also known that volunteering may be taken as an indicator for being work-ready (NCVO, 2020).

A stark example of the possible outcome of relying on philanthropy whilst reducing the welfare state is the existence of food banks, which originally appeared in 2004 "providing short-term emergency food relief" (Howarth, 2020, p. 2). However, food bank outlets proliferated during the financial crisis around 2007 and since then have become normalised—paradoxically in "one of the richest countries in the world" (Howarth, 2020, p. 1). Howarth described food banks "as new spaces of 'dependency'" (Howarth, 2020, p. 1) that stigmatise those living in food insecurity whose existence depends on it. Moreover, media portrayal of food bank users "centre on the undeserving poor" with references to migrants and "scroungers who are work-shy" (Price et al., 2020, p. 279). In addition to the stigma and shame suffered (Strong, 2021), the nutrient and energy intake of food bank users was also found to be substantially worse in comparison to the recommended guidelines, the quality of charitable food likely playing a role (Barker et al., 2016).

To understand the ways in which these discourses develop and influence public opinion, Slater (2012) drew on the theory of *agnotology* by Robert Proctor (1995) who studied the

discourse around the tobacco industry. Slater suggested that, like the *evidence* creation of the tobacco industry, policy makers engage(d) in—what Slater called—"decision-based evidence making" (Slater, 2012, p. 955), instead of evidence-based policy development. For the last few decades, governments have been increasingly utilising "independent" (Slater, 2012, p. 953) think tanks that not only find evidence for their decisions in a "*fait accompli* approach" (Slater, 2012, p. 953) but make dissemination an equal priority, thereby creating "semantic commonplaces" (Wacquant 2009a, pp. 47–48, as cited in Slater, 2012, p. 952) by the time policies are discussed in parliament. In contrast to epistemology, which examines what we know, agnotology investigates what we do *not* know (Slater, 2012). Slater's approach to ignorance also drew on the work of Gilroy's (2009, as cited in Slater, 2012) who understood ignorance as an "active construct" (Slater, 2012, p. 951), which is never neutral but contextualised by culture and politics. Slater's analysis of the current discourse around welfare, including Universal Credit, suggested that political and public attention are purposefully diverted away from several concepts. These include the structural and institutional factors of poverty, complexity of issues and their history, inequality beyond the working class and non-working poor, and alternative solutions—for example, universal basic income. Similarly, Murray (2019) identified injustice, inequality, powerlessness, power imbalance, lack of rights, meaningless jobs, job insecurity, debt, working conditions, and social isolation to be missing from the dominant narrative. Slater theorised that "manufacturing doubt" (Slater, 2012, p. 950) was part of the process of creating "institutional ignorance" (Slater, 2012, p. 950).

Through examining the stigma present in society, Baumberg et al. (2012) proposed three levels of stigma: (1) personal stigma, (2) social stigma, and (3) institutional stigma. They found that the latter two ranged from "quite common" to "widespread" (Baumberg et al., 2012, p. 3), especially since around 2008. Personal stigma refers to a "person's own feeling

that claiming benefits is shameful," social stigma to "the feeling that other people judge claiming benefits to be shameful and to confer a lower social status," and institutional stigma to "stigma that arises from the process of claiming benefits" (Baumberg et al., 2012, p. 5). Baumberg et al. (2012) found that stigma centred around the dichotomy of the "deserving or undeserving" (Baumberg et al., 2012, p. 3) status and argued that, based on non-means tested international benefit systems, stigma was not intrinsically linked to receiving benefits.

There are many common misperceptions around benefits (Turn2us, 2012). For example, contrary to the common belief that out-of-work benefit spending is high because of large families, the majority goes to families with one or two children (around 46% and 31%, respectively; Turn2us, 2012). Similarly, it was found that benefits do not pay better, rather many families would be better off in employment given that they would receive the National Minimum Wage (Turn2us, 2012). Furthermore, opposing the assumption that long-term claiming is widespread, evidence showed that "less than half of Jobseeker's Allowance claimants claim for more than 13 weeks" (Turn2us, 2012, p. 13). Incapacity Benefit, which is typically longer in duration, was 2 years or less for nearly 50% of claims (Turn2us, 2012).[18] Attitudes towards the unemployed seeking benefits "have always been sterner relative to other groups" (The National Centre for Social Research, 2018, p. 15). This said, the British Social Attitudes survey (The National Centre for Social Research, 2018) found that, since 2013, there has been a small but gradual increase in public support of benefits for the unemployed, albeit reaching a still relatively low 20% mark.

Benefit fraud is another example of a common misconception. According to official figures for the financial year of 2018–2019, an estimated "2.2% of total benefit expenditure was overpaid due to fraud *and* [emphasis added] error" (Department for Work and Pensions, 2019a, para. 1), which, after recoveries, was reduced to 1.6% (£3 billion), still including

[18] Between 2003 and 2008 before the introduction of Employment and Support Allowance (Turn2us, 2012).

errors by officials and claimants (Department for Work and Pensions, 2019a). In addition, underpayment was around 1.1% (£2 billion; Department for Work and Pensions, 2019a), which mostly stems from error made by the claimants and officials (Buchanan, 2017). In contrast, the tax gap amounted to £31 billion (4.7%) in the same financial year (ranging between £30bn and £36bn since 2005; HM Revenue & Customs, 2020). The tax gap[19] is defined as "the difference between the tax that should be paid to HMRC, in theory, and what is actually paid" (HM Revenue & Customs, 2020, p. 3). The credibility of official figures of the tax gap has been questioned by others, and alternative calculations have shown estimates to be as high as £90bn–£122bn (Brandy, 2019; Murphy, 2019; Reland, 2017). Critiques have argued that the shadow or hidden economy is far bigger than official estimations and that the official tax avoidance excludes activities via tax havens and profit shifting of multinational companies (Brandy, 2019; Reland, 2017). In light of the magnitude of difference between fraudulent benefit and tax related activities, social attitudes point towards a double standard with regard to tax avoidance and benefit manipulation with benefit recipients being "judged more harshly than tax offenders" (Geiger et al., 2017, p. 20). A comprehensive study of 18 datasets across six surveys conducted between 2000 and 2015 concluded that, although "there are no reliable figures on benefit fraud" (Taunton-Collins, 2013, para. 16) and public knowledge about what constitutes benefit fraud differed from official definitions[20], other than a substantial minority most people gave overestimates (Geiger et al., 2017). This said, the authors warned that the public's knowledge of public affairs is generally poor (Geiger, 2018). There is a more certain overestimation on the spending levels on benefits to support unemployment, with 44% of people[21] believing that it is the largest expense of social security

[19] The tax gap consists of simple errors, legal interpretations, evasion, avoidance, and criminal attacks (HM Revenue & Customs, 2020).
[20] For example, having more children to receive more benefits, people claiming benefits who have never contributed via tax or national insurance, or immigrants claiming benefits were wrongly believed to be fraudulent activities (Geiger et al., 2017)
[21] As surveyed in 2016.

spending, when unemployment benefits, including single parent benefits, were calculated to be the smallest area of social security spending (Geiger et al., 2017).

To counteract the negative rhetoric, Garthwaite (2011) recommended three steps: (1) to consider the reasons behind benefit claims; (2) to recognise that poor health does not automatically mean poor work ethic; and (3) to fill the gap of the missing narrative of actual lived experience of people receiving benefits that may be able to challenge the vilifying discourse surrounding them. This research hopes to fill some of the gap.

4.6.2. Invisible disability

This section explores the concept of invisible disability, using Davis' (2005) framework as foundation, and makes links to mental ill-health, depression, and mental health within the context of welfare.

According to Davis (2005), one of the first problems with the conceptualisation of *disability* is that this way of categorizing things is "large and diverse" (Davis, 2005, p. 156). The second issue is that it is based on "what they are not" (Davis, 2005, p. 156). The third issue is that the sub-category of invisible disability cannot be taken literally, rather it hinges upon the assumption that it is "invisible to a particular set of perceivers under a particular set of conditions" (Davis, 2005, p. 156). To state that something is invisible involves a judgement and that judgement assumes that the viewpoint of the perceiver is in line with the general human perspective and requires one to subscribe to normative standards (Davis, 2005). Davis further argued that these standards are "abstract and idealised constructions" (Davis, 2005, p. 156) and that such judgements are best understood to be "norm-relative and norm-dependent" (Davis, 2005, p. 157). She hypothesised that such norms are influenced by the prevailing "human paradigm" (Davis, 2005, p. 157) that underpins societies, which currently attaches great importance to "able-bodied standards" (Davis, 2005, p. 159). Davis

(2005) highlighted three morally and conceptually problematic assumptions that underpin, what she called, the "dominant ideology" (Davis, 2005, p. 164):

> The first is that it is normal for humans to be able-bodied. The second is that a person's disability is a consequence of (or results from) his or her not being able-bodied. The third is that it is principally their abnormality (or their not being able-bodied) that explains why those who are disabled suffer disadvantage in society: both the suffering and the disadvantage of those who are disabled are natural in the sense that they are consequences of the fact that their bodies are defective in certain respects. (Davis, 2005, p. 164)

These are the assumptions that the social model of disability challenges (see Section 4.4.2.).

The concept of *normal* is complex and is subject to ongoing debate (Davis, 2005). For someone to possess a trait that might be classed as *abnormal*, we would have to assume that such trait did not emerge as an *adaptation* to the environment but merely as an *anomaly* in a *normal* environment (Davis, 2005). Survivors of trauma, for example, would argue that their reaction is an adaptation to an *abnormal* environment, as opposed to an anomaly in a normal environment (Siegel, 2010). Within the social model of impairment, such reactions are thought of as an impairment *only* when barriers arise as the result of the interaction between the person and their (social) environment, as opposed to it being an impairment by itself (see Section 4.4.2.). Furthermore, the concept of *normal* is confounded by the inseparable interaction of individuals and their environment that is also influenced by the observer and their environment (Davis, 2005). Davis argued that statistical descriptions of normalcy and abnormality, or categories identified by groups of experts, are both deeply problematic, and could be a sign of the "epitome of oppression" (Davis, 2005, p. 179).

Regarding diagnoses of mental health illnesses, we heavily rely on means of self-report—and at times on observations and interpretations of experts or third parties—that make it open to misrepresentation. This said, some physiology-based illnesses are not exempt

from such counterfeit—for instance, the claim of not being able to lift something due to back pain might not be possible to objectively evidence and so can also be the subject of misbelief (Davis, 2005). The lack of physiological evidence of psychological illnesses may therefore attract the stigma, accusation of fraud, and/or unwillingness to change (Davis, 2005). For example, the detection of feigned mental illnesses, including depression, is subject to ongoing research (Tracy & Rix, 2017; Walters & Clopton, 2010). Furthermore, malingering is a debated topic in the contexts of benefit claims (see Section 4.5.1.), psychological injury claims in workplaces, forensic, and medicolegal settings (Drogin, 2001; Rix & Tracy, 2017). However, Davis predicated that the problem lies with the social structure that demands verification of the individual's experience of suffering or inability to function in expected ways, which—even with illnesses with identified physical causes—is an "irreducibly subjective component of illness" (Davis, 2005, p. 183).

Davis (2005) hypothesised that the *invisibility* of those who fall further from the able-bodied standard is not only due to habitual inattention but being socialised to not see. This, she claimed, might be understood as "defensive strategies" (Davis, 2005, p. 192) that hide what may be "frightening or unpleasant" (Davis, 2005, p. 192) to acknowledge. Moreover, these defences may manifest in self-fulfilling policies that are not adequately challenged (Davis, 2005). The notion of rendering persons invisible can create a fertile ground for marginalisation and social exclusion, and whilst some groups seemingly benefit from their privileged positions, they fail to notice that such marginalisation of difference can be damaging to all parties as they distance themselves from their own vulnerabilities (Davis, 2005). Furthermore, the exclusion of such groups often also results in their absence from the public sphere due to the social world being inaccessible or being accessible at a higher "transactional cost" (Davis, 2005, p. 200). This, in turn, can feed the 'rarity' myth that can lead to their underrepresentation within powerful positions that shape our environment

(Davis, 2005). Moreover, the inflexibility of the labour market can also create an additional reason for the exclusion of those who do not fit the prescribed standards, making them invisible in the social world (Davis, 2005). For instance, Biggs et al.'s (2010) study found that the attitudes of employers and employment agencies towards people with mental health needs were highly discriminatory, which reduced their chances of being put forward for or accepted for a job. In the social world, the formidable challenges disabled people face to successfully influence decision making processes can be illustrated with the example of the journey taken by the Disabled People's Movement. As Clifford (2020) described, although campaigners were invited to government debates, only the language was adopted that helped to convince the public that real changes took place. Principles, such as 'Nothing About Us Without Us', entered the mainstream health discourse; however, activists felt they were "co-opted to create the illusion of progress" (Clifford, 2020, p. 63).

Davis (2005) theorised that those with a nonobvious impairment have a choice between trying to meet able-bodied standards—thereby temporarily escaping stigmatisation but at a cost to their health or wellbeing—*or* revealing their disability to others in a convincing manner. The latter option can be an equally onerous one for several reasons. In these interactions, the disabled person might be asked to divulge personal and private details, revisit traumatic memories, be accused of requesting unfair treatment, forced to focus on their problems, made to educate others about the misconceptions of their conditions, and having to withstand the repeated exposure of such interrogations by both laypersons and experts (Davis, 2005). I would add that it also assumes that the disabled person has adequate vocabulary and understanding about their symptoms and is able to make comparisons to the 'norm', which they may or may not have experienced. In addition, they will need to be able to credibly illuminate their invisible disability to the listener, often under stressful circumstances (Davis, 2005). Above all, a disclosure will highlight the contradictions within

the dominant human paradigm that might result in the interrogator raising their defences and demanding further 'objective' proof. Consequently, bearing the "burden of proof" (Davis, 2005, p. 154) has high costs to the individuals. I would argue that conditions that are recurring in nature, fluctuate, or are energy limiting can be especially difficult to prove and might be challenged when seeking accommodation in the social domain. An extreme example of this is the so-called Work Capability Assessment (WCA). The WCA determines eligibility for state support for those who believe that they have a reduced capacity to work. WCAs can be especially challenging for those with conditions that are less or not visible, not objectively measurable, or fluctuating, such as mental health conditions. WCA has been shown to be discriminatory towards mental health conditions and to be detrimental to claimants mental health (Barr et al., 2016; Hansford et al., 2019; Mattheys et al., 2018; Warren et al., 2014).

Being able-bodied does not equate to health, human wellbeing, or a state of flourishing —sometimes, it is reduced to merely being *perceived* as able-bodied. Not meeting these standards may result in being devalued or seeing one's self as "inferior" (Davis, 2005, p. 163) if such values are internalised. This is also called *disabilism*, which is "discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others" (UK Disability History Month, n.d.-b, para. 14).

4.6.3. Intersectionality

Collins & Bilge (2020) give the following definition:

> Intersectionality investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytic tool, intersectionality views categories of race, class, gender, sexuality, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining

> complexity in the world, in people, and in human experiences. (Collins & Bilge, 2020, p. 1)

Building on the social movement activism, the "Mapping the margins" (Crenshaw, 1991) paper "marks an important transitional moment within intersectionality's history" (Collins, 2015, 2019, as cited in Collins & Bilge, 2020, p. 92). In addition to its being a theory, it is crucially a "social justice construct" (Collins & Bilge, 2020, p. 103).

Participants in this study share several intersecting layers. These include being disabled in the form of having the label of depression and carrying social identities associated with benefit claims and unemployment. These are in addition to other social constructs, such as race, gender, ethnicity, sexuality, class, religion or belief, and the social status associated with educational attainment (e.g., stigmatisation of lower educational levels) and age (e.g., in the context of the labour market), though there is limited research in this field (Salter et al., 2021). This view challenges the application of the Equality Act 2010 (2010) that—although originally intended to include the combination of protected characteristics—continues to assess discriminatory acts in distinct categories (Wren, 2018). Thus, the Act maintains a structural neglect of the complexity of issues related to intersectionality (Wren, 2018).

The final two sections of the Introduction chapter provide an overview of the relevant literature relating to the research question and state the aims and objectives of this study.

4.7. Overview of Qualitative Studies Exploring the Link Between Wellbeing and Welfare Reforms in the UK

A systematic literature review was carried out to locate existing articles similar to this study. This process helps to avoid potential duplication of existing research and to familiarise the primary researcher and the reader with the topic. The SPIDER tool (Cooke et al., 2012) suitable for qualitative studies was used with minimal adaptations to organise and guide the

search, which is detailed in Table 3. The exclusion and inclusion criteria applied are described in Table 4.

Table 3

SPIDER Tool with Description of the Main Concepts and the List of Related Search Terms

Elements of SPIDER tool	Relating main concept	Search terms applied
Sample	Working age adults who experienced depression	Depress*, CMD, common mental health disorder*, mental health, mood disorder*, affective disorder*
Phenomenon of Interest 1	The experience of unemployment	Unemploy*, fit-for-work, fit to work, fit-to-work, work ready, work-ready, labour market, workless*, jobless
Phenomenon of Interest 2	The experience of welfare support	Welfare, benefit, benefits, ESA, Employment Support Allowance, universal credit, UC, WRAG, social security, claimant*, claiming, claims, JSA, Jobseeker's Allowance
Design	Qualitative data collection	interview*, focus group*, case stud*
Evaluation	Experience	experienc*, opinion*, attitude*, percept*, belie*, understand*, perspect*
Research type	Qualitative or mixed method	ethnographic stud*, qualitative, phenomenolog*, grounded theory, content analysis, thematic analysis, field stud*, discourse analy*, ethnograph*, narrative analy*, mixed method*

Note. The following Boolean search strategy was employed to compensate for having two phenomena of interest and for the lack of standardised reporting of qualitative studies: Sample AND Phenomenon of Interest 1 AND Phenomenon of Interest 2 AND (Design OR Research Type OR Evaluation).
Limiters - Published Date: 19790101-20211231; Scholarly (Peer Reviewed) Journals; Narrow by Language: - English
CMD = common mental health disorders, ESA = Employment Support Allowance, JSA = Jobseeker's Allowance, UC = Universal Credit, WRAG = work-related activity group
* truncated words

Table 4

Inclusion and Exclusion Criteria

Guiding principles	Description of inclusion and exclusion criteria
Types of studies	Reference to qualitative data collection and/or qualitative data analysis.
Types of participants	Reference to depression and/or mental ill-health, unemployment and/or benefit claiming; working age adults 18 or above. Exclusion: if sample solely studying under 18s or pensioners.
Relevance of findings	Reference to engagement in the labour market or preparation to employment.
Geographical location of the study	Britain, England, or United Kingdom

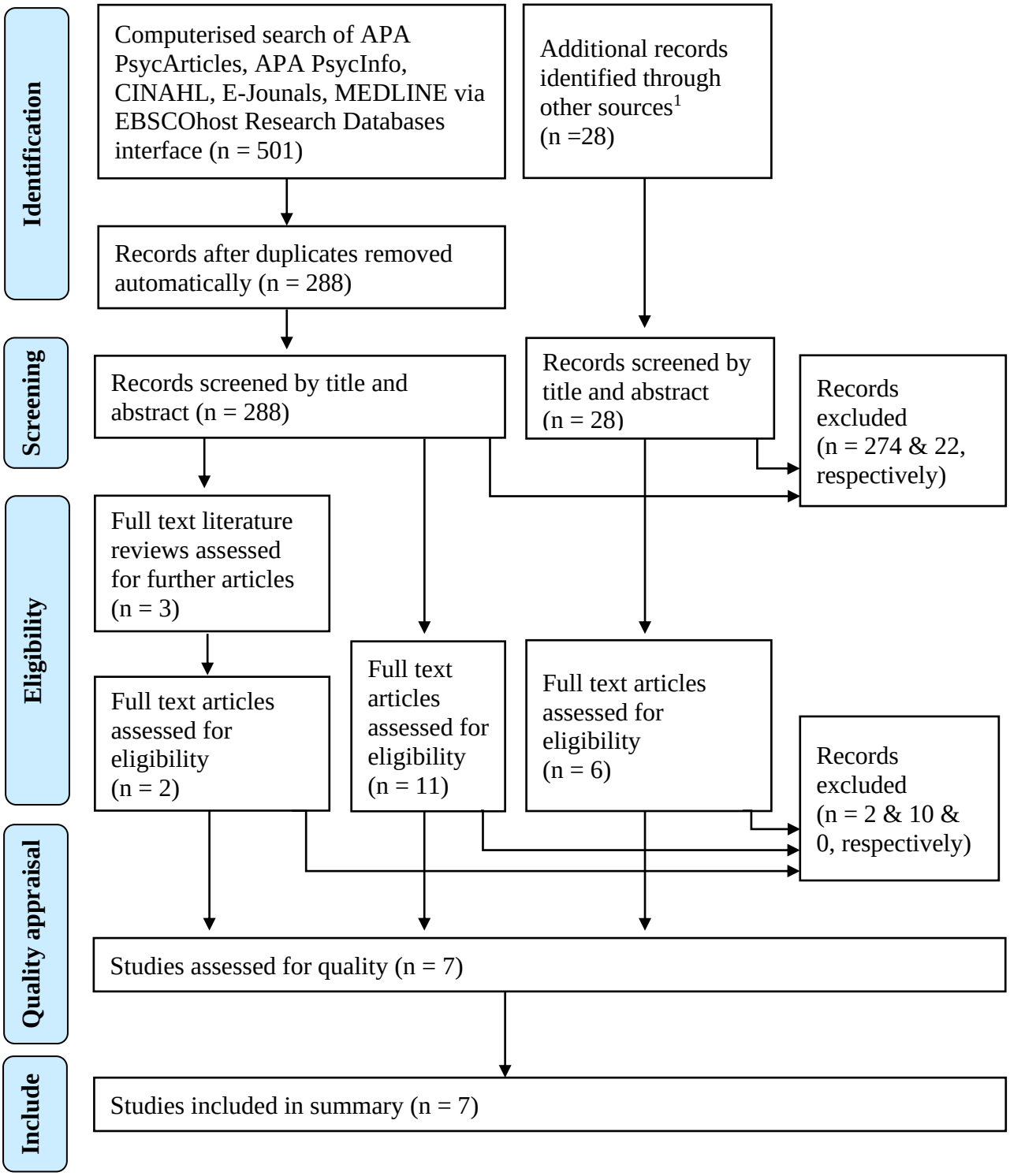
Note. Studies with insufficient details at title and abstract level were included in the full text assessment. If studies were published as a group of articles, related articles were searched for the necessary information. Social security systems operate differently in each country; thus, other countries were excluded from this review.

The literature review yielded seven suitable articles. The selection process is detailed in Figure 1. A pragmatic systematic review tool, QualSyst (Kmet et al., 2004), was chosen as the quality assessment framework to aid the critical appraisal of the studies. Scores were assigned using the manual specifically developed to evaluate primary qualitative research papers (see Appendix A). The total score is shown in Table 5 along with the summary

descriptions of the studies. Furthermore, an overview of the studies is provided here, starting with their critical appraisal.

Figure 1

PRISMA Flow Diagram of Study Selection



Note.

[1] Other sources included recommendations by Mendeley based on previous searches, non-systematic searches during the scoping stage, and reference chaining. Cochrane reviews were searched using a simplified search strategy in abstract and title (search terms: unemployment OR unemployed AND depression OR depressed OR mental) with 17 results found and excluded at title and abstract level screening.

Table 5

Summary and Quality Scoring of the Seven Articles Identified in the Literature Review

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
Boyce, 2008	Exploring the "experiences of mental health service users who have obtained work" with the "assistance of employment support agencies" (p. 78).	Part of SESAMI study with mixed methods. Qualitative arm	Interviews (40 and 75 minutes) Thematic analysis (Miles & Huberman, 1984)	20 participants who engaged with employment support agencies, showed severe and enduring mental health problems (assessed with a severity scale) and who had succeeded in returning to work. 13 males, 7 females. 17 White British, 2 Asian, and 1 White European. Age range: 27–64 Held jobs for 6 weeks to 7 years (or more).	Themes: (1) Perceived and actual barriers to work, (2) Job satisfaction (Positive views and Problems at work), (3) The impact of work on participants' lives. The study concluded that "receiving employment support could enable people to overcome" "barriers to getting back to work" (p. 77), but both the quality of the support and the job were important. Placement targets alone are problematic.	.65
Cheetham, 2019	To understand the impact of the roll-out of Universal Credit (UC) from the	Exploratory qualitative	Interviews (11 staff and 33 claimants) and five focus groups (26 staff)	33 UC claimants with complex needs, disabilities and health conditions, including 20 with	Central themes and subthemes: (1) Claiming UC; (2) Managing on UC with subthemes (a) Material impact, (b) Social impact, (c) Impact on physical and mental health; (3) Impact on staff	.8

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
	perspectives of claimants and staff supporting them in North East England (p1), which is a post-industrial area with a high level of deprivation.		Thematic analysis (Green & Thorogood, 2018)	self-reported mental health issues 13 females, 20 males Age range: 2–65 31 not in paid employment, 2 employed 37 staff from local government, housing, voluntary and community sector organisations	supporting UC claimants. The study found that "UC increased financial and housing insecurity and served to push vulnerable claimants further from the labour market, undermining the intended aim of encouraging people into work" (p. 7)	
Dwyer, 2020	The exploration of (1) "the impacts of the application of welfare conditionality on benefit claimants with mental health impairments" and (2) "the effectiveness of welfare conditionality in supporting people with	Longitudinal qualitative study. Part of WelCond which explored "the effective-ness and ethicality of behavioural conditiona-lity within the UK welfare	Interviews up to three times with around 12-month intervals. Top-down analysis of entire dataset using a framework matrix approach (Lewis, 2007) Bottom-up thematic analysis (Mason, 2002)	Social security benefit recipients with experience of a range of mental health issues. 207 participants who "discussed experiences of mental ill health" (p. 316) from the original sample. From the 207, 161 participated in 1–2 repeat interviews.	Findings "suggests that welfare conditionality is largely ineffective in moving people with mental health impairments into, or closer to, paid work" and, "in many cases, it triggers negative health outcomes that make future employment less likely" (pp. 311–312). "It is concluded that the application of conditionality for people with mental health issues is inappropriate and should cease" (p. 312).	.65

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
	experience of mental ill health into paid work" (p. 311).	state" (p. 315).	of selected subsets. Supplementary quantitative description of "movements into paid work" (p. 320).			
Hansford, 2019	The exploration of "people's experience of the Work Capability Assessment" (WCA) and the impact of "the narratives and culture surrounding welfare reform and the actual assessment itself" has on "mental health and wellbeing" (p. 351).	Part of a 2.5-year qualitative exploratory study of poverty-related distress.	In this study data was used from: 7 focus groups and 22 interviews (some over two sessions). Grounded theory approach	Participant (age range: 18–65) self-reported mental distress, and many experienced a combination of both physical and mental health issues. Recruited from across two study sites in the South West.	Themes: (1) Assessors' understanding of mental health conditions and the suitability of the assessment, (2) Conflicts between WCA decisions and the advice of other healthcare professionals, (3) Needing support to comply with the process, (4) Re-traumatisation, shame and alienation from support. The study suggested that "WCA process for people experiencing mental health issues" was "inappropriate" and that the process itself can "operate as a contributory factor towards worsening depression and anxiety, self-harm and even	.7

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
					suicidal thoughts and actions" (p. 362).	
Mattheys, 2017	Exploring the effects of austerity measures since 2010 on inequalities in mental health in North East of England, which is an area with high spatial and socio-economic inequalities.	Part of a five-year interdiscip-linary case study with cross-sectional survey and interviews. Exploratory and qualitative	In-person individual interviews with one over phone lasting an average of one hour. Interviews with stakeholders. Thematic analysis	17 who reported longstanding mental health problems. 5 from most, 7 from least deprived areas; and five from CAB. 10 females and 7 men. Mixture of ESA, JSA, IB, DLA/PIP claimants, employed and recently retired. 11 key stakeholders in the local authority.	Themes: (1) The daily struggle? Financial (in)security and the impact on mental health, (2) Keeping people in distress: The disproportionate impact of austerity. Findings suggests that "austerity measures are having a damaging impact on individuals and communities in the most deprived areas of this unequal place, whilst leaving those from less deprived areas relatively unscathed—with the exception of increased job insecurity" and that the "cuts in social security are impacting on health through both material and psychosocial pathways including increased	.6

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
					financial hardship and chronic stress" (p. 1275).	
Mehta, 2021	This study examines the "experiences of disabled people in the UK assigned to the Employment and Support Allowance Work Related Activity Group" (WRAG) with a specific focus on "the impact of processes of conditionality and sanctions" (p. 681).	Participatory qualitative	Interviews Thematic Analysis (Braun & Clarke, 2006)	15 disabled ESA claimants who had experience of being in the WRAG group. 6 females, 9 males. Age range: 29–63	Main themes: (1) A lack of equality between disabled claimants and other claimants; (2) significant impact of issues of compliance within a regime that imposes conditions and sanctions; and (3) alternative ways of experiencing and responding to this policy regime (p. 681). "The research found that processes of sanctions on welfare payments were ineffective in getting disabled people to engage in work-related activity. Instead, they create a range of punishing conditions that are often negative to health" (p. 381).	.75
Patrick, 2014	Aim: "the research set out to compare Government rhetoric with lived reality in	Longitudinal qualitative	Interviews at three time points Thematic analysis	22 initial interviews and 15 were selected for longitudinal study who were most likely to experience welfare reforms	Themes: (1) 'Existing, not living': benefits as a lifestyle choice?, (2) Working on welfare (I): 'getting by' on benefits, (3) Working on welfare (II): other forms of socially valuable	.55

Author & year	Study purpose	Study Design	Methods	Participants	Summary of findings	Quality score[1]
	order to assess how far the Coalition's conceptualisa-tion of welfare dependency, work motivations and the whole welfare-to-work domain matched individual lived experiences" (p. 705).			during the course of the study. Living in Northern city in England. Some had pre-existing mental health problems. Recruited via housing association and a charity providing support services.	contribution, (4) From welfare to 'work': focusing on paid employment. The study concluded "that 'getting by' on benefits often entailed substantial hard 'work'" and that "a strong orientation towards paid employment was evident across most of the sample and fluid movements in and out of work, characteristic of the 'low-pay, no-pay' cycle, was quite common" (p. 705).	

