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**Written submission for the Visit by the United Nations Special Rapporteur on extreme poverty and human rights to the United Kingdom**

**Introduction**

**‘De-Stress’** is an academic research study looking at **the impact of welfare reforms and austerity on mental health and wellbeing in low-income communities.**

The 2.5-year study (Nov 2016 – April 2019) is a joint collaboration between the Universities of Exeter and Plymouth, funded by the Economic and Social Research Council. Our findings have much to contribute to the Special Rapporteur’s investigation into the inter-linkages between poverty and the realisation of human rights in the United Kingdom.

We have collated a rich body of data exploring the lived experience of people in two low-income communities in South West England and the impact of austerity and recent welfare reforms on their wellbeing. Our findings are of particular relevance in that they demonstrate a common experience across people in low-income communities struggling to access adequate food, clothing, housing and healthcare, and access to support if they are unemployed, ill or disabled (Article 25 of the Universal Declaration of Human Rights).

This submission provides a brief overview of the study and our findings, including some case studies (Appendix 3). We would be happy to provide further information if required, including introductions to local residents who have been involved in the research.

We would welcome the submission being included on the website.

**Overview of study**

The project aims to understand how narratives around self-responsibility impact on the ways that people in low-income communities perceive and respond to poverty-related mental distress, particularly in the current climate of austerity and welfare reform.

**Methodology**

De-Stress uses a qualitative, mixed methods approach which has included:

* 16 focus groups with a total of 97 residents in two areas of high economic disadvantage to gain understanding of the way that narratives around responsibility manifest and impact on wellbeing;
* 80 interviews with people in low-income areas to understand their experiences of, and responses to, poverty-related distress;
* 10 interviews with GPs in and around the study sites, to understand the challenges they face providing effective mental health support within low-income communities;
* Detailed micro-analysis (conversation analysis) of 52 video-recorded GP-patient consultations to understand how mental distress and poverty are discussed and responded to within primary care settings.

**Relevance to the investigation**

Findings from the above are of particular relevance to the following questions:

(5) Could you specify how poverty and extreme poverty in the United Kingdom intersect with economic and social rights issues (such as the right to education or the right to health care)?

(9) Have austerity measures implemented by the government taken adequate account of the impact on vulnerable groups and reflected efforts to minimize negative effects for those groups and individuals?

(12) How have local governments been affected by austerity measures in the last decades? If possible, please specify the impact on public services such as police and fire departments, public libraries, and the administration of the welfare system by local authorities.

(16) What has the impact of Universal Credit been on poverty and the lives of the poor in the United Kingdom until now? It would be helpful to also distinguish the specific impact of Universal Credit on specific groups, including for example children, persons with disabilities, women and other groups which may be more vulnerable on the basis of their identity and circumstances.

(18) What has the impact been of various forms of ‘welfare conditionality’ in the context of Universal Credit in terms of incentivizing work?

**Findings**

Below are the overarching themes from our data:

**Stigma and moral judgement**

* Study site residents feel that the challenges of poverty and deprivation have intensified in recent years. Many attribute this to a lack of employment opportunities, an increase in insecure and zero hours contracts, poor housing, social isolation, welfare reforms and an upsurge in welfare sanctioning. These circumstances are widely associated with increases in mental distress.
* Moralising narratives around health and responsibility pervade many aspects of life for people in the study sites. The extent of this varies across demographic groups, with those with young children and those within the welfare system most commonly reporting feeling judged and shamed by others. Key sources of moralising and judgement are reported to come from government rhetoric, the media, job centre workers, health and social workers, schools, and, albeit to a lesser extent, from GPs. People feel that this judgement and shaming has intensified in recent years and that this is linked to a hardening attitude against people in receipt of welfare support.
* Most GPs interviewed felt that patients from low-income backgrounds faced increasing challenges as a result of austerity and welfare reform, and spoke of their ‘anger’ at what they feel is an ‘uncompassionate’ system.

