

**Towards inclusive service delivery through social investment in England
An analysis of five sectors with a particular focus on mental health**

Moth, Rich; Neary, Dave; Lavalette, Michael; Baeten, Rita; Elsinga, Marja; Haffner, Marietta; Messkoub, Mahmood ; Murphy, Mary ; Nicaise, Ides ; Ünver, Özgün

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Towards inclusive service delivery through social investment in England

An analysis of five sectors with a particular focus on mental health

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August 2018

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Executive summary

This report examines trends in social investment in England following the financial crisis of 2007/8. The first section considers social investment in relation to four policy arenas: housing, financial services, early childhood education and care, and water. The second part of the report provides an overview of social investment and disinvestment trends in the healthcare system in England since the 1990s with a particular focus on mental health services. This section includes a detailed account of service users' and professionals' experiences of the impact of liberalisation and austerity measures on mental health service delivery drawing on qualitative data collection. Throughout the report we identify policy recommendations to address the effects and impacts of emergent trends towards social disinvestment and liberalisation of public services. This study is part of the wider pan-European RE-InVEST project to investigate the impact of the EU Social Investment package on marginalised groups since the 2007 crisis.

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List of abbreviations

CMHN - Community Mental Health Nurse

CPN - Community Psychiatric Nurse

DWP - Department for Work & Pensions

NHS - National Health Service

NHSCCA - NHS and Community Care Act 1990

SDS - Self-directed support

Introduction

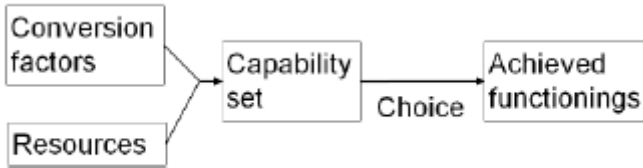
RE-InVEST: social investment, human rights and capabilities framework

Re-InVEST, a H2020 funded project under Euro 3 Europe after the Crisis, involves 19 organisations (universities, research centres and civil society organisations working with vulnerable groups). Re-InVEST aims to investigate the philosophical, institutional and empirical foundations of an inclusive Europe of solidarity and trust. To this end it draws on capability and human rights based participatory approaches to examine how the European Union Social Investment package can be strengthened.

Human rights form a common European basis of values and describe core elements of what constitutes well-being and a good life. Human rights are the basic rights and freedoms that belong to everyone. International law, including treaties, contain the provisions which give human rights legal effect. Specific groups are protected in specific treaties such as women, children, and people with disabilities, minorities, and migrants. Human rights are transformative. For vulnerable groups the usage of a rights-terminology has changed perspectives, by empowering people, by increasing awareness and creating tools to address compromises of these rights.

Capability approach as developed by Sen (1999) and Nussbaum (2011) defines a person’s well-being in terms of ‘what a person can do’ or ‘the beings and doings (the functioning’s) a person achieves and her capability to choose among different combinations of such ‘functioning’s’. Resources and conversion factors are preconditions or necessary for leading a life one values and has reason to value (Figure 2.1). Resources refer to the material conditions of a person: her income, the goods and services she disposes of. Conversion factors help her to convert resources into ‘doing and being well’. Both the achieved functionings as well as the freedom to choose a life one values matters.

Figure 0.1 Resources, conversion factors, capability set and achieved functionings



A human rights and capability framework for Social Investment in Services

Our model builds on human rights¹ and capabilities as building blocks for the social inclusion/wellbeing of individuals. (Formal) human rights (e.g. right to work, right to social protection) are values and social norms which do not automatically result in improved wellbeing. For the implementation of such rights (mainly in the field of economic, social and cultural rights), different types of policy measures need to be implemented: legislation, organisation of (public) services, subsidies, social transfers, inspection, judicial enforcement, ... Although some legal measures may establish effective rights (e.g. a guaranteed access to basic services), most policies necessitate additional ‘social investment’ in individual and collective capabilities through public or subsidised service provision, e.g. early childhood education and care (ECEC), health care, etc. and the transfer of power and resources - either directly to individuals/households (e.g. social housing), or to companies

and civil society organisations (e.g. subsidies to housing companies, water distribution, ECEC providers). These ‘collectives’ in turn interact with households and may invest in their capabilities

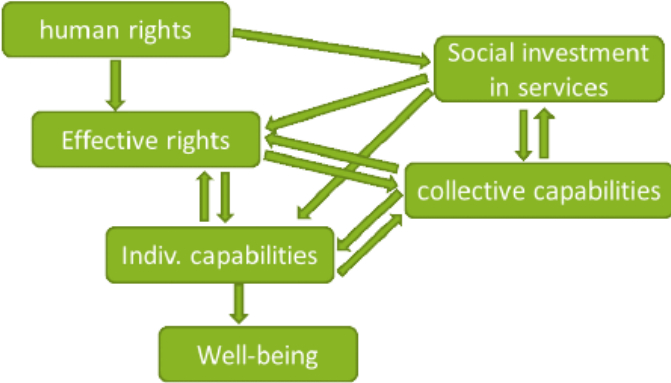
European Commission Social investment Package

In 2013 the Commission issued a communication on social investment for growth and cohesion, the Social Investment Package 2. The Package provides guidance to Member States to help reach the Europe 2020 targets by establishing a link between social policies, the recommended reforms in the European Semester and the use of relevant EU funds. According to the European Social Policy Network, the EU approach to social investment in the package is largely consistent with the scientific debate on the issue, but the Commission puts more emphasis on dimensions such as effectiveness and efficiency, policies to raise the human capital *stock* (e.g. through ECEC, vocational training, education and lifelong learning), *flows* (through policies supporting employment, active labour market policies) and *buffers* protecting people through risky transitions (such as adequate unemployment benefits and minimum income support schemes). Social investment strategies are seen as a package of policy measures in a life course perspective, that are complementary and mutually reinforcing. It is clear that the approach in the SIP covers more policy measures than social services, that form only part of the social investment strategy, but social services play an important role.

RE-InVEST define social investment as investment of resources into people - more precisely, into the sustainable enhancement of individual and collective agency’. The criterion to assess success becomes the sustainable impact on capabilities rather than the source or nature of the investment.

- In Section 1 we first briefly examine how social investment or disinvestment impacts on human rights and capabilities in England in four sectors: early childhood education and care (ECEC), housing, financial services and water.
- In Section 2 we focus on the direct research question, the impact of social disinvestment and liberalisation of mental health services in England on human rights and capabilities of service users.

Figure 0.2 From human rights and capabilities to individual wellbeing



Methodology - Participatory Action Human Rights and Capability Approach

RE-InVEST makes the links between rights and capabilities, with capabilities or resources and conversion factors understood as essential to turn abstract rights into real entitlements, ‘to have the capability to make rights real and live a life one values’. Central to such concepts are key human rights principles including agency, participation, and voice which can be realised at an individual and collective level. This theoretical framework translates into our choice to work, to much as possible, within a transformative and participative methodology paradigm to answer core research questions, conduct our analysis and formulate potential solutions. This qualitative, participatory research is not suitable as a means to ‘validate’ or ‘prove’ hypotheses and we make no such positivist claim. Rather we combine qualitative research with quantitative data to

deepen understanding of precisely how social investment in services and social policies relate to rights and capability.

As participative research the validity of our methodology lies in the co-construction of knowledge by a mixed group of researchers: academic researchers, NGO's and people experiencing poverty working through an iterative and ongoing process of action, knowledge creation and reflection. This practical utilisation of a capability approach in research methodology is a core outcome of the project. It is not just instrumental in facilitating a more grounded empirical answer to research questions but permeates our whole project. NGO's or civil society organisations and the representatives of vulnerable groups participating in the process enhance not only validity but our collective capacity to transform social environments, as such they are a core and valued part of our approach.

Participatory action research views participants as co-researchers who have special knowledge about their own situation. Hence they are not only 'interviewed' but take part in research by engaging in, examining, interpreting, and reflecting on their own social world, shaping their sense of identity. Crucial for this kind of knowledge generation is the 'merging' or 'crossing of knowledge' that comes from three parts: scientific knowledge as gained by researchers; knowledge which the poor and excluded have, from their firsthand experience, of the twin realities of poverty and the surrounding world which imposes it on them; and the knowledge of those who work among and with these victims in places of poverty and social exclusion (Figure 0.3).

Figure 0.3 Merging of Knowledge



In order to ensure PAHRCA engagement is significantly deeper than data extraction, PAHRCA entails a process that includes commitments to action and outcomes. This participatory approach commits to not only document specific problems but to actively work toward change using the empowerment principles associated with PAR. This approach is adapted to engage with specific research questions, examining different areas of policy relevant to enhancing social investment, human rights, individual capability and collective agency.

1. Social investment in England: housing, financial services, ECEC and water

1.1 Social investment and economic crisis in England

When the financial and economic crisis of 2007/08 fully emerged the New Labour government had already been in office for a decade. It had governed with an agenda combining notions of economic efficiency with social justice based on a political narrative that there would be economic stability and no more ‘boom and bust’ (Lee, 2008; Timmins, 2017). This narrative had been an integral part of the New Labour project that had seen a pre-1997 election commitment to adhere to Conservative tax and spending plans for the first 2 years (1997-99), deciding not to join the Euro and to fiscal rules that would guide government decisions on taxation, spending and borrowing that would last for a decade.

The first was the ‘golden rule’ that required the public sector over the economic cycle to borrow only to pay for capital investment with current spending being funded from taxation. The ‘golden rule’ required New Labour governments to have a balanced budget, or preferably a surplus, over the economic cycle.¹ The second was the sustainable investment rule that required the public sector debt at a ‘stable and prudent’ level that was defined as less than 40 per cent of national income (HM Treasury, 1998). New Labour imposed this fiscal framework upon itself in order to provide reassurance to the financial markets that it would be ‘prudent’ rather than ‘reckless’ with the public finances. The notion that ‘rules rule’ was at the core the political economy of New Labour’s Third Way (Thomas, 2001: 64-66; Balls 2002: 36) and part of the ‘politics of de-politicisation’ of economic policy informed the decision to grant independence and guidance to the Monetary Policy Committee for the setting of interest rates to control the level of inflation (Burnham, 2001: 128-137).

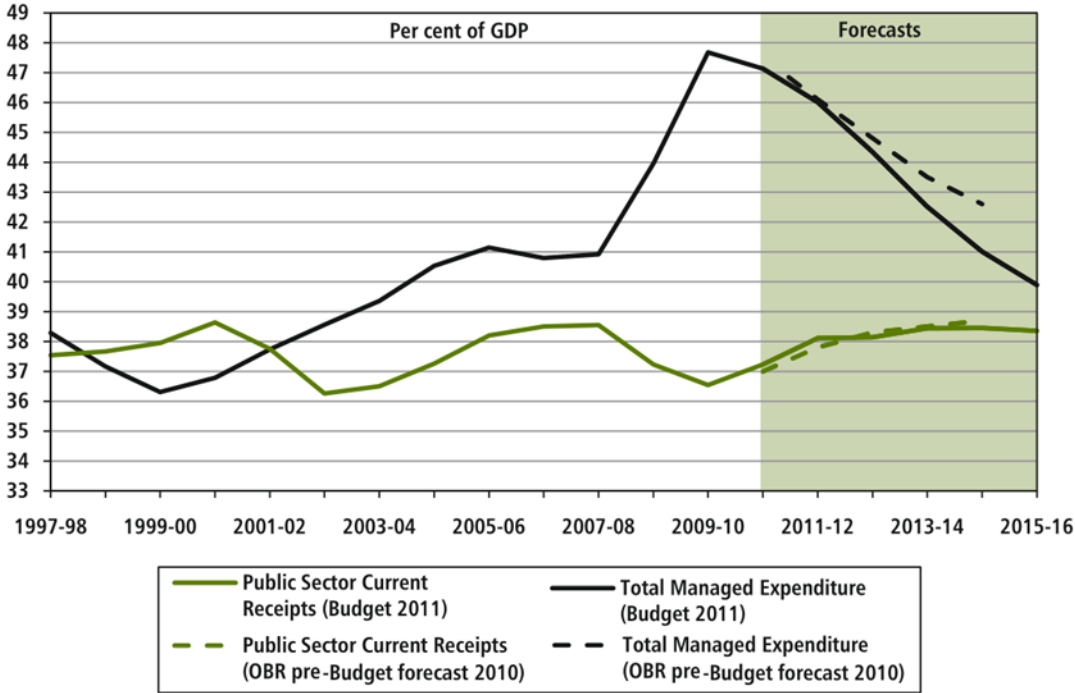
New Labour also supported social investment in a variety of forms, such as the New Deal welfare to work initiatives that provided training and employment programmes for young people, lone parents and people with disabilities as well as significantly increased spending on education and health care, along with capital investment in major infrastructure projects (Toynbee & Walker, 2005). However, this capital investment often involved the use of the Private Finance Initiative that transferred borrowing from the public balance sheet to public-private partnerships that raised finance at a higher cost and then effectively leased the new buildings or infrastructure back to the public sector at considerably greater costs over the lifetime of the investment (Pollock, 2004; Lister, 2008; Toynbee & Walker, 2010).

As the crisis developed and culminated in the events of the autumn of 2008, which involved over £ 50 billion of direct state investment (partial nationalisation) of Royal Bank of Scotland and Lloyds Bank and a further £ 400 billion of liquidity to underwrite the banking system, the fiscal framework was rendered obsolete (Crouch, 2011). The Pre-Budget Report in October 2008 announced ‘discretionary fiscal policy to support the economy through difficult times’ such as a temporary reduction in Value Added Tax and accelerating £ 3 billion of capital spending along with progressive increases on taxation of income to be followed by a sustained period of fiscal consolidation (HM Treasury, 2008). The level of government borrowing rapidly increased to reach a post-war high of 9.9% of GDP in 2009/10 (£ 149 billion) and the scale of the

¹ Defining the duration of an ‘economic cycle’ is a highly political as well as technical issue and there was considerable debate about the beginning and end of the cycle during the period of New Labour government. For example, the respected Institute for Fiscal Studies was critical of the definition of the duration of the economic cycle that was deemed to have involved moving the starting year in order to allow the Government to both borrow more money and to meet the golden rule. ‘The fiscal rules and policy framework’ Institute for Fiscal Studies, 2009. <https://www.ifs.org.uk/publications/4624>

fiscal crisis for the British government is shown in Figure 1.1 which demonstrates the rapid increasing in public spending and decrease in tax receipts following the financial crisis. This fiscal crisis of the state played an important role in the electoral defeat of New Labour at the 2010 general election and the formation of a Conservative-Liberal Democrat Coalition government committed to a programme of austerity based on significant public spending retrenchment cuts and tax increases (Coalition Agreement, 2010: Bochel & Powell, 2016).

Figure 1.1 UK government receipts and expenditure



Source: Office for Budget Responsibility and Office for National Statistics.

Source HM Treasury, Budget Red Book, March 2011

The Coalition’s programme of austerity involved a new fiscal policy framework, the Charter for Budget Responsibility, with a fiscal mandate to ‘protect the most productive public investment expenditure’ and a cyclically adjusted aggregate to ‘allow some fiscal flexibility at a time of economic uncertainty’ as part of a commitment to eliminate the deficit in the Parliament of 2010-2015 (HM Treasury, 2011). The initial aim of closing the deficit in a single Parliament was soon extended into the future as the rate of economic growth proved to be stubbornly low and the growth in tax receipts stalled (Ellison, 2016). A notable area of retrenchment was in capital investment, shown in Table 1.1, with significant cuts over the 2010-2015 Parliament.

Table 1.1 UK Public spending and capital investment

Table 2.3: Total Managed Expenditure

	£ billion					
	2010-11	2011-12	Forecasts			
			2012-13	2013-14	2014-15	2015-16
CURRENT EXPENDITURE						
Resource Annually Managed Expenditure	287.4	314.4	324.9	333.3	346.4	360.8
Resource Departmental Expenditure Limits ¹	345.4	342.3	344.7	349.1	348.2	352.5
<i>of which</i>						
<i>RDEL excluding depreciation</i> ²	326.1	326.3	327.1	331.1	329.0	333.1
Public sector current expenditure	632.8	656.7	669.6	682.4	694.6	713.4
CAPITAL EXPENDITURE						
Capital Annually Managed Expenditure	11.5	9.2	8.0	8.5	8.8	7.7
Capital Departmental Expenditure Limits ¹	50.0	44.5	42.6	39.2	40.3	42.7
Public sector gross investment	61.6	53.7	50.7	47.7	49.1	50.4
TOTAL MANAGED EXPENDITURE	694.4	710.4	720.2	730.1	743.6	763.8
<i>Memo:</i>						
<i>TME if AME margin as set for Spending Review 2010 period is spent</i>		711.4	722.2	733.1	747.6	

¹ The Government has not set DEL for 2015-16. Implied DEL numbers for 2015-16 are calculated as the difference between Resource AME and PSCE for Resource DEL (RDEL) and the difference between Capital AME and PSGI in the case of Capital DEL.

² RDEL excluding ring-fenced non-cash depreciation is the Treasury's primary control within resource budgets and the basis on which Spending Review settlements were agreed.

Source HM Treasury, Budget Red Book, March 2011

The austerity narrative informed the actions of the Coalition government (Gamble, 2015) although the scale of the reduction in the total managed public expenditure was only 4 per cent in real terms there were significant changes in the pattern of public spending. The budgets for the National Health Service, overseas development and schools were 'protected' in real terms while other areas of public spending such as social protection for people of working age and local government experienced drastic cuts. This 'systematic disaggregation' (Ellison, 2016: 34) of public spending had particularly significant impacts on vulnerable groups including children and young people, disabled people, minority ethnic populations and those with low skills and few educational qualifications (Lowndes & McCaughie, 2013; Toynbee & Walker, 2015). As Ellison noted:

'Looking at the Coalition's public spending record and the proposed spending strategy of the current Conservative government, it is hard to detect any commitment to a programme of social investment, let alone to more traditional forms of social protection for those experiencing the sharp end of austerity.' (Ellison, 2016: 46).