Note. SESAMI = Social inclusion through Supported Employment for people with Mental Illness; UC = Universal Credit; WelCond = Welfare Conditionality: Sanctions Support and Behaviour Change; WCA = Work Capability Assessment; CAB = Citizens Advice Bureau; ESA = Employment and Support Allowance; JSA = Jobseeker's Allowance; IB = Incapacity Benefit; DLA = Disability Living Allowance; PIP = Personal Independence Payment; UK = United Kingdom; WRAG = Work Related Activity Group.

[1] Quality score of the QualSynt (Kmet et al., 2004) can range between 0 and 1, with 1 marking the highest possible quality score.

The quality assessment scores ranged between 0.55 and 0.8 (possible range: 0–1). The composition of the studies, even the ones with similar scores, varied significantly. For example, information about the context of the study, details about recruitment processes and about participants, were presented to different degrees. In qualitative studies, contextual information aids the reader in assessing the dependability and transferability of the findings to other contexts (Lewis et al., 2014; Lincoln & Guba, 1985), on which some studies provided limited information (Dwyer et al., 2020; Hansford et al., 2019; Patrick, 2014). Given the topic of welfare, all studies discussed the policy context; however, only a few made references to theories (Hansford et al., 2019; Mattheys et al., 2018; Patrick, 2014) or used a psychological theory to underpin the research (Mehta et al., 2021). The clarity about the methodology, such as data gathering and analysis, also varied from naming a method without a reference (Hansford et al., 2019; Mattheys et al., 2018; Patrick, 2014) to demonstrating a systematic process and rationale (Boyce et al., 2008; Cheetham et al., 2019; Mehta et al., 2021) and/or used respondent validation or triangulation (Cheetham et al., 2019; Hansford et al., 2019; Mattheys et al., 2018; Mehta et al., 2021). There was only one study where the themes along with the data extracts presented were somewhat incongruent with the conclusions outlined (Boyce et al., 2008). Although the quality assessment framework does not reward participatory research specifically, one study consistently applied participatory methods throughout the research (Mehta et al., 2021). Moreover, there was limited evidence to suggest that any studies took race into account in their research, with only one providing details on ethnicity (Boyce et al., 2008) and only one having sought to recruit from racialised groups, such as asylum seekers and refugees (Dwyer et al., 2020). Reflexivity, along with the ontological and epistemological positions, were lacking in all studies, with only one indicating the role of the different authors during the coding process (Mehta et al., 2021).

Reflexivity and information about the researchers can enhance the research integrity and transparency (Ormston et al., 2014; Yin, 2011).

The seven studies provide a qualitative exploration of the link between wellbeing and welfare reforms in the UK, from which the relevant findings are summarised here. The oldest study examined the role employment support agencies play in helping people with severe and enduring mental health problems return to employment (Boyce et al., 2008). Findings suggested that receiving employment support could enable people to overcome barriers to employment. In addition, the authors concluded that "[e]ven those participants who were less satisfied with their jobs identified benefits and *none* described any negative effects" (Boyce et al., 2008, p. 77, emphasis added). This statement does not seem to be fully substantiated by their actual results (e.g., "two Agency E participants, both of whom were experiencing considerable problems and were considering leaving their jobs, positive and less positive views were fairly evenly spread across the agencies." and "The less positive views expressed by some participants revolved around discrimination, working conditions, lack of support and the impact of mental health problems on work;" Boyce et al., 2008, pp. 81–82). Their conclusion seems to support the controversial notion that 'any' job is better than no job, contrary to their findings. In Patrick's (2014) study a series of interviews with out-of-work benefit claimants between 2011 and 2013 indicated that those who struggled to make ends meet on benefits reported worsening mental ill-health and that existing on benefits "entailed substantial hard work" (Patrick, 2014, p. 705). Furthermore, a similar longitudinal study with a qualitative core component interviewing people with self-reported mental health conditions between 2014 and 2017 examined the implications of welfare conditionality (Dwyer et al., 2020). This large-scale project found welfare conditionality to be "largely ineffective in moving people with mental health impairments into, or closer to, paid work" (Dwyer et al., 2020, p. 311). Furthermore, conditionality was linked to negative health implications for

those already reporting mental ill-health (Dwyer et al., 2020) and for disabled people in general (Mehta et al., 2021). Similarly, the Work Capability Assessment (Dwyer et al., 2020; Hansford et al., 2019) and Universal Credit (Cheetham et al., 2019) were also identified as detrimental components of the welfare reforms for already disadvantaged groups. In addition, Mattheys et al. (2018) found that austerity measures unequally impacted on people with mental health conditions living at different ends of the inequality gap.

Hoping to build on existing literature, this study takes a broader view of welfare, not limited to one type of welfare benefit (e.g., Cheetham et al., 2019) or a component of welfare (e.g., conditionality or WCA in Dwyer et al., 2020; Hansford et al., 2019; Mehta et al., 2021), whilst more narrowly focusing on one psychiatric label as opposed to a group of psychiatric labels (Boyce et al., 2008) or disability (Mehta et al., 2021). Similarly to Mehta et al. (2021), this study also applies a participatory methodology—though to a lesser degree—and benefits from input from a representative of a disabled people's organisation. The literature review found no qualitative research that specifically explored the experience of transitioning from unemployment and benefits into paid work where the reason for claiming benefits was due to depression. Using a qualitative approach, this study hopes to provide further evidence from the perspectives of those who engage with statutory support systems in the forms of welfare benefits and mental health services that aim to move people back into work.

4.8. Study aims and objectives

The primary aim of the study is to explore the interaction between depression, work, and welfare support provided in England. The focus of the in-depth interviews is on the experience of the transition from unemployment to employment for those who have been diagnosed with depression and were eligible for legacy benefits or Universal Credit.

5. Method Chapter

5.1. Chapter Summary

This chapter first examines the ontological and epistemological positions of this study drawing on the philosophical position of pragmatism, and it details the rationale for a qualitative methodology and a thematic analysis as method. The researcher's position is outlined before giving details of recruitment, setting, research procedure, measure, sample, analysis, ethical considerations, and planned distribution.

5.2. Ontology, Epistemology, Methodology, and Axiology

From around the 1970-80s, critical approaches to social science research emerged and gained momentum with Kuhn's (1962, 1970, as cited in D. L. Morgan, 2007) and Lincoln and Guba's (1985, 1988, as cited in D. L. Morgan, 2007) works. Kuhn (1962, as cited in D. L. Morgan, 2007) formulated a structure for paradigm change and Lincoln and Guba (1985, 1988, as cited in D. L. Morgan, 2007) compared different paradigms within social science, using the "trilogy of concepts from the philosophy of knowledge: ontology, epistemology, and methodology" (D. L. Morgan, 2007, p. 57). *Ontology* is defined as a "branch of metaphysics concerned with the nature and relations of being" (Merriam-Webster, n.d.), whilst epistemology stands for "the study or a theory of the nature and grounds of knowledge especially with reference to its limits and validity" (Merriam-Webster, n.d.). In Guba and Lincoln's (as cited in D. L. Morgan, 2007) hierarchical structure, ontology holds the highest position, followed by epistemology then methodology, with each level imposing limits on the assumptions of the levels below. Ontological positions can be imagined on a continuum with realism at one end and idealism at the other (Ormston et al., 2014). Realism with its variants—fully or partially—prescribes to the idea that there is an "external reality which exists independently of people's beliefs about or understanding of it" (Ormston et al., 2014,

p. 25). On the other hand, idealism or relativism with its variants advocates for a view in which "no external reality exists" (Ormston et al., 2014, p. 25) independent of our beliefs or understanding. At the *epistemological* level, the corresponding approaches are known as positivism and interpretivism or constructivism (Tuli, 2010), which Lincoln and Guba (1985) originally termed 'naturalistic inquiry' (D. L. Morgan, 2007). Although, as Decoteau (2018) argued, positivism was never practised in its pure form within social sciences, its principles (e.g., causation; falsification; objectivism; outcomes linked to presumed predictability, homogeneity, and regularity of phenomena) continue to influence this field. Both interpretivism and constructivism emphasise the context (e.g., psychological, social, historical, political, and cultural) in which knowledge is actively created or constructed, which is never value-free and—at best—intersubjective (Ormston et al., 2014). On the third level, the two most common *methodological* stances are quantitative research and qualitative research (D. L. Morgan, 2007). It is worth noting that neither takes a predetermined ontological or epistemological position (D. L. Morgan, 2014; Ormston et al., 2014)—however, quantitative research is often closer to the realist and positivist positions. D. L. Morgan (2007) also discussed a fourth level, *methods*, the technical and mechanical concerns of knowledge production. D. L. Morgan (2007) highlighted that pragmatism "was consistently omitted from the list of approaches in the metaphysical paradigm" due to it taking "a much broader approach" (D. L. Morgan, 2007, p. 68). He argued that the metaphysical paradigms' emphasis on the philosophy of knowledge did not help to resolve methodological problems of the social sciences and it remained "disconnected from practical decisions about the actual conduct of research" (D. L. Morgan, 2007, p. 64). Much like the metaphysical paradigm, the pragmatic approach also considers the philosophy of knowledge—but, instead of a hierarchical relationship, it promotes a bidirectional influence and places methodology in the centre, so that method can affect methodology and, thus,

epistemological positions, and vice versa. Building on Dewey's (1922/2008, as cited in D. L. Morgan, 2014) work, D. L. Morgan (2014) promoted the view that, instead of embracing the dualism presented by the metaphysical paradigms—such as realism vs idealism—both hold "equally important claims about the nature of human experience" (D. L. Morgan, 2014, p. 1048).

> On one hand, our experiences in the world are necessarily constrained by the nature of that world; on the other hand, our understanding of the world is inherently limited to our interpretations of our experiences. We are not free to believe anything we want about the world if we care about the consequences of acting on those beliefs. (D. L. Morgan, 2014, p. 1048)

Instead of focusing on the ontological question of what is reality, or the epistemological question of what is knowledge, pragmatism prioritises the question: "What is the nature of human experience?" (D. L. Morgan, 2014, p. 1048). D. L. Morgan described the concept of *human experience*—borrowing from Dewey (1925a/2008, as cited in D. L. Morgan, 2014)—as the revolving interaction between beliefs and actions that are embedded in the social, historical, and cultural contexts. In this system, two types of experiences are proposed, namely *"habit"* and *"inquiry"* (Dewey, 1922/2008, as cited in D. L. Morgan, 2014, p. 1046; original emphasis). Habit, in its extreme form, is an unquestioned experience, whilst inquiry is a self-conscious, "careful, reflexive decision making" process (D. L. Morgan, 2014, p. 1046)—for example, one that research aims to be. Inquiry, beliefs, and actions are not thought to be rational, disembodied, or logical processes (D. L. Morgan, 2014). Experiences have "an emotional, embodied element" (D. L. Morgan, 2014, p. 1047) in which emotions are "often both the sources and outcomes of our experiences" (D. L. Morgan, 2014, p. 1047). D. L. Morgan (2014) argued that the knower and known are inescapably linked in research and promoted Dewey's view that knowledge, as the outcomes of research, amounts to a set of

"warranted assertions" (Dewey, 1941/2008, as cited in D. L. Morgan, 2014, p. 1048) that "serve as the basis for beliefs" (D. L. Morgan, 2014, p. 1048).

The pragmatic approach in research, in D. L. Morgan's (2007) view, relies on *"abduction"* (D. L. Morgan, 2007, p. 71) to connect theory and data, making use of both induction, associated with qualitative approaches, and deduction, which is prioritised by quantitative approaches. Pragmatism advocates for an *intersubjective* relationship to the research process, as opposed to subjective or objective ones, and supports *transferability* instead of generalisability or context-bound approaches. Similarly to the metaphysical paradigm, the pragmatic approach requires researchers to take a "reflexive outlook toward what we choose to study and how we choose to do so" (D. L. Morgan, 2007, p. 69). The emphasis on intersubjectivity compels the researcher to "achieve a sufficient degree of mutual understanding" (D. L. Morgan, 2007, p. 72) with both the participants and other researchers, whilst transferability and reflexivity require the researcher to investigate the ways in which other settings can make use of the knowledge generated.

In addition to the triad of metaphysical paradigm (i.e., ontology, epistemology, and methodology) that has little connection to *axiology*—another philosophical concept—values, ethical, and moral issues have been central concepts within pragmatism (D. L. Morgan, 2007). As D. L. Morgan (2007) explained, instead of "the abstract pursuit of knowledge", pragmatist researchers "attempt to gain knowledge in the pursuit of desired ends" (D. L. Morgan, 2007, p. 69). Our values and political views, which can be conscious or less examined, shape research goals and direct our attention during every step of research (D. L. Morgan, 2007). More recent works from pragmatist feminists have strengthened the bond between pragmatism and social justice and sought to share an "emphasis on openness, fairness, and freedom from oppression" (D. L. Morgan, 2014, p. 1050) with emancipatory research. Emancipatory research, by definition, aims to create knowledge that can be of

benefit to disadvantaged people (Oliver, 1997). Whilst Oliver (1997) argued that all disability research studies should aim to be emancipatory—and many are not—Danieli and Woodhams (2005) critiqued the way in which emancipatory research restricted methodologies within disability research and suggested that more eclectic methodologies are embraced.

Given the moral and political dimensions of the research question and its emphasis on the human experience (i.e., How do people who have the label of depression experience the transition back to the labour market from unemployment and benefits?), I believe pragmatism, as a philosophy, provides a fitting framework for this study. Consequently, I will use D. L. Morgan's (2014) interpretation of Dewey's (1910b/2008, as cited in D. L. Morgan, 2014) five-step systematic approach to inquiry to outline details about this study. The five steps are embedded into the cyclical connection between beliefs and actions and do not necessarily follow a linear path.

Step 1 consists of recognising a situation as problematic. Much of the recognition of different situations being problematic predate my engagement with this research. Some of the key factors included my supervisors, an external consultant, fellow trainees' understanding of the issues with the welfare reforms (e.g., conditionality and sanctions being detrimental to mental health), the limited presence and influence of service users' experiences on the development of clinical guidelines for depression, and the increasing oppression of disabled people (see Section 4.). I had a long-standing interest in workplace health/stress which drove me to choose a related topic for a previous assignment. During this assignment, I noticed the lack of research about unemployment compared to returning to employment from sick leave. Based on these ideas, the problematisation of the intersection of depression, unemployment, benefit claiming, and work were collaboratively developed with my supervisors and external consultant.

Step 2 requires the consideration of the difference it makes to define the problem one way rather than another. In collaboration with a disabled activist, my supervisors, other trainees with similar research topics, and—via informal conversations—with a Department for Work and Pensions (DWP) officer and two benefits advisors who advocated for their clients, other angles of this topics were considered (e.g., only focusing on experiences regarding Universal Credit would be restricting and the entry onto the benefit system has been subject to more research). Given the complexity arising from the intersections of several layers (e.g., disability and mental ill-health, unemployment, and benefit claiming), qualitative methodology offered the flexibility needed to research this topic. In particular, thematic analysis (Braun & Clarke, 2006) was thought to be a suitable method, which allows for both induction and deduction, staying grounded in the data, and developing interpretations.

Step 3 entails the development of a possible line of action as a response to the problem. In this case, academic research as an inquiry which, in Dewey's (1910b/2008, as cited in D. L. Morgan, 2014) terminology, is a systematic and reflective process, was believed to offer the possibility of contributing to the existing emancipatory works of disability activists. This required the research to be developed in a collaborative manner (i.e., with a disability activist who identifies as a disabled person) from inception to dissemination. Reflexivity was enhanced by the primary researcher proactively engaging with alternative discourses to increase self-awareness of biases related to the dominant narratives, studying the historical and cultural contexts of the topics, and using a reflexive log and personal therapy.

Step 4, namely evaluating potential actions in terms of their likely consequences, and Step 5, taking actions that are felt to be likely to address the problematic situation, are actions that will mainly take place following the completion of the thesis. However, plans for dissemination will be developed on an ongoing basis with the aim that the research findings can be disseminated to user-led organisations of deaf and disabled people for their use. This

might include, for example, being referenced in the civil society shadow report for the United Nations under the Convention on the Rights of Disabled People.

To enhance this pragmatic approach, a somewhat restricted version of a participatory design was employed (Barton, 2005). This meant that a disabled activist, a non-academic, who identifies as a disabled person (and has experience of mental health difficulties), was involved at every stage of the research. This included collaboratively problematising the research topics, formulating the research questions, identifying avenues for participant recruitment, refining research materials (e.g., interview topic guide and posters), supporting the data analysis at key points (e.g., after initial codes were created and after various drafts of themes were constructed), and providing feedback on draft chapters. Crucially, their involvement is also planned for the dissemination phase of the research. Moreover, three further non-academics (i.e., two benefit advisors and a civil servant with expertise in workplace mental health initiatives) provided some input regarding the focus of the research questions and the development of the themes. In addition to the limitations associated with the time and resources allocated, the constraints of the processes regarding the ethical approval of the study meant that the participatory design was restricted to the involvement of one disabled person whose role was to oversee and guide the research.

5.3. Methodology

In taking a pragmatic approach (D. L. Morgan, 2014), we use the research question as the starting point (i.e., How do people who have the label of depression experience the transition back to the labour market from unemployment and benefits?) to guide the selection of the appropriate methodology. Crucially, the voices of marginalised groups, such as people with the experience of mental distress, have often been neglected (Clifford, 2020) and “the structural determinants of mental health continue to be marginalized in research, policy, and service provision” (Morrow, 2013). Given the limited number of existing studies (see Section

4.7.) and *experience* being the focal point of the research question, a qualitative approach has the potential to forefront the experiences of marginalised groups, such as those being focused on in this study.

Qualitative interviewing is a commonly used method for "gaining access to people's experiences" (Roulston, 2013, p. 3); however, there is an ongoing debate about its methodological issues and about the rationale for using interviews as opposed to naturally occurring data (Roulston, 2013). Although naturally occurring data, such as online forums, can provide insight into people's experiences related to the research question, given the complexity of the phenomenon being studied, semi-structured interviews were believed to be the most suitable way of collecting data. Semi-structured interviews provided both the flexibility and the focused data collection that was needed for a time- and resource-limited doctoral thesis.

5.4. Researcher's Position Statement

Pragmatism requires "careful, reflective decision making in research" (D. L. Morgan, 2014, p. 1046). Similarly, an emancipatory approach to research necessitates that "we examine our own research practice in the context of the current oppressive social and material relations of research production" (Oliver, 1997, p. 29). A qualitative methodology in general, and in this case, a reflexive thematic analysis as method, also call for an ongoing reflexive approach (Braun & Clarke, 2020). Accordingly, this section outlines the different positions the primary researcher occupies, guided by K. P. Morgan's (1996) intersectionality framework. To complement this, a more detailed self-reflective account is offered at the end of the Discussion chapter.

My privileges arise from being White, credentialed (i.e., by holding a master's degree and educated to doctoral level, following the completion of this thesis), heterosexual, and—more or less—able-bodied. I have a diagnosis of dyslexia, which continuously impacts on my

life including this research project. I believe my determination to overcome obstacles is related to living with dyslexia. On the other hand, overcoming obstacles, such as reading and writing substantial amounts for the thesis, takes more effort and time with dyslexia. I have a European heritage; thus, I am privileged. However, I am categorised as an 'Eastern European migrant', a category subject to oppression in England. I am uncertain as to which 'class' I would be assigned to as I was not born in Britain. In the past, I worked in unqualified manual jobs (e.g., waitress, cleaner, and health care assistant), had short periods of unemployment, and lived on a minimum-wage income; thus, I believe I have experienced a working-class existence, though my future jobs as a qualified clinical psychologist would be more associated with a middle-class position. I am a cisgender woman; thus, being privileged for being cisgender, and oppressed in different situations as a female. English is my second language and, despite it being at an almost native level with a mild accent, it is one of the ways in which I experience oppression. To summarise, I am privileged in more ways than subject to oppression. I have been working on trying to increase my consciousness of these positions, including throughout the duration of this research study.

5.5. Participant Recruitment

Participants were recruited primarily via non-statutory organisations. Organisations were approached using contacts of the external consultant and directly via phone or email. Organisations were emailed information about their role and about the research (see Appendix B). Due to the restrictions that arose as the result of the COVID-19 pandemic, many of the original organisations were no longer in the position to collaborate. For this reason, additional organisations were approached (see Appendix C for the list of organisations). The identified organisations were a mixture of non-statutory disability and claimant networks (e.g., National Steering Group for Disabled People Against Cuts), community groups (e.g., Norwich Men Shed), minority groups (e.g., Filipino Community

Group in Norwich), and various online platforms (e.g., ‘Psychologist for social change’ group, The Men’s Health Forum, and a disability online column of a national newspaper). The method of recruitment varied from advertisement in newsletters and personal invitation by staff member of any of the supporting organisations, social media callouts, and invitation by participants who wished to invite others. Poster invitations (see Appendix D) and short text invitations were used, depending on the platform. A separate poster was developed to encourage potential participants’ involvement from marginalised groups (see Appendix E). Participants contacted the researcher directly via email to show interest, or their response to a newsletter or social media callout was forwarded to the researcher. The participant information sheet (see Appendix F) and the consent form (see Appendix G) were emailed or posted to the participants then a short meeting was arranged to check eligibility using screening questions (see Appendix H) to discuss participation and to allow any questions about the research. Some screening was conducted via email. Interview times and method were agreed once eligibility and the desire to take part was established.

5.6. Setting

Participants were recruited via gatekeeper organisations from across England. Participants who consented to taking part were allowed to choose their preferred modality for the interview. Interviews were by telephone or video call via the Internet, using both video and audio or solely audio functions. Face-to-face interviews were not permitted during the pandemic. Participants were able to select the time and date of the interview, which included evenings and weekends. Several meetings were rescheduled to fit around symptoms of depression and other duties of the participants.

5.7. Research Procedure

Once participants consented to take part and were found eligible, the virtual interviews were arranged. Participants were emailed a shorter version of the interview topic guide to aid their preferred preparation style (see Appendix I). Formal consent (see Appendix G) was collated via post, email, or recorded verbally at the start of the interview if the other two options had not been feasible. Interviews followed a topic guide (see Appendix J). Demographic data (see Appendix K) was collected at the end of the interviews (except for the first interview at which it was collected at the start), following which participants were asked to name their preferred way of receiving the high street voucher (£15). All participants, including those who were not eligible to take part, received a participant signposting information sheet (see Appendix L), some of which included additional organisations based on their location or ethnicity. At the end of the meeting, participants were able to opt in to receive a copy of the report. Interviewees were asked to confirm in an email that they had received their voucher.

Flexibility about timings, interview modality, voucher type, and form of consent were designed to improve accessibility and to empower participants. This was especially important during unprecedented circumstances due to the global COVID-19 pandemic and were in line with an inclusive emancipatory approach (Barton, 2005).

5.8. Measures

To enable a semi-structured interview method an interview topic guide (see Appendix J) was developed. The topic guide aimed to address the research questions whilst allowing flexible engagement with the interviewees. The interview guide was collaboratively developed with the supervisors, the external consultant, and via the informal help of two disability advisors from a local charity. A similar iterative process took place for all the other materials (e.g., participant information sheet, participant poster information, information

sheet for recruiting organisations, and the consent form). Authors of similar research topics were also successfully contacted to grant access to their interview topic guides (Cheetham et al., 2019; Dwyer et al., 2020). The involvement of a disabled external consultant helped to ensure that the research development, including the research topic and research questions, followed guidelines for emancipatory research (Barton, 2005; Oliver, 1997). Moreover, at the end of the interviews, participants were encouraged to give feedback about the questions they were asked. Their feedback was also considered for subsequent interviews.