*‘I have noticed that some people who are socially deprived feel that they are not listened to, that the system’s failed them and they feel very degraded, treated with a bit of less self-worth…that attitude towards patients who are, who are punished for, you know - who aren’t working - needs to be really challenged and changed”* [Female GP, Plymouth]

**Poverty-related distress**

* Links between poverty and mental distress are clearly evident in the study sites. Few options for formal help for this distress exist and it is universally agreed that important community-focused services e.g. Citizen’s Advice Bureau (CAB), have become harder to access.
* Access to support and to statutory services is an issue for residents in both study sites. In Teignmouth, residents now have to find additional time and funds to travel to Newton Abbott to visit housing offices, attend the job centre, and access services such as the CAB. In Plymouth, residents report being adversely affected by changes to GP surgery provision, with some waiting up to 6 weeks for an appointment.
* Child poverty has risen in recent years. This places extreme pressure and stress on parents who want to provide for their children whilst struggling to meet basic living costs. The embedded nature of the rhetoric around ‘responsibility’ means that parents commonly feel judged as ‘failures’ by service providers and fear that their children will be removed into statutory care. A common response is to avoid contact with such services. As a result, people do not receive the support they are entitled to.
* Accessing benefits entitlements is considered to be extremely stressful and time consuming. Welfare reforms in recent years have added to this complexity and burden.
* People who have been moved on to Universal Credit have been left in crisis situations with no access to money for periods of six weeks or more.
* Many people in the welfare system reported that the payment they received had been incorrectly calculated on numerous occasions, and that they spent long and stressful periods of time trying to resolve this. Accessing support workers on the phone or in person was difficult, time consuming and costly.
* Many people had experienced welfare sanctioning, often for minor and unintended errors. Instances of welfare sanctioning were reported when job centres had failed to inform clients of a change in meeting time.
* Accessing welfare forms and communications via internet is difficult. Few people have computers at home, or can afford to pay for internet access, yet there is a systemic expectation that all should be able to do this.
* The Work Capability Assessments experienced by those unable to work due to illness or disability were stated as a cause of mental distress in themselves; people felt that the assessments were not fit for purpose in terms of assessing the impact of multi-morbidities or mental health conditions. Some interviewees described the extreme stress they felt as a result of going through the assessments; one person reported cutting herself whilst waiting for her appointment, another reported suicidal thoughts.
* Most people seek medical help from their GP because they feel that this will provide them with appropriate mental health support. However, many report that they go to their GP because there is nowhere else to go to get help.
* For some people, being diagnosed with a mental health condition is deemed helpful, and can help them to make sense of, and more effectively deal with what is happening within their lives. However, many people in the study sites feel that their distress is being overly-medicalised. This is particularly evident for those within the welfare system who need to provide medical evidence to legitimate their benefits claims.
* With one exception, all GPs interviewed report a significant rise in cases of poverty-related distress in the past five years. They clearly articulate the association they see between benefits assessment / re-assessment and an exacerbation of mental health issues, and express clear frustration at being asked to act as gatekeepers for welfare claims.
* GPs state that increasing proportions of their patient caseload are experiencing what are primarily social/structural rather than medical issues, with estimates ranging from 10% to 50% of patients.

‘*I think what I am seeing now is a different level…. there’s a gross underestimate of quite how much distress we are talking about’ [Male GP, Plymouth]*

* GPs seeking to support patients experiencing poverty-related distress feel they have very limited options available to them - antidepressant medications, talking therapies or a combination of the two.
* GPs expressed frustration regarding the lack of support to address other behaviours associated with mental distress, such as alcohol and substance abuse; they felt there was a lack of support for addressing the constellation of issues people may be facing - rather, any support tended to address single behaviours e.g. substance abuse - and often further support could only be accessed once such behaviours had been addressed.

**Medicalising poverty**

Data show a huge upsurge in the prescribing of drugs for pain and distress in the UK over the past decade. These drugs are potentially harmful and are commonly prescribed to people living in poverty, and people in vulnerable situations e.g. homeless; prisoners/prison leavers.

* The increase in Pregabalin prescribing in England has been dramatic between 2007 and 2017, from 0.7 to 6.2 million items per year (9 fold increase).1 This has been accompanied by similar changes in gabapentin prescribing (1.4 million to 7.1 million).1 Total opioid prescriptions and codeine (20.3 million items per year) peaked in 2016, while morphine (5.0 million), buprenorphine (2.2 million) and oxycodone (1.4 million)1 has continued to rise.
* In the last ten years, we have seen a major increase in quetiapine (doubling to 3.3 million items/year)1 , with overall item increases across the anti-psychotic range (6.6 to10.5 million);1 there was a continued rise in ‘Z drugs’ and benzodiazepines (Diazepam and Zopiclone both peaking at over 5 million) until 2015.1
* There has been continued advancement in total anti-depressant prescribing (600% in 25 years)2 to 68 million items per year in England,1. Extremely high prescribing rates are associated with areas of deprivation3.