As the United Kingdom continues to negotiate with the European Union over the terms of Brexit and our future relationship, the current public deficit is now 2.3 per cent of GDP (£ 46 billion) although the prospects of achieving a balanced budget have been further postponed until the mid-2020s (HM Treasury, 2017). Current and future plans for public expenditure and social investment remain very tightly constrained by historic standards with forecasts and plans for 2022-23 showing £ 26 billion of borrowing and a twelfth year of real reductions in spending on public services (Emmerson, 2017).

1.2 Overview of national investment scenario in the four sectors

1.2.1 Housing²

1.2.1.1 General information

Since devolution of Scotland and Wales by the relevant 1998 Acts, the UK government remains responsible for the housing policies and provision only in England, including the administrative arrangements. Social security/welfare including housing benefit remains a national responsibility, as well as the policy on local government (Haffner et al., 2009; Jordan, n.d.; Orji & Sparkes, n.d.).

The origin of England's public housing is associated with mass industrialisation. This went hand in hand with the development of 'comprehensive powers for modern local authorities including for example powers to close uninhabitable properties, relief of overcrowding and the licensing of Housing in Multiple Occupation.' (Orji & Sparkes, n.d.: 7, 9, 60). Mass industrialisation as a result of WW1 caused housing shortages and also led to rent control implemented by the national government in a series of Rent Acts. The 1977 Rent Act introduced fair rents, which were below market rents, and eventually led to the further decline of private renting. This decline was reinforced by the creation of the above-mentioned alternative of mass public housing, which started getting momentum in the interwar period and in the postwar urban development projects. The 1977 homelessness legislation is basic to housing law in England. The 1998 Human Rights Act incorporated the European Convention on Human Rights in English law and introduced a right to housing for the homeless and an obligation for local authorities in the management and allocation of social housing.

When the Thatcher government launched the Right to Buy in 1980, the tenant's possibility of acquiring a public dwelling with a discount was introduced, and public rental housing's dominance (with secure tenancies) started diminishing reaching a share of 26 per cent in 1981 and seven percent of households in 2011. At the same time homeownership increased its share to 69 per cent in 2001, but declined to 64 per cent in 2011 (and 65 per cent in 2012-13) as a result of the global financial crisis. A small part of the loss of the market share of public housing was compensated by social housing with (fully) assured tenancies provided by housing associations (also called Registered Social Landlords). Their share increased from about two percent in 1981 to 11 per cent in 2011. Social renting comprised therefore 17 per cent in 2011-13.

Orji and Sparkes (n.d.) identify the Thatcher government of the 1980s as kick starting modern tenancy law in England. It introduced market reforms in the private rental sector in 1989, such as assured tenancies, which allowed for the setting of market rents and the assured shortholds for which tenant security was set at a minimum of 6 months. From a low of 10 per cent in the 1990s, the private rental market share increased to 18 per cent in 2011.

1.2.1.2 Recent reform(s)³

As a response to the global financial crisis the UK government has structurally reduced public expenditures (Orji & Sparkes, n.d.: 79, 58; see also Blessing, 2016). On the supply side, the aim is for public and social providers to charge 80 per cent of market rents and implement fixed term tenancies, while subsidies are being reduced. For local authority housing subsidy was ended in 2012, giving the authorities control over their own budget. Meanwhile the capital grant for social housing construction, for which social landlords have been allowed to borrow on the capital market since 1988, is slowly being reduced from more than £ 8 billion in the 2008-2011 Affordable Homes Programme to £ 1.7 billion in the 2016-20 programme (Goering & Whitehead, forthcoming). The objective is, however, a higher number of units (165,000 versus 155,000) therefore more finance from other sources (and higher rents) is needed.

2 We are grateful to Marja Elsinga and Marietta Haffner of Delft University of Technology who are co-authors of this Housing section.

3 Thank you to Christine Whitehead for helping to draw out the important reforms impacting on the position of vulnerable households.

Welfare cuts to housing benefits is another significant reduction in housing support in England (Orji & Sparkes, n.d.: 43, 80-83; Goering and Whitehead, forthcoming). Housing benefit is a means-tested national social welfare benefit (see also Haffner et al., 2009: 56-57). In response to budget deficits, the UK has introduced a number of changes to housing benefit in recent years. These include a cap on housing benefit (2012) and the under occupancy charge otherwise known as the 'Bedroom Tax' (April 2013) which aims to match dwelling size with household size. While there is limited evidence of the effectiveness of this policy in delivering its stated aim of encouraging residential moves, it has had adverse effects on the levels of poverty, wellbeing and health of affected households (Gibbons et al, 2017; Moffatt et al, 2016). In addition, since 2008 new private tenants have to rely on the Local Housing Allowance (LHA) which is no longer linked to actual rent paid, but rather to local rent levels. There is a freeze on the LHA until 2020, a limit to the annual uprating of the allowance (Moore & Dunning, 2007), a freeze on the rent cap and limited access for younger people (Goering and Whitehead, forthcoming).

The UK government is also phasing in Universal Credit, which will integrate certain means-tested benefits as of October 2013 (Orji & Sparkes, n.d.: 43, 80). The approach here is an increased focus on those who are less reliant on benefits (Orji & Sparkes, n.d.: 43), while affordable renting is oriented towards those with income generating potential (Blessing, 2016). Scanlon (forthcoming) observes that the share of social renting in new construction has more than halved between 2005/06 and 2015/16, while the bulk of new rental construction has become affordable rent (80 per cent of market rent).

The (implicit) aims of the Housing and Planning Act 2016 are to continue on the path of targeting, selling off social housing in expensive neighbourhoods, and home ownership. Consequently policy support for owner-occupation remains strong with different schemes available. Also, in the wake of the crisis, the Help to Buy scheme (2013-2020) has been identified as a significant contributory factor in the return to rising house prices in 2013 following a correction in 2006 and 2007 (Orji & Sparkes, n.d.: 21, 33).

When Buy to Let mortgages decreased after the crisis, the government launched the Private Rented Sector initiative in 2009 highlighting its faith in the role of the private rented sector in solving supply problems (Orji & Sparkes, n.d.: 28, 58). The Housing Stimulus Package of 2012 also contained a number of initiatives to facilitate institutional investment in private renting; e.g. the Build to Rent Fund (Bate, 2015; see also Blessing, 2016).

1.2.1.3 Impact on vulnerable groups

Table 1.2 shows the housing variables for the UK. English indicators⁴ may differ from those for the UK. The differences between the years 2007 and 2015 will not be useful, as a break in the time series is noted for all the variables. However, the difference between the population above and below the 'at risk of poverty' line may be indicative for England. Larger shares of the 'at risk of poverty' population generally are living in deprived and unaffordable housing than those not at risk of poverty.

4 English House Survey results: <https://www.gov.uk/government/collections/english-housing-survey>

Table 1.2 Data by poverty status, expressed as percentage of population - United Kingdom

	2007	Population		2015	Population	
	Total population	Above 60% of median equivalised income	Below 60% of median equivalised income	Total population	Above 60% of median equivalised income	Below 60% of median equivalised income
PEOPLE AT RISK OF POVERTY (social exclusion) [ilc_peps01]			23			24
TENURE STATUS [ilc_lvho02]						
Owner	73	78	52	64	68	43
* Owner, with mortgage or loan	47	53	22	36	40	17
* Owner, no outstanding mortgage or housing	26	26	30	27	28	27
Tenant	27	22	48	37	32	57
AFFORDABILITY INDICATORS						
Housing cost overburden rate [ilc_lvho07c] (break in time series 2012 and 2014)	16	10	46	13	7	40
Arrears on mortgage or rent payments [ilc_mdcs06]	5	4	9	4	3	9
Arrears on utility bills [ilc_mdcs07]	5	3	10	7	5	15
(Heavy) financial burden of the total housing cost - EU-SILC survey [ilc_mdcd04]	70	67	79	67	64	82
QUALITY INDICATORS						
Shortage of space in dwelling (2007 provisional; 2012 instead of 2015) [HC010]	16	15	19	15	14	19
Overcrowding rate [ilc_lvho05a]	6	5	12	7	6	14
Noise from neighbours or from the street [ilc_mddw01]	20	19	22	17	16	18
SATISFACTION (2007: provisional; 2012 instead of 2015) [MH080 and ilc_hcmp04]						
Percentage of people with high or very high level of satisfaction with the dwelling	94	94	91	94	95	91

Source EU-SILC 2007, 2015; all variables: break in time series 2012; does not provide info on homelessness

At risk of poverty: EU-SILC threshold is set at 60% of the national median equivalised disposable income after social transfers. Equivalised implies a correction for household size

Perceptions of respondents: financial burden, shortage of space, noise, satisfaction

Housing cost overburden (including costs for utilities and maintenance, etc.), EU-SILC definition: the share of population living in households where the total housing costs ('net' of housing allowances) represent more than 40% of disposable income ('net' of housing allowances)

Material housing deprivation: here defined as share of population with at least two poor amenities: a leaking roof, no bath/shower, no indoor toilet, or a dwelling considered too dark

Orji & Sparkes (n.d.: 32) report:

[T]here is a problem of severe overcrowding of low-quality rental properties and in defiance of Houses in Multiple Occupation controls, as well as the phenomenon of 'beds in sheds'; i.e. turning garages, sheds, etc. into very basic dwellings.

Goebel and Whitehead (forthcoming) conclude that even though the reforms should in practice affect low-income households living in expensive rent neighbourhoods, as of yet the reforms have not had the general

expected effect, partly because of the government introducing extra help in the form of discretionary payments for certain groups (bedroom tax), and partly because effects will impact in the longer term. However, these authors observe short-term effects for private tenants, and especially the homeless and roofless citizens (see also Fitzpatrick et al., 2015). But, more reforms are to come, and even if the total budget of income support in monetary terms is to increase (as expected), the help for households will decrease.

1.2.1.4 Policy recommendations

Safe, secure and affordable housing is a fundamental human right. In view of this we recommend the following measures: a renewed focus on rent controls to increase affordability in the context of housing costs outstripping wage growth; a shift away from an emphasis on the private rented sector and Buy-to-Let and towards increasing the supply of public housing through new construction; and, finally, reversal of cuts to housing benefit and abolition of the Under Occupancy charge (commonly known as the bedroom tax) which has had a range of negative impacts on the wellbeing of those tenants affected.

1.2.2 Financial services (UK-wide)⁵

1.2.2.1 General Information

Financial exclusion is defined as lack of access to an affordable range of financial services for the purpose of transactions, savings, borrowing/credit and insurance (for contingencies and retirement). It is not just about not having a bank account - i.e. ‘un-banked,’ but also not having access to the full range of banking product and services - i.e. ‘marginally banked.’ Financial exclusion should therefore be viewed across a spectrum of access to financial services. The main indicators of financial exclusion are lack of access to bank accounts (to manage payments and save), affordable credit, mortgages and insurance; and a situation of over-indebtedness.

According to the latest available EU wide data the UK is a country with low-medium level of financial exclusion, where about 6 per cent of adult population lack at least one type of financial product (see Table 1.3 for a comparison of the UK with other EU countries). A more detailed breakdown of financial exclusion shows that 9 per cent are ‘unbanked’, 6 per cent are ‘marginally banked’ and 15 per cent have ‘no transaction bank account.’ (EU, 2008a). More recent EU data (SILC 2008) put the percentage of people living in household with no bank account at 2.1 per cent, compared with an EU average of 11.6 per cent, thus making UK a low financially excluded country. (EU, 2010, Table 1, p. 6.)

Table 1.3 Level of financial exclusion (percentage of adults) by country, EU, 2008

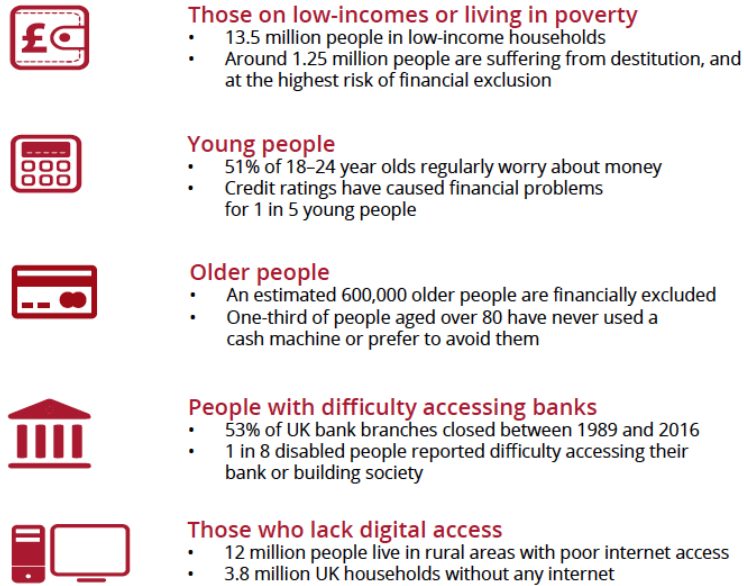
Level of financial exclusion (% of adult population)	Country
Low (less than 3%)	Luxembourg, Belgium, Denmark, Netherlands, France, Sweden
Low - Medium (3-8%)	Germany, Austria, the United Kingdom, Finland, Spain, Slovenia
Medium - high (12-28%)	Italy, Ireland, Portugal, Greece, Estonia, Czech Republic, Cyprus, Malta, Slovakia
High (34% and above)	Hungary, Poland, Lithuania, Latvia

Source Our compilation based on EU (2008a), p. 34

Figure 1.2 and 1.3 provide an up-to-date and striking view of those at risk of financial exclusion and the situation of financially excluded in the UK.

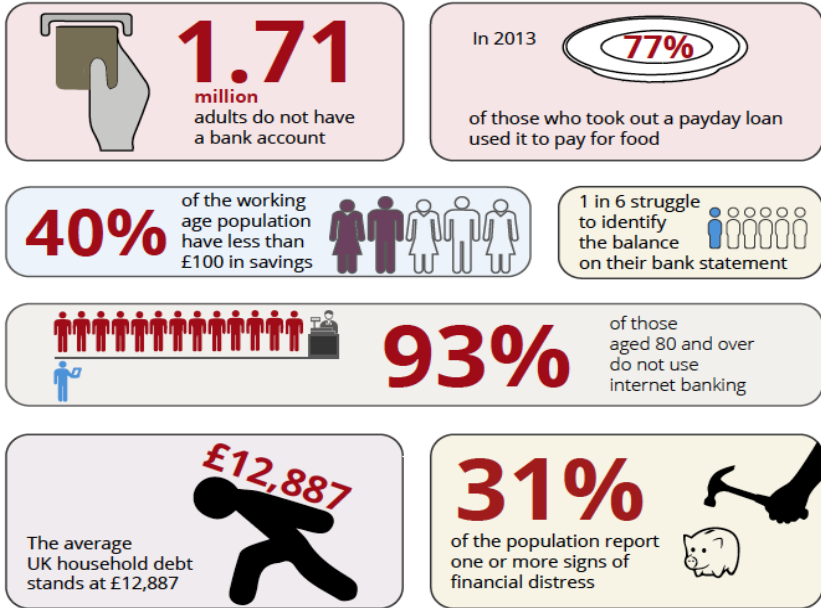
5 We are grateful to Mahmood Messkoub of Erasmus University Rotterdam who is co-author of this Financial Services section.

Figure 1.2 Those at risk of financial exclusion in the UK, 2016



Source House of Lords (2017), p. 14

Figure 1.3 Financial exclusion in the UK, 2016



Source House of Lords (2017), p. 15

A low level of financial exclusion in the EU is associated with the high levels of per capita income or consumption, and low levels of inequality (EU, 2008a). This does not seem to hold for the UK whose index of per capita consumption level in 2016 was 115 compared with the EU-28 average of 100 (EU, 2017a). The EU Barometer Data of 2003 indicate that there is a weak association between low financial exclusion and low level of income inequality. (EU, 2008a: 20.) That again does not appear to be the case in the UK which, with a Gini coefficient of inequality, is at the EU average of 0.30 (EU, 2017b).

As far as access to low cost credit is concerned it was found that 30 per cent of the UK adults had ‘no revolving credit’, 24 per cent had ‘a loan’ and 22 per cent had no savings. (EU, 2008a: 27).

The 2008 SILC survey of those without a bank account in the UK revealed a very small percentage (i.e. 1.3) of them had income above the poverty line of 60 per cent of the median income, whilst the figure for the income poor (below 60 per cent of the median income) was 5.7 per cent and for materially poor (those ‘deprived of 3 of 9 items’) 11.4; these are well below the EU averages of 22.5 per cent and 36.2 per cent respectively. The poor in general are therefore less ‘banked’ than the non-poor. A small percentage the unbanked (whether poor and non-poor), however declared that the reason was ‘no need-prefer dealing in cash’. (EU, 2010, Tables 2-3, pp. 8-9).

Some studies also found that people at risk of social exclusion (women, rural residents, unemployed and less educated) had a higher rate of financial exclusion (EU, 2008, p. 50.) There were small differences between genders and age groups of those without a bank account; 2 per cent were male and 2.2 per cent female. A larger percentage of the old (65 and over) were without a bank account compared with those in 25 to 64 age group, 2.8 per cent and 1.8 per cent respectively. The gender difference may in part be explained by the age difference since there are more women in older age groups. (EU, 2010, Table 4, p. 10).