The interviews started with the discussion or reiteration of ethical considerations, consent, and confidentiality (including their privacy during the interview) and allowed time for any questions. A short introduction was provided about the research and the interviewer before the first question was introduced. First participants were asked to reflect on the experience of transitioning from unemployment and benefits to working. In this section, interviewees usually provided an overview of the employment history with a specific focus on their mental health, benefit claiming, and experiences of their jobs. Prompt questions aimed to elicit more information about the ways in which depression affected work and benefit claiming. Participants were asked about the future in relation to working or employment. At several stages, interviewees were also asked what had been helpful or a good experience for them. This was to balance an expected bias towards negative experiences. The main part of the interview concluded with a question about their ideas for any improvements in the systems.

At the end of the interviews, participants were thanked for their time and contribution, asked for feedback about the interview process, were reminded about the next steps, the signposting sheet, and what would happen to the material. Once the voucher format was agreed, the interviewees could opt in for a copy of the report. The telephone interviews were

recorded via an encrypted digital recorder, and audio or video calls were captured using the built-in recording function of the applications used.

5.9. Sample

5.9.1. Sample Size

In quantitative research, if one knows the required significance level, power, effect size, and method of analysis, the sample size can be calculated in advance of the experiment (Tam et al., 2020). This method does not translate well into qualitative research.

Guest et al. (2006) compiled a list of existing guidelines for actual sample sizes for a variety of qualitative methods and found that most of the studies were not explicit about their evidence base. Having identified this gap in the literature, they analysed sixty interviews using thematic analysis. They found that the majority of high frequency codes (34/36) were present in the first 6 interviews, and 97% (35/36) were identified by the 12th interview. Their sample was thought to be homogenous (i.e., with regards to gender, occupation, and geographical location). Similarly, Ando et al. (2014) also suggested that, for their homogenous sample, 12 interviews were sufficient to reach saturation using thematic analysis. Both studies applied empirical methods (e.g., Cronbach's alpha to measure the reliability of code frequency distribution as the analysis progressed, *t*-test, and descriptive statistics) to determine saturation. Malterud et al. (2016) argued that the concept of saturation is often used out of its original context of grounded theory and that most qualitative research does not share the epistemological anticipation of grounded theory. They also emphasised that saturation assumes that the researchers are aiming "for a complete description of all aspects of the phenomenon" (Malterud et al., 2016, p. 1759). Instead of saturation, they proposed the concept of "information power" that "indicates that the more information the sample holds, relevant for the actual study, the lower number of participants is needed" (Malterud et al., 2016, p. 1759). In their view, if a "study offers new insights that contribute

substantially to or challenge current understandings" (Malterud et al., 2016, p. 1759) relevant to the research question, the study has achieved its aim. They suggested that "information power depends on (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy" (Malterud et al., 2016, p. 1753). The authors also advocated for an ongoing evaluation of sample size during research, instead of following a pre-determined number. Unfortunately, their model does not offer a method of pre-empting an approximate sample size needed for a study.

Braun and Clarke (2013) recommend 10–20 interviews for a medium-sized study (e.g., doctorate in clinical psychology of 40,000 words); however, they did not cite the evidence supporting these guidelines. It was, therefore, difficult to determine the sample size needed for this research in advance of the data analysis. This study applied mixed convenience sampling and snowball sampling (Patton, 2002) aiming to include information-rich cases that yield maximum variation. Thus, the sample that aims to capture a diversity of perspectives is a mainly heterogenous one with participants only sharing a few common characteristics. Following a guideline by Robinson (2014), the sample in this study was heterogenous on demographic characteristics (e.g., age, gender, education, occupation, ethnicity, and socio-economic status), geographical characteristics (including people from rural, urban, affluent, and deprived areas in the UK), physical characteristics (i.e., disabled and non-disabled individuals other than having a psychiatric label), and psychological characteristics (including individuals with different manifestations of their depression label at the time of the interview). Participants shared commonalities only with regards to life history; therefore, the sample was homogenous in terms of participants having some experience of unemployment, benefits, and depression. Taking Ando et al.'s (2014) and Guest et al.'s (2006) findings into consideration as a proxy guidance, in the absence of more suitable evidence, it is likely that if a homogenous sample requires about 12 interviews for thematic analysis, a heterogenous

sample would need more than 12. Patton also advised consideration of “available time and resources” (Patton, 2002, p. 244) that are likely to determine the maximum number of interviews suitable for the scale of the project, which in Braun and Clarke's (2013) view is a maximum of 20. Based on these ideas, the sample size was determined to be between 13 and 20. However, during unprecedented times of a global pandemic, the recruitment stage was significantly affected. For instance, many organisations that originally signed up to support the recruitment were fully or partially closed; hence, not in touch with potential participants. New avenues of recruitment were identified, and further organisations were approached to aid recruitment (Appendix C). That said, during the initial phase of the pandemic, it was difficult to develop working relationships with new gatekeeper organisations. This, along with the time constraints of the project, resulted in a reduced sample size of eight. On the other hand, the global shift to a virtual platform allowed for an easier communication with participants who, by the time of the interviews, were more familiar with virtual communication methods. This allowed the research to benefit from a national sample, as opposed to favouring in-person interviews with a limited localised sample. During recruitment, there was a specific emphasis on aiming to achieve a gender balanced sample and to include individuals from marginalised groups. Although no potential participants were excluded on the bases of gender or ethnicity, some gatekeeper organisations were specifically selected to help achieve these aims.

5.9.2. Inclusion and Exclusion Criteria

The study included those who met the following criteria.

a) Those who were trying to find work, or those who were working at the time of the interview but had had at least one period of unemployment including those who had not yet been in employment.

b) Those who have claimed or were eligible but have not claimed Universal Credit or legacy benefits in England. Legacy benefits include income-based Jobseeker's Allowance (JSA), income-related Employment and Support Allowance (ESA), Income Support (IS), Housing Benefit (HB), Child Tax Credit (CTC) and Working Tax Credit (WTC).

c) Those who had been diagnosed by a professional, including diagnoses by General Practitioners, with depression or depression with anxiety in which depression was identified as the dominant condition by the individual. (Participants were asked when and what type of professional diagnosed depression. This information was collected on a self-report basis and no further proof was sought.)

d) Those who experienced depression before or during their unemployment and believed that depression played a significant role in them becoming unemployed or had prolonged their unemployment. Depression could be in the past or ongoing to varying levels at the time of the interview.

e) Individuals with other non-mental health related disabilities as defined by the Equality Act 2010 (2010) were included if participants identified that symptoms of depression had played an important role in gaining or prolonging their unemployment status.

f) Those who were at least 18 years old.

g) Individuals who could speak English well enough to engage in the interview. However, the option of providing an interpreter was not ruled out.

Individuals were excluded from the study if:

a) they had a student status or were receiving pension at the time of the unemployment;

b) they only claimed Personal Independence Payment, Disability Living Allowance, and/or Attendance Allowance;

c) they also had another psychiatric diagnosis, such as bipolar disorder, personality disorder, post-traumatic stress disorder, or psychosis;
d) their depression was self-diagnosed, or if they could not recall the type of professional who diagnosed depression; or
e) they were receiving care from any inpatient units for their mental health condition.

5.9.3. Rationale for the Sampling Criteria

This section highlights key reasons behind the inclusion and exclusion criteria. Evidence suggests that different chapters within the mental health section of the *International statistical classification of diseases and related health problems* (10th ed.; ICD-10; World Health Organization, 2016) might be associated with different return-to-work outcomes (Lidwall, 2015); therefore, other psychiatric diagnoses were not included in the study to enhance the clarity of the findings. No participants were recruited in their capacity of NHS patients.

Sickness absence and return to work of employees is a well-researched area and many factors that influence this process have been identified. For example, workplace conditions (Ekberg et al., 2015), the collaboration between employer and employee on sick leave (Nigatu et al., 2017), and the ways in which the psychosocial work environment contributes to the sickness absence (Netterstrøm et al., 2015) were identified as important factors. These factors are likely not to be present in the same way in a population of unemployed adults; thus, those without a period of unemployment were excluded.

Furthermore, in the exclusion criteria, there is no restriction on how long ago the depressive episode and/or the period of unemployment happened. This was to allow long-term consequences of depression and/or unemployment to be captured in the participants' accounts. An example of this was reported in Hjarsbech et al.'s (2015) study that found that

some interviewees managed symptoms of depression by "altering prospects for their future" (Hjarsbech et al., 2015, p. 1674) which in some cases meant moving to a less challenging job.

The social security systems operate differently across the devolved nations (Mackley, 2020) and so only those individuals who had experience of the English benefit system were included.

5.10. Analysis

The six-step reflexive thematic analysis by Braun and Clarke (2006) was deemed to be a suitable method for the purposes of this study (see Section 5.2.). Thematic analysis was thought to be appropriate to create meaningful output of the data for the planned distribution (e.g., to professionals in policy development, disability activists, and clinicians).

According to Braun and Clarke (2006), "[t]hematic analysis is a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). In an attempt to demarcate thematic analysis clearly, they outlined a six-phase guide. Braun and Clarke defined the data *corpus* as *all* the data that was collected for the research, and the data *set* as a part of the data corpus that is utilised for the analysis. In this research each interview was a data *item*. Unlike content analysis, thematic analysis does not provide a quantified measure; for this reason, prevalence and "*keyness*" (Braun & Clarke, 2006, p. 82, original emphasis) required careful consideration. Although most themes appeared in the majority of the interviews, issues related to, for example, racialised experiences and to physical disability were conceptualised as key themes and/or subthemes to compensate for the underrepresentation of these experiences due to a sampling bias. These were thought to add meaningful elements to the analytic question. Prevalence was monitored via statistical information in NVivo (version 1.3).

The analysis followed a more inductive approach, as opposed to a theory-driven approach. The inductive approach involves data-driven analysis that does not try "to fit the

data into a pre-existing coding frame" (Braun & Clarke, 2006, p. 83). For this approach, a high level of reflexivity is required, as researchers "cannot free themselves of their theoretical and epistemological commitments" (Braun & Clarke, 2006, p. 84). This research utilised a combination of semantic and latent approaches. Existing research in the field was studied before, during, and after data analysis, instead of limiting this to the post-analysis phase, as in the semantic approach. The initial codes were predominantly developed in a semantic way, coding explicit meaning, whilst latent meanings were sought in the later stages of the analysis by "examin[ing] the *underlying* ideas, assumptions, and conceptualisations" (Braun & Clarke, 2006, p. 84, original emphasis).

As mentioned above, Braun and Clarke (2006) devised a six-step method for thematic analysis. The *first step* requires the researcher to familiarise themselves with the entire data set. Familiarisation included the interview, the transcription, and replaying the interviews whilst reading the transcripts at least twice. The main researcher manually transcribed telephone interviews using Express Scribe Transcription Software with the help of Dragon Naturally Speaking by Nuance, whilst video/audio calls were automatically transcribed by the built-in software and then edited manually. The key for the transcriptions is detailed in Table 6. Initial ideas for codes were captured after the interviews and during familiarisation.

Table 6

Transcription Notation System for Orthographic Transcriptions Used in This Study Based on Braun and Clarke's Guidance (2013, pp. 165–166)

Feature	Notation examples
Laughing, coughing	((laughs))
Spoken Abbreviations	Do not use abbreviation if speaker does not, such as UC vs Universal Credit

Feature	Notation examples
Pause	((pause))
Inaudible speech	(inaudible)
Non-verbal utterances	For example: ‘erm’, ‘er’, ‘mm’, ‘mm-hm’
Cut off speech and speech sounds	For example: wa—, wo—, worl—
Emphasis on particular words	For example: with no exaggeration
Reported speech	For example: Five-six months I was telling them, ‘I had no food’ and part of this was over Christmas
Identifying information	Replacing information with square brackets, for example, [the company name]
Removing parts from quotes	To indicate a missing part use […]

In the *second step*, initial codes were produced using a systematic approach by paying equal attention to each data item. As advised by Braun and Clarke (2006), this phase included (1) coding for a variety of possible themes, (2) allowing extracts to be coded more than once, (3) keeping the context for the extracts, and (4) paying attention to contradictions and coding these carefully. For practical reasons, coding was developed using NVivo (version 1.3). At the end of the second phase, around 1000 codes had been created. These were tagged with topic names, which formed part of the code name, to ease the navigation during the coding process. These topics included, for example, work, unemployment, public attitude, Jobcentre, DWP, depression, benefits, COVID, and a combination of these, such as depression plus work.

During the *third step*, ideas for provisional themes were noted and different visual maps were developed (see Appendix M) and discussed with the primary supervisor and the external consultant. At the end of this phase, the hexagon concept took shape along with the two overarching themes. In line with theory, themes and codes were kept that did not seem to belong to any themes, and some codes were noted under two themes. An ongoing emphasis was placed on not dismissing deviant cases in order to enhance validity and sensitivity.

Following this, in the *fourth step*, the themes were reviewed, and subthemes were developed with the aim of creating themes that were distinct from each other and showed internal consistency. Although the entire data set was not revisited, all code extracts that belonged to each theme were re-read to assess whether the themes, subthemes, and the thematic map reflected the data. This phase ended when a satisfactory thematic map was devised that included defined themes with subthemes, showed their relationships, and created an "overall story … about the data" (Braun & Clarke, 2006, p. 92).

The *fifth step* focused on refining the overarching themes, main themes, and subthemes. In this phase, themes were illustrated and underpinned with vivid examples from the interviews to provide sufficient evidence for each theme. The report writing also started during this step when the research, with its provisional findings, was presented at the internal Staff and Student Conference in 2021. Theme names at this point were more descriptive with an emphasis on the notion of feeling trapped by the system (e.g., Financial trap, Communication trap, and Invisible captivity cycle of welfare).

During the *sixth step*, the iterative process continued until the final stages of the report writing, as advised by Braun and Clarke (2006). The theme names were revised following discussions with the supervisors and the external consultant about the first draft of the Results chapter. Thus, the Results chapter was adjusted to reflect the new theme names. One element of a subtheme was also moved to another theme. Quotes were also checked for accuracy. The

final version of the Results chapter aims to show a concise, logical, coherent, and complex story in relation to the research questions and to create an analytic narrative that goes beyond mere data description.

Descriptive statistics were developed based on the demographic data collected, which are detailed in the Results chapter.

5.11. Ethical considerations

5.11.1. Ethical Approval

The ethical approval was granted by the Ethics Committee at the University of Essex (see Appendix N) and an amendment was also granted regarding the interview modalities and consent collection method during the COVID-19 pandemic (see Appendix O). The Code of ethics and conduct by the British Psychological Society (The Ethics Committee of the British Psychological Society, 2018) was adhered to throughout.

5.11.2. Consent and Confidentiality

Provisional consent was sought at the screening stage, following which eligible participants were emailed or posted the consent form. Each item on the consent form was read out and questions were answered fully. At each contact (including email correspondence), informal consent was sought about continued participation. Participants were reminded that they could withdraw from the project at any point. Formal consent forms were collected via post, email, or audio recorded at the start of the interview. The latter was a necessary option to increase accessibility for those who did not have the technology to sign the form electronically and when posting the consent form would have delayed their participation.

Confidentiality was maintained for both individuals and organisations throughout the process, including the dissemination stage. Confidentiality was ensured by assigning

pseudonyms to participants. Names were chosen to match the gender and the order of the interviews following an alphabetical order. This was with the exception of the first interviewee for whom a popular name was selected to reflect their ethnicity. All identifiable information was removed from the anonymised transcripts to preserve participants' privacy. Data was stored on a password protected device and encryption was used for the digital voice recorder. Following the completion of the study, the data was moved to the university archive in an encrypted file. Moreover, emphasis was placed on informing the participants of the fact that study was being conducted independently from Department for Work and Pensions (DWP), Jobcentres, and other related agencies. This was to ensure that participation was not hindered by concerns about confidentiality. Reassurance was given that participation would not affect participants' benefits and no identifiable information would be passed to any agencies they were in contact with, including the recruiting organisation.

5.11.3. Impact on Participants

This study collated the views of those who had had at least one depressive episode and explored their journey into the labour market. In line with expectation, those who volunteered to take part had symptoms of depression to varying levels at the time of the interview. Depressive symptoms were not explored with a measure as this was not relevant for the study. Participation was voluntary and only progressed if the person felt their mental health would not be adversely affected. One potential participant had several interview dates rescheduled, partly due to their mental health needs, and was eventually unable to take part due to the time constraints of the recruitment phase.

During the interview, participants were asked to speak about their difficulties in relation to depression, employment, unemployment, and related welfare benefits. As interviewees reflected on these issues, it was anticipated that they might experience psychological distress. With this in mind, distress was monitored throughout the interviews, and interviewees were

asked if they wished to stop or take a break when this seemed relevant. Participants were forewarned of potential distress before consenting to participation and were debriefed after the interview. A signposting information sheet (see Appendix L) was sent to all interviewees and to some potential participants. A safeguarding plan was in place if any participant were to have disclosed information that could have raised a safeguarding issue.

Contrary to the expectation of distress, participants gave positive feedback about the interview process. Some also offered to support the recruitment by disseminating information about the research.

5.11.4. Impact on the researcher

It was recognised that the study could have an impact on the researcher due to hearing about participants' difficulties and being immersed in their stories. This was managed by discussing issues with supervisors and with the external consultant, keeping a reflective log, and utilising personal therapy.

5.12. Dissemination

Following the completion of the thesis dissertation, a summary of the study will be sent to participants who asked for a copy at the end of their interviews. The research is planned to be disseminated to stakeholders including those organisations that contributed to the project. In line with emancipatory research (Oliver, 1997), dissemination hopes to reach a wider network of disabled people's organisations to contribute to their work. In addition, it is planned to publish the study as a peer-reviewed journal article.

6. Results Chapter

6.1. Chapter Summary

The Results chapter presents the findings of the qualitative analysis and provides the relevant demographic and contextual information about the participants.

6.2. Participant Information

The recruitment phase lasted between July and December 2020. Although not everyone remembered where they saw the advertisement for the research, it is likely that most people learnt about the study via a newsletter or social media callout through non-statutory disability and claimant networks, and one via a Twitter message posted by a disability columnist of a national newspaper. Altogether 13 people showed interest in the research; however, three did not meet the inclusion criteria, one was not available for an interview, and one did not engage in the screening process. All potential participants and interviewees spoke English. The interviews took place between August and September 2020; three interviews were conducted via telephone (all females), four via a video conferencing application, of which only one used both audio and visual functions. Interviews lasted between 54 and 113 minutes with an average of 80 minutes. The average age of those interviewed was 37.3 (age range: 25–51; age range of females: 25–36; age range of males: 29–51). Table 7 details the demographic information of the interviewees.

Table 7

Demographic Characteristics of the Eight Interviewees

Characteristic	n	%
Gender		
Female	3	37.5
Male	5	62.5

Characteristic	n	%
Sexuality		
Heterosexual	6	75
"Gay"	2	25
Relationship status		
Divorced	2	25
Single	2	25
"In a long-term relationship"	4	50
Number of children		
Without children	7	87.5
Adult child	1	12.5
Ethnicity and race		
"White British"	5	62.5
"British South Asian"	1	12.5
"Indian Jamaican British"	1	12.5
"Irish"	1	12.5
Belief and religion		
Not practicing a religion	6	75
Practicing Islam	1	12.5
"Curious"	1	12.5
Education status		
No GCSE or 'O' levels	2	25
GCSE or 'O' levels	3	37.5
Industry specific training	2	25
University degree	3	37.5

Note. Answers to the questions collecting demographic information were not predetermined; quotations reflect the participants' words.

In keeping with the pragmatist philosophy (see Section 5.2.), which sees research taking place in a social context, further contextual information is provided here about the participants in addition to the wider contexts discussed in the Introduction chapter (D. L. Morgan, 2014, p. 1050).

Regarding the employment history of the interviewees, all were unemployed at the time of the screening, and one had started a full-time job a week before the interview. On average, the last period of unemployment up to the interview dates had lasted for 2.7 years (range: 0.5–5 years), although many had experienced several periods of unemployment. All participants had worked in paid jobs for at least four years and up to roughly 35 years. Participants engaged in a wide variety of industries and positions.[22] Interviewees were looking for employment in five regions in England.[23] In addition to paid employment, five participants had volunteered at least once, another participant had taken time off from work to care for a family member, and one interviewee said that they would consider working for free as work experience in the field of their interest.

In terms of welfare support, six had experience of claiming one of the legacy benefits (two were on JSA, three on ESA, one claimed both at different points; two had received working tax credit in the past; and at least two received housing benefit). Out of these six participants, two continued to claim ESA and four had transitioned to Universal Credit, two of whom were allocated into the 'all work-related requirements' arm and two were allocated into the 'work preparation' or 'no work-related requirements' groups of Universal Credit.[24] In addition, two participants had support only via Universal Credit and were placed in the 'all work-related requirements' group. The shortest claim, up to the interview date, was for 6 months; however, most participants had received legacy benefits and/or Universal Credit for a few years, some with gaps over several years. Personal Independence Payment (PIP) was received by three participants. It was issued to one participant for mental health reasons, one for the combination of mental health and visual impairment, and one for mental health and

[22] Jobs included engineering; administration; social care; fund raiser; retail assistant and manager; delivery driver; self-employment; employment in statutory and charitable organisations; and minimum wage jobs in the hospitality, food production, and retail sectors.
[23] Job sought in or near Greater London (n = 4), in the North West (n =1), in the West Midlands (n = 1), and in the Greater Manchester areas (n = 2).
[24] Participants were not sure which arm they were under.

mobility reasons. Food banks were part of one participant's life on a regular basis and this individual had also been signposted to a non-statutory debt reconciliation agency by the Jobcentre.

Regarding participants' accommodation, two were in social housing, two in council property, two lived with their parents, and one rented privately. In addition, one participant, who lived in a caravan on an illegal site with water and electricity supplies but no postal address after leaving unsuitable temporary council accommodation, was classed as homeless. In the past, two participants had been homeless[25] and two spoke about their fear of becoming homeless in the future.

In line with the inclusion and exclusion criteria, all participants had been diagnosed by a clinician with depression or depression and anxiety. Although most participants described having had depression for many years with good days and bad days—some going back to childhood—all had received the diagnosis at least two years ago. Some interviewees named specific events that marked a significant deterioration (e.g., divorce, bereavement, or falling behind with their studies) or a sudden shift with no identifiable trigger, whilst others described a more gradual change with several contributing factors relating to work and/or other life events that had led to them seeking help and receiving the label of depression. No two descriptions of depression were exactly the same; however, there were some similarities regarding the symptoms. A couple of interviewees spoke about mental health crises escalating to deliberate self-harm and/or attempted suicide whilst some expressed feeling suicidal in the past. Some participants had received mental health support from the Accident & Emergency (A&E) department, crisis team, and/or community teams in the past, or had phoned a non-statutory helpline when in need. All participants had taken anti-depressants at some point—some were still prescribed medication, and one had switched to a food

[25] One in a homeless shelter and one staying with a friend after not being able to access a homeless shelter.

supplement. In addition, individual cognitive behavioural therapy (CBT) had been offered to four participants, group CBT to one; three had tried counselling following a General Practitioner (GP) referral, one via student support, one via an employee support programme; one was accessing open-ended private counselling funded by PIP, one had had six free sessions of counselling via a non-statutory group, and one had taken part in a community gardening programme for mental health support. Although some stated that medication, CBT, counselling, or the gardening programme helped somewhat, others expressed criticisms of the interventions or treatment they had received.[26] No one spoke about being cured or recovered, even though some described having good mental health at the time of the interview. Despite expecting some distress due to the research topic, all participants gave positive feedback at the end of their interview.[27]

6.3. Analysis

The analysis followed the six-step thematic analysis method described by Braun and Clarke (2006), which is detailed in the Method chapter. In total, six main themes with 13 subthemes were constructed. In addition, two overarching themes with three subthemes highlight the relationship between the six main themes. Table 8 lists the overarching themes, main themes, and subthemes along with illustrative quotes.

[26] Criticisms included one describing CBT as childish, one felt that group CBT placed a pressure on them to be social more than they could manage, and some said that the treatment was too short, or the impact/effect wore off; one felt counselling was culturally inadequate, and some said that the negative side effects of the medication outweighed the benefits.

[27] Some distress arose from experiencing some difficulties about finding the words to describe their experience (e.g., regarding depression), which they did not usually talk about.

Table 8

The List of Themes and Subthemes with Illustrative Quotes

Overarching themes	Main themes	Subthemes	Illustrative quotes
Interacting barriers			our system shouldn't be made to be endured, any of it, we shouldn't have to endure it, it should work (Chris)
	Communicating confusion		
		"A lot of it isn't fully explained to you"	the one thing that makes it quite sort of stressful it's just that a lot of it isn't fully explained to you and you feel quite sort of helpless […] it feels like erm ((puffs)) they don't really tell you exactly what's going on and I—I also feel like each month like when we get the money I always sort of—it's kind of a relief when we get the same amount (Gina)
		"They still don't have that joinedupness"	once you go to the doctor and you might say 'I'm a bit depressed'. 'Okay, we'll get you to see someone within a month. Okay, I'll sign you off for three months' but what he's not taken into account is that appointment is not there in a month. […] He's [GP] pissed off when I go back the second time that I still need another three months' extension on that [sicknote] but he's not taken into account that that help wasn't there. (Chris)
	Managing in hardship		
		Choosing between essentials	it's just non-existence or you've gotta choose between food or heat you know and that—that's not a nice place to—a nice world to live in, really, is it? (Dave)

Overarching themes	Main themes	Subthemes	Illustrative quotes
		Facing financial insecurity when moving between benefits and working	jump through all the hoops for Universal Credit, which in itself is a nightmare whether you've got a health problems" (Ben)
	Managing mental health		
		Weighing up treatment options	every time I talk to him [GP] they keep suggesting I go on meds again […] it really wasn't good for me […] every time I've been CBT, it's always been group CBT, I would love to do an individual one I think that might be—that could be the answer but obviously I'd have to pay for it (Hanna)
		Bouncing between the stresses of depression, unemployment, and work	I think now that with COVID-19 the restrictions [sic: conditions] have been lifted slowly and I'm not—I'm not—I'm not having to provide as much evidence now. So I think it's helped me in there erm I don't feel under a lot of pressure, lot of stress […] because in the end of the day and life in general can become very stressful and depression and anxiety makes it even worse (Sahil)
	Considering the consequences of working		
		Defining past experiences	I felt a bit hopeless and that I would never work again and then I got that job and obviously erm you know it showed me that I was wrong about that (Hanna)

Overarching themes	Main themes	Subthemes	Illustrative quotes
		Considering the suitability of jobs	I feel like I'm sort of expected to just take <u>any</u> job I can […] I could then get a job that has a big effect on my mental health as I think my other jobs have had […] personally I don't want to just get—get <u>any</u> job I can 'cos I think I'd feel much worse off, yeah I'd rather have less money than be or have slightly more money but be yeah be feeling depressed (Gina)
	Questioning volunteering: who gains—or loses—and what?		and 'cos you are volunteer […] you're not being paid so […] you can say one week 'I can't do it this week', […] it's not like you're working and you've got that—you've gotta be there, you've gotta do this, you've gotta do that, it wasn't like that. It was more, you know, they understood that 'cos you're volunteer, you're—you're giving your time voluntarily (Frank)
	Facing discrimination		I've been working now on and off for 30 years. So I remember you had to go in and sign a book and all that and go in there, but there was never that stigma. When you went into a Jobcentre you felt they are actually there to help you, it didn't have that—but now in a Jobcentre—when I see Jobcentre now I'm scared, I'm literally I don't wanna—I won't set foot in a Jobcentre (Frank)
Counteracting the barriers			
		Seeking human connection	she [Jobcentre staff in specialised team] went out of her way […] she met me outside of the office and she got my claim going and when she told me that I erm have certain protective [sic:

Overarching themes	Main themes	Subthemes	Illustrative quotes
			protected] characteristics […] what laws are protecting me, I've never had that before (Chris)
		Persevering and being proactive	feeling of inadequacy […] and not being good enough […] but I stuck at it erm did that job and did it within two of the teams erm for a number of years" (Emma)
		Removing structural barriers	One area they could explore is erm supporting people better with employment opportunities and providing relevant courses or courses what are geared to—to providing erm job opportunities, especially qualifications at a subsidised cost (Sahil)

6.4. Overarching Themes, Main Themes, and Subthemes

A description of the six main themes and their subthemes is provided below, framed with the presentation of the two overarching themes. Illustrative quotes (with time stamps)[28] and contextual information about the participants are drawn from the data to support the descriptions. This chapter concludes with an extended summary in which narrative examples illustrate the complex relationship of the themes.