Our evidence suggests this increase in prescribing is closely linked with the stresses of austerity and the introduction of punitive welfare reforms.

**Antidepressant use**

* Use of antidepressant medications in the study sites is very high. 46 of the 57 people interviewed had been prescribed, and/or had taken, antidepressant medication at some point in their lives, often for issues that were more social/structural than medical.
* Experience with *long-term* antidepressant use is commonly reported in the study sites.
* Despite the high level of antidepressant use within the study sites, a significant proportion of study participants have reported surprise at being prescribed these medications. The feeling of being ‘fobbed off’ with medicines is very commonly reported, with participants feeling that most GPs do not have the time or resources to listen and respond appropriately to their needs.
* GPs interviewed for the study recognise that medications are often a ‘sticking plaster’ approach, but explain that they have few other viable options available to them to help people living with poverty-related stress.

*‘You know by doing that* [prescribing antidepressants] *you feel that at least you have tried to give something when you can’t change their… you can’t get their, you can’t give them a roof over their heads, you can’t change the fact that they don’t have any support or family around’ (Female GP, Plymouth)*

**Access to Psychological Therapies**

* Most interview participants have been offered talking therapies through their local service providers. However, waiting times, a reluctance to talk to a stranger, or in a group, and the logistical difficulties of attending appointments deter many from attending. Attending appointments is a particular issue for people in insecure employment/zero hour’s contracts, and people who need childcare, where the cost and logistical implications make this difficult.
* Experiences of attending psychological therapy treatments varied across participants. However, only eight people interviewed felt that the treatment actually been beneficial to their health and wellbeing, and even then, only parts of the experience are seen as effective.
* All GPs interviewed for the study express particular frustration at the ‘fractured’ nature of mental health provision and the difficulties they face referring patients to appropriate secondary mental health care. Patients are commonly refused access to IAPT services if their needs are considered too high, and are then referred back to their GP rather than on to specialist care. This is demoralising for already distressed patients, and considered by GPs to be an unnecessary burden on their time and resourcing.

**Alternatives to medicalisation**

* Community support groups play a fundamental role in supporting people living with poverty-related stress. However, they have been severely impacted by resource cuts, and where they exist, are often sporadic in nature and extremely under-funded.

**Emerging critical issues**

* Our data show that people may avoid accessing support services if they feel they will be unfairly judged because of their low-income background and circumstances.
* Austerity and welfare reforms are impacting adversely on poverty-related stress and well-being, and this is adding burden to GP workloads.
* GPs have limited options to offer patients from low-income groups experiencing poverty-related distress. It is widely recognised that anti-depressant medications are being used, often on a long-term basis, to alleviate what are essentially social and structural issues.
* Accessing IAPT services can be problematic for patients from low-income backgrounds. The vast majority of those who do access the service do not find it useful because it does not address the poverty-related issues causing their distress.
* There is an almost universal perception that mental health provision is fractured, and that a deeply problematic disconnect exists between primary and secondary care.
* The Work Capability Assessment (WCA) applied to recipients of Employment and Support Allowance exacerbates distress and anxiety in vulnerable populations such as those experiencing mental health issues, long-term health conditions, and multi-morbidity, as does the threat and implementation of sanctions.
* The WCA is felt to be unfit for purpose by both residents and GPs, in that it does not accurately or realistically assess the capability of those with complex conditions, particularly mental health and multi-morbidity, and often contradicts the judgement of health professionals.

**Appendix 1:** DeStress team

**Appendix 2:** References

**Appendix 3:** Case studies that demonstrate the impact of welfare reform on vulnerable individuals

**Appendix 1**

**DeStress Project Details**

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**Appendix 2**

References

1. NHS Digital (2018). Prescription Cost analysis. <https://digital.nhs.uk/data-and-information/publications/statistical/prescription-cost-analysis/prescription-cost-analysis-england-2017>  (last accessed 16 8 18)