Other empirical evidence confirms the relationship between social exclusion and financial exclusion. (Collard, et al., 2001) Devlin (2009) noted that the following factors affected financial exclusion in the UK: educational attainment, housing tenure, household income, employment status, age, regional and ethnic variation, but not gender. Other studies however do note that gender as one of the determinants of financial exclusion in the UK (Bunyan, et al., 2016).

As far as access to credit card, over-draft facility and outstanding loans, including mortgages are concerned, a higher percentage of the poor than the non-poor reported lack of access - 11.4 per cent of the non-poor compared with 33.5 per cent of the income poor and 37.7 per cent of the materially deprived poor. (EU, 2010, Table 6, p. 13.) The corresponding figure for the total population was 15.5 per cent.

It is interesting to note that 11.2 per cent of total population, 22.0 per cent of the income poor and 13.5 per cent of the materially deprived reported that they did not have any need to borrow. Only 0.8 per cent of the total sample reported that their ‘application for loan turned down’ or that ‘banks refuse credit to people like us’, reasons that can be deemed as financial exclusion. (EU, 2010, Table 9, p. 19.) The response of the income poor were equally low: 2.8 per cent, and the same for the materially poor: 6.8 per cent. (EU, 2010, Tables 10-11, pp. 20-21.)

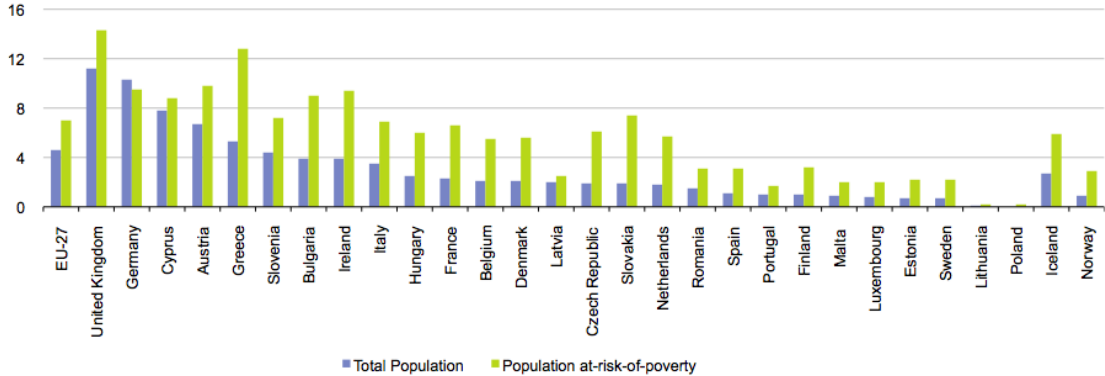
These low percentage figures shed a new light on the issue of ‘financial exclusion’ by the formal financial sector. The question is how one should interpret the fact that 78 per cent of the income poor and 86.5 per cent of the materially poor reported that they had ‘no need to borrow.’ At one level it is an issue of ‘living within one’s means’, and at another level the complexity and ‘remoteness’ of the formal financial sector from the day-to-day needs of the poor that makes financial exclusion a structural problem. There is a need to investigate whether ‘no need to borrow’ or relying on ‘friends/family’ is an expression of deliberate ‘self-exclusion’ or structural exclusion.

1.2.2.2 Impact on vulnerable groups

The 2008 data collected by the EU provides the evidence on the financial pressure on the poor. Figure 1.4 presents data on population at critical situation with respect to arrears and outstanding debt by poverty status. In general a larger proportion of the poor, shown in light colour (the right hand side columns in Figure 1.4) are at critical situation with respect to arrears and outstanding debt.

In the UK about 14 per cent (twice the average of EU-27 and the highest in the EU-27) of the poor are in a ‘critical situation’ compared with 11 per cent of the total population. The poor share the same experience of financial pressure irrespective of the level of affluence of the country. The poor in affluent UK and Sweden are in the same position as the poor in Greece.

Figure 1.4 Proportion of the population at critical situation with respect to arrears and outstanding amounts by poverty status, 2008 (% of specified population)



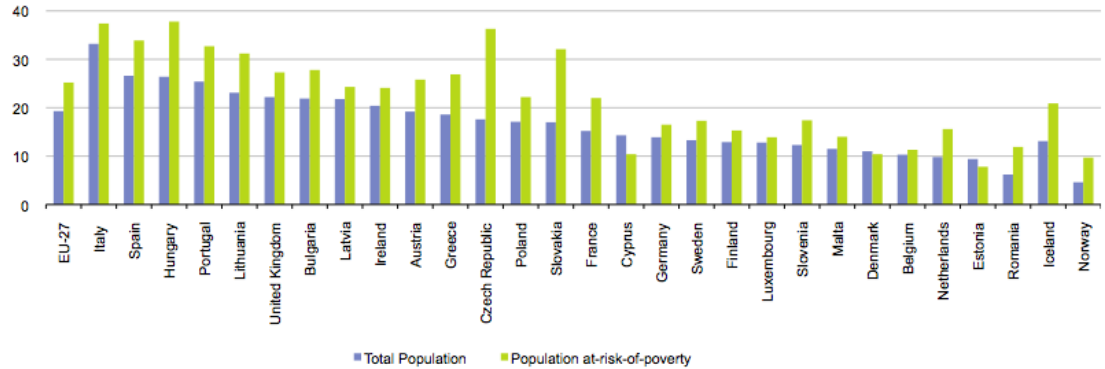
Source: Eurostat 2008 ad-hoc module 'Over-indebtedness and financial exclusion'

Source EU (2012a) Archive: Over-indebtedness and financial exclusion statistics. Figure 1.

The importance of access to financial resources becomes more relevant when we consider changes in circumstances, especially in relation to drop in income. Figure 1.5 provides a snap shot view of the response of total population and those at risk of poverty who reported a drop in income in the 12 months leading to the time of the interviews.

In the UK a higher percentage of poor people (28 per cent) experienced a drop in income compared with the total population (22 per cent); an experience shared with other poor people in the EU.

Figure 1.5 Proportion of the population that reported a drop in income in the previous 12 months by poverty status, 2008 (% of specified population)

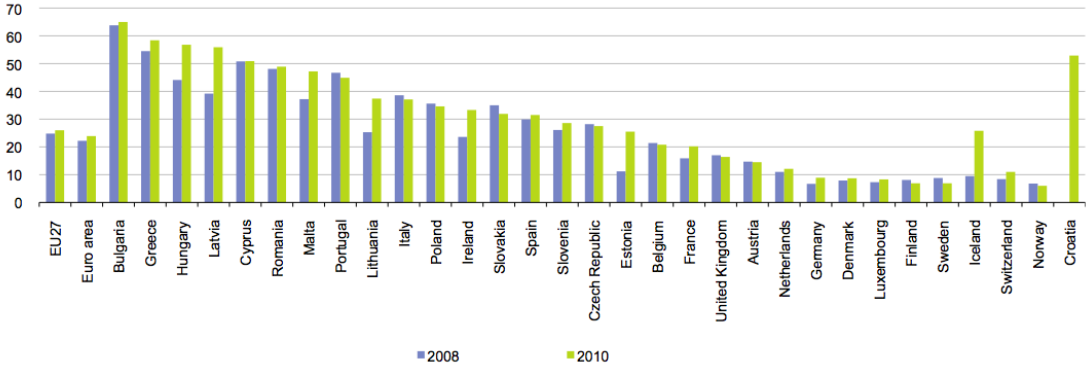


Source: Eurostat 2008 ad-hoc module 'Over-indebtedness and financial exclusion'

Source EU (2012a) Archive: Over-indebtedness and financial exclusion statistics. Figure 4.

In the years following the financial crisis of 2007/8 the percentage of people who reported '(great) difficulty to make ends meet' declined by a very small amount (Figure 1.6). That could well be due to the fact that about 18 per cent of the population who were in difficulty before the financial crisis still could rely on social security support to make ends meet. This is also corroborated by data on those facing unexpected financial expenses. As Figure 1.7 demonstrates between 2013 and 2014 there has been very little change in the percentage of the UK population who could not 'face unexpected financial expenses.'

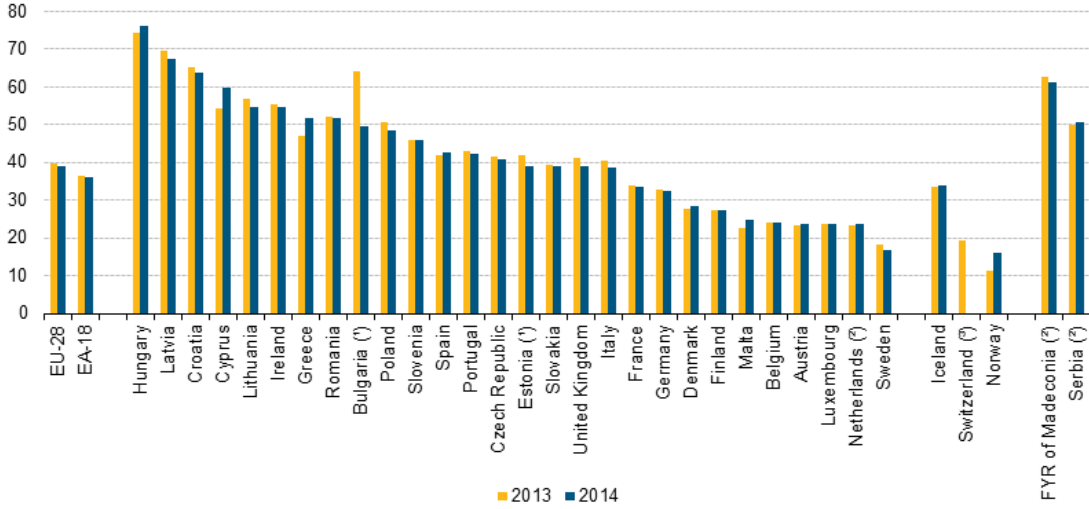
Figure 1.6 Proportion of population living in households with (great) difficulty to make ends meet, before (2008) and after the financial crisis (2010) (%)



Note: Countries in descending order of 2010 series.
 Source: Eurostat (online data code: ilc_mdcs09)

Source EU (2012a) Archive: Over-indebtedness and financial exclusion statistics. Figure 7

Figure 1.7 Inability to face unexpected financial expenses, 2013 and 2014



(*) 2014: break in time series.
 (*) 2014: provisional data.
 (*) 2014 data not available.

Source EU (2017). Europe 2020 indicators - poverty and social exclusion. Figure 5

1.2.2.3 Policy Recommendations

The financial sector in the UK is one of the most advanced in the world yet a section of the population do not have full access to all its services (House of Lords, 2017) It is acknowledged that the poor pay a ‘poverty premium’ by not having access to regular banking services (e.g. pay-electricity meters are more expensive than billed meters which would be settled through bank accounts) whilst bank closure and digitisation of banking services both intensifies and widens the impact of such exclusion (Ibid).

We therefore broadly support the following recommendations from the Financial Inclusion Commission (2015): a transactional account for every adult, promotion of regular saving to build up resilience against

financial shocks and as an additional resource for retirement, access to fair insurance, access to credit at a fair price, and promotion of financial education starting at primary school level.

We also commend the proposals below from the House of Lords Select Committee on Financial Exclusion (House of Lords, 2017):

1. Financial exclusion should be addressed at every level of government with appropriate coordination among the different levels of local, devolved and central governments; working with business community and the civil society.
2. Appointment of a minister for Financial Exclusion to lead and coordinate work in this area.
3. Proactive regulations on financial inclusion to be enacted whilst the remit of the Financial Conduct Authority to be expanded to promote this aim.
4. Financial education to become part of the school curriculum and supervised by the Office of Standard in Education (Ofsted).
5. Local debt advice services to be strengthened to help households manage debts.
6. The banking sector to be encouraged to take a more proactive role in reducing financial exclusion by providing affordable services to the unbanked. An important banking service is easy access to cheap over-draft facilities; absence of which has driven a large number of people to high cost short-term credit sector such as payday lenders. This sector should have better regulation in particular with respect to capping of borrowing costs and interest rates charged. Moreover, credit unions should be given more flexibility to expand their services to those in need of short-term credit.
7. The role of Post Offices in providing banking services to be promoted, considering the increasing closure of commercial bank branches and the move towards internet and digital banking. This is particularly important for the disadvantaged groups among the elderly, disabled people and those with mental health problems.
8. The current evidence strongly suggests that the government welfare reforms contribute to financial exclusion and therefore should be modified to prevent welfare recipients falling into debt.

1.2.3 Early childhood education and care (ECEC)⁶

1.2.3.1 General information

Social investment in early childhood, education and care was an important feature of the New Labour government first elected in 1997. Along with the notable commitment in 2000 to eliminate child poverty over 20 years and to halve it in a decade (Timmins, 2017), a network of Sure Start Children's Centres was developed providing health and family support along with early education available to all but with a focus on deprived areas containing larger numbers of vulnerable families (Toynbee & Walker, 2010).

There was a sustained expansion of funding and provision of childcare to enable families, particularly lone parent households, to more equitably balance paid work and family life. The level of provision expanded from 12.5 hours per week of free early education for 33 weeks per year for all 4-year-olds in 1998 to cover all three and 4-year-olds being entitled to 15 hours per week for 38 weeks by 2010. This expansion was largely financed through the childcare element of means-tested working tax credits that covered up to 80 per cent of the cost of a place and later through childcare vouchers available to working parents not eligible for tax credits (Lewis and West, 2016). While collective funding increased, the variety of registered ECEC providers - registered childminders, home childcarers and childcare outside the home - remained largely through the private market with parents facing comparatively high fees (Alakson & Hurrell, 2012).

After a decade in office, the newly established Department for Children, Schools and Families published the Children's Plan with the bold commitment '...to make this the best place in the world for our children

6 We are grateful to Özgün Ünver and Ides Nicaise of KU Leuven who are co-authors of this ECEC section.

and young people to grow up (DCSF, 2007:1).’ Social investment in children, particularly for the most vulnerable families during their early years, was considered to be enhancing human capital for the future benefit of the economy and wider society. Edwards and Gillies characterise this as a period of universalism with progressive aims but with authoritarian tendencies, particularly towards those families who were considered to be high risk and high cost in need of ‘tough love’ guidance (Edwards & Gillies, 2016).

While in opposition, the Conservative Party experienced a tension between modernising economic and social liberals who favoured marriage equality (Mods) and traditional moralists (Rockers) who focused on the ‘troubled families’ of ‘Broken Britain’ and argued that welfare dependency, educational failure, severe debt, poor health and family breakdown were the causes of poverty (ibid; Churchill, 2016). The Conservative-Liberal Democrat Coalition government formed in May 2010 was firmly committed to an economic agenda of austerity to balance the public sector deficit but their social agenda for children and families reflected this Mods versus Rockers tension.

1.2.3.2 Recent reforms

The Coalition Agreement stated that ‘... strong and stable families of all kinds are the bedrock of a strong and stable society...’ and committed to the goal of ending child poverty by 2020 while also seeking to reform the administration of tax credits to reduce fraud and overpayments and to ‘...take Sure Start back to its original purpose of early intervention, increase its focus on the neediest families, and better involve organisations with a track record of supporting families (Coalition Agreement, 2010: 19). These tensions produced continuity and change as well as conflicts and contradictions in policies for early childhood, education and childcare.

The Department for Children, Schools and Families was abolished and its responsibilities shared between other government departments. The importance of early childhood was recognised in two reports authored for the Department for Work and Pensions by backbench Labour MPs who had worked with the Secretary of State, Iain Duncan Smith, a leading traditional moralist Rocker who promoted the Broken Britain narrative in opposition and took these views into government. Graham Allen’s report called for early intervention with children and families, a Foundation Years strategy and investment (Allen, 2011) but during a period of austerity this was not forthcoming from the public purse. Frank Field, a veteran MP with more than 45 years experience as an anti-poverty campaigner, authored a report on child poverty that redefined child poverty away from the 60 per cent of median income and placed greater emphasis on improving health during pregnancy, maternal health, early childhood development and parental education (Field, 2010). This informed the Coalition’s Child Poverty strategy that was intended to address the root causes of childhood disadvantage and not just an arbitrary income poverty line (DWP, 2011) and the Social Mobility strategy which were published together. This led to the establishment of an independent Commission to provide analysis, comment and guidance on policy in this area (Social Mobility and Child Poverty Commission, 2011).

The austerity agenda directly affected public expenditure on early education, childcare and Sure Start Centres with a reduction of approximately 25 per cent from £ 2,508 per child under the age of five in 2009/10 to £ 1,867 per child in 2012/13 (Stewart & Obolenskaya, 2015). Financial support for children in vulnerable households through means-tested tax credits was limited to annual 1 per cent increases from 2010-11 onwards and then frozen in 2016 with third and subsequent children entirely excluded from the system (Lupton, 2016; McKay and Rowlingson, 2016). Significant cuts to local government funding gradually reduced both the quantity of Sure Start Children Centres, nearly 10 per cent (350 centres) have closed since 2015, and the range and quality of services offered (Walker, 2017).

A single funding formula based on participation with supplements for quality and flexibility initiated in 2007 was fully implemented in 2011 and crystallised the key policy issues - the balance between rising costs with available good quality places and the focus on child development or supporting parental employment - that have been a persistent and seemingly intractable issue for policy makers. Policy responses have included deregulation such as increasing the ratio of children to trained staff and encouraging lower cost childminders (risking the dilution of quality) and limiting funding for free provision (risking the availability

of supply). While 3- and 4-year-olds benefitting from ECEC provision supported by government funding was 93 and 97 per cent respectively there are greater challenges in providing care for 2-year-olds with only 58 per cent from their 15 hours of free provision in 2015 (Lewis and West, 2016).