6.4.1. Interacting Barriers

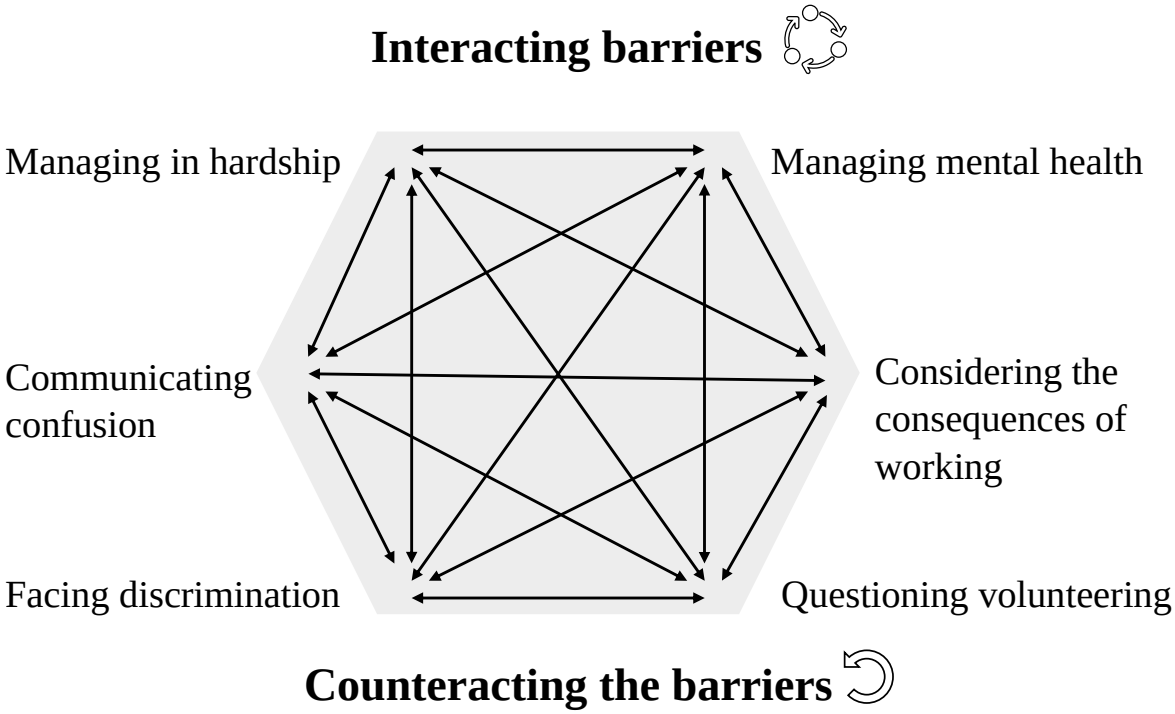
The *Interacting barriers* is an overarching theme that emphasises the interconnectedness of the six main themes. To illustrate this, Figure 2 shows that the main themes are arranged in a hexagon, with two-way arrows connecting each of the six themes. In reality, the six themes in the hexagon do not exist by themselves—rather, they are frozen in time for the purpose of this analysis. In the lives of the interviewees, the dilemmas and barriers presented by the six themes were inextricably linked. As an example, Chris summarised his personal experience and what he had seen as an activist by saying that "if you can't look after yourself and your country can't look after you and that's what's worrying so that puts you on edge" (Chris, 1:19) and that "our system shouldn't be made to be endured, any of it, we shouldn't have to endure it, it should work" (Chris, 1:42).

The presentation of the six main themes starts with the *Communicating confusion* theme following a clockwise order. An additional overarching theme, called *Counteracting the barriers*, demonstrates the actions that mitigate barriers one step at a time, which is discussed last.

[28] Some of the shorter quotes are arranged as block quotes to increase readability, which departs from the 40-word rule guideline of the Publication Manual of the American Psychological Association (7th ed.; APA-7; American Psychological Association, 2020).

Figure 2

Visual Representation of the Six Main Themes in a Hexagon and Two Overarching Themes Highlighting Their Relationship



6.4.2. Communicating Confusion

This theme brings together examples of (1) lack of transparency, lack of information, and (2) disjointed communication between welfare systems that not only hinder access but create confusion, distress, and—in some cases—helplessness.

"A Lot of it Isn't Fully Explained to You." Regarding the transparency of the communication in welfare systems (e.g., health care and social security support), participants highlighted issues from the initial assessment to the ongoing monthly payments, such as the lack of quality assurance of benefit assessments, lack of information about monthly benefit payments, and ineffective complaint procedures in large support organisations.

Interviews that assess potential claimants' eligibility for benefits are not automatically recorded for quality purposes. In Frank's experience, "they use any excuse […] they made it really hard like at the end [to record]" (Frank, 0:15).

Confusion and issues with transparency were a feature of monthly benefit payments. Universal Credit claimants spoke about not being sure as to why they were given the amount they received and whether it would be the same the following month. This uncertainty, and the lack of information, left Gina feeling helpless and Sahil confused:

> The one thing that makes it quite sort of stressful it's just that a lot of it isn't fully explained to you and you feel quite sort of helpless […] it feels like erm ((puffs)) they don't really tell you exactly what's going on and I—I also feel like each month like when we get the money I always sort of—it's kind of a relief when we get the same amount. (Gina, 0:51–52)

> I don't understand like erm whatever sanction and renewed at that time or was applied and now it hasn't applied so I just do not know, there's too much defi—there's too much terminology. (Sahil, 0:15)

Furthermore, participants also noted that the complaint procedures for large organisations were ineffective, cumbersome, and required time and determination. For instance, Dave explained that he tried to communicate his difficulties accessing food banks to his work coach online without a workable resolution for months:

> I used to be forever telling Universal Credit that I got no food and I couldn't get to the food bank because of my mental health situation […] for like six months I was telling them 'I had no food' and part of this was over Christmas and New Year one year and it's—it's just disheartening ((pause)). (Dave, 1:15–16)

Chris spoke about the lengthy complaint procedures large organisations tend to have that makes them "untouchable because the rigmarole you have to go through in order to make ((laughs)) a complaint" (Chris, 2:24).

"They Still Don't Have That Joinedupness." Participants found that a great volume of information is collected about them during the process of accessing benefits and mental health support that is not followed up on, checked, or shared with relevant bodies to aid joined-up support.

For instance, mental health risks, such as suicidal ideation, are explored during the eligibility assessment for benefits; however, in the participants' experience, this was not done with the aim of locating support and notifying relevant support teams to manage such risks.

> [I] was quite alarmed to be honest because the adviser […] then started talking about my mental health erm and it was very much 'Right, are you feeling suicidal?', 'No' , you know and it was very much kind of 'I'm gonna ask you questions but no matter what answer you give me, I'm just gonna make a note of it' ((pause)) you know and it—it almost kinda felt very impersonal and like there was gonna be no sort of offer of any support erm at the end of it […] it would have just been noted down and left and you know potentially that's leaving people at risk. (Emma, 0:16–17; 0:20)

Furthermore, disjointed communication was noted between Jobcentres and GPs, and between different services supporting the mental health needs of people (e.g., between A&E and GP, within mental health services, and slow transfer of medical records between different GP surgeries).

> In the NHS but there's nothing national about it 'cos he [doctor] can't get my files from any of the other surgeries, not in a time scales [sic] that's needed to help someone in an immediate situation, but now they are connected they still don't have that joinedupness. (Chris, 1:38–39)

> Once you go to the doctor and you might say 'I'm a bit depressed.' 'Okay, we'll get you to see someone within a month. Okay, I'll sign you off for three months' but what he's not taken into account is that appointment is not there in a month. […] He's [GP] pissed off when I go back the second time that I still need another three months' extension on that [sicknote] but he's not taken into account that that help wasn't there. (Chris, 1:36–37)

Chris' second example drew attention to a misalignment between different parts of the welfare system (i.e., sicknote not being renewed even though he had not even started the mental health treatment). This showed that not being able to receive mental health support in a timely manner had implications for other parts of welfare support.

The *Communicating confusion* theme detailed ways in which lack of transparency and the disjointed welfare systems, including health care and social security, added further distress to participants' lives.

6.4.3. Managing in Hardship

The *Managing in hardship* theme explores ways in which (1) unmet basic needs and (2) the cumbersome benefit system can hinder re-engagement with the labour market for those who are balancing on the poverty line.

Choosing Between Essentials. Interviewees explained the ways in which insufficient funding via benefits hindered their ability to engage in the labour market. Accounts suggested that if people's basic needs were not met (e.g., having suitable accommodation, access to heating, water, food, broadband, and IT facilities), their attention was more focused on finding ways to meet those needs, which, in turn, negatively impacted their ability to engage in work-related activities. For instance, Dave, who lived on his own, felt that it was harder to make ends meet as a single person on benefits without support from family. He explained that he often had to choose between essentials, such as heating and food:

> It's just non-existence or you've gotta choose between food or heat you know and that—that's not a nice place to—a nice world to live in, really, is it? (Dave, 1:21)

Dave relied on food banks for long periods, which he found a "really degrading" experience (1:18).

Chris found being in "temporary accommodation housed by the local council […] less than ((pause)) inhumane" (Chris, 0:29). Chris' solution was to live in a caravan on an illegal

site with access to utilities but without a postal address, which meant that communication with statutory services was problematic. Gina was the only interviewee who could afford private rent jointly with her partner, unlike others who lived with their parents or in a council house to reduce living costs. Gina explained that she lived in a small town where the rent was cheap but, in turn, there were fewer job opportunities, which left her feeling "quite sort of trapped" (Gina, 0:35). Even Gina, who had a joint Universal Credit (UC) claim with her partner, reduced council tax, £20 weekly top-up for UC to mitigate for the financial impact of the COVID-19 pandemic, and savings from cancelled travels, found these were only just about enough to live on. Furthermore, Hanna found herself in "crappy accommodation" (Hanna, 0:15) after her parents moved away as her job ended. She noted that her place was not suitable for working from home and did not have good Internet connection, which was essential for job searching. Hanna also explained that applying for jobs in a noisy Internet café with bad computers brought additional challenges, such as it being "hard to sit and apply for—and focus and apply for jobs there" (Hanna, 0:16).

Any reduction in benefits payment, such as sanctions or the removal of any components, proved to have a long-standing detrimental impact on participants. Frank, for example, entered a long process of appeal after the mobility component of his benefits was withdrawn amounting to a £90 per month reduction, whilst Sahil lost his accommodation after being sanctioned.

> I was sanctioned many times and then as the result my housing benefit was stopped so I had to then move into a hostel. (Sahil, 0:9)

Dave also added that debt can quickly escalate under these difficult circumstances, which put him on "one big downer really" (Dave, 1:18), and that being signposted out by the Jobcentre to a debt reconciliation charity seemed like statutory services shifting their responsibilities to charities.

> The fact that the government's put people here to help people out of debt or [debt reconciliation charity] they're just debt conciliation-like things […] debt concilidation [sic] is really, really is a bad state of affairs (Dave, 1:18 & 1:40)

Balancing on the poverty line also meant that, by not having a financial buffer, people were more restricted in their options of trying to make life more manageable. More costly solutions, such as (re)training or education (e.g., Gina: "I can't really have that opportunity again because of tuition fees;" 0:41), and even ones with smaller expenses were inaccessible. For instance, Hanna's laptop, essential for job searching, broke and she could not replace it as she chose to save up the COVID-19 top-up to move "somewhere more suitable" (Hanna, 0:34).

This financial instability and consequent insecurity seemed to have consequences beyond the individuals. Gina explained that the financial insecurity affected her mother's mental health and subsequently hers, which led to the longer-term impact of Gina not doing well at university and having been stuck in minimum wage jobs since graduating:

> We never had much money erm when I was growing up […] my mum was always kind of worrying about money like she'd just talk about that quite a lot […] it wasn't necessarily a sort of happy environment […] it was always—always things to be stressed about and I sort of think yeah I sort of picked that up from her. (Gina, 0:45–46)

Facing Financial Insecurity When Moving Between Benefits and Working. The way in which the current benefit system (including legacy benefits and Universal Credit) is organised posed several issues for those who wanted to leave the benefit system and enter paid employment. The main issue the interviewees brought to light was that there were multiple risks to starting and stopping jobs in case the job came to an end or was not suitable for the individual. It was highlighted that reapplying for benefits was difficult, not only because it was a lengthy process but also because successful application was not guaranteed, nor was securing at least the same amount of funding. Interviewees who had experience of

the old (i.e., legacy benefits, such as JSA) and the new (i.e., Universal Credit) systems were able to compare them. For instance, according to Hanna, in addition to the five-week built-in delay for first payment of UC, she had waited an extra month because her last partial salary payment from a temporary job was over the permitted monthly income limit, preventing her from applying for UC as soon as she knew her last working day. With JSA, Hanna had been able to apply in advance and the funding would start close to when her job ended. With UC, this gap was over two months long for Hanna.

> I think Jobseekers was better because […] my job ended I think it ended in June or July and then—but I was still getting payment up until August and then they said you can't even apply at all if you're getting any payments, even if you're getting a payment that's like—it's a small amount […] from an employer you can't even apply for Universal Credit which I just think it's crazy erm ((laughs)) so I mean it takes something like five weeks anyway er from you know when you apply to when you start receiving but I mean you know it could potentially be even longer than that when you consider you know I mean £230 to cover rent and everything else you know in a calendar month that is crazy so erm you know do—the Jobseekers it didn't really leave you in that er dire state so erm yeah I think it was better in that respect (Hanna, 0:32–34)

In addition to the gaps in payment, the uncertainty of whether one could successfully re-apply for benefits and the cumbersome application process were also named as barriers. For instance, Ben stated that one has to "jump through all the hoops for Universal Credit, which in itself is a nightmare whether you've got a health problems" (Ben, 0:33–34). Dave found it harder to get onto ESA than onto JSA, similarly to Chris, and explained that he found that the assessment was disadvantageous to those with a mental health condition:

> I could never actually get onto ESA […] they just use to fail me off at the medicals […] they'd get me into medical and say, 'Can you like stand up and do this, and can you touch your toes, can you—can you put your arms above your head?' […] they didn't seem erm to take—take it in that I was suffering from mental health which is—which is what I explained to them and put it down in all forms and all and all the stuff

> ‘cos it the forms are quite relentless what you’ve gotta fill in for—for these interviews. (Dave, 0:7–9)

For those who are on the old system, the bad reputation of UC could be a deterrent from starting a job that they might not be able to keep, as it was for Frank:

> Universal Credit is something I don’t wanna touch (inaudible) luckily I’m avoiding it at the moment where I am they—it’s not rolled out in here. (Frank, 0:38)

It was also mentioned that the gig economy, such as zero-hours contracts or even part-time jobs with the weekly UC top-up seemed to carry too much risk:

> If I was to take one of those jobs and all the top-up stuff I mean it’d be like all this like paperwork […] to sort out every week and then you’re reliant on a number of people like doing their jobs correctly, just in order for that to be processed on a weekly basis so it just sounds like erm a bit of a sort of Pandora’s box, a bit of a nightmare so I wouldn’t really wanna be in a sort of situation where I’m dealing with top-ups or something like that I would—I would not consider a part-time job. (Hanna, 0:36–37, who has good computer skills and had jobs in administration)

The combinations of these conditions (i.e., gap in benefits payment, no guarantee of receiving benefits, and no security in weekly supplement payment) create barriers for those without a financial buffer and could hold people back from entering a zero-hour contract, a temporary job, or a job that they are not sure they can sustain.

6.4.4. Managing Mental Health

The *Managing mental health* theme encompasses issues around (1) treatment options for depression (e.g., accessibility, suitability, choice, and timely support) in addition to highlighting (2) the stresses linked to unemployment, depression, and work.

Weighing up Treatment Options. Everyone interviewed took medication at some point with no or limited success and suffered from its side-effects.[29] All interviewees asked for and received psychological support from at least one source; however, the ongoing emphasis on medication coupled with the lack of actual and/or perceived alternative options seemed to be a deterrent from seeking help again. For instance, both Gina and Hanna were "reluctant" (Gina, 0:58) to go back to their GPs in the fear of being told to restart medication and not being offered a suitable alternative option. Both the modality and the intensity of the alternative option were decisive factors in the usefulness of the support, which is illustrated with Hanna's and Ben's examples:

> Every time I talk to him [GP] they keep suggesting I go on meds again […] it really wasn't good for me […] every time I've been CBT, it's always been group CBT, I would love to do an individual one I think that might be—that could be the answer but obviously I'd have to pay for it. (Hanna, 0:22–23 & 0:25)

After a failed suicide attempt, Ben felt pressured to "take more tablets" (Ben, 0:56) by his care coordinator at the crisis team and noted that the six weeks of CBT with the NHS "barely started to touch the surface" (Ben, 0:58). In Ben's experience, there were "no real other options" and this created a "big gap in the middle between sort of the very mild bottom of mental health and then the top end where it's inpatients" (Ben, 1:0).

Like to Ben, Dave expressed his disappointment with the cycle of unhelpful referrals between different parts of the mental health systems. He said he believed "the NHS's been underfunded for such a long time" (Dave, 1:9) resulting in "skeletal" services (Dave, 1:0), and that "the NHS is having a mental health crisis, this was before COVID kicked off" (Dave, 0:27).

[29] Side effects, such as anger (Chris), weight gain (Hanna), feeling detached (Gina), not caring enough about work (Emma), and having no appetite during the day and increased hunger at night (Frank) were noted by participants. They took these factors into account when considering long-term use of medication.

> I've been reluctant to visit A&E these days. I—I don't find that what people go to A&E with a mental health erm they don't have the right people there to—to talk to you about it, they'll have a mental health nurse what's on call and they'll come and refer you back to the mental health crisis team which I've been complaining about for many years at [town of residence] the crisis team it's just er they're not worth talking to to be honest, the support they offer you is not enough, and also what they do is send me back to my GP to get high—more highly medicated which I—I don't wanna do. […] crisis team erm they'll give you a ring about erm within three days of your appointment at hospital and they just offer the same service that I've had before which is CBT, cognitive behavioural therapy or one to one chats which I've explained I've—not always had a positive effect on myself. (Dave, 1:7–8)

The suitability of the treatment option can also be determined by the degree of adaptability of assessments and interventions to accommodate for cultural differences and complex access needs, such as disabilities. In Emma's experience, therapy was adapted to her "visual impairment" (Emma, 1:7); however, in contrast, the therapy Sahil tried via a small company, he found to be culturally inadequate. Sahil felt understood by his GP who was from the same background:

> She [therapist] was a trained counsellor […] a white British lady […] she didn't show the level of understanding or empathy, she couldn't relate to the cultural dynamics […] whenever I saw my GP and I told him because he was from South Asian background he understood completely […] He says erm 'I can totally understand what you're against or what the problems you may be faced with your family.' (Sahil, 0:49–51)

When interviewees were weighing up treatment options, their own mental health was also a factor they considered. Gina, who said she tended to "downplay" (Gina, 1:0) her difficulties, avoided asking for help in case it spoiled the good days, whilst Hanna found the "social dynamic" of a group CBT "too much" and "dropped out" of the treatment (Hanna, 0:24). Attending appointments, or attending appointments in a calm manner, was also a challenge for some. Chris' examples below highlight two paradoxical situations whereby he

was asking for help in an abusive manner due to his mental distress that resulted in him not getting help from the mental health service, whilst other times he was so unwell that he refused the service that led to his discharge when he needed help the most.

> How can I really be myself and truthfully communicate how I <u>really</u> feel if you're [mental health staff] telling me 'Don't come to me unless you're going to act this way.' If I can act that way [in a calm, non-abusive manner], I wouldn't need a doctor, I could just get on with my life. I want help so that I <u>don't</u> treat people this way so that I <u>don't</u> fly off the handle. (Chris, 0:52)

> I'm that much in a rot and I refuse that service, that's not a ticket for the NHS to say, 'Okay, I'm done. He's off of our books' that tells you that you need to call him back tomorrow or the day after, or the day after, and you need to keep calling him until you know he has spoken to his doctor and […] he turned up to his appointment with his mental health worker like that—there needs to be some follow through. (Chris, 2:8)

Bouncing Between the Stresses of Depression, Unemployment, and Work. The changes in welfare policy due to the ongoing welfare reforms and the COVID-19 pandemic allowed interviewees to draw comparisons. Emma explained that "the old one [ESA] was kinda better almost in that […] they referred you to kind of other organisations who could help you, whereas with this one [new ESA] you are just left to it" (0:56), which disadvantages those who "need a lot more specialist help" (Emma, 1:26). On the other hand, Sahil found that the reduced pressure from his work coach during the pandemic helped his mental health.

> I think now that with COVID-19 the restrictions [sic: conditions] have been lifted slowly and I'm not—I'm not—I'm not having to provide as much evidence now. So I think it's helped me in there erm I don't feel under a lot of pressure, lot of stress […] because in the end of the day and life in general can become very stressful and depression and anxiety makes it even worse. (Sahil, 0:12)

The interaction between wellbeing and unemployment showed a two-way relationship, in which bad mental health can be a contributory factor to becoming unemployed and, vice

versa, unemployment can worsen mental ill-health (e.g., Hanna saying that "I mean unemployment you always feel crappy anyway;" 0:9). This circular link was evident in Dave's example. Dave's financial condition whilst on benefits created a situation in which he was having to rely on food banks, which he found "degrading" (Dave, 1:18) further lowering his mood, which, in turn, made it harder for him to get out of bed, "go out and deal with people" (Dave 1:17), and to leave the house to visit the food bank. This said, Gina's experience with unemployment had an additional positive element that provided a temporary relief from minimum wage jobs that made her "feel very down a lot of the time" (Gina, 0:27). Hanna noted that unsuccessful job interviews, difficulties with colleagues, line managers, and relationships could all make her mood worse; however, depression, in her experience, "surfaces sometimes like even when I am in a good position" (Hanna, 1:13). This fluctuating and unpredictable nature of depression[30] was echoed by others and seemed to hinder labour market engagement. In Frank's and Chris' case, exercising self-preservation took priority over having a job:

> It's hard thing to admit but it's the truth 'cos I could try and go and get a job in a bar or do a zero-hours contract, but […] well my mental health—I wouldn't last—it would really affect me. (Frank, 0:16)
>
> You can't stop the snowballing […] you don't go and get a job, you don't go and have those interactions, you keep yourself in a protective bubble. (Chris, 0:47)

The *Managing mental health* theme outlined ways in which inadequate and misaligned support from different parts of the welfare system (i.e., social security and health) created a

[30] Interviewees also spoke about the fluctuating and unpredictable nature of depression. For example, Ben felt depression "crept up on me" when he "wasn't paying attention to my own mental health" (Ben, 0:15), whilst Gina said it is "under the surface" and it "can come out any time" (Gina, 1:1). Frank described depression as "there's literally nothing you can do about it to stop it, you just have to go through it again. […] It's like going through a storm or fog you know like a fog you can't see where you goin'—like you know when it gets foggy, you can't see" (Frank, 0:28).

circular link between wellbeing, work, unemployment, and welfare, limiting interviewees' chances of getting better and seeking out a suitable job.

6.4.5. Considering the Consequences of Working

The *Considering the consequences of working* theme captures two facets of the work-related dilemma; namely, (1) the ways in which the wish to avoid the repetition of negative work-related experiences limit future work options, and (2) the notion that people consider the suitability of potential jobs. This theme builds on the *Managing mental health* theme. All interviewees had had at least one job and had worked for at least a few years. The reasons for becoming unemployed varied across participants and jobs. Job loss was often due to a combination of factors, such as financial difficulties, organisational ethos, discriminatory practices, mental (ill)health, physical fitness, temporary arrangements, caring responsibilities, and workplace bullying. This said, accounts also showed that loyalty and perseverance kept people in jobs despite the challenges, which is further detailed under the *Counteracting the barriers* theme.

Defining Past Experiences. One of the driving forces in navigating the labour market seemed to be the desire to avoid the repetition of negative experiences in the workplace. Examples included being publicly embarrassed by the line manager (Hanna), having a skewed work-life balance (Ben), or being shouted at instead of being trained up for the job (Chris).

Interviewees also highlighted exploitative practices in workplaces, especially in minimum wage jobs, leaving them feeling stuck and powerless. For example, Gina explained that she did not have "much say over" (0:18) her shift patterns (e.g., finishing at 10pm and starting back at 6am) and was made to feel by her managers that she "was being unreasonable" (Gina, 0:18). Gina felt the job was "taking over my life" (0:13) and that "in jobs like that a lot of the time you feel quite helpless" (Gina, 0:17). Similarly, Ben also talked

about “dreading going to—going to work every day” (Ben, 0:32) and receiving “phone calls on the day off and at the weekend abou—about unimportant things and emails at midnight” (Ben, 0:24).

Interviewees also spoke about the impact negative experiences at work had on their mental health. For example, Chris was traumatised by his colleague’s abusive behaviour and Hanna recalled being “really depressed” in a job with a “very very toxic work environment” where she received no “respect” (Hanna, 0:19). Emma described working in an organisation where she experienced barriers related to her visual impairment. This said, both positive and negative work experiences seemed to directly influence participants’ confidence and hopefulness that appeared to affect their ability to apply for jobs and to interview well. This created a feedback loop, which is illustrated with Emma’s and Hanna’s examples:

> When I left erm work erm I just got no confidence erm no sort of you know I wa—well to be honest I couldn’t see me ever working again because I didn’t really feel that I had anything to contribute because it had been sort of quite a negative experience [in my last job] […] I’m in a different role erm with different people erm I—I see it a lot more brightly erm and I’m hoping that you know once they sort of see my potential erm you know there’ll be opportunities to sort of develop and progress. (Emma, 0:13 & 0:50–51)

> I felt a bit hopeless and that I would never work again and then I got that job and obviously erm you know it showed me that I was wrong about that. (Hanna, 0:19)

Both Hanna and Emma found their union’s support helpful when their work situation turned sour. Emma was in contact with the Occupational Health department; however, her employer “wasn’t implementing any of the recommendations” (Emma, 0:11).