1. Lewer D, O'Reilly C, Mojtabai R, Evans-Lacko S. Antidepressant use in 27 European countries: associations with sociodemographic, cultural and economic factors. Br J Psychiatry 2015 Sep;207(3):221-6
2. Exasol (2017). Research shows that over 64m prescriptions of antidepressants are dispensed per year in England. Retrieved from <http://www.exasol.com/en/news/2017-04-13-over-64-million-prescriptions-of-antidepressants-dispensed-per-year-in-england/> (accessed 16/9/2017)

**Appendix 3: Case studies**

**Case Study 1**, Clare, provides an example of the mental distress caused by the Work Capability Assessment process for someone with mental health issues. The negative impact of the assessment process itself on Clare’s mental was something that was commonly reported in interviews. The case study also illustrates the extreme hardship (i.e. struggle to access adequate food and heating) caused by the sanctions system, again an experience that was commonly reported.

In **Case Study 2,** Pete is claiming benefit as he is unable to work due to a complex mixture of physical and mental health issues. This example illustrates how the increasing stigma of worklessness contributes to his depression. The case study also shows how the contradiction between the advice he is receiving from health professionals (that he needs to accept that he is no longer able to work) and the message he is being given by benefits advisors (that he should be seeking work) further contributes to his mental distress and frustration.

**Case study 1: Clare**

Clare is a 50 year old female who, in her words, experienced a ‘complete breakdown’ as a result of a pressurised work situation 9 years ago. Since then she has been living with depression and anxiety and finds it difficult to leave the house. At the time of the first research interview Clare explained that she was claiming ESA and had been in the ‘Support Group’ (with no requirement to look for work) for six or seven years. Clare described the stress and anxiety that she experienced each time she went through a Work Capability Assessment (WCA)

*From the minute that you get the letter saying you’ve got to go and see ATOS or whatever company it is that’s doing it now, it’ the same frigging house, same place, same staff, everything, you’ve got the wait for the appointment. So, that whole time you're judging yourself through strangers’ eyes, with a depressive mind-set, because you feel low about yourself anyway. So, the constant thought that’s going through your head is, well, you're not worth anything anyway so of course they're going to make you do this and they're going to say you're skiving or whatever, scrounging…*

*And it terrifies me, the whole fucking process terrifies me. And then you have to go to the appointment, and you're waiting in a room with other people, and your tension is getting worse and worse and worse. I take crochet with me everywhere I go because I can focus on that, stop the thoughts, stop the shaking, stop the panic attacks, stop the flop sweats, the heart racing, stop everything. And you're in a room, you're talking for half an hour to a complete stranger who doesn’t know who the fuck you are, hasn’t got a clue as to whether or not you're on a good day or a bad day, doesn’t… It… [long pause] [sighs] The whole time you're doing that process, the whole time you're waiting for that, in my case I was disappointed that I woke up each morning.*

After a recent assessment Clare had been informed that she was being moved to the Work-related Activity Group, which would require her to travel to the job centre in another town every two weeks, and would reduce the amount she would receive. Clare explained how she’d been feeling extremely low since receiving the letter and that her mental health support worker was dealing with the paperwork for her appeal as she knew that it would ‘tip me over the edge’. Both Clare and her support worker felt that the assessment report was an inaccurate reflection of the information she had given at the assessment, and that the assessor had little understanding of mental health issues.

At the time of Clare’s second research interview she had attended a follow-up assessment the day before – she wasn’t sure whether this was as part of her appeal or just a routine re-assessment. Again she described how distressing she had found the experience, which included being asked to describe her previous suicide attempts and why they didn’t succeed.

As well as the mental distress caused by the benefits system Clare also described her previous experience of the economic impact of mistakes in the system

*I’ve had problems with the DWP before anyway…Five times I sent a year’s worth of statements to them. I posted them twice, recorded, disappeared. [Support worker] took copies as well and took them to the jobcentre in [town] where they were scanned in and faxed or emailed or whatever it is they do and they managed to lose those as well. Five times in 18 months. I didn’t have any money at all over Christmas two years ago because they decided that I had too much money and they sanctioned me completely and for nine weeks I had no money at all and I was living on the foodbank, handouts, I had friends who were lending me money just so I could put electric and feed the dogs and myself*

Clare described how, as a result of the fear she was feeling in relation to assessment, she had decided not to apply for the Personal Independence Payments she believed she was entitled to as she couldn’t face more assessments. In the two days leading up to her most recent assessment she had stopped taking the medication ‘that keeps me stable’ because she felt that the medication ‘numbed’ her enough to be able to talk, creating a false impression of her mental state and so ‘in order for them to see me as I am I felt driven to that extreme’.