Given the variety of provision and variation between high cost London and other regions along with the mixture of government funded free provision of 15 hours per week for part of the year, it is difficult to accurately measure the costs of childcare for families. However, despite the complexities of provision and difficulties in accurately measuring costs there should be no doubt that childcare costs have risen more rapidly than wages over the last decade (Trades Union Congress, 2017). The Family and Childcare Trust, a respected voluntary organisation, conducts a major annual survey that presents an authoritative source and the figures below show the average costs across England, Scotland and Wales.

Table 1.4 Headline childcare costs in England, Scotland and Wales

	25 hours of care in a nursery		25 hours of care from a childminder		Care after-school for a child aged 5-11	
	For under 2s	For 2 year olds	For under 2s	For 2+ year olds	Child-minder	After-school club
Scotland	£111.37	£106.16	£105.25	£104.53	£62.22	£55.71
Wales	£101.42	£102.30	£101.03	£101.03	£55.43	£43.13
England	£117.43	£113.43	£110.68	£110.11	£68.12	£52.80
Britain	£116.25	£112.38	£109.84	£109.29	£67.11	£52.58

Source Harding, Wheaton and Butler, 2017

The combination of a commitment to austerity requiring reductions in support for childcare and favouring market-based solutions has contributed to rising costs for parents and, since 2012, a 26 per cent fall in the number of registered providers to 42,273 (OFSTED, 2017). This is a serious issue given the Conservative government’s commitment to expanding the provision of free childcare from 15 to 30 hours per week (Government, 2017) with only a third of local authorities reporting that there will be enough childcare in their area for eligible families and 44 per cent concerned that the relatively low level of funding will further threaten the sustainability of some providers (Harding et al, 2017).

1.2.3.3 Impact on vulnerable groups

The health and wellbeing of children in the United Kingdom has long been recognised as poor compared to other wealthy countries (UNICEF, 2007; UNICEF, 2013) and despite ECEC policy aiming to focus on the most disadvantaged children and families there are limited grounds for optimism. Lewis and West in their assessment concluded that heroic assumptions have been made about ensuring high quality provision without the expenditure of significant sums of public money by reducing regulation. ‘The main preoccupation is to ensure market competition free from bureaucratic control, which it is believed will make more provision available and affordable (Lewis & West, 2016:344).’ This market-based approach in England differs from typical European approaches that involve a greater level of state involvement and significantly lower costs for parents.

While the ‘childcare market’ involves nearly £ 5 billion of public expenditure, it is only a small part of the wider policy domain affecting children and families through social security benefit, taxation and the provision of public services. The era of austerity combined with the Mods and Rockers tensions in family policy has produced ‘... personalised and normalised inequality alongside reducing broad and universal state support for families ... a strategy of reduced tax payments by well-off families and reduced welfare benefits for poor families that is now being assiduously nurtured by the Conservative government ... Increasingly, state spending and public services are residual, only for the poor and undeserving families, not for the likes

of us (Edwards & Gillies, 2016:258).’ If this approach continues then the issues of affordability, access and quality will persist and have the greatest impact on the most vulnerable groups.

The independent Social Mobility Commission has continually warned about deep social divisions from before birth and across the whole life course and the impact of austerity on social mobility (Social Mobility Commission, 2017). In their most recent report, the Commission noted the stark differences in early education opportunities across the country with less than half of disadvantaged children in 94 local authorities (29 per cent) being school ready by the age of five with large variations between the best and worst performing areas. Parenting support on child development was very limited in most local authorities and often not based on strong evidence with an estimated 80,000 disadvantaged 2-year-olds (29 per cent) missing out on their free childcare (Social Mobility Commission, 2017).

1.2.3.4 Policy Recommendations

The recommendations of the Social Mobility Commission for early childhood, education and care are eminently reasonable for future social investment. They recommended a new parental support package at key transitions in family life, inc., including a guarantee of help for parents if their child’s 24 to 30 months check shows them falling behind and that every local authority should develop an integrated strategy for improving disadvantaged children’s outcomes. This should include quality improvement support for early education settings, including collaborative working groups, tailored advice and comprehensive training for early years teachers driving uptake of the early education offer for disadvantaged two-year-olds and ensuring that they do not lose places to children eligible for the 30-hour offer. It should also ensure that all parenting support programmes are evidence based and experimenting with ways to offer effective advice to more parents (Social Mobility Commission 2016 and 2017).

1.2.4 Water⁷

1.2.4.1 General Information

The water industry in the UK (England and Wales) was subject to privatisation in 1989 when publicly owned regional water companies were sold to individual and institutional investors. Subsequently there have been three phases of ownership models starting with stock exchange listed public limited companies up to the mid-1990s when multi-national ownership of the industry took hold until the early 2000s when private equity consortia began to become an increasingly important feature. By 2016, over half of the industry had been taken over by private equity consortia with four foreign-owned private equity firms owning around 40 per cent of turnover. In contrast to England’s water companies, Dwr Cymru Welsh Water is a ‘not for profit’ organisation owned by Glas Cymru, a single purpose company with no shareholders that is run ‘solely for the benefit of customers’ with an emphasis on using profits to fund capital investment projects rather than dividends for shareholders.

Water companies are accountable to Ofwat, the Consumer Council for Water, the Environment Agency and the Drinking Water Inspectorate. Water charges are regulated by Ofwat using a measure of inflation, the Retail Prices Index, with an additional measure for capital investment and profit as dividends for shareholders. The Consumer Council for Water in England and Wales is an independent and statutory consumer body that acts as a champion for consumers with the English and Welsh governments. The Environment Agency is a quasi-autonomous non-governmental organisation sponsored by the Department for Environment, Food and Rural Affairs that is responsible for water quality, abstraction and flooding along with a range of other environmental duties. The Drinking Water Inspectorate was established in 1990 to provide independent monitoring of drinking water quality with a particular focus on periodic failures by companies in ensuring safe drinking water.

7 We are grateful to Mary Murphy of Maynooth University who is co-author of this Water section.

1.2.4.2 Recent Reforms

The crisis has intensified the ownership by private equity consortia with United Utilities, the water company serving 7 million people across the North West of England, remaining as the largest remaining stock market listed company in the face of interest from private equity firms. If United Utilities is taken over by private equity then that would increase this form of ownership to more than 60 per cent of the industry by turnover and reduce the share of publicly quoted stock exchange companies to 25 per cent.⁸ The growth of the private equity ownership has been based on a financialisation model that has enabled debt refinancing largely through the securitisation of revenue streams with financial engineering replacing civil engineering as the notable feature of the industry.

Over the last 10 years water charges have increased faster than both earned incomes and inflation leading to many people struggling to make ends meet as their pay is stagnant and their living costs go up. This squeeze on living standards is not necessarily because of economic recession but the lack of competition means consumers are at risk of being exploited by highly profitable companies. In the last 10 years water bills have risen by 64 per cent compared with a 28 per cent increase in average earnings bills meaning that water bills are now some 20 per cent higher in real terms than 10 years ago. More than £ 100 a year, around 30 per cent of an average household water bill goes on profit for both capital investment to improve water quality that has been driven by national and European Union regulations as well as dividend payments to shareholders, compared with 9 per cent in the energy sector.

Figure 1.8 Comparing water company performance across the UK, 2009-10



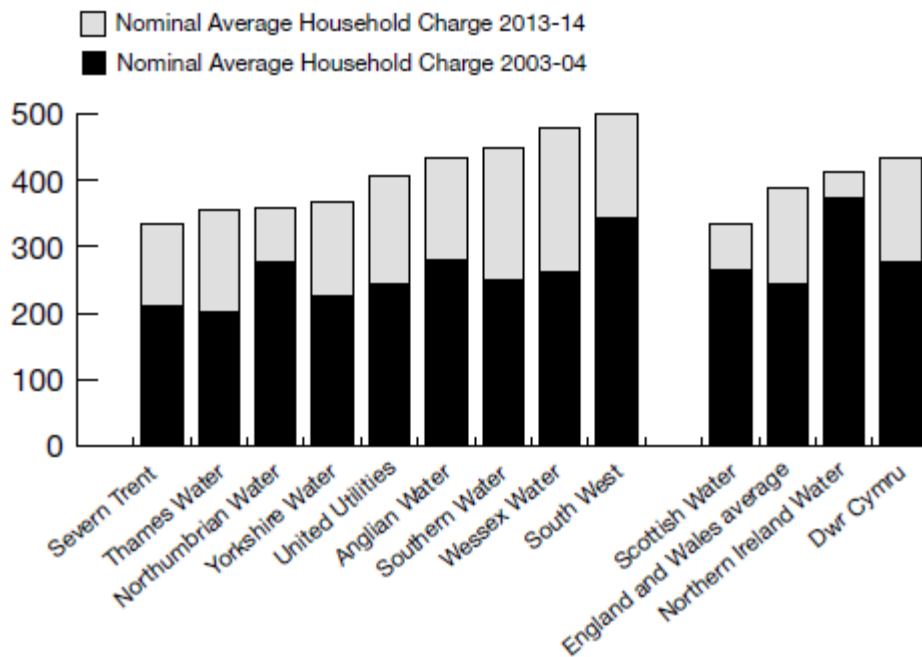
Source Ofwat, Northern Ireland Water, Scottish Water

1.2.4.3 Impact on vulnerable groups

Affordability: In England and Wales, affordability of water services is addressed by the Government's national Water Sure tariff. This mechanism caps the bills of customers in receipt of a qualifying mean-tested or universal child benefit to the average household bill for their company with the additional costs of providing the Water Sure tariff to qualifying households are cross-subsidised by other customers. The hidden disadvantage of these cross-subsidies is the fact that they increase the financial burden on other low-income groups, since they originate from the rateable value system, which is the scheme applied to households that do not have a water meter.

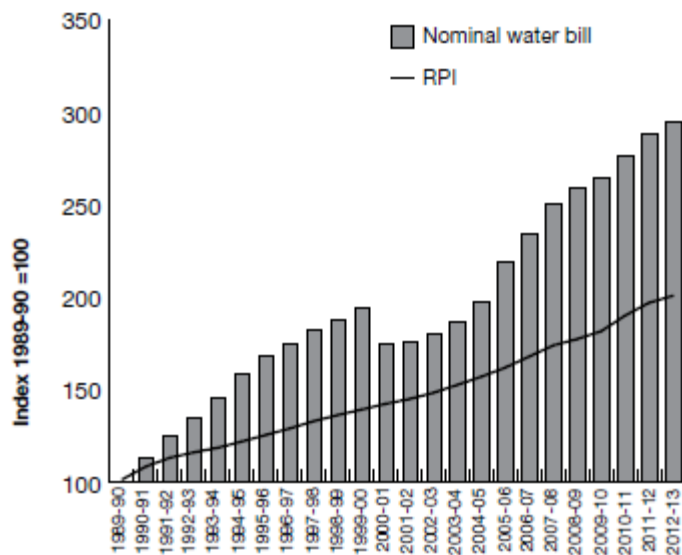
⁸ Financialising household water: Thames Water, MEIF, and 'ring-fenced' politics John Allen and Michael Pryke, Cambridge Journal of Regions, Economy and Society 2013, 6, 419-439.

Figure 1.9 Comparing water bills in the UK, 2003-04 to 2013-14



At a time when many families are struggling to keep their heads above water the water industry is enjoying high profit margins and dividends to shareholders, while consumers are hit with ever rising bills.

Figure 1.10 Average water bills and retail prices, 1989-90 - 2012-13



Source Ofwat, ONS

In 2011/12 the average bill was € 37 per month (€ 444 per year) and ranged from an average of just over € 30 per month in Severn Trent (the Midlands) to an average of just over € 50 per month in the South West

of England.^{9 10} For those on low income, the water bill can take an appreciable chunk of income and is around 6 per cent for single adults with incomes on the poverty line. Indeed Hutton found in 2012 that 2 per cent of households spent up to 8 per cent of their household income on paying their water bill. In 2015, National Debtline took a record number of calls for help with water debts with more water-bill related calls than calls relating to rent or mortgage difficulties. Smet also finds that in London the average customer pays 3.4 per cent of income on water, above the affordability threshold of 3 per cent.

Table 1.5 Examples of countries with low-income populations spending a high proportion of income on water and sanitation services

Country	Statistic
Argentina	Lower quintile spends more than 11% of income
Armenia	12.3% of households spend more than 5% of income
Burkina Faso	Lower quintile spends more than 29% of income
Chile	Two lower quintiles in Valparaiso spend over 5% of income, on average
Colombia	Lower decile spends more than 9% of income
Ecuador	Lower quintile spends more than 9% of income
El Salvador	Lower quintile spends more than 11% of income
France	1% of households spend more than 4.8% of income
Hungary	Lower quintile spends more than 5.3% of income
Jamaica	Lower quintile spends more than 11% of income
Latvia	Lower quintile spends more than 5.1% of income Poor households spend over 6.3% of income
Poland	Poor households (<50% of median income) spend over 10.8% of income
Romania	Lower quintile spends more than 5.7% of income Poor households spend over 8.1% of income
Russia	Lower decile spends more than 6% of income
Surinam and Bolivia	Lower quintile spends more than 8% of income
Ukraine	6.4% of households spend more than 6% of income
United Kingdom	2% of households spend more than 8% of income
Uruguay	Lower quintile spends more than 10.4% of income

Source cited from [4], original source [11]

The water industry in England has changed since privatisation in 1989 with growing involvement of international private equity consortia in the ownership of companies with regional monopoly power. During this time there have been significant improvements in water quality and environmental standards that have been driven by national and EU regulations. The regulatory framework for the industry has continued to produce higher water bills for customers that have only been partially mitigated by Government policy through the Water Sure tariff during a prolonged period of stagnation in earnings and household incomes. While water supply security for households remains intact there are growing numbers of people experiencing a sustained squeeze on their living standards due to rising water bills.

9 Farnsworth, Kevin; Irving, Zoë 2012 Journal of Poverty and Social Justice, Volume 20, Number 2, June 2012, pp. 133-147(15). McIntyre, O. (2014). The human right to water and reform of the Irish water sector, Journal of Human Rights and the Environment, 5(1). doi: <http://dx.doi.org/10.4337/jhre.2014.01.04>.

10 Paying for Water: Equity, Efficiency and Sustainability | June 2013 p. 8 TASC.

1.2.4.4 Policy Recommendations

We recommend the following policy responses to address the issues raised above: government scrutiny of the operation of the Water Sure tariff to ensure customers are not paying above the water affordability threshold especially as it is estimated that around 30 per cent of average household water bills underpin private utilities' profits; implementation of controls on private equity takeover of water utility companies in light of the negative impacts on capital and civil engineering projects and consumer bills.

2. Social disinvestment and liberalisation of mental health services in England: implications for rights and capabilities

2.1 Health policy in the European context¹¹

European health care systems since the 1980s have been under permanent pressure to reform in order to slow the rate of increase in expenditures, improve overall operating efficiency and to strengthen patient choice of provider, institution and/or physician (Saltman, 2015). The main drivers for rising healthcare costs are technological innovation, demographic ageing, increasing expectations from the population and system-specific incentives to over-spend and over-use services.

Reforms since 1990 aimed to address these challenges. Cost control mechanisms and increasing competition among health insurers in social health insurance based systems (SHI) and increased choice for patients and competition between providers in National Health Systems have been typical features of many health reforms in the EU. The introduction of market mechanisms in the health sector aimed to improve the performance of the systems (Pavolini and Guillen, 2013). Some market-oriented reforms, such as in Sweden and England, were also ideologically driven, aiming for a more market-oriented society (Pavolini, 2015). CEE countries moved towards more pluralistic systems by creating semi-autonomous health insurance agencies and varying degrees of privatisation in particular of ambulatory care and also of health care facilities. Some also took measures to reduce hospital capacity, strengthen primary care and reform financing (Dubois C.A, 2004).

The early 2000s saw an increasing focus on care integration, seeking to improve the management of long-term conditions of the growing group of people with chronic illness and to reduce their utilisation of expensive inpatient care. Furthermore, a variety of performance based payment mechanisms have been introduced to link provider payment to clinical outcomes. The public/private mix of providers (e.g. in England and Sweden), and health insurers (e.g. in the Netherlands) became more diverse (Saltman, 2015). Many Member States also saw a major shift back towards central government of control over important policy decisions as well as fiscal matters and there have been increased efforts to better regulate the growing competition between public and private providers (Saltman, 2015). These include reinforced supervision over regions in Italy and over sickness funds and hospitals in Germany. This recentralisation has been pursued mainly for economic reasons (Pavolini, 2015). Both Sweden and England have shifted a great deal of regulatory authority from state decisions to market mechanisms (Stamati and Baeten, 2015).

Since the onset of the economic crisis, many European health systems have gone through deep reforms often with steep health budget cuts, mainly aimed at controlling public expenditure on health. The countries most heavily hit by the crisis enacted the most stringent reforms, subject to strict conditionality in exchange for financial assistance from the EU and the IMF (Stamati and Baeten, 2015). Yet, many countries have also been embracing austerity for ideological rather than fiscal reasons (Ruckert et al, 2015). For instance, Sweden and England showed a wave of deep institutional changes (Pavolini, 2015).