In addition to battling with thoughts of worthlessness (e.g., Gina saying “why would anyone want to employ me to do something?;” 0:40), a fragmented work history or one with bigger gaps brought its own challenges. Ben expressed his concerns that his “employment

history for the last couple of years is shaky at best" (Ben, 0:49), whilst Hanna's multiple seasonal jobs were hard to explain at interviews.

> I can't really neatly summarise like you know my work history and so obviously people [interviewers] get bamboozled. (Hanna, 1:18)

Considering the Suitability of Jobs. When considering a job or the possibility of working, participants reported that they assessed possible jobs from different angles for their suitability. Interviewees unanimously emphasised that they would only take a job that would not make their mental health worse, which is illustrated with Gina's example:

> I feel like I'm sort of expected to just take any job I can […] I could then get a job that has a big effect on my mental health as I think my other jobs have had […] personally I don't want to just get—get any job I can 'cos I think I'd feel much worse off, yeah I'd rather have less money than be—or have slightly more money but be yeah be feeling depressed. (Gina, 0:53–54)

Another essential criterion was that jobs must not create worse or insecure financial conditions for them whilst working or when the job ends. Both dilemmas are also referenced under the *Managing mental health* and *Managing in hardship* themes with further examples. For instance, Dave, as a single person without family backup, found low-paid work not to be "financially viable" (Dave, 0:21).

> I got a job with [international retailer] first as a self-employed delivery driver erm which I could deal with quite—quite well but I was working from six o'clock in the morning till ten o'clock at night and not making any money. So in the end I packed that in. (Dave, 0:19–20)

In addition to the mental health and financial considerations, another necessary criterion of a future job was not to be discriminated against during the application process and whilst employed. In Emma's experience, the support worker who was part of her reasonable adjustment arrangements for her visual impairment became a "threat" (Emma, 0:28) to her

job; consequently, since then, she was only looking for positions that she could do without a support worker:

> I'll look round for jobs that I want to do and erm I apply for those. (Emma, 0:14)

Equally, Sahil talked about "inequality," "injustice," and "racism" in Britain (Sahil, 57–58 mins) and that these factors, along with the possibility of accommodating his religious practices needed to be taken into account when assessing the suitability of jobs:

> Even if you were to go to work, you have to take all of these factors into consideration like: Am I going to be faced with more inequality for working in this environment? (Sahil, 58 mins).

The timing of the return was also a factor to consider. For instance, Chris noted that the "people around me [his mother, partner, and GP] that made me go and get this job, I wasn't ready for work" (Chris, 1:8). In Chris' experience, premature return can also be detrimental.

Interviewees also hoped that their future employer would accommodate their mental health needs by having a flexible approach and allowing time off when needed:

> It'll have to be that leeway for me not to be able to go in like—not to—I would be able to have that leeway to say, 'I can't come in today.' (Frank, 0:47)

Furthermore, participants expressed a desire to have something in return for working in addition to a salary. Ideas included being able to save up for a holiday to get through the difficult days at work (Sahil and Gina), "being valued as a worker" (Dave, 0:39) or—at least—being appreciated by customers, doing something meaningful, or "doing work what's beneficial to change erm to—the needs of a vulnerable groups in society" (Sahil, 1:3).

> Even though [international retailer] didn't pay us right or appreciate us, I think the customers did in the end and sometimes that's all you need, just a little bit a job satisfaction, that's enough to go on. (Dave, 1:27)

Further to the necessary criteria, participants also discussed some additional ideas they considered desirable but not essential in a job. Most importantly, these included a job in their

area of interest and, for some, the opportunity to gain new skills and to "progress" (Emma, 0:51):

> Getting all further professional erm development, qualifications, and skills and making myself even more employable for the like next job. (Hanna, 0:50)

Keeping these criteria in mind, participants face difficult decisions when they try to balance their mental health needs whilst navigating the labour market and the benefit system. Some expressed their scepticism about the existence of suitable jobs that could accommodate their fluctuating mental health needs. As Frank noted, he believes that when he needed a day off at short notice, his employer "wouldn't understand it, most employers wouldn't, there's very few jobs out there that do understand" (Frank, 0:43).

6.4.6. Questioning Volunteering: Who Gains—or Loses—and What?

Both the opinion and the experiences of volunteering showed a mixed picture, ranging from multiple benefits to exploitative, sceptical to optimistic, and valuable to risky. The volunteering landscape for benefit claimants brought its own challenges, such as risking exploitation or being judged to be work-ready. For instance, in Frank's experience, volunteering and hobby activities were monitored by official bodies, such as the Department for Work and Pensions (DWP), and these, he feared, could be taken as proxy indicators for fitness to work. Frank argued that a hobby activity providing an additional income or volunteering were each fundamentally different from paid employment due to the more generous allowances and flexibility and that, therefore, these should not be used as proof for work readiness:

> And 'cos you are volunteer […] you're not being paid so […] you can say one week 'I can't do it this week', […] it's not like you're working and you've got that—you've gotta be there, you've gotta do this, you've gotta do that, it wasn't like that. It was more, you know, they understood that 'cos you're volunteer, you're—you're giving your time voluntarily. (Frank, 0:59)

> You gotta be careful with that [earning from the hobby] 'cos if you're doing that the DWP will say 'oh, look, you could do that, that's a job, that's working,' it's not working, it's not—it doesn't give you a living. (Frank, 0:45)

Interviewees had mixed experiences and opinions about volunteering. Hanna was initially sceptical about the value of volunteering, thinking it was a "waste of time" (Hanna, 1:7); however, after several volunteer positions she felt she benefitted in many ways. For instance, Hanna gained a laptop as a reward and her social life improved, whilst Frank volunteered to occupy his time but found the customers' stories at the food bank intensified his "anxiety" (0:54). Sahil also had several volunteer jobs but, contrary to Hanna, he found these exploitative as he had similar duties to paid staff members.

> It's only for the gain of the employer, so benefits are to the employer […] they're benefiting via—erm making their pockets larger. (Sahil, 1:05)

To summarise, volunteering can have its benefits; however, it can also bring the risk of losing one's eligibility for social security or being exploited. Thus, participants explained the need to consider several factors and decide if the benefits of volunteering could outweigh the risks.

6.4.7. Facing Discrimination

The *Facing discrimination* theme collates examples of discriminatory practices and stigmatisation manifested on the micro, meso, and macro levels, along with self-blaming attitudes and shame.

Common mental health conditions or even psychological distress are less visible impairments. As there are no biological markers for mental health conditions, professionals have to rely on people's descriptions of their experiences and symptoms when diagnosing depression (see Section 4.). This also leaves room for not being believed, which can feed ignorance. In Chris' example, he was told by his GP that he "shouldn't be feeling like that"

(Chris, 1:14). Similarly, when Dave was assessed for ESA, he felt his physical health was prioritised and his mental health difficulties were ignored:

> I just thought it was so wrong how the government treat people […] they're not willing to accept that you've got mental health and you've not got a physical disability as such, obviously they can say 'it's in your head', can't they, erm that 'there is nothing wrong with you' which is what they've been saying to me all along. (Dave, 0:14)

Sahil's example speaks to the discrimination he encountered on the intersection of mental ill-health and racism when he met a White therapist who did not understand his cultural context (detailed under Section 6.4.4.). I note here that Sahil was not offered another, culturally more appropriate intervention. Similarly, Emma faced discrimination at the intersection of physical disability and mental ill-health. Emma was initially offered group CBT, which was then changed to individual CBT adapted to her visual impairment (see Section 6.4.4.). Although the CBT programme was adjusted to Emma's needs, one could argue that inclusivity was not part of the design, rather an afterthought; therefore, the adjustments could have served as an emphasis of her difference, reinforcing institutional discrimination.

In addition to experiencing discrimination due to mental ill-health, further stigmatising attitudes were noted due to claiming benefits. The shift in public opinion and government attitude was noted by Frank, who had had many jobs with gaps in between for about three decades. In his view, the stigmatisation of benefit claimants has not always existed:

> I've been working now on and off for 30 years. So I remember you had to go in and sign a book and all that and go in there, but there was never that stigma. When you went into a Jobcentre you felt they are actually there to help you, it didn't have that—but now in a Jobcentre—when I see Jobcentre now I'm scared, I'm literally I don't wanna—I won't set foot in a Jobcentre ((pause)) 'cos they—they're trying to—I feel they're trying to catch you out and trying to get you off anyway they can, even if it

> means you die ((laughs)) literally it meant you had no food, they don't care, a lot of them—a lot of people—they just don't care. (Frank, 1:14)

Sahil noted that the pressure from the Jobcentre was linked to ideas, such as people on benefits "just need to be given a push" (Sahil, 0:22), "people on benefits are very lazy, very selfish or very idle" (Sahil, 0:22), which, he believed was what "the government are trying to imply" (Sahil, 0:22). Similarly, Chris spoke about his understanding of benefit claimers being treated with suspicion and assumed to be guilty of benefit fraud by default:

> But just 'cos you [Jobcentre staff] think that he's a scrounger, doesn't mean that he is a scrounger, so it doesn't mean you should talk to him like a scrounger. (Chris, 1:20)

> I'm not gonna go down there [Jobcentre] and be put und—the under the spotlight and made to feel like I'm under interrogation for something that you said that I was entitled to in the first place. (Chris, 1:58)

Sahil had an idea for a business helping homeless people and asked his work coach for help to apply for a grant. He felt his idea was dismissed without consideration:

> Whenever I've spoken to the Jobcentre about this, I said to them, they've said, 'No, we don't think it's suitable for you' […] 'there is no teams in place' […] they're just haven't listen to me […] they just ignored me or dismissed me […] she just says… she switched the conversation, she said to me erm 'how many jobs have you applied for?' (Sahil, 0:31–32)

Frank called attention to the difficulty of renting for those on benefits, the ways in which media portraits of claimants exacerbate the stigmatisation of this group, and the disproportionate focus on benefit fraud in comparison to other matters, such as tax avoidance.

> I'm not working, so straight away when you're not working, you can't go rent—people don't wanna rent—straight away you got that stigma, some people 'No DSS' you see it on the erm you see it on the erm advertisements. (Frank, 1:17)

> Some people think I'm earning, you know, getting thousands and thousands a month ((pause)) which the mainstream media will have you believe we're all living the life

> of Riley, I can tell you now, we're not 'cos I wouldn't—I wouldn't wish this life on anyone. (Frank, 0:17)
>
> Benefit fraud it's like 0.07 percent or something stupid like that […] real fraudsters gonna want—that's no—that's no money for them. (Frank, 1:13)
>
> We've got these big companies now like these big online giants like Amazon who don't pay hardly any tax to—to the UK Government. (Dave, 1:27–28)

Ben admitted that initially he believed people were exaggerating the difficulties they faced when in need of welfare support:

> I heard stories like all the time I was working, people moaning about the benefit system and what a nightmare it was and I thought well people've being a bit overdramatic, if I am honest I sort of thought that then yeah sorta I discovered that that they weren't. (Ben, 0:34)

As Ben admitted his initial ignorance, Frank also spoke about his experience of the public, employers, or even friends and family members not being aware of the issues around disabilities, unemployment, and benefit claiming. In Frank's experience, sometimes only drastic measures, such as blocking a road as part of a demonstration to raise awareness of the unfair treatment of disabled people, would "bring attention" (Frank, 0:11) and help to make the public listen. Frank hypothesised that the reason for the lack of awareness could be because some people "don't want to believe 'cos I suppose ((pause)) it's a scary thing" (Frank, 0:12), some "people think they're untouchable" (Frank, 0:12), "some people don't wanna see it, they rather not know" (Frank, 0:21), and "some people—they're blind even when you show them what's exac—h—what's happening and you can show them , they couldn't even see it […] people're just shut off to it sometimes" (Frank, 1:12). He also argued that the public has accepted the existence of food banks, which might be another example of public ignorance:

> Like food banks, why we accepted in this country that food bank should exist 'cos they didn't exist 15 years ago, did they, no one would know what a food bank was

> […] we shouldn't have food banks, should we, in the fifth richest country in the world. (Frank, 0:53–54)

In contrast to Frank's focus on public attitudes and public ignorance, others spoke about personal failures and feelings of shame, which could be a manifestation of internalised stigma. For example, Gina used many expressions that suggested a self-blaming attitude. These included "I had that opportunity and I messed it up" (0:41), "I could have done better if I'd just tried harder" (1:8), "I failed" (0:18, 0:40, & 1:1), "thinking about that it [job or failing at university] does make me feel […] a bit sort of ashamed" (1:3), "I sort of have a sense of guilt" (1:6). Gina's explanations were predominantly limited to her own shortcomings, whilst she seemed to discount the potential impacts of situational factors, such as growing up with money worries, having an anxious mother, divorced parents, and experiencing family conflict that demanded her attention during her university years. Gina was new to benefit claiming and seemed to have less exposure to alternative narratives advocated for by activist groups. Nevertheless, the feelings of personal failures were also echoed by Emma, Hanna, and Ben following negative work experiences, which they later re-evaluated, and, for example, Emma realised with the help of CBT that "it wasn't all down to me and that there was external factors contributing to it as well" (Emma, 0:39).

Different types of systemic and structural discrimination were also noted that influenced respondents' lives. Sahil spoke about his experience of communities being racialised which was noticeable in the amount of police in their neighbourhood, yet "difficult to prove" (Sahil, 1:2) on both individual and community level:

> You see police patrol they're always constantly rolling, rolling. If you're going to another area for example where it's predominantly white-orientated, you won't see any police patrol, you won't see any litter, you wouldn't see any drug dealing, so erm with less use of services but in BME communities it's like people are very watchful in terms of you being watched constantly day in and night. (Sahil, 0:59)

Furthermore, Dave highlighted the North-South divide, which he felt was exacerbated by the unequal impact of the austerity measures, which had implication for support services and for the demand-supply ratio of jobs:

> I just feel as if the government just failed to invest money, especially in the northern part of the world where we live. (Dave, 0:55)

Linked to spatial and racial inequalities, some participants talked about crime in their neighbourhood that had a negative impact on their lives (e.g., by not feeling safe to go to the food bank).

The *Facing discrimination* theme detailed ways in which respondents experienced stigma and discrimination related to mental illness, benefit claiming, ethnicity, and/or physical disability and their intersections. Shame, the manifestation of internalised stigma, was also a feature of some accounts.

6.4.8. Counteracting the Barriers

The *Counteracting the barriers* theme captures common actions that helped to tackle barriers described by the other six main themes. These are explored in three subthemes, namely (1) *Seeking human connection*, (2) *Persevering and being proactive*, and (3) *Removing structural barriers*.

Seeking Human Connection. Being connected to at least one person who understood the participants seemed to be one of the most important factors offsetting the various challenges detailed in the six main themes. Being listened to, feeling connected to others, spending time with people with similar issues or interests and values, or giving or receiving formal support were all beneficial to participants. For example, Hanna could message her mother and partner when feeling low at night; Frank, Hanna, and Gina described their partners as understanding; Hanna helped “people in the community” (1:6) by volunteering; and Frank and Chris benefitted from belonging to groups that shared their interests and

passion (e.g., joining forces as activists). The need for being understood and having a connection with someone was present, despite respondents' tendency to isolate themselves when feeling low.

In addition to the emotional support, friends, family, and acquaintances also helped in practical ways. These included a friend helping Emma apply for a job and a colleague putting her "in touch with a union rep" (0:12), Chris' partner communicating with the Jobcentre on his behalf, and Ben's friend helping him apply for benefits.

Formal support was also appreciated by interviewees. For instance, Ben uses his PIP funding to pay for a long-term talking therapy with his chosen professional. The recommendations from Chris' long-awaited psychological assessment improved the communication with the Jobcentre (i.e., a work coach met him outside of the Jobcentre building as per the psychologist's recommendation):

> She [Jobcentre staff in specialised team] went out of her way […] she met me outside of the office and she got my claim going and when she told me that I erm have certain protective [sic: protected] characteristics […] what laws are protecting me, I've never had that before. (Chris, 1:52)

Hanna received help from a charity that supported homeless people, which was situated next to the homeless shelter she lived in. Hanna appreciated being known by her name and having access to IT facilities. Her coaches at the charity were successful businesswomen who offered practical advice about job interviews, "how to dress", "what research to do" (0:58), and more importantly had "faith" (0:57) in Hanna:

> I actually think that the way like my business English is just better from having spent time with them because erm you know they both had a great sort of vocabulary and stuff and they were both really inspiring and I managed to get some really good interviews while I was sort of—while they were supporting me. (Hanna, 0:58)

Persevering and Being Proactive. Alongside external help and opportunities, interviewees demonstrated perseverance and a proactive approach to improving their

circumstances. Some spoke about persevering in the face of struggles at work—for instance, Emma noted that despite "feeling of inadequacy […] and not being good enough […] but I stuck at it erm did that job and did it within two of the teams erm for a number of years" (0:8), whilst Ben reluctantly left his job saying that it "went against my work ethic" (Ben, 0:25). Emma proactively asked for feedback after an unsuccessful job application and negotiated a volunteering position to complement her degree with the relevant work experience.

> I applied for a job with a national charity which I felt that I fitted the criteria for and wasn't even invited to interview. Now in my head that was completely out of the question, so I got in touch with them and said erm 'Why haven't I been invited to interview, what's—what's going on, you know, why not?' erm to which their response was the normal Catch-22 situation 'well, your qualifications are good but you haven't got any experience' […] and I said, 'Well, how can I get experience, if you won't give me the chance to the job' and they hummed and hawed about it and then they offered me—because it was a charity, they offered me some voluntary work on a two-day a week basis just to try and help me gain some experience and also on the basis of it would look better when I was applying for jobs for other employers. (Emma, 0:2–3)

Similarly, Frank took several steps to counteract the barriers when he was offered a gardening course as part of his mental health treatment. He appreciated being around people who had similar issues to him. This course also helped Frank find a new interest, which he turned into a job opportunity by starting his own business. Frank managed to keep his business going for about two years; however, given the lack of financial security, he decided not to continue as the pressure of solely relying on his business for an income was too high:

> There is this gardening course I started doing which I found quite helpful erm 'cos you was outside and people there knew that all the people there had issues […] it was good […] and then from there, […] I thought […] I'm gonna try and do my—my gardening 'cos I like my gardening so I tried to start a little business erm that I've already done that for a couple years, and it just—it was just getting too much—too

> much for me […] when you haven't got anxiety and depression, is hard enough but, you know, unless you've got loads of money to back you up. (Frank, 0:6–7)

Removing Structural Barriers. There were three ideas that the majority of participants mentioned in their interviews that could improve their lives in the future—namely, the need for (1) more employment opportunities, (2) more and affordable training, and (3) more specialist help relating to both (un)employment and mental ill-health. The first subtheme, *Seeking human connection*, also detailed examples of formal support—however, these were described as exceptions rather than the norm:

> One area they could explore is erm supporting people better with employment opportunities and providing relevant courses or courses what are geared to—to providing erm job opportunities, especially qualifications at a subsidised cost. (Sahil, 0:53, who found that the training organised by his work coach has not improved his chances of securing a job)

> I was just basically left to my own devices ((pause)) you know there was no sort of assistance or support offered or anything like that [from the Jobcentre]. (Emma, 0:16)

The *Counteracting the barriers* theme drew on the main ideas that helped respondents to take action in a positive direction, which by no means provided a comprehensive list of actions to counteract the multiple and interlinking barriers in people's lives.

6.4.9. Summary of the Findings

In this section, I offer examples in a narrative format to demonstrate the complex ways the themes interrelate in the participants' lives constantly blurring the boundaries between the separate themes.

Dave's story touches on both overarching themes and most main themes with the exception of the *Questioning volunteering* theme. Dave described himself as someone who "loved going out" (0:39), was "extremely social" and "knew everybody in town" (Dave, 1:11). Dave loved "being good" at his job, "being valued as a worker," and "being paid a

decent wage" (0:39). Following a difficult and significant bereavement, Dave was not able to return to his profession for several reasons. For instance, the bereavement following his relative's unnatural death impacted on his ability to concentrate. Moreover, the industry he previously worked in shifted to a digital way of working whilst he was absent; however, he was not able to re-train due to his cognitive and mental health difficulties. Yet, Dave's mental health difficulties were not acknowledged by the benefit system (i.e., he has not been awarded ESA despite spending considerable amount of time and effort with the application processes); thus, he experienced the system as discriminatory towards mental health difficulties. As Dave was trying to survive on the lower-paid JSA, whilst making difficult choices between heating or eating, he got into debt that escalated quickly, which also contributed to his mental distress. Dave proactively reported his financial and food insecurities towards the Jobcentre but received little help. Dave was signposted to a debt reconciliation organisation, which he felt was a stark example of the state passing its responsibilities onto charities to care for the most vulnerable people in society. This strengthened his sense of being stigmatised at the intersection of being an unemployed benefit claimant in destitution and experiencing increasing mental distress. The debt reconciliation organisation would only help Dave if he accessed food banks four times a week. During these challenging times with financial and mental health difficulties, Dave struggled to be amongst people, get out of bed, or to leave his house, which made accessing food banks even more problematic. Dave also felt that relying on food banks was "<u>really</u> degrading" (0:18), which further lowered his mood. In addition, the crime in his area increased (which he believed was partly due to unequal state investment in the North), which meant that he did not feel safe to go to the shops or visit the food bank. To counteract his situation, Dave asked for help for his mental health in several ways; however, he found that medication "never really worked" (0:27). Nevertheless, "the doctor would just double my

tablets" (0:28) or change to new ones. When Dave was growing up, his mother had mental health difficulties, and Dave experienced her being "drugged up" (0:4) and not being emotionally available. For these reasons, Dave was not keen on taking higher doses of any medication. Moreover, Dave did not find the nine hours of CBT helpful as he was asked to talk about his difficulties, which negatively impacted on his mood. Furthermore, Dave found the cycle of mental health referrals unhelpful, in which when he visited A&E for mental health reasons, he would be referred to the crisis team that would refer him back to his GP and both would encourage him to take higher doses of medication. These experiences strengthened his view that the continued underfunding of the NHS meant that mental health support remains insufficient and/or unavailable and impedes his improvement, and, in some instances, makes his mental health worse. Another strategy to try to improve his situation was to find suitable work. Dave did not feel safe to be in charge of other people at work due to his cognitive and mental health difficulties, which reduced his options somewhat. Dave also noticed decreasing job opportunities where he lived, which he believed was partly due to the North-South divide. Dave tried different jobs that were either too challenging physically for his age or he found that he was not "better off" (0:21) financially compared to being on benefits despite working at least 40 hours per week. In Dave's experience, re-training for another profession was not possible due to diminished state-funded options and a lack of the financial resources.

This narrative demonstrates the circular impact of one's financial (in)security and mental (ill)health, social security and mental health support and their processes, discriminatory practices, the challenges of engaging with the labour market, and job and training opportunities along with the deficient communication practices. To complement Dave's experiences, elements of Sahil's story (e.g., volunteering and racial discrimination) are described next to emphasise other aspects of the complex system the themes form in reality.

Sahil's financial difficulties started during his marriage and worsened when his marriage broke down; both seemed to contribute to Sahil feeling low. Sahil became unemployed when he refused to accept a modified contract by his employer that would have reduced his income. Whilst on benefits, Sahil was sanctioned several times and when his housing benefits stopped, he tried to move into a hostel that "refused to keep [him] in" due to his suspended benefits, which "put [him] back down" (0:9). Sahil had less work experience than Dave and was mandated to attend training and encouraged to volunteer by his work coach; however, he found that neither increased his chance of securing a job. In fact, Sahil experienced volunteering as exploitative when he realised that paid members of staff had similar or the same responsibilities as him. In addition to doubting "what job [he] could do" "with [his] depression" having "lost confidence, motivation, self-esteem along the way" (0:10), when searching for jobs, he also had to consider whether he would be "faced with more inequality for working in this environment" (0:58). In Sahil's view, people "get marginalised and penalised further for belonging to a specific community" (0:58), which he experienced throughout his life. These narratives demonstrate the intricate ways the themes continuously interact in the interviewee's lives.

In conclusion, this chapter detailed the findings and provided data extracts to support the various themes. In the Discussion chapter, themes are expanded on by providing further interpretations with links to theory and existing research before drawing conclusions and considering wider implications, strengths, limitations, and self-reflections.

7. Discussion Chapter

The Discussion chapter provides a deeper analysis of the findings starting with the six main themes before expanding on the two overarching themes (i.e., *Interacting barriers* and *Counteracting the barriers*). Following this, strengths and limitations are discussed, and recommendations and implications are offered. The chapter closes with a self-reflexive account of the main author.

7.1. Communicating Confusion

The *Communicating confusion* theme captures two facets of communication that contribute to respondents' distress. Lack of transparency and clarity are detailed under the "*It isn't fully explained to you*" subtheme, whilst the disjointed communication between different parts of the welfare system is highlighted by the "*They still don't have that joinedupness*" subtheme.[31]

Feelings of confusion and helplessness were reported in relation to the uncertainty surrounding the benefit payments, application process, and sanctions. Respondents did not seem to understand why sanctions were applied, or for how long they applied, and found the lack of information about the variable rate of UC distressing. In addition, the complaint procedures were also reported to be ineffective. This supports research exploring the experiences of disabled claimants in relation to the roll-out of Universal Credit (Cheetham et al., 2019). Under the theme of *Claiming UC*, the claiming process was described as "complicated, difficult, demeaning, impersonal and punitive" (Cheetham et al., 2019, p. 3). In addition, numerous system errors were noted, coupled with poor quality of response to queries (Cheetham et al., 2019). Similarly, the "concept of uncertainty" (Mattheys et al., 2018, p. 1281) about benefits payments was also stated under the *Keeping people in distress:*

[31] The names of these two subthemes are direct quotes from participant; thus, they appear in quotation marks.

The disproportionate impact of austerity in another qualitative study. Contrary to the official intention of the UC policy—namely, to simplify the benefits system and to increase the transparency (Timmins, 2016)—these accounts suggest it has had the opposite effect. Fletcher et al. (2016) further argues that "gaming the system" (Department for Work and Pensions & Grayling, 2012, para. 9), as suggested by the narrative around benefit fraudsters, requires knowledge and understanding of the system. Based on the combined findings, lack of clarity and transparency in the processes of the social security system seems to prevail, which, in turn, increases the vulnerability and the distress of already disadvantaged groups.

Although this subtheme focuses on the communication issues surrounding the social security part of the welfare system, lack of clarity and transparency were also a feature of the mental health system, which is referenced under the *Managing mental health* theme.