**Case study 2: Pete**

Pete is a 56 year old male claiming Employment Support Allowance as he is medically unfit for work due to chronic nerve pain, vertigo, diabetes and depression, with a previous episode of psychosis. In the past he worked in various manual trades for around thirty years but has been unable to work for the last 10 years.

Asked how he felt about his current situation, Pete talked about how his inability to work and constant pain contributed to his feelings of frustration and depression.

*I do try to do things but the pain just kills me at the end of day and I just can't concentrate. Annoyed. Everybody thinks sitting at home doing nothing is great, 'til you try doing it for years and the days just blend into one, they don't change, you try to do things, you can't, as I said you can't do it, you can't concentrate, I can't use the tools like I used to...I used to be a tradesman at one time; I've done various different jobs over the years, can't use a trade, I've lost interest in using a computer, can't remember the last time I turned it on to be honest, couple of weeks ago I would imagine, used to be on it quite a lot, but can't concentrate on it, so, no, not very enjoyable…And being dosed full of tablets I'm not allowed to use certain stuff anyway, so… I don't know what else I can say about that, apart from unhappy.*

He also talked about how the health professionals supporting him had advised him that unwillingness to accept that he was unable to work may be negatively contributing to his physical and mental health,

*When I saw I'm going to do something I will finish it eventually but I'm going to suffer when I do it…That could be part of me that's saying I'm still fit to work, I can still do this job, I've had this from the psychiatrist, I've had it from various people I've talked to, I've had it from the doctors. You're not accepting you can't do certain jobs. I know that! I won't accept it, I can't accept it because I've always worked, since I was young.*

Despite being classed by his GP as not fit for work, Pete explained that his claim for Disability Living Allowance had, after a period of dispute, been rejected,

*I had my medical last year, unfit for work, so I put in for, 'cos I had mobility problems, I put in for, oh, what the hell's it called, oh DLA. Went through the usual rigmarole, got to an appeal tribunal, they looked at my medication and said you shouldn't be working, you're entitled to DLA, so I had the phone call on Thursday to say that I was going to get it, they said they send you a letter, I received a letter on the Saturday telling me what I had, and in the same post I had a letter from DWEP saying they'd stopped my DLA and I had to go for another medical, so I had it for two days*

Pete also reported that during the time he had been claiming Employment and Support Allowance (ESA) he had experienced being moved between the Support Group (in which he did not have to seek work) and the Work-related Activity Group several times and was clearly confused about his current status

*I'm on, how's it work, I'm no idea if I'm ESA, PIP or Job Seekers. They keep changing their mind; one minute I'm a try list, then I'm not a try list, this has been going on for years. So now what I'm on is, I'm on unemployment… I just keep going through the rigmarole*

The apparent contradiction between the advice Pete was being given by health professionals and the judgements of the benefits agency, his own daily experience, and his realistic assessment of his own ability to find employment that he would be able to sustain were clearly causing further mental distress

*They don't listen,* ‘can you do this?’*,* ‘can you walk up a step?’ *- no,* ‘can you sit on that?’ *- no,* ‘can you do that?’*,* ‘when do you feel pain?’ *- all the time,* ‘how far can you walk before you feel pain?’ *- do you not listen, I'm in pain with my feet twenty four hours a day, I don't even have to stand on my feet, my feet are giving me grief now. The base of my spine is giving me grief now. Other parts of my body are giving me grief now.*

*But they can't understand what constant pain is. Constant pain is constant. What do they not understand about constant. Ridiculous. So, when they find me a job, I'll do it. Whether I can do it any good is another thing altogether. But I'm prepared to give it a go, but they don't find me a job, they say you find a job. What am I meant to be looking for? They say you know what you can do. Yeah, I know what I can do, you find me a job out there that fits my description. I can't find a job that fits my description.*

Having to deal with an expectation that he should be moving towards employment in order to be entitled to welfare, whilst knowing that realistically it was unlikely that he would be able to meet the demands of employment was clearly adding to the mental distress and frustration that Pete was already dealing with as a result of his health conditions.

**We have a large set of case studies demonstrating how austerity and welfare reforms impact on people’s mental wellbeing. Please do not hesitate to contact us if you would like further examples.**