Furthermore, the European sovereign debt crisis provoked a radical change in the way the EU engages in national health system reforms. EU institutions acquired unprecedented powers - especially in the Eurozone countries - to supervise national budgetary and economic policies. Within this context, healthcare systems represent a particular target. Whereas, traditionally, EU involvement in this policy area was limited to supporting voluntary cooperation between member states, henceforth EU institutions are calling for major healthcare reforms as a means of consolidating public expenditure. Not only have the countries in

¹¹ We are grateful to Rita Baeten of European Social Observatory (OSE) who is a co-author of this 'Health policy in the European context' section of the report.

receipt of financial assistance been required to implement the detailed list of reforms stipulated in their respective Memorandums of Understanding (MoUs); other member states too have been encouraged to undertake reforms to their national healthcare systems and the EU has continuously strengthened its tools to enforce compliance (Baeten and Vanhercke, 2016).

Under the European Semester for Economic Policy Coordination, an increasing number of Country-Specific Recommendations (CSRs) on health care have been issued and they have grown in scope and detail. The focus of CSRs is mainly, but not exclusively, on fiscal consolidation; the call is for long-term structural reforms aimed at improving cost-effectiveness. The reforms stipulated under the MoUs, on the other hand, are not exclusively aimed at a more cost-effective use of financial resources but include also measures designed simply to decrease costs in the short term, thus shifting costs from the public system to patients and workers.

2.2 Key developments in health and mental health policy in England

2.2.1.1 General overview of healthcare system in England

In this section we will begin with an overview of key health policies and delivery mechanisms in England, before turning to a concise summary of significant developments in policy and service

The National Health Service (NHS) in the United Kingdom is a devolved system with the Westminster government responsible for the NHS in England with the administrations in Scotland, Wales and Northern Ireland having control of health and social care services (Timmins, 2017). The underlying principles of the NHS since it was established in 1948 as universal, free at the point of need access to a comprehensive range of health care services largely provided by the public sector and funded predominantly through general taxation as single-payer system remain although there are differences in their operation and organisational structure (Bevan et al, 2014).

In England, the NHS and Community Care Act 1990 established an internal market with a division between commissioners and providers, largely hospital based secondary care trusts, which has been the basis for the operation of the system for the last 25 years. During the 2000s, the NHS received the largest sustained increase in funding in its history with an average increase in resources of 7 per cent per year from 2000 to 2007 (Driver, 2008). Rationing by queue has been a feature of the NHS but a number of key performance indicators related to waiting times - notably 98 per cent of people going to a hospital accident and emergency department being seen, treated and either admitted or discharged along with a maximum of 2 weeks waiting for diagnostic cancer tests for 93 per cent of patients and 92 per cent of patients should start consultant-led treatment within 18 weeks of referral from their GP - and an NHS Constitution (Department of Health, 2009) of rights for patients contributed to the level of public satisfaction reaching a record 70 per cent in 2010 and levels of dissatisfaction falling from 50 per cent in 1997 to only 23 per cent (Appleby, Robertson and Taylor, 2016). However, the impact of the financial crisis on the NHS, with a budget approaching £ 100 billion per year, was inevitable and swiftly recognised by David Nicholson, the chief executive of the NHS, who called for organisational stability and efficiency savings of £ 15-20 billion over the 2011-14 period (Nicholson, 2009:42-47).

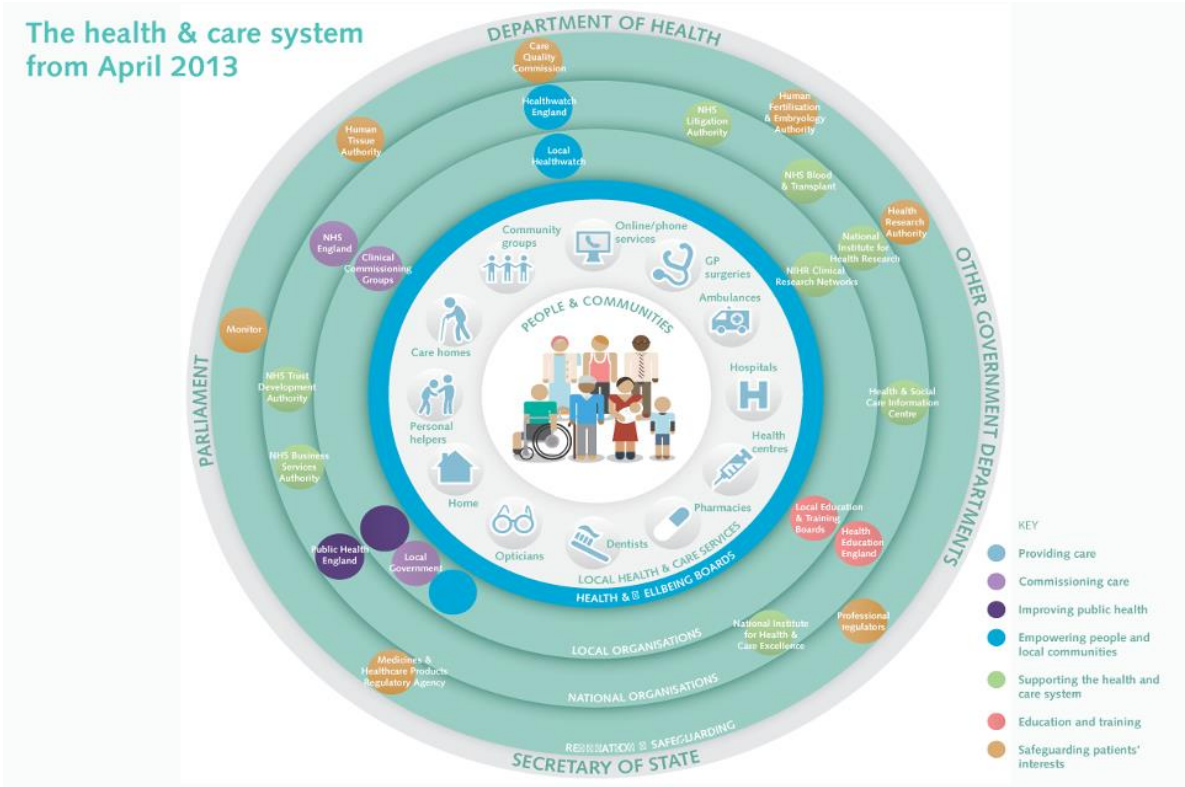
2.2.1.2 Recent reforms

The formation in May 2010 of the Conservative-Liberal Democrat Coalition government guaranteed that health spending would increase in real terms each year, pledged to free staff from political micro-management and to ‘... stop the top-down reorganisations of the NHS that have got in the way of patient care (Coalition Agreement, 2010:24).’ However, in July 2010 the Department of Health published the White Paper ‘Equity and Excellence: Liberating the NHS’ (Department of Health, 2010) that outlined a package of reforms that were highly controversial during the prolonged legislative process (Davis & Wrigley, 2013; Paton, 2016).

The reforms involved the abolition of existing area based commissioners - primary care trusts and regional strategic health authorities - and their replacement by consortiums of general practitioners (which would eventually be called clinical commissioning groups) who would commission appropriate health care for their patients and have control over approximately £ 75 billion of the NHS budget. A new national commissioning board (which would eventually be called NHS England) would oversee the operation of local commissioners and commission primary and specialised care. All hospitals in England would incrementally become Foundation Trusts, first established in 2006 and granted greater freedom from central control to borrow money for capital projects and earn money by treating a limited proportion of private patients. The management costs of the NHS were to be reduced by 45 per cent within this new system with numerous health quasi-autonomous non-governmental organisations being abolished and their functions being absorbed into the Care Quality Commission, Monitor (the economic regulator for the NHS which became NHS Improvement in 2016), Public Health England or NHS England (Campbell, 2011; Ex-worthy & Mannion, 2016: Powell, 2016).

These complex reforms were introduced in April 2013 and are shown in the diagram below.

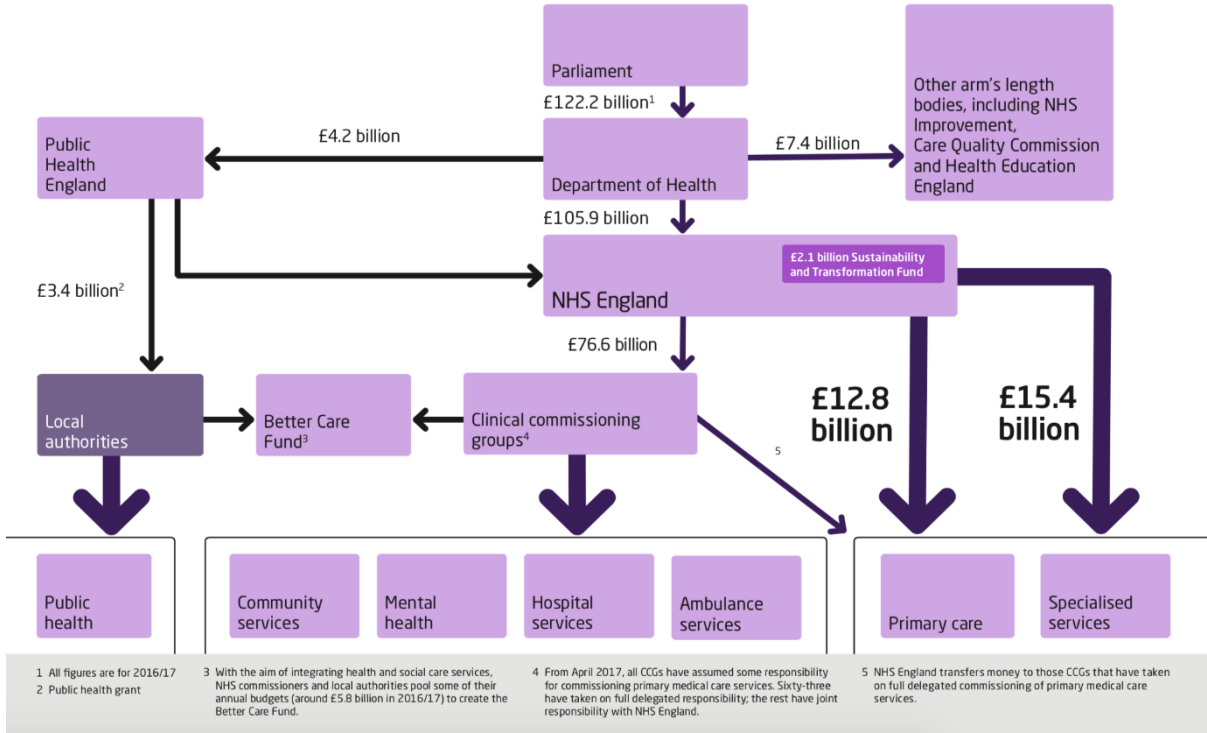
Figure 2.1 The health & care system from April 2013



Source Department of Health and Social Care)

The flow of resources with figures for 2016/17 through this ‘re-disorganised’ system (Toynbee & Walker, 2015) is shown in the diagram below.

Figure 2.2 Flow of resources through the 're-disorganised' system, 2016-17

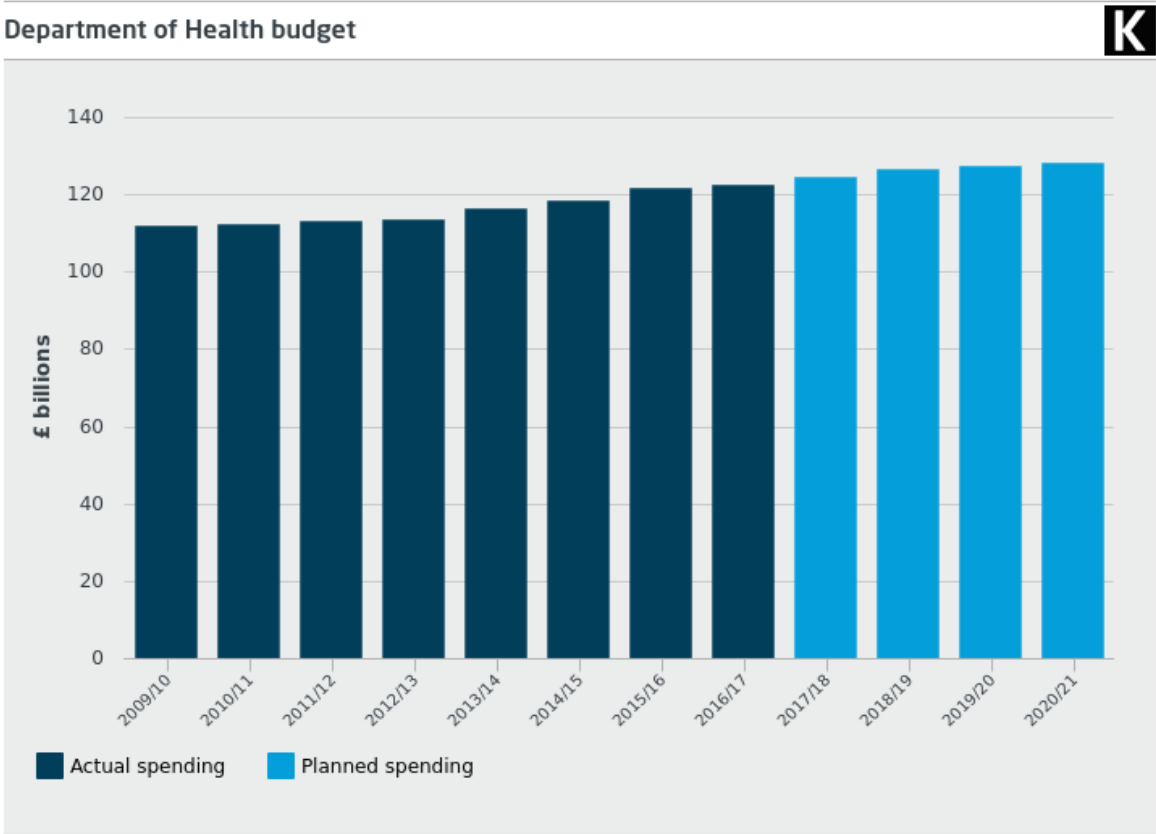


Source King's Fund, 2017a

This reform process was so politically painful and organisationally challenging that Timmins in his study of the Health and Social Care Act concluded that: ‘...never again must the NHS...be subjected to such a car crash of policy making. One that had caused both its proponents and its opponents within government huge political damage while creating an Act that is, in many people’s eyes, a complex mess (Timmins, 2012: 121).

NHS reforms have historically often been lubricated with additional resources but the health budget was tightly constrained with a real terms rate of growth of less than 1 per cent per annum from 2010 onwards when it is generally accepted that with increasing health needs due to population ageing and relative health prices effects that 3 to 4 per cent budget increases are required (Toynbee & Walker, 2015; Charlesworth, 2016). Minimal budget increases were achieved by reducing the costs of running the system, reductions in payments to hospitals through the national tariff system and a very restrictive national public sector pay cap policy that has eroded the real incomes of staff in the NHS (ibid; Hyde & Exworthy, 2016). Financial constraints of this scale and duration are already unprecedented but are planned to continue for the foreseeable future as the diagram below demonstrates.

Figure 2.3 Department of Health budget



Data are the Department of Health total Departmental expenditure limit (TDEL). Figures are expressed in real terms at 2017/18 prices, using deflators published by the Office for Budget Responsibility in November 2017.

Source: Department of Health annual report and accounts 2016/17; Autumn Budget 2017; Office for Budget Responsibility November 2017 Economic and fiscal outlook: Economy supplementary tables.

Source King’s Fund, 2018

The financial sustainability of NHS organisations has become increasingly insecure with the National Audit Office (NAO) noting the deteriorating financial balances in a series of reports. In 2015/16, NHS Trusts had a net deficit of £ 2.45 billion on a total income of £ 76 billion with two thirds of all NHS providers in deficit and the NAO noted that this ‘... continued deterioration in financial performance was not sustainable and that financial problems were endemic (NAO, 2016:6).’

A key feature of the Health and Social Care Act 2012 was opening virtually all clinical services to tender with Any Qualified Provider status whether they be NHS, private or voluntary sector providers. It is difficult to measure changes in NHS commissioners using private sector providers, which has been a feature of the last 15 years, due to accounting and data definition but the private sector share of the NHS budget increased from 7.3 per cent in 2015/16 to 7.7 per cent in 2016/17. This growth has usually been for relatively modest contracts for elective hospital treatment amounting to around £ 1 billion along with community and mental health services to voluntary and private sector providers. The privatisation of NHS provision would have been more significant if a 10 year £ 1.2 billion contract for cancer and end-of-life care in Staffordshire had not been abandoned in 2017 or Hinchingbrooke Hospital which was franchised to Circle, a private sector operator, in 2011 because of persistent deficits and being put into special measures for the quality of care had not been handed back to the NHS in 2015 (King’s Fund, 2017b).

Faced with a projected gap of £ 30 billion between planned funding and the costs of existing provision by 2021/21, NHS England published The Five Year Forward View in 2014 (NHS England, 2014). It advocated a radical upgrade in public health prevention although public health had been transferred from the NHS to local government and experienced cuts in funding (King's Fund, 2017c), and new models of care to break down barriers between primary and secondary care and to foster health and social care integration pilots begun through the Better Care Fund. This provided the framework for the development of 44 local NHS 'footprints' that are amalgams of the 209 clinical commissioning groups to develop Sustainability and Transformation Plans in November 2016 (NHS England, 2016a). These plans urged greater collaboration between NHS organisations and with local authorities providing social care in order to address increasing needs and improve efficiency including the development of Accountable Care Organisations that would integrate care services to meet local needs within a fixed budget against a set of outcomes (NHS England, 2014 & 2017a).