The second subtheme, "*They still don't have that joinedupness*", brings examples of the misalignment between and within different parts of the welfare system. It was highlighted that the WCA assesses psychological risks in an insensitive manner; however, risk management of suicidality is not built into this process. Furthermore, respondents were not signposted to support services after WCA. Others also reported on WCA being experienced "as an uncaring and insensitive process" (Dwyer et al., 2020, pp. 316–317). Whilst Hansford et al. (2019) noted GPs complaining that their opinion was often overruled by work capability assessors, the misalignment between the length of the fit note and the wait times for mental health treatment was highlighted in this research. Both point towards disjointed welfare systems. Participants in this study did not mention being offered support by an employment adviser (EA) or being referred to the Individual Placement and Support (IPS) service in a mental health setting; thus, we can only assume that interviewees fell through gaps in the system (see Lelliott et al., 2013 and Essen, 2012 for IPS; and Hogarth et al., 2013 for EA). Despite policies (e.g., No health without mental health: HM Government, 2011a, 2011b)

intended to promote equal priority to physical health and facilitate joined-up care for people with mental health conditions, the experiences of interviewees suggest that gaps remain in the implementation of such initiatives.

To summarise, there are numerous issues regarding communication, information sharing, transparency, and clarity in the welfare system. These negatively impact upon the experience of those who need its support and provide an additional source of stress for those hoping to be helped in times of need.

7.2. Managing in Hardship

The second theme explores the participants lives whilst *Managing in hardship*. The two subthemes discuss the consequences of living in poverty under the subtheme of *Choosing between essentials*, and the impact of an undulating employment status, which is called the *Facing financial insecurity when moving between benefits and working* subtheme.

The first subtheme highlights the stark reality of having to make difficult decisions and how small changes can have serious consequences for those who live on a restricted income. Choosing between essentials means, for example, choosing between food insecurity and housing insecurity (or substandard housing); or not having access to a computer and broadband, which are both essential to access the fully-digitised benefits system. Living on a reduced income also meant that there were very few options available for individuals to improve their situation. Constrained choices included not being able to use re-training or continuing education as a tool to mitigate difficult circumstances. Surviving under these tough conditions seemed to increase the stress of participants and hindered their chances of re-entering the labour market. This phenomenon is not unknown by policy makers. A specialist employment support provider gave evidence to a report on disabled support via UC, which stated that “[p]overty leads to unstable housing, mental health conditions, worsening physical health, debt, and, at best, can provide a major distraction from the business of

finding work" (House of Commons & Work and Pensions Committee, 2018, p. 19). These findings seem to be consistent with a range of qualitative and quantitative studies. The *Managing on UC* theme in Cheetham et al.'s (2019) study indicated that "UC increased financial and housing insecurity and served to push vulnerable claimants further from the labour market" (2019, p. 7). MacInnes et al. (2015) analysis of poverty showed that two-thirds of working-age couples without children live in material deprivation (i.e., cannot afford three or more essential items). Similarly, a qualitative longitudinal study of the impact of the welfare reforms also evidenced the "hard choices" (Patrick, 2014, p. 712) and the "hard work" (Patrick, 2014, p. 714) it entailed to live on benefits. This added further evidence to the idea that living—or, rather, surviving—on benefits was not a "lifestyle choice" as promoted by UK governments (e.g., Osborne, 2010, para. 159). Furthermore, more deprived communities reported having fewer choices when attempting to find a "way out" (Mattheys et al., 2018, p. 1280) of difficult circumstances compared to their peers from less deprived backgrounds. Relatively small changes in circumstances or income were reported to have significant and long-lasting consequences (e.g., sanction leading to homelessness), which has also been described by other studies (Dwyer et al., 2020; Patrick, 2014).

The second part of this theme focuses on the actual and feared financial consequences of moving between benefits and working. Accounts suggested that the combination of several factors made the transition between benefits and working problematic. These included: (1) the cumbersome application process of benefits; (2) the eligibility assessment (i.e., WCA) being experienced as discriminatory towards people with mental health conditions who believe they have a reduced capacity to work; (3) the in-built delays in payment; (4) the lack of a guarantee that re-application for benefits will be successful; (5) the possibility that benefits could be reduced at re-application; and (6) the weekly paperwork coupled with high chances of potential errors in the processing of in-work benefits. These could all risk or cause

further financial insecurity. Although the WCA was only one factor, it was shown to play a significant role in creating unfavourable circumstances for those who sought to access benefits due to mental ill-health. WCA has been found to be ill-suited to assess what Davis (2005) called invisible disabilities, such as mental ill-health. This adds further evidence to the mounting concerns that WCAs reinforce structural inequalities between physical and mental health support systems (Barr et al., 2016; British Psychological Society, 2016; Hansford et al., 2019; Mattheys et al., 2018; Warren et al., 2014).

The lack of a guarantee that securing a job will help the transition out of poverty also contributes to the challenges of transitioning between benefits and working, which is discussed in more detail later in the *Considering the consequences of working* theme. Given the limited options, the multiple uncertainties, and the small margin for errors, participants described feeling trapped. Turton (2001) assessed the unemployment trap (i.e., when working brings little financial benefit) and the poverty trap (i.e., when additional earning does not yield additional income as benefits decrease and tax increases) and found that "people with mental health problems face greater unemployment and poverty traps than the general population" (Turton, 2001, p. 285), a finding that seems to have remained relevant 20 years later. Although there is a built-in taper (i.e., gradual reduction of benefits as income increases), participants indicated that the effort required to engage with the bureaucratic processes around the salary top-up was especially challenging alongside a mental health condition. Consequently, for some participants, this ruled out the option of accepting a part-time job. Both Miller (2017) in the US, and Lansley (2013) in the UK have highlighted the inequality regarding the amount of financial support available for those hovering around the poverty line and just above it (called the 'squeezed middle') compared to higher earners. Despite regular national efforts to eradicate poverty (e.g., Poor Law 1601 and Beveridge Report, 1942), poverty continues to be an issue with the numbers vulnerable to poverty rising

in the last 30 years; increasing the number of those in the squeezed middle (Bennett et al., 2018). The health implications of poverty have been widely researched internationally (e.g., Di Cesare et al., 2013) and in the UK (Bennett et al., 2018; Dwyer et al., 2020; Mattheys et al., 2018; Mehta et al., 2021; Patrick, 2014), and are also evident from the accounts of the participants of this study. Despite these structural barriers, most participants had re-entered the labour market several times, which underlines the fact that the poor and the unemployed are not static groups (Layte & Whelan, 2003) but, rather, consist of people taking steps to improve their situation (see *Counteracting the barriers* theme).

7.3. Managing Mental Health

The third main theme, *Managing mental health*, captures two key issues: (1) the dilemmas participants described regarding the management and treatment of their mental health (i.e., *Weighing up treatment options*), and (2) their experiences of multiple sources of stress (i.e., B*ouncing between the stresses of depression, unemployment, benefit claiming, and work*).

Examples given by interviewees pointed towards their decisions being guided by two overlapping objectives. First, participants expressed their desire to avoid the deterioration of their mental health, especially wanting to avoid the lowest point they had been at in the past. The lowest point differed for everyone, though some referred to a suicide attempt, suicidal ideation, or inpatient admission as their lowest points, and some noted that they were not in full control of the fluctuation of their depression. Second, respondents were keen to avoid treatment that had been previously detrimental (or not useful). For many, the side-effects of medication outweighed the benefits, hence re-starting medication or increasing the dose were not viable options. In addition, in the participants' experience, there was an overemphasis of medication on the part of their clinicians. This meant that, in order to avoid being forced to take (more) medication, respondents chose not to seek further help. Moreover, based on their

experience, the number of alternative options was limited. Although some psychological or psychosocial interventions were helpful to a degree, the general experience was that non-medical interventions were insufficient and/or inappropriate. The belief that suitable psychological treatment is unlikely to be available became an additional barrier to help-seeking.

Further complication of engaging with treatment arose from several paradoxical situations. These included not seeking help when feeling better, so it would not spoil the good days; not receiving help in a crisis when mental distress fuelled abusive behaviour; or when extreme self-neglect prevented engagement and led to discharge from mental health services.

One of the original aims of the NHS was to reduce the regional variability of care and to efficiently distribute resources (Klein, 1984). NICE also set out to standardise care and to develop pathways based on the best available evidence to guide clinicians (National Institute for Health and Care Excellence, n.d.). The implementation of mental health guidelines has been supported by IAPT since its launch in 2008 (Evans, 2018). This study indicates that gaps remain in the treatment of depression. Furthermore, accounts show that the implementation of the depression guideline (National Institute for Health and Care Excellence, 2010) is not adequately followed. The guideline advocates that clinicians build trusting relationships with their clients, inform them about treatment options and support groups whilst being sensitive to cultural, ethnic, and religious backgrounds (National Institute for Health and Care Excellence, 2010). Respondents' descriptions suggest that trust, clarity around treatment options (including side-effects of medication), information about support groups, and cultural adaptation (of assessment or treatment) were not fully present. These issues, coupled with the experiences of insufficient and/or inappropriate non-medical treatments, brought unintended consequences in the form of impeding further help-seeking for depression. This provides further evidence for the importance of researching service user

experience (McPherson & Beresford, 2019) that can highlight ways in which the real-life application of 'evidence-based' policies or guidelines can be counterproductive.

The second subtheme, B*ouncing between the stresses of depression, unemployment, benefit claiming, and work,* brings together examples of stress arising from depression, deprivation associated with unemployment and benefit claiming, the pressure to work or of working, and the interaction of these factors. Similarly, Mattheys et al. (2018) evidenced the accumulated consequences of austerity on those on a reduced income, which was termed "chronic welfare system induced stress" (Mattheys et al., 2018, p. 1285). For instance, qualitative evidence showed the stressful nature of "assessments and reassessments; increasing conditionality; and oppressive processes" (Mattheys et al., 2018, p. 1285), poverty being "emotionally draining" (Patrick, 2014, p. 714), and that "conditions and sanctions exacerbate mental health problems" (Wright et al., 2020). These align with findings from Mehta et al. (2021) study that evidenced the fear of sanctions and their detrimental consequences, and the fear of re-starting then stopping work potentially leading to negative financial circumstances. This study was consistent with previous findings and highlighted further factors that seemed to contribute to what Mattheys called the chronic welfare system induced stress. These included the fear of mental health deteriorating as a result of unsuitable employment or treatment along with the fear of homelessness, starvation, increasing debt, worsening mental health and/or suicidality as the result of any negative changes or a combination of factors. The stress arising from unsuitable jobs or the pressure from Jobcentre staff to work is further discussed in the next theme.

In summary, this theme emphasises the coinciding multiple dilemmas faced by interviewees relating to managing their mental health.

7.4. Considering the Consequences of Working

The fourth theme, *Considering the consequences of working*, captures the ways in which (1) past experiences, with an emphasis on the negative ones, influence future engagement in the labour market (i.e., *Defining past experiences*), and (2) participants assess the suitability of potential jobs from many angles (i.e., *Considering the suitability of jobs*).

The *Defining past experiences* subtheme is constructed around two somewhat distinct phenomena. First, it explores participants' desire to avoid the repetition of negative experiences in the workplace. Participants spoke of maltreatment, exploitative practices, discrimination (e.g., race, religion, and disability-related), and—in extreme examples—abuse. Interviewees also elaborated on the deleterious impact of these—often traumatic—events on their mental health. This contrasts with another small qualitative study in which it was concluded that "all participants identified positive impacts that working had had on their lives, […] even those participants who were less satisfied with their jobs identified benefits and none described any negative effects" (Boyce et al., 2008, pp. 83–84). It should be noted that participants in Boyce et al.'s study were in a mixture of sheltered and competitive jobs, whereas interviewees in this study engaged in competitive jobs. Second, the stopping and starting of jobs resulted in a fragmented work history, which was experienced as an undesirable feature at job interviews. This corresponds with Boyce et al.'s *Problems at work* theme, in which "disjointed employment history was seen as a major barrier to work for participants who were not on the Workstep programme" (i.e., not in sheltered jobs; Boyce et al., 2008, p. 81). Furthermore, The British Psychological Society, jointly with others (BPS et al., 2017), has warned that precarious work can be detrimental to mental health.

The second subtheme expands on this notion by bringing together the dilemmas interviewees described when assessing possible jobs for their suitability. This theme is built on the premise that claimants are strongly encouraged—or compelled— to accept "any job"

(Gina, 0:53) and captures their reaction to this idea. Even those on more protected forms of benefits (e.g., ESA) could not fully escape the feeling that they were pushed towards work. The 'any job' aim has been arguably a core feature of work activation policies that prioritised quantity over quality of jobs (Taylor, 2017).

The *Considering the suitability of jobs* subtheme lists certain essential and desirable conditions under which participants would consider employment (including self-employment). The two main essential criteria were that a future job should not make them worse off financially or exacerbate their mental ill-health. Moreover, a job should not be discriminatory in terms of mental ill-health or otherwise (e.g., relating to ethnicity, disability, or religious practices) and should accommodate the fluctuating nature of depression. Furthermore, the timing was also an important factor, as premature re-engagement in the labour market was shown to have the potential to delay employment in the future. In addition to these essential conditions, participants talked about the additional benefits of working, such as doing something meaningful, being valued, having money for holidays, and/or having the potential to progress. These additional benefits correspond with other studies, in which "latent benefits" (Schneider, 1998, p. 83) and "social and psychological advantages attached to engagement in paid work" (Patrick, 2014, p. 720) have also been identified.

Although there is data showing that employment can—on average—improve mental wellbeing (e.g., Curnock et al., 2016), analyses relying only on group means can obfuscate the real life experiences of outliers as well as significant proportions of people falling outside the mean. Contesting the popular idea that *any* work is better than no work, several authors in the UK and elsewhere have argued that 'bad' jobs can be detrimental to mental health (Butterworth et al., 2013; Houston & Lindsay, 2010; Mehta et al., 2021; Watts, 2019) and that work does not guarantee a way out of poverty (Shildrick et al., 2012).

The idea that being in open (i.e., mainstream) employment shows the success of a rehabilitation process has been present for several decades (Ministry of Health, (58) 57, 1958, as cited in Jones, 1961). This is coupled with the notion that people need to be—primarily—'activated' into work with a combination of incentives, conditions, and sanctions (Daguerre & Etherington, 2014), as opposed to being *enabled* by removing structural barriers or permitting alternative occupations. Activation policies use the biopsychosocial model of disability by Waddell-Aylward (Shakespeare et al., 2017; Waddell & Aylward, 2010). This now-discredited idea argued that disabled people are held back from jobs due to their attitudes to work and their abilities (Clifford, 2020). In contrast, despite some participants in this study describing having no confidence in their ability to work again, they kept trying and some succeeded in securing at least a temporary job. Looking beyond individualistic explanations, others have hypothesised that multi-dimensional changes in job characteristics (Baumberg, 2014), the marginalisation of certain groups in a post-industrial world (Houston & Lindsay, 2010), or the discriminatory nature of unregulated markets (Parker Harris et al., 2012) could offer alternative theories for the underemployment of people with mental health conditions. Moreover, it also overlooks the possibility that disabled people's engagement in mainstream employment happens at what Davis called a higher "transactional cost" (Davis, 2005, p. 200). Similarly, Grover & Piggott (2010) argued that we should question the assumption that, once reasonable adjustments are in place, disabled people can be as productive as their non-disabled peers. This study echoes findings from other studies (e.g., Essen, 2012) that people's ideas of possible and ideal jobs vary—not everyone hopes to work in competitive (and full-time) employment. There is evidence to show that people from less deprived backgrounds adjust their working arrangements to suit their mental health needs (Mattheys et al., 2018). Furthermore, Watts (2019) highlighted that the current working definition of 'work' is reduced to economically viable activities, thereby discounting

alternative forms of occupation, such as volunteering, which is discussed further in the next theme.

7.5. Questioning Volunteering: Who Gains—or Loses—and What?

The *Questioning volunteering: Who gains—or loses—and what?* is the fifth main theme. By talking about working, conversations spontaneously included participants' experience of alternative occupations. The main form of alternative occupation was volunteering, but some talked about caring for relatives or gaining an additional income via other activities such as hobbies. Respondents spoke about another dilemma in addition to the ones about mental health treatment and working, as discussed in related themes. To answer the question 'Who are the winners and potential losers of volunteering?,' responses pointed towards several possibilities. Volunteers can benefit in many ways, such as having a structure, connecting, giving back (i.e., doing something meaningful), and gaining work experience if tasks are relevant to a future job. As with paid employment, volunteering can offer some of the latent benefits Schneider (1998) described. On the other hand, organisations also benefit from free labour and, in some circumstances, these practices might be exploitative—for instance, when the responsibilities of the volunteers are the same or more than the responsibilities of paid staff. In addition to potentially being subject to exploitation as volunteers, alternative activities can risk the claimant being found to be fit for work. Respondents in this study, similarly to other findings (Patrick, 2014), emphasised that volunteering should not be used as a proxy measure for work readiness, due to its more flexible set-up and more generous allowances. The perceived risk of volunteering speaks to the current narrow emphasis on economically viable employment forms (Patrick, 2014) that not only neglect to promote and to value other forms of socially meaningful contributions but potentially punish them. Disability adds a further layer of complexity to this issue. For instance, claimants might not be able to enjoy the latent benefits of volunteering or use volunteering as a platform on which

they could test out their maximum capacity to work (Maclean et al., 2017; Watts, 2019). Moreover, for some, paid activity might not be a possibility; however, their non-economic activity is not recognised as a valued contribution to society (Clifford, 2020). Patrick advocated for an "inclusive citizenship framework" (Patrick, 2014, p. 722), in which alternative forms of contributions would be also recognised (e.g., volunteering, caring, and parenting).

A longitudinal study of volunteering by Strauß (2008) examined different forms of civic engagement in relation to the labour market in the UK and Germany. In her book, she emphasised the 'heterogeneity of the phenomenon of volunteering' (Strauß, 2008, p. 19). Strauß argued that sub-differentiation is needed to understand the role of volunteering for the unemployed by, for example, taking into account the type of organisation, tasks assigned to the volunteer, their social environment, and the gender of the volunteer. The need for differentiation was also evident from the participants' descriptions in this study. Furthermore, Strauß' findings point towards the significant importance of the welfare state regulations. These regulations play a role in facilitating or hindering the different aspects of volunteering. Volunteering can be a mode of social integration, a source of social recognition, and an alternative activity to paid labour. This said, volunteering is often viewed as a labour market instrument (e.g., developing qualification, a platform for job searching, or even providing a subsidy for state activities). The current policy regulations control many aspects of volunteering, for example, the hours permitted, type of organisations one can volunteer for, and ways of reimbursements (Department for Work and Pensions, 2019b; NCVO, 2020). The findings from this study suggest that the current welfare state regulations do not allow claimants to fully enjoy the benefits of volunteering, and that restrictions might even contribute to a delay in their re-engagement in the labour market.

7.6. Facing Discrimination

The *Facing discrimination* theme collated experiences of discriminatory practices and stigmatising narratives. Interviewees emphasised the felt sense of the increase of stigmatising attitudes around welfare benefits and contested the dominant anti-welfare discourses (e.g., idleness, lifestyle choice, scrounger, benefit dependency, and benefit fraud). Participants' efforts to challenge these narratives pointed towards their impact on their wellbeing. This shows support for a range of wider evidence (Baumberg, 2014; Daguerre & Etherington, 2014; Geiger, 2017; Howarth, 2020; Pemberton et al., 2017; Sutton et al., 2014). Similarly, another qualitative study concluded that "[g]overnmental discourse, as currently conceptualised, fails to reflect lived reality, instead serving to stigmatise and arguably (de)moralise out-of-work benefit claimants" (Patrick, 2014, p. 706). Correspondingly, Jensen described a "broader cultural political economy of 'welfare disgust'" (Jensen & Tyler, 2015, p. 478).

An example of stigmatising attitudes manifesting in discriminatory practices was the comment on "No DSS." The short code of "No DSS" hides a complex problem. "No DSS" means that landlords will not consider potential tenants who claim housing benefits or—sometimes even more broadly—social security benefits. DSS stands for Department for Social Security, which was replaced by Department for Work and Pensions in 2001, yet the phrase remains and has been acknowledged as a form of "housing benefit discrimination" (W. Wilson, 2020, p. 4). As a briefing paper to parliament (W. Wilson, 2020) explained, historically, the reluctance to accept tenants on Housing Benefit (HB) related to the delays in processing HB applications. Moreover, landlords can be restricted by mortgage contracts specifying the exclusion of claimants and by insurance policies. This issue was further exacerbated by the introduction of the Local Housing Allowance (LHA) in 2008, its additional restriction since 2011, a four-year freeze of LHA rates from 2016, and the four-

year freeze of benefits since 2019. Essentially, HB claimants were priced out of the market. Moreover, the uncertainties about the roll-out of Universal Credit contributed to landlords seeing claimants increasingly as a "risk" (e.g., not being able to pay or displaying anti-social behaviour associated with benefit receipt). This impacts on around 2 million households in social rents who potentially cannot afford private rent and on around 900,000 in private rent who receive Housing Benefit (Ministry of Housing, Communities and Local Government, 2019), in addition to those who endure a form of homelessness. Housing benefit discrimination is also linked to the issue of the under-supply of housing, which contributes to impaired labour mobility (W. Wilson & Barton, 2021).

Another aspect of discrimination highlighted spatial inequalities (e.g., North-South divide), which supports findings by Mattheys et al. (2018)—namely, that the austerity cuts exacerbated spatial and socio-economic inequalities. The presence of crime was also linked to deprived areas by interviewees. In a previous study, this phenomenon was conceptualised as the "amplification of deprivation thesis" (Mattheys et al., 2018, p. 1285) that captures the "additional impacts of living in deprived areas" (Mattheys et al., 2018, p. 1284) due to, for instance, lack of services and jobs, crime, and environmental issues.

Interviewees also spoke about their own ignorance prior to claiming benefits and the ignorance of the public that serves to maintain the stigmatisation of claimants and mental illness. Accounts showed support for Davis' hypothesis of "defensive strategy" (Davis, 2005, p. 192) that posits a tendency of being socialised not to see those who seem further from the able-bodied standard.

In addition to discrimination and stigma associated with unemployment, benefit claiming, and deprivation, respondents' examples highlighted discriminatory practices linked to mental ill-health. These included the WCAs and clinicians' and employers' attitudes, which supports previous findings (e.g. Biggs et al., 2010; Boyce et al., 2008; British

Psychological Society, 2016; Scullion & Curchin, 2021). Moreover, Hansford et al. (2019) argued that the combination of stigmatisation of welfare dependency and mental health issues can lead to an "alienation from healthcare services" (Hansford et al., 2019, p. 364), which was replicated in this study. Furthermore, an additional barrier was also raised by participants—namely, that mental health treatments were not inclusive by design (e.g., in terms of disability or race). These examples speak to the issue of intersectionality that emphasises the reality of interlocking forms of oppression (Collins & Bilge, 2020). This is in contrast with the application of the Equality Act 2010 (2010), in which the protected characteristics function as distinct categories (Wren, 2018).

The internalisation of stigma can manifest in feelings of shame (Davis, 2005; Sutton et al., 2014), which was a feature in the interviews. Baumberg (2012) called this "personal stigma" (Baumberg et al., 2012, p. 16) in relation to benefit claiming, which was also noted in Hansford et al.'s (2019) and Patrick's (2014) study. As in Patrick's study, claimants in this study did *not* identify themselves as undeserving of state support despite showing shame. This said, some could name possible examples of misuse of the system, as in Patrick's study. Consequently, Patrick questioned whether in practice anybody could be targeted by the narrative around benefits as a lifestyle choice since "no one interprets it as a description of themselves" (Patrick, 2014, p. 711). Claimants who can work and are trying to work and those who cannot work due to impairment or other responsibilities would be "arguably ill-served by a stigmatising discourse that continually equates benefit reliance with passivity and idleness" (Patrick, 2014, p. 722).

7.7. Interacting Barriers

The *Interacting barriers* is an overarching theme that was constructed to draw attention to the relationship between the six main themes. The six themes discussed communication within the welfare system, surviving in financial hardship and the complications of living on

welfare, management of mental (ill)health, the challenges of working, and being the subject of multiple forms of discrimination. Gupta and Huston (2009) who studied women on a low income in the US, conceptualised an "interactionist model" (i.e., bidirectional or transactional; Gupta & Huston, 2009, p. 111) between depression and economic factors. Echoing Gupta and Huston's findings, respondents in this study also brought examples of depression worsening due to hardship, and hardship worsening due to depression, whilst equally showing that, with the decrease of hardship, depression can also improve and that, with the improvement of depression, people can manage hardship better. Similarly, a qualitative UK study has also described the "link between austerity and mental health" as "complex" (Mattheys et al., 2018, p. 1284).

Furthermore, a study explored the barriers and solutions to returning to work from the perspective of Dutch unemployed workers who were sick-listed due to mental health problems (Audhoe et al., 2018). The theme called *Interaction of multiple problems* was found to be a "distinct barrier to return to work for unemployed workers" (Audhoe et al., 2018, p. 30). The multiplicity of dilemmas is also evidenced in this study under the six main themes, and the complexity of their interaction emphasised in this overarching theme.

7.8. Counteracting the Barriers

The second overarching theme, called the *Counteracting the barriers*, is constructed to show ways in which different factors, actions, and events have mitigated—or could address—the barriers. The three subthemes speak to different aspects of this construct and are named, (1) *Seeking human connection*, (2) *Persevering and being proactive*, and (3) *Removing structural barriers*.

The *Seeking human connection* subtheme refers to actions that require an active agency from all involved in the transaction and includes both giving and receiving. Connections arose from moments of feeling understood, being listened to, knowing others are available if

needed, giving back, having faith in somebody, and connecting via shared interests or objectives (e.g., in political activism). In addition to the many forms of informal connections, formal support was also discussed. These also came from many sources, such as Unions, Occupational Health, Jobcentre staff, benefit advisors, health care professionals, and coaches specialising in supporting homeless people, and were gratefully received. The sense of connectedness was also described by Mehta et al. (2021) under the *Alternative ways of experiencing and responding to this policy regime* theme. It highlighted the "importance of peer support" (Mehta et al., 2021, p. 694), which, at times, came in the form of resistance to oppression via activism and becoming politicised—a notion also present in this study. It is worth noting that not all forms of peer support were suitable (i.e., due to mode or timing), which was highlighted by the example in which the social aspect of group CBT led to treatment drop-out in this study.

The second subtheme, namely, *Persevering and being proactive*, reflects participants' experiences of taking active steps toward improving their circumstances. These included examples of staying in a job, at times for years, despite unfavourable, exploitative, or discriminatory working conditions with explicit references to wanting to be loyal and being guided by a strong work ethic. This shows support for other studies that emphasised the strong work ethic of their participants (e.g., Mehta et al., 2021) despite "experiencing 'poor work' and 'low-pay, no-pay' churning … [or] repeated setbacks in their efforts to secure paid employment" (Patrick, 2014, pp. 720–721). Lister (2014) also noted that responses to poverty (i.e., managing, leaving, resisting, and taking collective action) involved an active agency (Patrick, 2014). Being proactive seemed to coexist with a fluctuating sense of powerlessness. Powerlessness was a recurring theme in several similar studies (Dwyer et al., 2020; Hansford et al., 2019; Mattheys et al., 2018). I would argue, however, that despite feeling a mixture of powerlessness, helplessness, worthlessness, and hopelessness, a desire to counteract the

barriers was demonstrated by all interviewees. This took the form of acts of seeking and accepting help, trying out different jobs, keeping jobs going under difficult circumstances, prioritising mental health over work, and building a business from scratch and persevering with it for a couple of years despite financial insecurity. This goes against the political rhetoric that benefit claimants are "passive, inactive dependents who require support and even compulsion to lift them out of entrenched welfare dependency" (Patrick et al., 2011, p. 275).

Whilst participants described ways in which they were proactive in things they could control, they called for the removal of structural barriers (third subtheme). Simply put, respondents called for more training, more jobs, and more specialist support to help them better access opportunities. Participants were actively challenging the feasibility of the 'work-first' approach (Kowalewska, 2016), especially with the diminishing services that help address structural barriers. Others suggested that that neither the Nordic-style 'train-first' nor the Anglo-Saxon 'work-first' approaches are suitable for certain groups (e.g., female parent workers with childcare responsibilities) who are already disadvantaged in the labour market (Kowalewska, 2016). The idea of addressing societal barriers, such as disabling workplaces, or structural barriers, such as the demand-side of jobs, has also been highlighted by others (Fletcher et al., 2016; Patrick, 2014). However, there is an ongoing debate about whose responsibility it is—if anyone's at all—and how it might be resolved (Patrick et al., 2011). This also has links with the current narrow definition of 'work' that "neglects the many other forms of socially valuable contribution which disabled people can and do make as carers, volunteers and service users" (Patrick et al., 2011, p. 276).

7.9. Conclusions

This study provides a unique contribution to the existing literature in three ways. First, this study assesses the joint impact of several co-existing social security benefits, as opposed

to restricting the research question to one type of benefit (e.g., UC in Cheetham et al., 2019) or one feature (e.g., WCA or conditionality as in Dwyer et al., 2020; Hansford et al., 2019; Mehta et al., 2021). This is important to explore as those with fluctuating engagement in the labour market are likely to be exposed to more than one type of benefit. Second, this study takes a narrower focus on one psychiatric label as opposed to a group of psychiatric labels (Boyce et al., 2008) or disability (Mehta et al., 2021) to explore the possible interaction between one of the most prevalent diagnostic labels and labour market engagement. Third, it focused on the transition from unemployment to the labour market, which is a less studied field compared to the experience of becoming unemployed and applying for benefits (e.g., studies of the WCA as in Barr et al., 2016; British Psychological Society, 2016; Hansford et al., 2019; Mattheys et al., 2018; Warren et al., 2014).

The findings from this study demonstrate the value of listening to, and engaging with, the lived experiences of those directly affected by programmes addressing mental ill-health and economic inactivity. Data generated in this study found that people are faced with many interlinking dilemmas and face the challenge of having to analyse the possible consequences of any changes to their circumstances and in their health in an ever-shifting environment where information is not readily available. Some of the key dilemmas are: How will work affect my mental health? Do I go back to the GP and risk being forced to take more medication, restart medication, try the same therapy that did not work, or not ask for help? Will volunteering truly increase my chances of getting a job or will that risk losing my benefits if I am seen to be fit for work? How will I survive another day/week/month on benefits? How do I get officials (e.g., Jobcentre work coach, WCA assessors) to understand that my mental health impacts on my life? What would the consequences be on my health, on my finances, on my housing situation, or regarding my benefits and the re-application process if the job does not work out or only lasts for a short time?

Several policies and initiatives aim to get people currently in receipt of social security payments due to mental health conditions back into work (Daguerre & Etherington, 2014; Frayne, 2019b). These set out to support claimants' moves into employment (e.g., the long-term unemployed and disabled) with a range of labour-focused and psychology-focused strategies (Frayne, 2019a; Watts, 2019) and to achieve parity of esteem between mental health and physical health for the whole population by 2020 (Health and Social Care Act 2012, 2012; HM Government, 2011b, 2011a). These are supported by the Equality Act 2010 (2010) that legislates against any discrimination of disabled people, such as those with a diagnosed or diagnosable depression.

The accounts gathered in this study would suggest ways in which these policies, intentions, and programmes have not fully materialised or—in some cases—achieved the opposite. Instead of being protected from discrimination as required by the Equality Act 2010, interviewees reinforced previous research findings that drew attention to the notion that mental health conditions are systematically discriminated against, for example, during the benefit assessment process (WCA), by jobcentre staff and employers during the interview process or in workplaces. Some also questioned whether the model of reasonable adjustments provide a realistic solution for those with fluctuating needs and ability to work. In addition to the concrete events, the ongoing sensation of being stigmatised (e.g., tangible in media reporting and political narratives) was also described as a burden that has a negative impact on one's wellbeing. The shortcoming of the Equality Act 2010, namely, that it does not legislate for intersectionality (Wren, 2018), neglects the complexity of these issues. This was also a notable feature of the interviews. Looking beyond the legal rights of those with protected characteristics, this study helps to expose some of the inadequacies of society (Clifford, 2020; Finkelstein, 2007). For instance, findings highlight that the postcode lottery continues to exist in psychological support, a problem both the NHS and NICE hoped to

address (Klein, 1984; National Institute for Health and Care Excellence, n.d.). For those who sought help for depression, low intensity care via IAPT and other mental health services proved insufficient, inadequate, or just not available (actual and perceived). Furthermore, the real-life application of the depression guideline by NICE (National Institute for Health and Care Excellence, 2010) seemed to revolve around an actual and perceived overemphasis on medication that hindered help seeking, prevented improvement, or—in some cases—contributed to the worsening of mental ill-health. This is not to negate the valuable work delivered by the NHS, IAPT, and other mental health services—rather, to draw attention to the gaps that continue to exist.

Moreover, despite UC aiming to improve the clarity and transparency of the benefits system and to make transition in and out of work easier (called dynamic benefits; Timmins, 2016, p. 11), the opposite was reported by those interviewed. Regardless of whether participants were claiming UC, or other benefits and hoping to avoid the transition to UC, multiple and interlinking factors contributed to UC acting as a deterrent from entering employment. These included the complex application process, the uncertainty resulting from a weekly top-up method for those in work, the financial consequences of possibly reduced benefits compared to legacy benefits, and the delay in payment inherent in the set-up of UC.

Furthermore, health care and social security are part of the welfare system, yet their disjointed application contributed to delaying the move into employment. In spite of the barriers raised by the welfare system, the labour market, and housing, participants in this study demonstrated a myriad of ways in which they were trying to improve their lives, or at least trying to avoid making them worse. However, interviewees explained that their efforts are often not enough and that the work-first approach is not suitable for them (i.e., already disadvantaged groups) if the demand-side of the labour market and structural barriers are not addressed whilst training needs are ignored.

Based on the accounts of interviewees with first-hand experience of navigating the welfare systems (i.e., benefits and health), I would argue that their description depicts a chaotic, turbulent, and unstable environment. This phenomenon is widely known in business and leadership studies as a VUCA environment, which stands for volatile, uncertainty, complexity, and ambiguity (Lawrence, 2013; Murugan et al., 2020). Respondents voiced the stress caused by lack of clarity regarding their benefits and mental health treatment (ambiguity), numerous internal and external factors that interplay in their lives (complexity), lack of predictability of their mental health, benefit assessment procedures, financial and health-related state support (uncertainty), and the nature and volume of change regarding benefit claiming, work environment, and their mental health (volatility).

This is in stark contrast with the recommendation of Scullion and Curchin (2021), who urged that trauma-informed care principles (i.e., safety, trustworthiness and transparency, collaboration, empowerment, choice, and intersectionality; Bowen & Murshid, 2016, p. 223) are to be embedded into the social security systems to avoid causing psychological harm and/or re-traumatising claimants as the result of the default "trauma-blind" approach (Quadara & Hunter, 2016, p. 39). Interviewees described traumas and many traumatic experiences in relation to work, family life, the social security system, the health care system, treatment of depression, housing support, and deprivation—thus, it is important that the analysis does not stop at the label of depression. Interviewees' accounts identified a myriad of ways in which power operated in their lives as this study focused more on what happened to people as opposed to what was wrong with them. Thus, the PTMF (Harper & Cromby, 2020; Johnstone et al., 2018) provides a suitable framework that helps to understand this complex environment. For instance, the legal, economic, and material powers were strongly intertwined within the benefit system, which identifies one's legal eligibility for financial state support that ensures that one's material needs are met. Any unfavourable decisions, such

as a reduction of benefits, a declined benefit application, or a delay in benefit payment, often had long-lasting and significant consequences for the participants. The labour-focused strategies, such as the mandatory meetings, assessments, and trainings with the additional system of conditionality and sanction, were examples of coercive power. The disease model (or the medical and biopsychosocial models alike) and its operation with a medication-focused depression treatment increased the biological/embodied power over the participant's lives. The biological power, namely, that one received a diagnosis of depression from an approved professional, was a pre-condition of state support; hence, was linked with the legal, financial, and material powers. This was coupled with the ideological power that stigmatised the unemployed, the benefit claimant, and the mentally ill whose worth for state support and as a valued and productive member of society were constantly questioned. Thus, taking a trauma-informed approach both during the design and the delivery of the welfare systems could minimise the power imbalances that currently operate within these systems.

The dilemmas, challenges, risks, and jeopardy documented in this study, when considered under the social model of disability (Clifford, 2020), highlight different forms of systemic barriers. Such systemic barriers create a disabling environment that contributes to the continued segregation of those oppressed and stigmatised by the system. Furthermore, these dilemmas also demonstrate that engagement with an ableist society could be at a higher transactional cost (Davis, 2005) for those who carry the label of depression. Within the—complementary—social model of impairment, this higher transactional cost is called material deficit, which becomes an impairment when met with discriminatory practices. Instead of focusing on the individual differences, these pan-disability models provide a tool to challenge oppression. Those with a depression label, as the findings highlighted, are subject to multiple forms of oppression. First and foremost, depression is viewed as an illness of the individual within the dominant disease model (akin to medical or biopsychosocial models), which

neglects partly or fully the societal environment of the individual in line with capitalist and (neo)liberal ideologies (Martinez & Garcia, 2000; Parker Harris et al., 2012). In contrast with the individual models, the social model of disability acknowledges the individual's wider context and does not locate the problem within the individual (Clifford, 2020). The material deficit, as described by the social model of impairment, can be experienced as pain, distress, or neglect resulting from discrimination. People in this study talked about their differences being treated in a discriminatory way. For example, the mental health system offered treatment options (e.g., medication, group therapy, or CBT) that were unsuitable for the individuals and led to reduced help seeking. Findings showed that the benefit system, and in particular the benefit assessment, misconstrue mental health difficulties that resulted in further financial, material, and, in turn, mental health distress. Furthermore, the inherent uncertainties in the welfare systems seem to also contribute to one's mental distress; thus, are a source of material deficit. In addition, workplace discrimination, such as not implementing the recommendations of the occupational health team or being forced to return to work even if it could be detrimental to one's wellbeing were further examples of the manifestation of material deficit. This research hopes to challenge some of the systemic discriminatory practices that exist within the social security and mental health systems.

These findings are even more relevant given the longer-term impact of the COVID-19 pandemic on the labour market (e.g., types of jobs and economic activity) and mental health difficulties (Timmins et al., 2022) alongside the rising financial strains on citizens due to high inflation and increasing food and energy prices (Francis-Devine et al., 2022). This is with the addition that some groups have been "disproportionately economically impacted by the coronavirus outbreak" (Powell et al., 2022, p. 4), including disabled workers, low paid workers, and ethnic minority groups.

7.10. Critique and Directions for Future Research

This section offers a critical appraisal of the current study along with directions for future research. It loosely follows the structure of the quality assessment framework used in the literature review section (Kmet et al., 2004).

The research questions were described, and rationale was provided for the design, including methodology and method. Although the study benefited from the involvement of an external consultant who identifies as a disabled person, it was not fully participatory (Barton, 2005). For example, the involvement of focus groups during the development stage could have improved the design of the study.

The study was placed in a wider political, social, and economic background and further contextual information was given about the participants. This was in line with the pragmatic and emancipatory approaches (D. L. Morgan, 2014; Oliver, 1997). Although a longitudinal design could have been an alternative (e.g., Dwyer et al., 2020; Patrick, 2014), the time constraint of the doctoral thesis did not allow for this. Instead, the research focused on collecting the views of those who could offer a longitudinal perspective of their experiences regarding the research questions. Thus, the study benefited from the retrospective accounts of the interviewees.

The social model of disability and the social model of impairment (Clifford, 2020) formed the theoretical underpinning of the study. However, alternative approaches and theories could have been considered, such as the Capabilities Approach (Austin, 2018; Nussbaum, 2000).

The sampling strategy (i.e., convenience sampling) was an important limitation of the study. Although several organisations were mobilised to support the recruitment, most participants reported having seen the advertisement by Disabled People Against Cuts. This carried a sampling bias, which might have resulted in participants being familiar with similar

alternative discourses. The sample showed a reasonable gender ratio; however, marginalised groups—such as disabled people, single parents, non-White and non-British groups—were underrepresented. Although race-related issues were carefully considered throughout, more could have been done to align with an anti-racist research design. For example, gatekeeper organisations specifically supporting Black and Minority Ethnic communities and other marginalised groups could have been approached earlier in the process, not only to help with the recruitment but also with the development of the research. This said, the sample was heterogenous in many ways, which helped to capture a complex picture, in which underrepresented voices were paid careful attention.

The sample size did not reach the planned number, which was partly due to restrictions that arose as the result of the COVID-19 pandemic. This said, according to the theory of information power (Malterud et al., 2016), a smaller sample size can be acceptable if the sample consists of information-rich cases relevant to the study, which was the case for this sample. Moreover, the study contributed "new insight" (Malterud et al., 2016, p. 1759) to existing research so it achieved its aim, regardless of the size of the sample. It was not possible to draw conclusions about the gender differences of the findings due to the small number of participants in each group. That said, as females were higher educated (all holding a degree) than males in this study, further research could assess the risks to the individual and to the economy at large that higher educated females face as the result of the 'work first' approach that encourages unemployed people to take *any* job even if it was not well-matched to their skills and experience (Timmins et al., 2022).

The data analysis closely, though not fully, followed the steps outlined by Braun and Clarke (2006). The pandemic-related delay in the data analysis and report writing phases allowed a fuller immersion in the data, as advocated by Braun and Clarke (2020), extending this period to over a year. Braun and Clarke (2020) warned of the pitfall of "confusing

themes and topics" (Braun & Clarke, 2020, p. 14). It was particularly challenging to move beyond the dichotomy of barriers and solutions (e.g., Audhoe et al., 2018), or positive and negative experiences (e.g., Boyce et al., 2008). Although the two overarching themes are a version of the barriers and solutions topics, they aim to offer meaningful contributions that are more than descriptions of topics. Alternative analysis methods could have expanded on the language use of the interviewees—for example, by using discourse analysis. This could have explored the language around 'depression'. Although alternative discourses were present regarding the benefits system, participants' descriptions of 'depression' seemed to remain within the dominant medical or biopsychosocial model of illness (Engel, 1977). It is possible that the research question itself, which did not challenge the meaning of depression, influenced the narratives. It is also possible that questioning depression as a label was not in the interest of those who were compelled to accept the label in order to receive both psychological and financial support from the state. Moreover, the study provided evidence of the barriers people with the label of depression face; thus, challenging the individual deficit model of disability (Dwyer et al., 2020). However, more could be done in future research to contribute to a more balanced understanding, in which a "nuanced and positive view on the diverse contribution that all members of society can make" (Kennedy Scott, 2016, p. 6) receives equal attention. Alternative narratives of depression were not explored in the current study and could be a topic of future research.

The use of a verification procedure is advisable in qualitative research, and can take various forms, such as triangulation, peer review, and inter-rater reliability (Kmet et al., 2004). The reflexive thematic analysis does not necessitate the use of research teams (Braun & Clarke, 2020); thus, verification is not a key component of this method. This said, initial ideas for themes, thematic maps, and variation of the themes and subthemes were discussed in detail with the external consultant to adhere to participatory and emancipatory approaches

(Barton, 2005; Oliver, 1997). Although verification is not essential in reflexive thematic analysis, reflexivity, on the other hand, is (Braun & Clarke, 2020). Reflexivity, in the form of a reflective log, personal therapy, and conversations with the external consultant and supervisors, was an integral part of the research.

A pragmatist philosophical position requires the researcher to examine the transferability of their findings (D. L. Morgan, 2007), which is addressed in Section 7.11. Moreover, both the pragmatic and emancipatory approaches advocate for the research findings to contribute to or lead to action that addresses the problematic situation identified by the research question (D. L. Morgan, 2014; Oliver, 1997). With the help of the external consultant, the dissemination of the findings is planned to take place in several stages as detailed in the Dissemination section. Thus, it is not yet possible to evaluate the degree to which this research achieved being pragmatist and emancipatory.

7.11. Implications

7.11.1. Wider implications

The question is: What is the relevance of this small-scale study to the big world outside of it? Having considered the warning by Walker et al. (2018), it is important to start with what this research is *not* implicating. This study does not support the simplistic view promoted by the Waddell-Aylward biopsychosocial model of disability (Waddell & Aylward, 2010). It does not support the idea that conditions and sanctions help claimants to find suitable work. Moreover, accounts showed that work does not guarantee good mental health nor a way out of poverty, contrary to government narrative.

Walker et al. (2018) also highlighted that, realistically, psychological research typically has very limited influence on policy, if any at all. In addition, research that is service user based is likely to fall even further from the attention of policy makers. Keeping this in mind and the fact that the complexity of social policy has baffled policy makers for decades, I

tentatively offer a few thoughts. (1) We need to question (and make it a subject of research) the way in which the NICE guideline for depression is being implemented[32] and its long-term consequences. This study suggests that the guideline's expectations are not met in practice (perhaps GPs and clinicians are being set up to fail), which can drive people further away from help. This is especially important due to the weaker scientific accountability of NICE as noted by McPherson and Sunkin, 2020. (2) I would also urge academic programmes in the field of psychology to educate their students about the political drivers that influence the ways in which psychology is applied in practice. Only this understanding can help practitioners and researchers apply their critical lens and, hence, counteract institutional ignorance (Slater, 2012). Clinging to the apolitical bubble of psychology continues to perpetuate oppression. (3) Social security and health care, though they belong to the same system, do not join up sufficiently. Alternative models that show promise could be considered, such as the social prescribing model that allows clients to be in control of their care and receive joined-up care in an environment that fosters trust (Hassan et al., 2020) or the facilitated and self-organised community networks as described by Miller (2017).

In addition to dissemination in academic circles, it is planned to share the findings with a wider network of disabled people's organisations to contribute to their work.

7.11.2. Clinical Implications

Accounts showed the importance of being connected to others and being understood (not surprising to psychologists). Group interventions, however, can be detrimental or can lead to treatment drop-out and, thus, damage the trust between services and their clients. Clinicians could consider helping their clients to link in with other forms of social connection—such as activism, informal or formal volunteering, user-led groups (e.g., recovery colleges)—at an

[32] The whole journey starting from the first assessment of depression in primary care.

early point in their journey and on an ongoing basis. Moreover, clinical teams could inform their clients about their rights, how protected characteristics apply to them, and provide easy-to-follow complaint procedures. More widely, clinical teams need to assess the ways in which they unwittingly perpetuate the oppression of those already marginalised.

This research also highlighted numerous ways in which psychological 'help' had been unhelpful or even harmful. Offering help that is not at the 'right' level (not matching severity), right 'dose' (often too short), right modality (e.g., overemphasis of 'cost-effective' group interventions), right time (e.g., if waiting lists are long), and not culturally sensitive can inadvertently cause psychological harm by damaging the trust between service users and the service and can lead to long-term consequences in service user's relationship to help. Research into the iatrogenic effect of psychological help—which is not limited to one service, team, or modality of intervention—is needed.

7.12. Self-Reflexive Comments

In this section, I address two questions: (1) How have I "attempted to avoid bias" in my analytic process? (Anonymous reviewer, n.d., as cited in Braun & Clarke, 2020, p. 1) and (2) "Who gained?" (Oliver, 1997, p. 20). One of the main biases I battled with throughout the research, was the value 'work' has in my personal viewpoint. This has been influenced by my grandparents' values who lived in the communist era in Hungary under Soviet occupation; and my parent's values who tasted both communism and capitalism. Both support the view that work is the 'right' thing to do (i.e., either to be a valued member of society or to create a good life for you and your children). I noticed during the process that even my research question was tainted with this bias as I unwittingly used a reduced definition of work (i.e., economically productive). The book, "The work cure" (Frayne, 2019b), helped to make this bias more conscious. During the research, I realised that (1) I have never properly questioned the existence of foodbanks, (2) I was oblivious about the drawbacks of volunteering, and (3) I

naively thought that in minimum wage jobs people might enjoy not having many responsibilities and forgot how powerless these jobs can make us feel if we do not have a viable alternative. In addition, I struggled to challenge the individualistic lens of capitalism and (neo)liberalism. Miller's (2017) book about poverty, webinars (e.g., Centre for Welfare Reform) helped me critically appraise the role, for example, IAPT, workplace wellbeing initiatives (which in a previous job I co-ordinated), and—more broadly—psychological therapies play in maintaining the *status quo*. Another bias my research question carries is the dominant perception of depression (i.e., the medical or biopsychosocial model of illness). Books—for example “Insane medicine” by Tamini (2021) and "The alternative" by Miller (2017)—webinars (e.g., AD4E, n.d.), articles, and lectures with a critical lens helped to stretch my understanding of the social construct of depression. I felt I was out of my depth more often than I can count. I continue to feel lost and confused about welfare benefits, which is possibly an empathic response to participants’ confusion and a realistic response to this increasingly complex system. Guilt, as I counted my privileges, was also part of this process. I accessed seminars, podcasts, and webinars (e.g., *“Racism and mental health: How to be an anti-racist mental health researcher” series*, 2021 and *“Sitting with Discomfort” series*, 2020-2021) to study my privileges and the ways in which they influence my research.

Dyslaxia [sic: without autocorrection] was both a burden and a blessing. It made writing, reading, and learning about new topics a slow and painful process. On the other hand, it gave me the opportunity to apply the social model of disability and impairment (Clifford, 2020) to myself, which helped me immerse myself more in the stories of the participants. This said, another bias I grappled with is the personal tragedy theory and charity models of disability (Clifford, 2020). During the data analysis, I had to consciously challenge myself to look beyond these models, in which Miller's (2017) book was an ongoing exemplar.

Before answering the second question (Who gained?), I note here the daunting responsibility I felt to do justice to the topic and the participants, be truthful to their stories, and—crucially—not to do harm to participants and their peers directly or indirectly with the research (Walker et al., 2018). I was aware of the power academic research can carry and, after reading Oliver's (1997) analysis, I—sadly—agree with him: the primary beneficiary of this study is the researcher. Once my thesis is complete, I gain a degree and entry into jobs. This said, with the help of my external consultant and my supervisors, we hope to widely disseminate the findings and enable disability activists to make use of them.

The knowledge I gained will continue to influence my life beyond the thesis, I will continue to share it with others, and I believe it will also make me a better clinician. I am forever grateful for Sahil, Ben, Chris, Dave, Emma, Frank, Gina, and Hanna for sharing their stories and believing that research can make the world a better place one small step at a time. I hope it will live up to their expectation.

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9. Appendices

Appendix A

Summary and Quality Scoring of the Seven Articles Identified in the Literature Review

Questions assessing quality components	Assigned scores for each question per article						
	Boyce, 2008	Cheetham, 2019	Dwyer, 2020	Hansford, 2019	Mattheys, 2018	Mehta, 2021	Patrick, 2014
Question / objective sufficiently described?	2	2	2	2	2	2	2
Study design evident and appropriate?	2	2	2	2	1	2	2
Context for the study clear?	2	2	1	1	2	1	1
Connection to a theoretical framework / wider body of knowledge?	1	1	1	1	1	2	1
Sampling strategy described, relevant and justified?	2	2	2	2	1	1	2
Data collection methods clearly described and systematic?	1	1	2	1	2	2	1
Data analysis clearly described and systematic?	2	2	1	1	0	1	0

Questions assessing quality components	Assigned scores for each question per article						
	Boyce, 2008	Cheetham, 2019	Dwyer, 2020	Hansford, 2019	Mattheys, 2018	Mehta, 2021	Patrick, 2014
Use of verification procedure(s) to establish credibility?	0	2	0	2	1	2	0
Conclusions supported by the results?	1	2	2	2	2	2	2
Reflexivity of the account?	0	0	0	0	0	0	0
Raw score	13	16	13	14	12	15	11
Total score[1]	.65	.8	.65	.7	.6	.75	.55

Note. 2 = yes; 1 = partial; 0 = no. Assigning 'not applicable' is not recommended for any of the items when assessing qualitative studies.
[1] The total score is calculated by dividing the sum of the scores (raw score) with the possible maximum score (20).

Appendix B

Information Sheet for Recruiting Organisations

Research project information sheet for organisations invited to support recruitment for the study

I am Krisztina Nemeth, a student of University of Essex, working towards becoming a Clinical Psychologist. I have a longstanding interest in the field of work and wellbeing and I am researching this topic as my thesis.

I would like to invite your organisation to collaborate with me on my research project by helping to recruit participants for my study. I would be keen to meet with staff to explain about my project and to ask them personally over the phonecall to help me engage some of their clients for this study, if appropriate.

What is the aim of this project?

We would like to learn about how people transition from unemployment to employment if they have experienced depression and had dealings with welfare benefits (legacy benefits[33] and Universal Credit). Instead of questionnaires, I will interview participants to build rich accounts of their experiences, barriers into employment in relation to welfare benefits and depression and to explore what helped them along their journeys.

Who can take part?

I would like to recruit people who meet the following criteria:

1. Individuals who had a period of unemployment or have never worked.
2. People who are trying to find work, and those who are working.
3. Individuals who have received any of the legacy benefits[1] or Universal Credit, or who were eligible but have not successfully claimed these benefits.
4. People who experienced depression before or during unemployment and believe that symptoms of depression is one of the main factors that led to unemployment or is prolonging this phase.

[33] Legacy benefits include income-based Jobseeker's Allowance (JSA), income-related Employment and Support Allowance (ESA), Income Support (IS), Housing Benefit (HB), Child Tax Credit (CTC) and Working Tax Credit (WTC).

5. Depression was diagnosed by a clinician. Depression can be current or in the past.
6. Individuals do not also have another mental health diagnosis, such as Bipolar Disorder, Personality Disorders, Post-traumatic Stress Disorder or Psychosis.
7. Participants need to be at least 18 years old.
8. People with a student status or those who are receiving a pension are not included in this study.
9. I am keen to talk to people from a variety of backgrounds, especially those from black and minority groups.
10. It is important that we include people who have good, not so good and mixed experiences. In this project everyone's opinion is important.
11. The study includes about a 1 hour-long interview and participants will need to be able to speak English to engage in the interview. It might be possible to provide a translator, which is subject to further arrangements.

How to enrol potential participants?