2.2.1.3 NHS performance and vulnerable groups

The NHS has experienced increasing 'demand' for health care with average daily accident and emergency attendance increasing over the last 5 years by 8 per cent from 58,687 to 64,782 while the 95 per cent target of attendance lasting under 4 hours has not been met in any month since 2015. Across England 16.5 per cent of patients spend over 4 hours at A&E, the number of 'trolley waits' of over 4 hours for a bed reached a peak of over 2,500 patients per day in January 2017 when the British Red Cross declared a humanitarian crisis in parts of the NHS (British Red Cross, 2017) and is heading to similar levels during this year's 'winter pressures' and were 320 per cent higher than in 2012. Delayed transfer of care from hospital to social care in the first eleven months of 2017 stood at 1.97 million 'delayed days' (an average of 5,904 per day) compared to 1.26 million over the same period in 2012 (an average of 3,773 per day) reflected the pressures within the NHS and social care provision which has seen substantial cuts since 2010 (Miller and Glasby, 2016). The 92 per cent target for 18 weeks from referral to treatment has not been met in any month since 2016 as the waiting list increased by 47 per cent from 2.52 million in November 2010 to 3.72 million people in November 2017. Currently 92 per cent of people on the waiting list have been waiting for less than 20 weeks and the 'zero tolerance' policy to patients waiting longer than 52 weeks remains largely intact. Urgent cancer referrals from a GP to a consultant have increased by 60 per cent to 1.66 million per year from 2012 to 2017 with the 93 per cent target being met in all but 2 months over the last 8 years with the first treatments for cancer after a decision to treat target also being met. The long-term downward trend in bed availability has continued with 10,900 (6.7 per cent) fewer overnight beds available in the first quarter of 2017 compared to the same period in 2011 and average occupancy rates for all bed edging up from 84.1 per cent in the third quarter of 2011 through the 85 per cent level that is considered to be clinically safe to 87 per cent in the same period in 2017 (House of Commons, 2018). While universal access to a comprehensive range of services has been maintained, the most vulnerable groups of people in need of treatment are having to wait longer for procedures.

2.2.1.4 Policy Recommendations

The NHS represents an excellent social investment as it has been rated highly for care process, access, administrative efficiency and equity but poorly for health care outcomes by the Commonwealth Fund, a respected American health foundation (Schneider et al, 2017). There is a strong case for increasing levels of social investment in the NHS, social care and public health prevention in order to maintain the quantity and quality of provision.

2.2.1.5 Overview of mental health care provision in England

The provision of mental health services in England is primarily through the NHS. However, community care policies have resulted in increasing movement towards the funding and delivery of mental health services outside of the health sector, and consequently these are provided by a mixture of NHS, local government,

voluntary and private sector organisations (Knapp and McDaid, 2007). Nonetheless, around 80 per cent of mental health care continues to be delivered by NHS Mental Health Trusts (Gilbert, 2016).

2.2.1.6 Policy reforms in mental health care

After slow initial progress towards deinstitutionalisation, the pace of the transition from psychiatric hospital to community-based treatment and support in England increased in the early 1990s (Gilbert, 2016). This period saw the introduction of the NHS and Community Care Act (NHSCCA) 1990 which gave lead responsibility for community care to local government and introduced a mixed economy of provision into the publically funded system (Glasby and Tew, 2015). Long stay psychiatric patients were transferred to residential accommodation provided by the voluntary and private sectors, whilst acute inpatient care was provided in smaller NHS in-patient units on district general hospital sites. This expansion of services beyond hospitals saw the establishment of a joint finance mechanism integrating both NHS and local government, alongside a single model of care based around new community mental health teams (Gilbert et al, 2014).

The next ‘modernisation’ phase of reform under the New Labour government of 1997-2010 (DH, 1998) was characterised by an initial increase in funding and greater standardisation of service delivery via service plans known as National Service Frameworks. Central features included the development of new functionalised community team models to reduce demand for in-patient beds (Gilbert et al, 2014), and workforce reforms involving more distributed responsibility across occupational groups (Glasby and Tew, 2015).

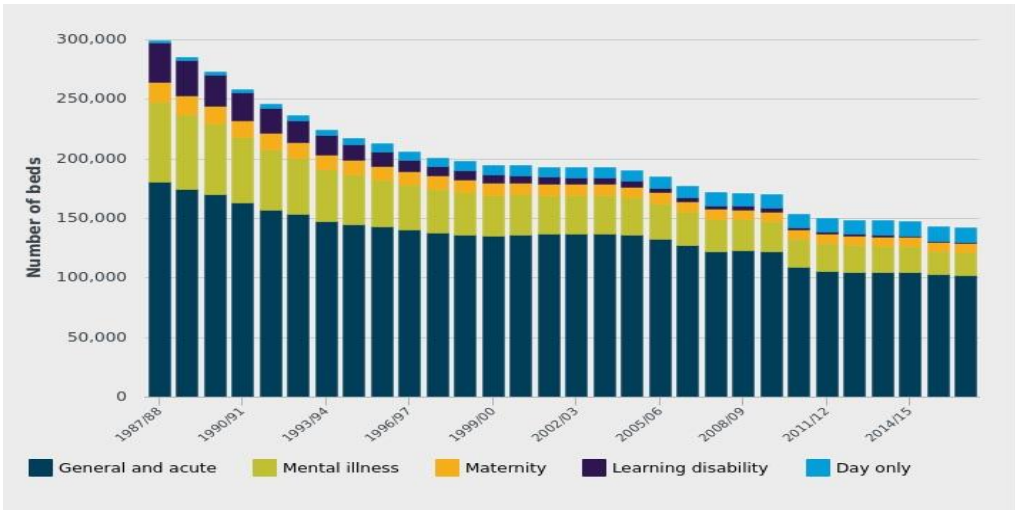
While the organisational forms for mental health service delivery established in the modernisation phase have not been subject to significant change since the election of the Conservative-led Coalition in 2010 (and the subsequent 2015 Conservative administration), this period has been characterised by significant funding constraints and uncertainties produced by the prospect of further institutional change, with an imminent move towards place-based planning and greater integration of mental and physical health care pathways under the Sustainability and Transformation Plans (STPs) (Naylor et al, 2017).

2.2.1.7 Investment and disinvestment trends in mental health care

The Coalition government (2010-15) committed to ring-fence the NHS budget (HM Government, 2010), however evidence from diverse sources suggests considerable disinvestment in mental health services as part of wider austerity-related public spending reductions since 2010 (Docherty and Thornicroft, 2015; McNicoll, 2015). While the Health and Social Care Act (HSCA) 2012 enshrined in law the principle of *parity of esteem*, which nominally gives equal access to care and treatment for both physical and mental health needs, there remains a disparity between planned and mandated spending promises and actual funding for mental health (Gilbert, 2016).

One significant area of disinvestment has been in-patient beds (Buchanan, 2014a). While there has been a significant overall drop in the number of NHS overnight beds across all categories since 1987, one of the largest reductions is in mental health, where bed numbers have fallen by 72.1 per cent between 1987/8 and 2016/17 (see Figure 2.4). In 1987 there were around 70,000 beds, falling to under 22,000 by 2016. This was initially driven by the policy shift from institutional to community care. However during the period of austerity policy implementation the pace of bed reductions has intensified with a 15 per cent reduction in the total between 2012 and 2016. Alongside this, during the same period (2012-16), there has been a reduction in the availability of community support with the total number of service users supported down 7 per cent, community staff levels reduced by 4 per cent and number of contacts with service users falling by 6 per cent (Centre for Mental Health, 2017; Ewbank et al, 2017; NHS Benchmarking Network, 2016; Dunne, 2016).

Figure 2.4 Average number of NHS beds available by category, 1987/8-2016/17



Source Ewbank et al, 2017/NHS England, 2017b

The Improving Access to Psychological Therapies (IAPT) programme, located within primary rather than secondary care, is one area that has seen increasing investment, with plans to further expand provision in order to increase patient numbers by 50 per cent to 1.5 m per annum between 2016 and 2021 (NHS England, 2016b). However this programme has been subjected to critical scrutiny as a result of its alignment with welfare policy goals (Friedli and Stearn, 2015). Such convergence looks likely to be an increasingly central feature of mental health policy development with the Work and Health Programme, a joint initiative between the Departments of Health and Work and Pensions to promote patient re-engagement with the labour market, just one pertinent example (Department for Work and Pensions and HM Treasury, 2015).

As well as changing levels of funding, the mechanism for financing NHS mental health provision has also been subject to reform. Since 2013 the direction of travel has been away from retrospective reimbursement through block contracts towards prospective reimbursement utilizing the Mental Health Payments (formerly known as Payment by Results) system (Jacobs, 2014), thus further embedding market mechanisms. However block payments currently remain the predominant form of payment to mental health providers (Gilbert, 2016). The profile of NHS providers has also shifted, with accelerated growth in provision of publically funded health care by non-NHS providers following implementation of HSCA 2012, which increased the incentivisation of competition in NHS procurement to encourage further diversification (Timmins, 2012). These processes of reduced funding and increased diversification/marketisation intersect in arenas such as mental health in-patient bed provision, where the independent (private) sector now accounts for 29 per cent of UK provision in the context of reductions in NHS bed numbers (LaingBuisson, 2016).

2.2.1.8 Impact on vulnerable groups

The mental health of individuals and groups are shaped to a significant degree by their social, economic and material environment, with inequalities in these contexts particularly detrimental (Marmot et al, 2010; WHO and Calouste Gulbenkian Foundation, 2014). The proximal conditions of people’s everyday lives, the health systems they are able to access and the distal political-economic forces that shape these systems are all social determinants of mental health and disorder (Allen et al, 2014).

The policy reforms outlined above have implications for these social determinants, shaping the capabilities and rights of vulnerable groups as defined by social class, gender, race/ethnicity and age. There is a distinct social (class) gradient with higher risk of mental health needs amongst adults in lower income groups (Campion, 2013) and socio-economically disadvantaged children also more than twice as likely to develop

mental distress (Reiss, 2013). This gradient is further exacerbated for black and minority ethnic communities by experiences of racism and discrimination (Nazroo, 2004).

As noted above, a further social determinant is access to services and here a salient factor is the ‘treatment gap’ whereby only 25 per cent of those with mental health needs in the UK receive treatment compared to 75 per cent of those with physical health issues (Ormel et al, 2008). Disinvestment in services is largely responsible for this (Docherty and Thornicroft, 2015) with, for instance, significant underfunding of health and care provision reducing older people’s access to community care (Age UK, 2015), while 28 per cent of young people referred to NHS Child and Adolescent Mental Health Services (CAMHS) have been denied access in the context of service cuts of £ 50 m (6 per cent) between 2010 and 2015 (Buchanan, 2015; Children’s Commissioner, 2016). Nor is there evidence that the market-oriented focus of recent service reforms have had positive impacts in improving access or redressing health inequalities (Bambra et al, 2014).

However the treatment gap also draws attention to the role of mental health stigma and discrimination in discouraging help-seeking behaviour (Clement et al, 2014). Moreover services themselves may inadvertently reinforce stigma or even perpetrate human rights violations (UN Special Rapporteur on the right to health, 2017). Social movements of service users and their allies have played an instrumental role in mobilising to resist such dynamics and to strengthen rights and enhance capabilities by promoting psychosocial models of practice and more egalitarian, anti-discriminatory orientations within mental health services and beyond (Beresford, 2012).

2.3 Research methodology

The Liverpool Hope team continued our exploration of the broad topic of mental health initiated in WP3 and WP5. However our focus during this work package shifted from the impact of austerity and welfare reform to the effects of recent mental health service reconfigurations outlined above.

Our research questions were as follows:

- What has been the impact of social dis/investment and liberalisation (market-based reform) policies on mental healthcare provision in England?
 - In what ways have the market-based reforms of the healthcare system since the early 1990s and later social dis/investment policies reshaped the nature and context of mental health service delivery?
 - What are the implications of these reforms for the rights and individual capabilities of mental health service users?
 - What are the implications of these reforms for the collective capacities and agency of service users and workers in the mental health system?

In order to answer these research questions we chose to extend our sample. While three of the mental health service user respondents involved in WP3 and WP5 decided to continue their involvement with the project, we also included workers from statutory and third sector mental health services in our sample. Drawing on this range of experiential standpoints enabled us to broaden our lens on service reconfiguration. We also drew on relevant research data from a further two service user research participants from WP5 who had described their experiences of changes in their mental health service provision. We will now outline our recruitment, methods and sampling strategy for WP6 in greater detail.

2.3.1.1 Process for recruitment

Data collection for WP5 had been preceded by a one-day conference in Liverpool in November 2016 on the impact of current ‘active’ welfare reforms for people with mental health needs. As well as highlighting the social costs of recent social protection and labour market activation reforms and developing collective campaigning and networks of support in response to it, we had envisaged that the conference would enable us to deepen our contacts and establish a broader group who could take part in this third phase of the

RE-InVEST research. The conference had been attended by a number of statutory (NHS and local authority) and third sector mental health workers in addition to the service user and claimant participants. We were consequently able to draw on these networks to recruit to the study three attendees who are social workers working in statutory mental health services.

2.3.1.2 Sampling

The study used a combination of non-probability sampling techniques including purposive, convenience and snowballing. The purposive sample was oriented to those with knowledge or experience of social dis/investment and market-based reforms of mental health services in England, and for this reason we selected two groups. The first were adults (aged 16-64), resident in the North West England region, experiencing mental distress who are currently users of mental health services. The second were mental health workers currently employed in statutory or third sector services in the North West England region. We also included one participant who had recently retired after a long career working in mental health services and currently involved in providing voluntary support to mental health service users. Convenience sampling involved the utilisation of WP3 and WP5 participants with additional contacts from the WP5 conference. Snowball sampling was also utilised with mental health workers who were asked to approach colleagues regarding participation in the study. Data were collected between March and September 2017.

The total number of participants included (n=21) was as follows:

- 4 mental health service users (3 female, 1 male)
- 12 mental health social workers (9 female; 3 male)
- 4 Community Mental Health Nurses (CMHNs) (3 female; 1 male)
- 1 mental health support worker (male)

We were particularly keen to recruit participants with extensive experience of either professional practice or use of mental health services who would be in a position to reflect on relevant changes in the nature of service provision over a longer period. Our service user participants had long-term experience of service use ranging from a period of 14 to 27 years. Though one of the practitioners (social worker) was relatively newly qualified (3 years), and another had around 7 years' post-qualifying experience, the length of employment in services of our other practitioner participants' (social workers, CMHNs & one support worker) ranged from 17 years to 35 years (n=15, average 27 years). Our participants worked in or used services of five different service providers in total (three NHS Mental Health Trusts, one local authority and one third sector setting).

2.3.1.3 Methods of data collection

The project uses a qualitative methodology, with data collected via two methods: group interviews and/or individual in depth semi-structured interviews. We collected data via five group interviews, and one individual in-depth interview. We also utilised relevant data from two group interviews (GRP02 & GRP03) collected for WP5.

An overview of the data set is presented in Table 1.2. The five group interviews and one individual interview took place between July and September 2017 (except group interview 2 which was held in March 2017).

Table 2.1 Data set for WP6

Format	Code	Type of participant	Group size	Participant gender
Group interview	GRP06	2 CMHNs + 2 social workers	4	3 Female, 1 Male
Group interview	GRP07	8 social workers	8	6 Female, 2 Male
Group interview	GRP08	2 social workers	2	1 Female, 1 Male
Group interview	GRP09	2 CMHNs	2	2 Female
Group interview	GRP10 & GRP03	3 service users	3	2 Female, 1 Male
Individual interview	INT14	1 support worker	1	Male
Group interview	GRP02	1 service user	1	Female

2.4 Social disinvestment and liberalisation of mental health services: practitioners' and service users' experiences

We will now turn to presentation of qualitative data exploring our participants' descriptions of and responses to liberalisation and social dis/investment. The discussion will be organised in four parts that relate to stages in the evolution of policy mechanisms for embedding markets in mental health services in England. We argue that in order to understand the nature of the impact of the crisis of 2007 on mental health services in England it is necessary to examine its roots in market-based reforms (liberalisation) of this system that significantly pre-date these events. For this reason we begin with implementation of the NHS and Community Care Act (NHSCCA) 1990 and internal market across the NHS and social care system. The following section considers the punitive turn from the mid-1990s characterised by an increased emphasis on targeting resources towards risk management. The third considers the deepening of market mechanisms in the mid-2000s. The fourth examines the effects of the austerity agenda and welfare state transformation under post-2010 governments. All names used in this report are pseudonyms.

2.4.1 The internal market: introducing a 'business model'

Due to political resistance and public opposition, the NHSCCA reforms introduced by the Conservative administration of 1987-1992 were unable to deliver wholesale privatisation of the health system (Bartlett & Harrison, 1993). Nonetheless they created a new infrastructure to enable a number of 'routes to market' for healthcare provision (Clarke, 2004). The primary mechanism for this in its initial stages was the internal market. This was introduced across the NHS, including within secondary mental health services¹², from 1993. It was implemented via a purchaser-provider split, the concomitant outsourcing of care provision and the devolution of budgetary responsibility to a more localised level (Ruane, 1997). In this section we will explore the effects of these changes for practitioners and service users.

¹² Secondary mental health care refers to the various types of in-patient (hospital) setting and community mental health services and teams (the latter employing a range of practitioners including nurses, social workers, psychiatrists and psychologists) for service users with higher levels of need. Primary care refers to services to meet less complex types of mental health need delivered within general practitioner (GP) or other associated settings, for instance time-limited therapies under the Improving Access to Psychological Therapies (IAPT) scheme.