When staff identified potential participants and showed them the 'Research Project Invitation' sheet, they can forward the individual's name and preferred contact details via email to kn18837@essex.ac.uk. Alternatively, individuals can contact the researcher directly. Participants will be contacted for an initial screening within a few days and if they consent to continue, arrangements for the interview will be agreed between the participant and the researcher. A poster could also be displayed in your building visible to clients, who may refer themselves directly to me. Alternatively, the research invitation could appear in your newsletter or distributed via social media callouts.

A few more things to know

- Participation is voluntary. People can withdraw at any time without justifying their decision.
- Potential participants will need reassurance that their individual information will not be shared with any organisations. This project is independent of DWP, HM Revenue and Customs, Job Centres, and other support organisations.
- Some participants might become upset during the interview. This will be dealt with in a sensitive and supportive manner and they will be able to pause, postpone or terminate the interview.
- Participants will be given a £15 high street voucher for the interview.
- People's identity will be kept confidential and data will be kept secure. Only a small research team, namely Dr Ewen Speed (supervisor and Senior Lecturer at University of Essex), Dr Susan McPherson (supervisor and Senior Lecturer at University of Essex) and Krisztina Nemeth (student at University of Essex) will be able to identify participants. The reports will include quotes from the interviews under a pseudonym and all identifiable information will be removed from these quotes. The research team also includes Ellen Clifford, an external consultant in her roles as a disability consultant and as a member of the National Steering Group for Disabled People Against Cuts, who will not have access to identifiable information.
- The project will be written up as a thesis dissertation at the University of Essex and is planned to be further disseminated to stakeholders including those who contributed to the project. In addition, findings are planned to be published as a journal article.

- This project is organised by Krisztina Nemeth, Trainee Clinical Psychologist and is funded by the Health and Social Care Department at the University of Essex. The title of the project is: Depression, Work and Welfare: their Interaction over Time
- For complaints, please contact Sarah Manning-Press on sarahm@essex.ac.uk or +44 (0) 1206 873561.
- Recruitment will only start after all permissions are received.

Thank you for taking the time to read about my project. Please let me have any questions you may have.
If you would like to take part in the recruitment, please confirm at your earliest convenience by emailing me on kn18837@essex.ac.uk .

Kind regards,

Krisztina Nemeth
Student of University of Essex
kn18837@essex.ac.uk

Appendix C

List of Organisations Supporting Recruitment

The following organisations and groups have given their consent to support recruitment prior to gaining ethical approval. In addition, the researcher used social media callouts via their professional accounts.

- Sentinel Leisure Trust*
- National Steering Group for Disabled People Against Cuts (DPAC)
- Disability Advice North East Suffolk*
- Reclaiming Our Future Alliance (ROFA)
- The Bridge +*
- Unite the Union
- Norwich Mens Shed*
- Filipino Community Group in Norwich (PINAS)*

* These organisations were not able to support the recruitment due to the COVID-19 pandemic.

The following organisations were also approached to collaborate in the recruitment:

- The Feed: https://thefeed.org.uk/
- CATCH-22 Employability support
- Brighton Unemployed Centre Families Project (BUCFP): https://bucfp.org/contact-us
- ‘Psychologist for social change’ group
- The Men’s Health Forum
- Mental Health Forum
- National Survivor User Network (NSUN)

Appendix D

Participant Poster Information (General)

Research participants needed

If you have experience of

depression

unemployment

and

welfare benefits,

I would like to hear your story.

If you are interested, please contact me to ask for more information.
I am a student of University of Essex and I can be reached on kn18837@essex.ac.uk

University of Essex

HEALTH AND SOCIAL CARE

Appendix E

Participant Poster Information (BME)

Research participants needed

If you have experience of

depression,

unemployment,

and

welfare benefits,

and you are from a black or minority community,

I would like to hear your story.

If you are interested, please contact me to ask for more information.
I am a student of University of Essex and I can be reached on kn18837@essex.ac.uk

University of Essex

HEALTH AND SOCIAL CARE

Appendix F

Participant Information Sheet

Research project invitation

University of Essex

HEALTH AND SOCIAL CARE

I am a student of University of Essex and I am looking for participants for my project about unemployment, depression and benefits. This project is independent of Department for Work and Pensions (DWP), Job Centres and other related agencies.

To see if you can help, please answer the next four questions.

1. Have you been unemployed (now or in the past)? Yes / No
2. Are you trying to find work or are you currently working? Yes / No
3. Have you experienced depression before or during your unemployment? Yes / No
4. Have you needed welfare benefits (now or in the past)? Yes / No

If your answer is 'yes' to all four questions, I would like to hear about your experiences in relation to unemployment, benefits and depression. In this project, I collect stories about how people tried to break out of unemployment. I hope to learn about things that helped, and issues or barriers people experienced.

I am keen to talk to people from a variety of backgrounds, including those from minority and marginalised groups. Participants will be mainly from a large area between London and East Anglia.

It is important I talk to people who have good, not so good or mixed experiences. In this project, everyone's opinion is important.

What do I get out of participating?

It is an opportunity for you to speak freely about your experiences. Please often find talking about their experiences enjoyable and worthwhile.
I will be keen to let you know about the findings, and to tell you how the findings are shared with a wider audience.

Your time and effort will be much appreciated, and as a 'thank you' you will receive a £15 high street voucher after the interview.

If you are interested in the study, it is important that you understand the purpose of the research and what it will involve. Please read the information below carefully and take time to decide whether you would like to take part. I will be happy to answer any questions you have to help your decision.

How do I sign up?

You can let the person who invited you to know that you are interested and give them your name and preferred contact details. Alternatively, you can contact me directly via email: kn18837@essex.ac.uk

What happens next?

I will get in touch with you within a few days and will ask a few questions about you and answer any questions you have about the research.
If you are still happy to take part, I will arrange a suitable time and mode for the conversation. The meeting will take about one hour. We can talk via a video call or over the telephone, whichever way you feel the most comfortable. When the research is completed, you will receive a report about the findings, if you are interested.

A few more things you need to know

- You need to be at least 18 years old to take part.
- Participation is voluntary. You can withdraw at any time and you do not need to explain why you would like to stop participating. If you withdraw from the study, you can ask the researcher to use or destroy your data and any information you have given and not to contact you again.
- You have the right to refuse to answer or respond to any question that is asked of you.
- Your name will not be used and will be replaced with a random name.
- Your anonymity and your identity will be kept confidential and data will be kept secure.
- The project will be written up as a thesis dissertation at the University of Essex. It is planned to be shared in relevant circles and published as a journal article.
- Some of your words may be used in reports but under another name so the readers will not know who you are.
- Participation will not affect your benefits. No information about you is shared with Department for Work and Pensions (DWP), Job Centres, HM Revenue and Customs (HMRC) or the agency that asked you to take part.
- This project is organised by Krisztina Nemeth, Trainee Clinical Psychologist and is funded by the Health and Social Care Department of the University of

Essex. The title of the project is: Depression, Work and Welfare: their Interaction over Time.

- The legal basis for processing your personally identifying data is that you have consented to it. The data controller is the University of Essex. Essex University's Data Protection Officer can be contacted on dpo@essex.ac.uk .
- The proposal has been reviewed by the Faculty of Science & Health Ethics sub-Committee.
- If you have any issues or problems with the study, please contact the researcher (kn18837@essex.ac.uk) or the project supervisor (espeed@essex.ac.uk). For formal complaints, please contact Sarah Manning-Press on sarahm@essex.ac.uk or +44 (0) 1206 873561.

Kind regards,

Krisztina Nemeth
Student of University of Essex
kn18837@essex.ac.uk

University of Essex

School of Health and Social Care

Doctorate in Clinical Psychology

ERAMS Reference: ETH1920-0727
Version number: 9.3 (13.02.2020)
Title: Depression, Work and Welfare: their Interaction over Time

Appendix G

Consent Form

Participant Identification Number for this Study:

Name of Researcher: Krisztina Nemeth

Title of Project: Depression, Work and Welfare: their Interaction over Time

Summary: This research focuses on people's experiences of depression, welfare benefits and the labour market whilst transitioning from unemployment to employment.

Please tick the appropriate boxes:

I have read and understood the participant information sheet date …. version….. ☐

I have been given the opportunity to ask questions about the project and have had these answered satisfactorily. ☐

I agree to take part in the project which means:
I agree to be interviewed
I agree to be recorded during the interview
☐

I understand that I participate on a voluntary basis and that I can withdraw any time without further explanation and without my legal rights being affected. ☐

Information about data handling

I understand that my personal details will only be available for the research team. Personal details are collected by the main researcher, Krisztina Nemeth, student of the University of Essex. Supervisors will primarily access anonymised data; personal data will only be shared with the project supervisors (Dr Ewen Speed, staff at the University of Essex; Dr Susan McPherson, staff at the University of Essex) if it becomes necessary. The research team also includes Ellen Clifford, an external consultant in her roles as a disability consultant and as a member of the National Steering Group for Disabled People Against Cuts, who will not have access to identifiable information.

☐

I understand that my data will be analysed and interpreted by the researcher as part of collections of interviews. ☐

I understand that all information about me will be treated in strict confidence and all data arising from the research will be stored securely. ☐

I understand that my real name will not be used in any reports or publications. ☐

I understand that my words might be quoted in any research related publications and will be anonymised. ☐

I understand that identifiable information will be stored in a separate password protected file on the university's drive allocated to the researcher in an encrypted folder. ☐

I agree that all information I provide will be kept up to 6 months following the completion the researcher's university course. ☐

I understand that the project will be written up as a thesis dissertation at the University of Essex in 2021. Upon completion, the thesis will be placed in the Albert Sloman Library. Findings are planned to be shared in relevant circles and published as a journal article between 2021 and 2026. ☐

If you would like to know more about data handling, please tick this box. ☐

Copyright

I agree to assign the copyright I hold to Krisztina Nemeth over any materials related to this project.

_____	_____	_____
Name of participant (CAPITALS)	Signature	Date
_____	_____	_____
Name of researcher (CAPITALS)	Signature	Date

Project contact details for further information:

Krisztina Nemeth
Trainee Clinical Psychologist
School of Health and Social Care
University of Essex
Wivenhoe Park
Colchester, Essex, CO4 3SQ

kn18837@essex.ac.uk

ERAMS Reference: ETH1920-0727

Version number: 4.2 (12.02.2020)
Title: Depression, Work and Welfare: their Interaction over Time

Appendix H

Procedure for Assessing Eligibility for the Study

The following text is a guide script to aid the assessment of participants' suitability for the study, to create space for questions about the study, and to support the selection of a diverse and balanced sample. It will be conducted over the phone or in an email (some text will be omitted for the emailed version which is indicated in square brackets).

I am pleased to hear that you are interested in the study. How did you hear about the study? [What do you know about the study?] Do you have any questions about the study, any worries or thoughts?

I would like to ask a few questions about you to find out if I could include you in the study. People who take part will have to have some things in common. There are also things that would mean that someone cannot take part. For example, this study does not include those who do not work because they are students. [Are you okay if I ask a few questions?]

1. Have you been unemployed (now or in the past)?
    a. Were you a student or receiving a pension at that time?
2. Are you trying to find work or are you currently working?
3. Have you experienced depression before or during your unemployment?
    a. Who diagnosed depression and when?
    b. Have you got any other mental health diagnoses?
4. Have you needed welfare benefits (now or in the past)? If you know which type, please say.

I would like to ask further information about you. This will help me monitor who takes part, and later to describe the background of those who contributed to the research. This will also help me ensure that I include a variety of people with all sorts of experiences and backgrounds. Please answer only the questions you are comfortable with.

1. Your age:
2. How do you define your gender?
3. How do you define your ethnicity?

In the near future, I will contact you again to arrange time and place/mode for our conversation. We could talk over the phone or via a video call. Which one do you think would be best for you (convenient and easiest way to talk)?

When we have our conversation, I would like to talk to you about your experience of the transition from not working to working. I hope we can touch on topics of benefits, depression, not working, looking for work and/or staying in work. Some people will find talking about these topics difficult, some easier. I can only include people who feel that their mental health will not be adversely affected by the interview. Some people might get a little upset during the interview but then be okay afterwards. Do you think talking about your experience of depression, unemployment and benefits could be too upsetting for you? If yes, then I won't be able to include you in the study, but you will be able to see the finding in a report. If no, I would like to email/post you the form that asks for your consent to take part in the study. I would need you to send a signed copy back to me before the interview takes place. (the address is University of Essex, School of Health and Social Care, Administrator of DClinPsy, FOA: Krisztina Nemeth, Wivenhoe Park, Colchester CO4 3SQ).

I will also email/post a copy of the information sheet about the study and a short description of what we will discuss in the interview.

Would you like to talk over the phone or use a video call? [Discuss details of the preferred option.]

Would you like a paper copy or an email?

Do you have any questions about the study, any worries or thoughts?

Appendix I

Interview Topic Guide Shared with Participants in Advance

During our conversation I would like to talk to you about your experience of the transition from not working to working. I hope we can touch on topics of benefits, depression, not working, looking for work and/or staying in work.

Appendix J

Interview Topic Guide

1. Initial questions
2. Discussing ethical issues, consent and confidentiality
3. Interview topic guide

    Introduction

    Main topic:

        Your experience of transitioning from not working to working:

        - how does the journey until now looked like?
        - what were your experiences along the way?

            Prompt Questions:
            - contact with welfare support (Job Centres, legacy benefits or UC)
            - barriers and issues during the transition
            - what has been good
            - Does depression affect work? If yes, how.
            - Does depression affect claiming benefits? If yes, how.
            - work and future
            - the (fluctuating) journey through the labour market whilst experiencing depression
            - ideas for system improvement

4. Demographic questionnaire
5. Debriefing
    - How was this meeting for you?
    - Do you have any feedback on your interview experience?

If any participant feels distressed, the researcher will support participants and signposting them to a relevant organisation on the information sheets.

Appendix K

Demographic Questionnaire

I would like to ask further information about you. This will help me monitor who takes part, and later to describe the background of those who contributed to the research. Please answer only those questions you are comfortable with.

Questions about education, work and benefits

How long was your last unemployment (if still ongoing, write the length and 'ongoing')?

What type(s) of employment related benefits have you claimed, tried to claim or are you receiving?

How long have you been receiving these benefits for?

What is your current occupational status?

What is your level of education?

Are you currently unemployed or working? If working, what is your current occupational status?

Health related questions

Are you disabled (for example, have a chronic illness, mental health, physical health, learning disabilities, and/or sensory difficulties)? Yes – No – Not sure

If yes, or not sure, please name the condition(s).

Who (type of professional) and when diagnosed depression for you?

When did you notice the first symptoms of depression?

What does depression look like in your case?

What support have you received for depression (for example, medication and counselling)?

General questions

Your age:

How do you define your gender?

How do you define your ethnicity?

How do you define your sexual orientation?

What is your marital status?

Do you have dependants (caring for young children)?

What is your housing situation?

What is your religion, if you have one?

Appendix L

Participant Signposting Information Sheet

(further local information might be added; one version was modified to suit screen-readers)

Thank you for taking the time and effort to participate in this study.

Although we talked about a difficult topic today, I hope, overall, you had a positive experience. We had a lot to cover and I hope that you felt that you were able to share your experiences and felt understood.

It is possible that today or in the next few days, you will think about our conversation. If you need practical advice, medical help or feel upset and would like to talk to someone, you could contact one of these organisations below:

[*Alternative sentence*: Thank you for considering participating in this study. You might find this list useful if you felt that you needed further information or support after our conversation.]

[*If an organisation provides personalised support after the interview, the details will appear here*: If you feel like you want someone from your organisation to contact you, then please let XXXX know. They will be able to arrange this for you. Their contact details are XXXX or XXXX.]

Practical Advice

- **Citizens Advice** is a charity which offers free, confidential advice online, over the phone and in person in the following areas: benefits, work, debt and money, consumer, family, housing, law and courts, immigration and health.
  National Adviceline (Monday-Friday: 9 - 5pm): 03444 111 444 and Text relay: 03444 111 445
  www.citizensadvice.org.uk has more information and links to your local office.
- The **TURN2US** is a charity which offers free, confidential and independent advice online or over the phone. TURN2US can help with completing benefit calculation, find grants, find an adviser to help with benefits, debt, housing and legal issues.
  Helpline (Monday-Friday 9 - 5.30pm): 0808 802 2000
  www.turn2us.org.uk and info@turn2us.org.uk
- **Law Centres** provide free legal advice and representation to disadvantaged people face to face (Ipswich and London) or via telephone. For more information, please visit www.lawcentres.org.uk

- **Age UK** offers benefits advice for older people face to face, via telephone or home visits.
  Age UK Helpline (8am – 7pm): 0800 169 6565 and www.ageuk.og.uk
- **Gingerbread Single Parent Helpline** provides advice and practical support for single parents, including advice on benefits and tax credits.
  Helpline: 0808 802 0925 and www.gingerbread.org.uk
- **JobCentre Plus**
  Local offices can help with job searching and benefit claims.

Mental Health and Disability Support

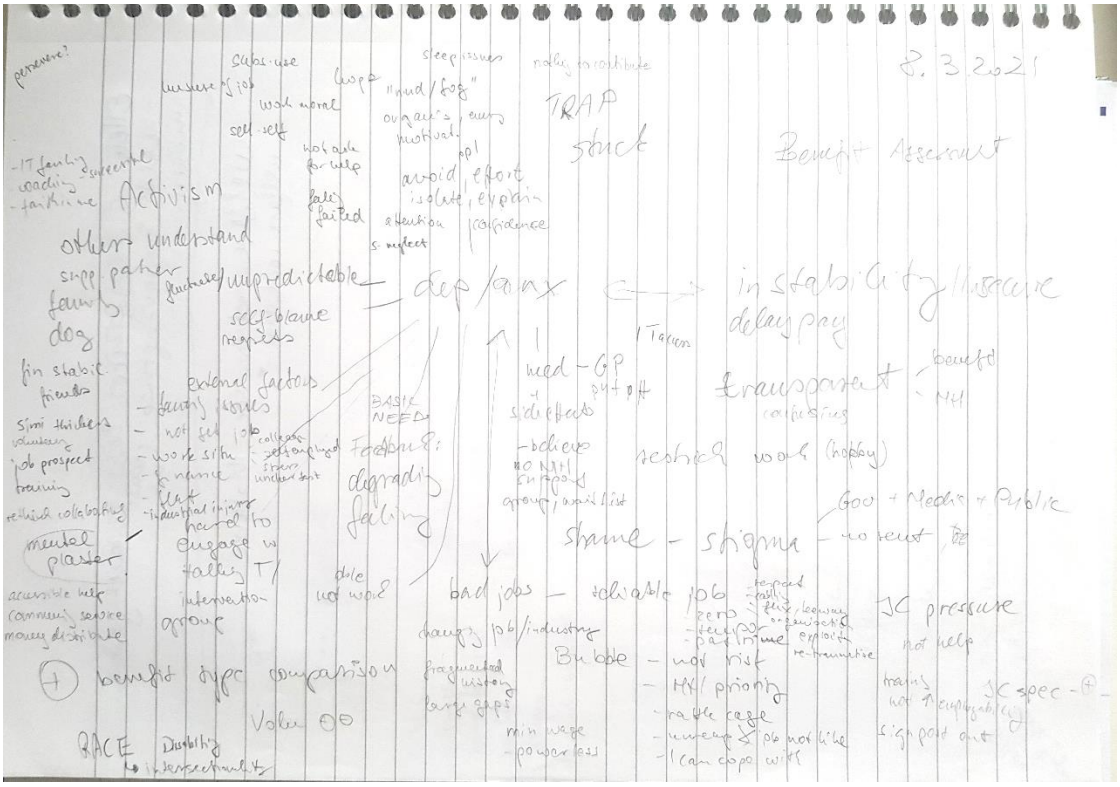
- You can contact your GP if you feel like speaking to them would be helpful.
- **Together** is a national mental health charity: www.together-uk.org
- **Mind** is a national mental health charity: www.mind.org.uk
  Mind info line (9am - 6pm): 0300 123 3393 or Text: 86463 and info@mind.org.uk
- **Equal Lives** (Norfolk) is led by people who face disabling barriers and is dedicated to making your voice heard. Main Tel. 01508 491210 and www.equallives.org.uk
- **Inclusion London** supports Deaf and Disabled people's organisations in London. https://www.inclusionlondon.org.uk/disability-in-london/useful-links/useful-links-for-disabled-londoners/

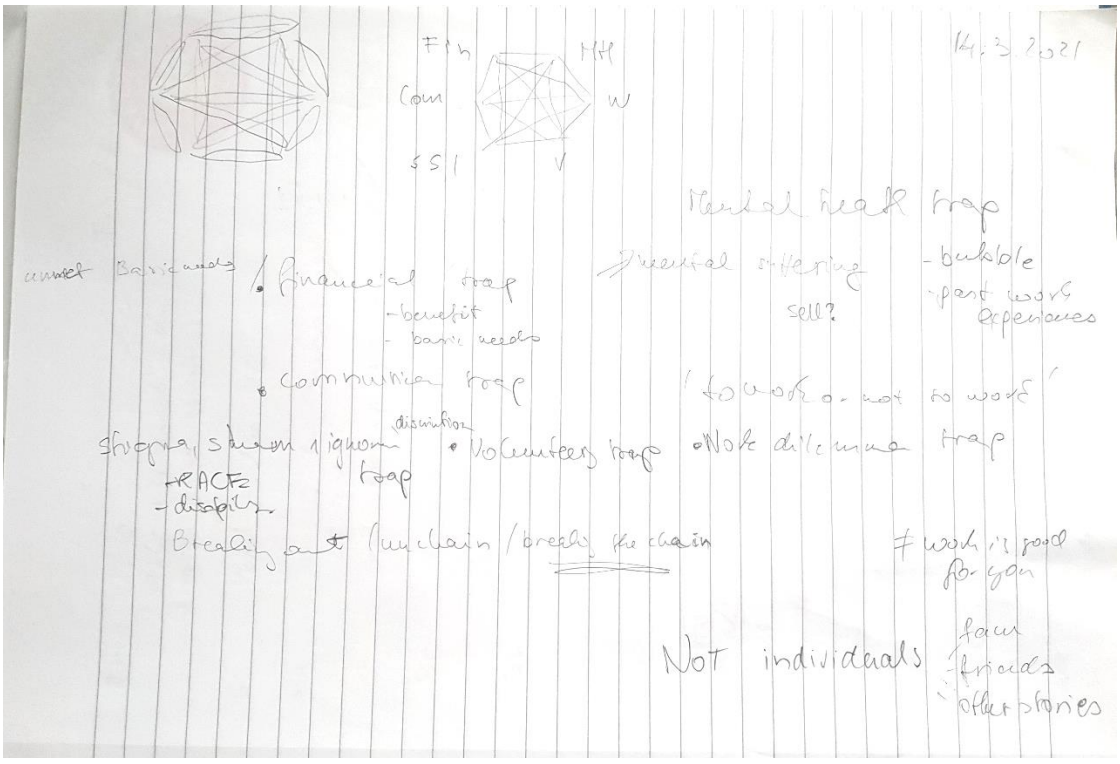
Emotional Support

- For a listening ear or just someone to talk to the **Samaritans** are open 24 hours a day, 7 days a week. You can call them on 116 123 or email jo@samaritans.org. More info on www.samaritans.org
- **Shout** is the UK's first free 24/7 text service for anyone in crisis anytime, anywhere. It's a place to go if you're struggling to cope and you need immediate help. Text SHOUT to 85258 or visit website: www.giveusashout.org
- Find your nearest **Mind** office for information on local support:
- IAPT (Improving Access to Psychological Therapies) is a nationally available service offering talking therapies. Some IAPT services run under different names. Local services can be found here or via your GP
  https://www.nhs.uk/Service-Search/Psychological%20therapies%20%28IAPT%29/LocationSearch/10008
- You can contact your GP if you feel like speaking to them would be helpful.

Appendix M

Extracts from Data Analysis Process





Protective bubble

Slip -> fall through the nets of welfare support

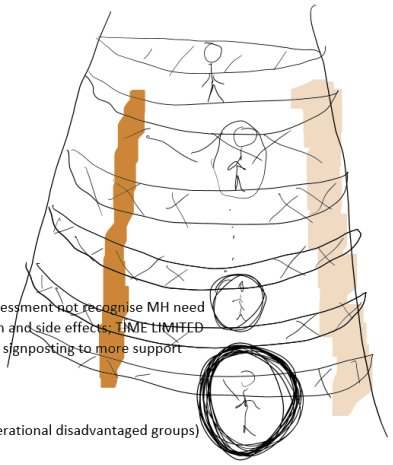
If there is not enough support, ppl will protect themselves, it's survival

Protection:

1. MH provision
2. Basic needs met – welfare support
3. Friends and family, or at least one person who understands (group therapy might not be the best, peer support might be better, interest groups, activism, gardening group, volunteering to help others with similar issues)
4. Protecting self, survival strategies

LAYERS:

1. Education
2. Work:
    a. Line manager
    b. Ethos, values ppl
    c. Colleagues
    d. Work environment (shift patterns, responsibility, own business pressures)
    e. training
    f. HR
    g. Union
    h. OH
    i. EAP
3. job application successes or failures
4. Savings – vs transgenerational poverty
5. Family support – vs transgenerational MH suffering
6. Welfare, benefits vs delayed pay, creating dept to Gov, and letting it escalate + benefit assessment not recognise MH need
7. MH provision - vs bigger delay, not in sync with length of sick leave, or benefit; medication and side effects; ~~TIME LIMITED~~
8. JC recognising extra support need vs asking "what jobs have you applied for", JC light – no signposting to more support
9. Council housing
10. Foodbanks
11. Homeless shelter, other homeless states
12. RACE- confounding all the layers (therapist, jobs, GP, neighbourhood in poverty, transgenerational disadvantaged groups)



The gaps, fractures in the welfare system supporting those with a label of depression **are too many to count**

Being at the mercy of a welfare system that has holes/gaps to many to count

Appendix N

Ethical Approval

From: Haplo <erams@essex.ac.uk>
Subject: (CC) Decision - Ethics ETH1920-0727: Ms Krisztina Nemeth
Date: 8 April 2020 at 09:04:18 BST
To: Ewen Speed <esspeed@essex.ac.uk>

University of Essex ERAMS

Dear Ewen

The following notification has been sent to **Krisztina Nemeth** and is copied below for your information.

08/04/2020

Ms Krisztina Nemeth

Health and Social Care

University of Essex

Dear Krisztina,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Depression, Work and Welfare: their Interaction over Time" has been reviewed by the Science and Health Ethics Sub Committee.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Izzie Easton

Ethics ETH1920-0727: Ms Krisztina Nemeth

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).

Appendix M

Ethical Approval with Amendments

Nemeth, Krisztina

From: ERAMS
Sent: 04 October 2020 20:38
To: Nemeth, Krisztina
Subject: Decision - Ethics ETH2021-0137: Ms Krisztina Nemeth

University of Essex ERAMS

04/10/2020

Ms Krisztina Nemeth

Health and Social Care

University of Essex

Dear Krisztina,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Depression, Work and Welfare: their Interaction over Time" has been reviewed by the Ethics Sub Committee 1.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Dr Camille Cronin

Ethics ETH2021-0137: Ms Krisztina Nemeth

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).