Community mental health nurse (CMHN) Joanna described how, when she first came into NHS mental health nursing in the 1980s, the clinical/professional elements of her role were foregrounded rather than administrative/budgetary considerations:

You didn't hear about a budget, never, ever, ever, budgets were not mentioned to you [...] you were a nurse, you nursed [...] You think back and think when did that change, when did it all go different and I think it was the internal market (GRP06: 19)

Hugh (social worker) described this as the advent of the 'business model' (GRP07: 14), whilst Mary (social worker) explained how mental health practitioners' roles changed under this new system:

The way that filters down is, is that we're more managerial. It's like management of care, isn't it, so we don't provide care [...] we're managing the care and [...] that's quite a big shift [...] The care is about something that is, you know, packages of care or trying to find resources, people to provide the care that maybe you would have been doing is now something that you're getting, contracting, sourcing other people to do that, you know, so it's very sort of compartmentalised [and] fragmented (GRP06: 11)

This fragmentation of care had significant implications for frontline practice and the quality of care provision as Denise (CMHN) explained:

One of the things the contracting has done, is it's led to border disputes between sections [...] We used to be in the same organisation as drugs and alcohol, now [they] are contracted, so they're privatised and they've got five different agencies providing them [...] so you'll have five different people, none of whom share notes with each other or with us, so we have no idea what's going on (GRP09: 49)

Though a degree of variation across professional groups was noted, this new model universally necessitated a greater role for managerial tasks such as assessment, monitoring and review of care packages and contracts. This transformation of practitioners' labour process from care provision to management was frequently commented on and problematised by our participants. For Gina (social worker):

I don't think social workers are social workers anymore, I think they're case managers [...] They are overseeing other professionals doing stuff and managing the risk that way [...] You're not using yourself and your skills as a social worker to analyse and understand the dynamics of something and work with it and work with the family and look at the social and family issues and how you can help that person along that way, it does seem to be a provision of service from somewhere else, tick boxing, and we're no longer using ourselves as a resource (GRP07: 13)

Hugh (social worker) concurred describing the current role of the practitioner as a:

People processor or electronic technician, inputting data on the computers, so it's like you no longer use the skills you were trained to do (GRP07: 13)

To illustrate the extent of the perceived change from therapeutic-relational to administrative orientation (Harris, 1998), current CMHT social worker Leah compared her workload in a typical week to that of another social worker, Adam, when he had worked in a CMHT from the late 1990s until early 2000s (he is now employed in a management role). Leah described regularly spending 50 per cent of her week on computer-based recording and assessment tasks, 40 per cent in various multi-disciplinary and other meetings, and only 10 per cent in face-to-face contact with service users. By contrast, during the 1990s, Adam would spend 20-25 per cent of his week on information recording and paperwork, 25-30 per cent in multi-disciplinary meetings and as much as 50 per cent of his week in direct contact with service users.

2.4.2 The punitive turn: foregrounding risk and responsibility

Alongside the increasing prominence of budgetary/administrative responsibility within a market orientation, the foregrounding of risk was widely regarded by our participants to be another highly significant change in

the nature of community mental health provision since the 1990s. Joanna (CMHN) succinctly captures these twin concerns in her description of perceived priorities within a fragmented contemporary service landscape:

Everybody's arguing [...] who's going to carry the risk, who's going to carry the cost and those are the two things that it's come down to (GRP06: 19)

However the particular construction of risk here requires further unpacking. Our data suggests at least two dimensions that will now be elucidated.

2.4.2.1 Risk as devolved accountability

Pete's story above draws our attention to the tendency to redistribute and devolve accountability and risk from governmental and corporate institutions towards individual practitioners and service users in the new business model (Brown and Baker, 2012). Hugh (social worker) expanded on this theme, describing its effects on practitioners:

One of the main problems all professionals are having in every area, [...] particularly in mental health is [...] risk management and instead of looking at risk management in terms of the wider community or the individual, we're talking about it in terms of managing risk in terms of liability for the corporation for those risks and that becomes the focus of their management model, so you'll find somebody, either it'd be a care coordinator [in a community team] or the senior nurse in charge of an inpatient ward and you put the focus on them to take all the liability and the responsibility for these actions and it just becomes too much for people to go into that profession (GRP07: 10)

We will describe in section 2.4.3.1 below how such trends in statutory services are paralleled in outsourced third sector provision. However Hugh's description also suggests a further dimension: negative risk.

2.4.2.2 Negative risk as 'danger'

Mary (social worker) described the centrality of this phenomenon to mental health practice since the 1990s:

The big thing is risk, I can't tell you how big a thing risk is [...] There was an obsession with risk, I think, which hangs sort of over everybody, doesn't it, the sort of coroner's court, if we do this, you know, don't do this, the coroner's court, the homicide rate, the suicide rate (GRP06: 8-9)

The construction of people with psychiatric conditions as purportedly posing a danger to society has a long history stretching back to antiquity (Thiher, 2004). However, Mary's testimony points to the re-emergence and rejuvenation of these longstanding negative risk discourses in mental health services in England. A specific set of factors underpinned this renewed prominence in the context of the policy shift from deinstitutionalisation to community care during the late 1980s/early 1990s. There were a small number of high profile homicides by psychiatric patients at this time (Rogers and Pilgrim, 2014). Even though, during this period, the overall trend in the number of such homicides was actually downward these incidents received extensive political and public attention, inflamed by media coverage that has been characterised as a moral panic (Holloway, 1996; Taylor & Gunn, 1999).

As a consequence, subsequent policy reforms foregrounded risk assessment and management as an increasingly central task in the everyday practice of professionals. Mary noted how:

[W]e develop[ed] zoning, that was in the nineties [...] you'd have a traffic light system (GRP06: 8)

Zoning was also known as 'ragging' based on the acronym for red, amber and green. Denise (CMHN) explained how service users are 'graded':

You're rated red, amber or green and that defines how many visits per, you're entitled to, so it dictates and there's no sense of the autonomy of the clinician (GRP09: 7)

While those rated 'red' receive higher input, Bridget (CMHN) noted that, 'everybody on green is not getting anything [support]'. Denise concurred, though noted that users on 'green' might occasionally get 'flying

visits [...] like drive-bys' (GRP09: 9). Denise explained the hierarchy of risks which practitioners' were required to manage:

The priority is about risk of preventing admission, [...] it's like how do you prevent [in-patient] admission is the top, [...] or [prevent] things that will lead to serious harm, but in terms of risk of distress, that isn't [a priority]... the level of distress doesn't necessarily dictate whether you're entitled to the extra resources that you need, so it is risk dominated (GRP09: 9)

For Mary it is through practices such as 'ragging' that the two dimensions of risk, devolved accountability and negative risk management, intersect:

['Ragging'] was [Trusts'] way of targeting resources [...] passing responsibility to the workforce for the management of that risk (GRP06: 8)

Cathy (social worker) described the potential implications of this responsabilisation of risk to practitioners by the NHS in the event of a serious incident:

As soon as anything happens you'll be thrown to the lions, [...] it'll be, well, [...] she's [professionally] registered you know

In summary, our data support the thesis that there has been a wider shift from need to risk as a central pre-occupation in welfare services (Kemshall, 2016). Moreover, as universal provision is curtailed in the face of liberalising reforms, risk increasingly operates as a means to assess entitlements and allocate scarce resources (Foster, 2005). Management of the latter is devolved to practitioners who are required to prioritise risks posed *by* service users: either the financial cost to the Trust of admission or reputational risk in the event of a serious incident (c.f. Hibbard et al, 2005) whilst, conversely, risks *to* service users from high levels of distress or unmet need are increasingly regarded as low priorities in the system.

2.4.3 Extending markets and targets

In the decade from the end of the 1990s to late 2000s, the market orientation within the NHS in England (and wider public services) was extended and deepened by the New Labour government using new public management principles (see Hood, 1991; Newman, 2007; Simonet, 2015). Following the earlier implementation of liberalisation structures such as the internal market, a new stage of marketisation of mental health services proceeded via several mechanisms. These included a renewed emphasis on outsourcing of support services, proliferation of an array of targets and performance indicators, and the creation of quasi-market bodies such as Foundation Trusts (Price et al, 2011; Gwyn and Hood, 2006). In the period from the late 2000s onwards, a number of further market mechanisms were developed in mental health services. These include new care pathways through Payment by Results¹³ (PbR) clusters (MacDonald and Elphick, 2011). Towards the end of this period a large-scale programme of psychological interventions in primary care settings (Improving Access to Psychological Therapies - IAPT) was introduced that involved highly marketised systems of delivery (Griffiths et al, 2013). We will now consider the impact of these processes on practitioners and service users.

2.4.3.1 Intensified outsourcing of NHS provision

As we noted earlier, following the NHSCCA 1990 reforms and implementation of the purchaser-provider split the outsourcing of NHS provision began to gather pace. However this trend was significantly intensified following the NHS Plan of 2000 (Leys and Player, 2011). While we have already described the emergence of the care management role amongst NHS practitioners, Ben (third sector support worker) noted the impact of this process on the non-NHS workers to whom care provision was increasingly frequently devolved:

¹³ PbR is now known as the Mental Health Payments system – see below Section 2.4.3.2

Looking at the way the third sector has come in [to the NHS] I think we'll see more and more, [...] workers on low pay (INT14: 8)

Ben spoke from personal experience. His support work role had previously been provided by the NHS but once outsourced he was transferred to a third sector provider where he faced one third cut in pay as well as increased workload. Service user participant Pete had also been employed as a care worker in three different posts in outsourced mental health services during the early 2000s. He too described an increasing burden of responsibility in a context of reduced managerial support for third sector care staff. These workers were mostly without professional qualifications and on relatively low pay. This low pay/high responsibility nexus that is mirrored within statutory services, as we noted in Section 2.4.2.1, exacted an injurious toll on Pete's own mental health:

The company I worked for were like a social enterprise but they would bid in for contracts and the money was in the [service users] who were harder to support. People's jobs were getting merged together and being isolated, there weren't two people on at the same time in handover periods and [...] reduced staff cover [...] the support workers were being forced into running the whole service [...] Personally, I had three breakdowns after each job (GRP10: 6-7)

This is consistent with wider evidence from statutory and third sector care providers that the reconfiguration of worker roles and reduced resources is having harmful effects on the mental health of workers (Evans et al, 2006).

2.4.3.2 The impact of bureaucratic demands on relationship-based practice

Another effect of the purchaser-provider split on frontline practice is the escalation of bureaucratic demands to collect data and meet key performance indicators for a wide range of purposes such as local authority contractual targets, Monitor (independent NHS regulator) Compliance Framework information, and Commissioning for Quality and Innovation (CQUIN) payment framework goals. These are additional to NHS Trusts' own internal targets. In this way market and quasi-market mechanisms are further transforming the labour process of statutory mental health workers.

Bridget (CMHN) described how there had previously been greater space and time for relationship-based practice:

We used to get people to actually sign their own [care plan] forms, because that was then them participating, 'cause we had an ethos, didn't we, in the nineties, of people actually being involved in their care, because we had enough time and staff to do that, you could actually talk to people about what they wanted (GRP09: 10)

She contrasted this with current arrangements whereby:

People aren't participating in their care, it's being done to them, in a way, or it's being done on a computer or on a system that they actually don't really understand or have any knowledge of (GRP09: 10)

She later continued:

If you looked back to 2007 and before then, things were not necessarily always rosy but there was space, there was space and time for you [...] to actually form relationships [...] whereas now [...] that was much, much more difficult and you had to do it almost secretly, [...], you wouldn't write in your notes, took [service user] for a coffee to see how they were [...] you would just say 'seen', because it wasn't acceptable use of your time (GRP09: 40-1)

Cathy (social worker) too had been subjected to criticism for refusing to acquiesce to a target set by her service manager of completing five service user visits per day. She explained that this was in order to maintain a relationship-based practice ethos rather than reducing each meeting to a ten-minute 'drive-by':

You try and keep working with people and I do, I get into trouble all the time (GRP06: 39)

Hugh (social worker) noted that, as a consequence:

The bureaucracy and targets are the goals [of practice], rather than meeting [user's] needs (GRP07: 13)

Service user Emma described a similar perspective, arguing that the effects of excessive bureaucracy had detrimental impacts for those accessing the mental health system:

There's so much pressure on staff for these ridiculous targets that they're pressured, we [service users] pick up on that, so the whole system is damaging and failing and toxic (GRP10: 08)

Cathy (social worker) concluded that the information infrastructure operated in the interests of neither workers nor users but of Trusts:

The electronic patient records system, [...] is there for North-town Trust's finance department, that's all it's for, it's all about payment by results. It's not a system for us, it's a system for them.

As Lister (2008) has noted, the establishment of Foundation Trusts (FT) marked a step change on the path towards neoliberal restructuring of the NHS, with FTs now functioning as semi-independent business units.

2.4.3.3 Payment by Results (PbR) and care clusters

Many of our participants connected escalating bureaucracy and quantification with market processes. For instance Don (CMHN) linked the increasing role for information technology and electronic data collection with:

Marketisation. [...] It's all about counting things, so you can sell it. [...] If you can't count it, you can't sell it, can you, if you can't bar code it, you can't sell it, that's the rationale for having all these other people bean counting us and monitoring our activity (GRP06: 11)

One significant example of such a recently implemented mechanism is the NHS Mental Health Payments (formerly PbR) system. This involves the allocation of mental health service users to a diagnosis-related category or 'cluster' using the Health of the Nation Outcome Scale (HoNOS) to determine the type of care they receive in line with the transfer from block to individualised funding arrangements. The assignment of a cluster constitutes the allocation of a fixed price for a patient's care for a specified period (Yeomans, 2014). The clustering process thereby facilitates the reconfiguring of services as commodified units more amenable to a competitive orientation within statutory mental health services (MacDonald and Elphick, 2011). For Bridget (CMHN) this process has little clinical relevance to service user or worker:

A lot of the questions are completely irrelevant [...] It's a tick box, it makes no difference to that person, your scoring, what their HoNOS score is, apart from the Trust can then forward those figures and they get some funding (GRP09: 22)

However, such systems are susceptible to forms of 'gaming' to achieve desired outcomes (Yeomans, 2014). One example is *up-coding* - Bridget describes this as a form of strategic agency to ensure the service user continues to receive a service in a context of wider restrictions on access:

Your incentive is to make them much, much more unwell than they are, because otherwise [...] they could be discharged. So then you're under pressure. [...] basically you're actually not filling it in accurately (GRP09: 23)

However as Bridget later commented this practice also has potentially beneficial revenue implications for the Trust because, as she ironically noted, 'points mean prizes' (GRP09: 25). In contrast, social worker Leah (GRP08: 28) expressed concern about an alternative form of gaming (described by Yeomans, 2014, as *dumping*) where the HoNOS score was used to justify discharging service users with complex needs back to their GP in order to reduce costs.

2.4.3.4 Marketisation of psychological therapies

An increasingly significant trend identified by Leah is for people with mental health needs in HoNOS clusters representing less complex needs to be redirected to the IAPT programme in primary care services. As

noted earlier IAPT is an area of expanding provision. Market principles are more advanced and embedded in IAPT than in statutory secondary mental healthcare with competition between providers for contracts, and payment subject to a more rigorous PwR outcomes framework (Griffiths et al, 2013). After 25 years working in secondary services, Denise (CMHN) moved into a role as an IAPT primary care therapist in 2009. She described expanding investment in primary care as driven by an emphasis on reducing sickness absence and increasing labour market re-engagement:

For people with severe mental illness [in secondary services] the money's been cut, but there was an economist who argued [...] CBT [cognitive behavioural therapy] can cure 50% of people with depression and therefore if we set up CBT [...], then businesses will have everybody back at work [...] So, my service is being funded and massively expanded because we have this myth that we can cure 50% of people who are referred to us.' (GRP09: 21).

Emma (service user) concurred with this view of the emphasis within IAPT:

It is getting you back to work, it's like the IAPT stuff, it's all getting you back to work, get you in the right mind-set to sort yourself out.' (GRP10: 10).

This emphasis within the programme has raised ethical concerns, in particular the potential for claimants to be coerced to engage with work-related psychological interventions in the context of a punitive welfare system (Friedli and Stearn, 2015; Moth and Lavalette, 2017).

Denise went on to describe the extent to which her practice in this setting is shaped by a managerialist target regime:

The computer asks you for so many boxes, it is absolutely ludicrous, so when I see people [...] we have to tick a box that says did you see them face to face or by email or by Skype or by something else, you see them one to one or in a group, what sort of therapy did you provide for them, are they working, are they on sick pay or not, have they got an employment need [...] I have to get them to fill out a form which has got nine questions for depression, the PHQ9 [Patient Health Questionnaire scale for depression], seven questions for anxiety, the GAD7 [Generalised Anxiety Disorder], eight questions for work and social functioning, WSAS [Work and Social Adjustment Scale], [...], three for phobia and then I have to input them onto the computer at the end.' (GRP09: 10).

This extensive dataset is primarily used to calculate outcome payments to provider companies (Griffiths et al, 2013). However Denise went on to describe how this model of intervention placed stringent limits on her 'autonomy':

They've trained us and we know what we're doing, but they have sort of guidelines which dictate, regardless of what the patient actually experiences, [...] and their illness isn't following that model, but you have to follow the model because [...] these things are being measured and are being dictated and red flags will come up.' (GRP09: 46).

Moreover, as with clustering in secondary care, perverse incentives were generated by this new marketised performance regime. In her service, Denise described targets being monitored by 'an army of admin workers' yet, in order to meet various performance indicators, service users with more complex needs were 'inappropriately' booked with less experienced wellbeing practitioners even when perceived by the assessor as likely to need support from a more highly trained clinical psychologist:

We will book people in with the wrong professional in order to tick the box that we've seen them within 6 weeks, because we have got a waiting list for the right professional, but it's better to get them seen because that's a target that we're marked on nationally. So the targets dictate what you do, even when it's not clinically recommended, a pointless appointment.' (GRP09: 23-4).

This practice enabled the provider organisation to meet its six-week target and generate income even though Denise (CMHN) described this as causing distress for the service user and frustration for practitioners. Such gaming practices, she noted, were endemic, 'we got an email full of how to fiddle your figures [...] it wasn't called that [...] but that was essentially what the email was, how to review your figures' (GRP09: 25). Perhaps

even more concerning is the way in which this regime constructs the purpose of therapeutic intervention itself. Once again Denise explains:

'You get people who are really depressed and think they're crap [...] really low self-esteem, [you ask] how are you, [they say] well, I'm not too bad, you know, there's people worse off than me and they'll score really low [for level of need], but they're barely getting out of bed, right, they're in absolute misery and quite suicidal but they don't really want to score it much because, [they say] I'm sure you've got other people that [...] are worse off than me [...] Actually, part of your therapy is about getting people to acknowledge how unhappy they are and to stop writing that off as not mattering. And so you might get people to increase their numbers and scoring and actually that's a successful therapy, but it's a black mark for the government and my service and me. I'm marked on it and it's the start of your [monthly] supervision with managers: [...] these are your numbers, this is how many people you've seen, this is how many people you've got better.' (GRP09: 22).

These examples demonstrate how *event* rather than *process transparency* in the performance regime (Bevan and Hood, 2006b) can result in a fundamental distortion of clinical priorities (Mears, 2014).

2.4.4 Austerity and welfare state transformation

Following a period of increased levels of NHS funding between 2000 and 2008 (Appleby et al, 2009), the Conservative-Liberal Coalition government introduced an austerity programme from 2010 involving swingeing cuts to public spending. While health spending was nominally ring-fenced increases in the NHS budget were low by historic standards (2.7% real terms growth between 2009/10 and 2013/14) and insufficient to meet growing demand in the context of an ageing population (Lupton et al, 2015). Moreover, as part of wider liberalisation-oriented welfare state restructuring, the NHS was subjected to further market-based reforms and increased competition via the Health and Social Act 2012. These processes of austerity and market reform have placed significant strains on the partnership arrangements between local government and the NHS through which mental health services are organised and delivered,¹⁴ and as a consequence these integrated structures have recently come under pressure (Lilo and Vose, 2016).

This section will set out four key service transformation trends during this period identified by our participants: decaying infrastructure and shrinking community teams; the removal and relative neglect of long-term support services; intensification of the embedding of market logics in provision; and the impact of welfare reform on users and mental health services.

2.4.4.1 Decaying infrastructure & shrinking community teams

While a decade earlier the New Labour government had set out a critique of a dilapidated psychiatric infrastructure before increasing spending (Department of Health, 2001), some respondents pointed to a return of problems with the fabric of buildings in the austerity era. Mary explained that her office building was 'literally falling apart...floods... a sewer that leaks underneath... [you] see the decay' (GRP06: 9). Alongside this she identified diminishing team sizes and staffing levels:

'Our team just, it's just tiny, compared to what it was. In fact, we have days now that the office shuts 'cause there's just not enough people in the building ... there's a shrinkage of staff.' (GRP06: 9).

Denise (CMHN) used a surgical analogy to describe the effects of an increasing focus on efficiency savings during the New Labour era which was intensified by the Coalition government's austerity agenda: 'we've long, long got rid of any fat in the NHS, we've cut quite a lot of the muscle and it's really weak and now they are chopping off whole arms and legs' (GRP09: 19).

¹⁴ Since the late 1990s pooled health and social care budgets under Section 75 agreements (of the NHS Act 2006) have funded integrated structures whereby local government staff (mainly social workers) are seconded to work within services delivered mainly by the NHS.

2.4.4.2 Neglecting ‘chronicity’: removing layers’ of long-term support

One effect of cost reduction interventions that was identified by a number of participants was the removal of support for people with longer-term or so-called ‘chronic’ needs. Bridget (CMHN) described:

‘The level of acuity that is acceptable to be discharged back to the care of the GP and the care of the carer, if there is one, is much greater than it used to be. [...] I know of a woman who has chronic schizophrenia, who can’t go outside her front door to put her bin out without her husband, [...] she cannot go out on her own ever, she can’t even go to the corner shop, [...] she can’t have a bath without him standing outside the door, she can’t go to the toilet, discharged from services, because apparently there’s nothing you can do.’ (GRP09: 30).

Joanna (CMHN) regarded an emphasis on ‘early intervention’ services to have:

‘Diverted money, so [people with longer-term needs] get starved of the funds that could possibly keep them well.’ (GRP06: 19).

For Denise (CMHN) this diversion is from secondary to primary care, and has led to the disappearance of whole strata of provision for this group of service users:

‘They are putting money into primary care, whilst they’re hammering secondary care and the gap between primary and secondary care just gets bigger and bigger as they squeeze secondary care [...] There’s a whole set of services, [...] layers that have been removed. So you get the acutely ill high risk and then you get primary care and then there’s a huge black hole in the middle.’ (GRP09: 29, 35).

Don (CMHN) described this gap as a form of institutional neglect:

‘Somebody that’s not going to kill themselves, unless they have an accident and not going to kill anybody else, so they’re kind of left to rot.’ (GRP06: 19-20).

Moreover, for Denise (CMHN), workers who were no longer able to offer support to this group became more defensive:

‘Having to face those people in the middle who don’t meet the service [criteria], you have to be really hard faced.’ (GRP09: 35).

While the conception of chronicity in mental health care came to be regarded as stigmatizing in the context of the emergent recovery model (Bister, 2017), recently there has been critique of the institutional de-legitimation of the kinds of longer-term support needs to which this label is applied (Metzl & Kirkland, 2010; Recovery in the Bin, no date).

2.4.4.3 Embedding market logics in a shrinking welfare state

Coterminous with austerity cuts has been a continuation of policy trends to realise market transformation of health service delivery. This section will consider three examples described by our participants that illustrate emergent ways in which market mechanisms are embedded within the processes and practices of mental health service provision. These are: individualised tendering for care service provision via service specifications (‘specs’); the growth in NHS and private sector markets for scarce resources such as in-patient bed provision; and the promotion of an individualised recovery model. Furthermore these examples illustrate the interaction between market development and the austerity agenda.

2.4.4.4 ‘Service specs’: workers as purchasers in care markets

The Care Act 2014 has promoted the development, ‘shaping’ and extension of care markets, with a move away from block provision to more individualised process of bidding for and securing contracts (Allan, 2015). Leah (social worker) described how, after assessing a service user:

What we do is [...] service specifications [of care needs]. So this is a kind of [...] free market idea, where, you know, you put these service specs out and then the market bids on [them], whereas it used to be, I think, you would have your contacts and links with the different organisations and services that you might phone up. And now we don't do that and [...] you're not even allowed to think to do that [...] It goes to commissioners, they send it out and then you get these bids back. (GRP08: 5).

This marketised process functioned, moreover, as a mechanism of cost control in the context of austerity. Leah described the decision-makers (commissioners) as being focused on 'protecting the budget' (GRP08: 6) rather than oriented to supporting service user choice or need.

2.4.4.5 Fundraising beds: providers maximizing revenue in the beds market

With the introduction of NHS Foundation Trusts (FT) in 2003, service providers were transformed into corporate entities with independence from government control and expected to produce surpluses through competitive activity in health care markets (Price et al, 2011). Participants described to us one particularly striking adaptation to the market imperative imposed on FTs: 'fundraising beds'.

We noted earlier, in Section 2.2, the significant decrease in bed numbers driven by funding constraints that has undermined patient access to local service provision. This led to a steep increase of out of area placements (OAPs) for patients from 2014 (BMA, 2017). The scarcity of NHS beds constituted a gap in the market that has enabled significant expansion of private sector in-patient provision. For Bridget (CMHN) this was an intended consequence:

Well, I also think market forces mean that because this Tory Government have actively encouraged the development of private beds in mental health specifically, then it's not in anybody's interest to look at the consequences of having less NHS beds, because basically if you increase the number of NHS beds, less people would be going to the private sector and obviously then those companies, [for example] The Prioxy company, they're expanding exponentially across the country, left, right and centre.' (GRP09: 52).

However this scarcity represented an opportunity not only for the private sector but also some FTs, as corporate entities, to maximise their income. Since implementation of the Health and Social Care Act 2012, FTs have the legal capacity to raise up to half their income from private patients or other sources (Allen, 2013). Fundraising beds constitutes one such strategy. Joanna (CMHN) explained how:

'Our bed manager is told to keep some fundraising beds back and not give them to East-town residents, even though they're in East-town and he'll get people asking, is there a bed for somebody that needs sectioning [detention under the Mental Health Act]. He's, [...] not supposed to give that bed away, but he does because it's completely unethical, but this is what the Trust HQ is telling him, don't give those beds away because if we get somebody from out of area, they generate much more money for us, so keeping East-town residents out [...] Well, it becomes a business, doesn't it.' (GRP06: 24).

This illustrates the interaction of austerity as a mechanism of neoliberal welfare state transformation with market reform. Meanwhile this practice is likely to further exacerbate the harmful impacts of the beds crisis for patients and service users.

This also highlights how, rather than heralding greater choice *for* patients, market reforms have instead delivered greater choice *of* patients by private providers (Pollock and Price, 2013). For Gina (social worker):

'The real worry about the private beds is that they're really picky and choosy about who they will take, so they will do lots of risk assessments, saying we haven't got the staff or we can't manage this.' (GRP07: 1).

Hugh (social worker) explained the problematic consequences of this for the NHS as a whole:

'The private sector will charge more and take more out of services for those patients who may need less.' (GRP07: 1).

This leaves NHS wards as residualised providers for patients with the highest levels of need but more limited resources for care provision.

2.4.4.6 Recovery: responsabilising the consumer?

In this section we will examine a similar tension between the policy rhetoric of patient choice and control deployed in relation to the recovery agenda and the lived experiences of service users and frontline workers. There was a high degree of consensus amongst our participants that the recovery model has been deployed as a means to responsabilise service users and as a cover for cuts. For Mary (social worker):

'Really it's to enable people not to use a service, it's not really to enable, it's [...] self-management isn't it. Not saying there's not a role for that, but in the meantime, the services go.' (GRP06: 14).

Don (CMHN) made a similar point about the recovery model and individual budgets arguing for a 'both/and' rather than 'either/or' conception of the relationship between individual and collective service provision:

'There's a strong ethos, strong philosophy around recovery, [...] 'cause obviously no-one's going to disagree with the need for recovery and individualism, but they're using it to reduce the provision of services really, [...] so SDS [self-directed support] budgets [...] they're closing the swimming baths and they're closing the collective provision of services for people, whilst they're saying that the individual can choose to [...] have a computer instead or get a Playstation [...] That would be great if it was on top of normal provision, but normal provision has been decimated really.' (GRP06: 4-5).

Louise (service user) explained the impact of austerity on her support package, and how this was reframed through a discourse of enhancing recovery and independence that created distrust and exacerbated her distress:

'I've had [mental health] support workers through the years [...] They would help me just cope with living and then maybe getting out of the house [...] Now [in] 2015 [social services announce] an assessment of everyone [...] because 'we want to see what other support we can offer you, how can we enhance this service' [...]. My support worker [...] came to my house, [...] asked all about the support I received, what it did for me, how it enhanced my recovery, enhanced my life, what my prospects were through it, what more could they do for me. It then turned out that they [...] scored every single client zero points. [...] They cut, just closed overnight, took the support away, that was after 2015 with the cuts to the social care budgets. [...] For me, was like being thrown into the sea to sink or swim. [...] It was deceitful as well, coming in and saying, how can we help and then just pulling the rug out like that, they never even had the intention of helping us, it would have been better if they'd just come and said, we're taking everything away, at least that would have been honest.'

This chimes with the arguments of critics who have noted that a more progressive conception of recovery has been appropriated in neoliberal policy agendas as a means to de-emphasise the provision of mental health services, inculcate tendencies to reduced consumption of services by users and thereby minimise so-called welfare dependency (O'Donnell and Shaw, 2016; Harper and Speed, 2012; Brown and Baker, 2012; Spandler and Calton, 2009).¹⁵

2.4.4.7 Welfare reform and benefits distress

Another significant theme emerging in this period is welfare reform. This has had an impact on the role of mental health workers who spend an increasing proportion of their time supporting service users who have been negatively impacted by such changes. For instance Cathy (social worker) explained:

'I spend my working time fighting with the DWP [Department for Work & Pensions], that's all I do and I have people who are really, really unwell because of the DWP, I mean, it's solely down to that.' (GRP06: 36).

Leah (social worker) also described a significant amount of time writing supporting evidence and letters for service users and attending benefit assessments:

¹⁵ See more on recovery below, sections 2.5.5 and, in particular, 2.5.7

'[It's] just constant [...] there's so many more reviews of people's benefits now [...], people get sanctioned and stuff like that, so [...] you're just trying to keep on top of everybody's benefits at all time, [...] it does take a lot of our time.' (GRP08: 34).

She considered supporting service users to manage benefit pressures as important 'preventative work' (GRP08: 34) due to its potentially detrimental impact on claimants' mental health.

For our service user participants there were a number of concerns in this area. Pete (service user) described the intense work and stress involved in maintaining a claim:

'Go[ing] to see someone at the [benefits advice centre], that's a hell of a thing to do, it's really hard, 'cause you don't know what to take with you, you don't know what to say [...] will they want to listen. I've got so many things going on, I don't have anyone to talk to, that's why [...] you definitely need professionals [...] or workers [to help] [...] There's such a short period now you get to fill a form in or to prepare yourself for an assessment [...] Which creates even more stress and creates even more ill health.' (GRP10: 17).

A further concern was the stigma associated with being a welfare claimant. Abi (service user) described how accessing benefits: 'makes you feel like a failure' (GRP10: 37), whilst Emma (service user) described the shift in dominant discourses from structural to individual explanations for unemployment:

'It's going back to the Victorian era of it's your own individual failure, why you're unemployed, it's your individual deficit. You can't blame the society, it's your fault, you're pathetic, you're useless.' (GRP10: 38).

Another consequence of an increasingly restrictive, punitive and stigmatizing welfare system is that an increasing number of people are not claiming benefits to which they may be entitled, the so-called *deterrence effect* (Baumberg et al, 2012; Contini and Richiardi, 2012). Denise (CMHN) described how:

'We actually have a category on our [monitoring] forms now, [...] 'not working, not on benefits'. That's never been a category until 3 or 4 years ago, [...] that's a category we tick a lot, that's the shocking thing, [...] When it first appeared, I was going, bloody hell, [...] I'm glad they recognise that [...] You used to put unemployed or long term sick, but actually not working, not claiming benefits is a more accurate description of where people are at.' (GRP09: 43).

The emergence of foodbanks was another trend described by Denise. This was a form of provision that, she noted, was rarely seen before the austerity period. As a result of these processes an increasingly large proportion of the population are faced not only with poverty but destitution (Fitzpatrick et al, 2016).

In summary there is increasing evidence of the harmful effects of welfare reform, a policy agenda that is not only exacerbating mental health difficulties (Barr et al, 2016), but also appears to be a causal mechanism for them, a phenomenon we have described as 'benefits distress' (Moth & Lavalette, 2017).

2.5 Impact on human rights: addressing access, affordability, quality

While the recent Health and Social Care Act 2012 included the principle of equal priority for mental and physical health, the data presented above have illustrated how such parity of esteem is far from being realised in England. Indeed, the national human rights bodies, known collectively as the United Kingdom Independent Mechanism (UKIM) have noted that mental health services across the UK have been significantly underfunded with a range of detrimental consequences including a reduced number of beds, long waits for treatment, users forced to travel long distances for treatment and various unmet needs (EHRC, 2017a). One highly concerning consequence of this is that 75% of people with mental health conditions in the UK receive no or inadequate support from services (The Mental Health Taskforce, 2016).

The UN's Special Rapporteur has recently restated the core principles underpinning the right to mental health and examined barriers to their realisation (UN Special Rapporteur on the right to health, 2017). In this section we will address each of these principles (participation, non-discrimination, accessibility, availability, acceptability and quality) as they relate to our data and evidence from mental health services in England.

2.5.1 Participation

This right refers to the involvement of service users in the design and implementation of provision. In Section 2.4.3.2 CMHN Bridget described how an ethos and culture of supporting user participation had begun to emerge in the NHS during the 1990s in the wake of deinstitutionalisation. Don (CMHN) also lauded a more inclusive direction of travel during this period:

'In secondary care [... we] are more aware about knowing people as individuals, as personalities, as individuals, with history, with things to say [...] 'cause previously [...] we never had a good history of actually getting to know people and listening, particularly on the nursing side [...] I used to tape some sessions when I was starting off in the therapy and [service users with schizophrenia would] say, no-one's listened to me like this for 20 years [...] so I think that's a change. But as we're listening to [users], we're giving them less services.' (GRP06: 05).

Don's note of caution echoes Bridget's (CMHN) earlier point (also Section 2.4.3.2) about increased paternalism and reduced service user participation in their care in a context of cuts and managerialist reform. For Pete (service user) a participatory environment, with user involvement and peer support at its centre, is a crucial enabling factor in the management of mental distress:

'In some ways with the staff though, the best staff are the ones who recognise the peer support [...] And they're the ones who realise that we [service users] support each other and that we really rely on an environment where we're sort of leading the group, but they're facilitating it [... so we] get into areas where we feel comfortable and we have trust.' (GRP10: 3).

However this quote also highlights an important role for workers and services in offering a supportive organisational and emotional infrastructure for processes of peer support.

2.5.2 Non-discrimination

This principle addresses the right to non-discrimination in services on the basis of characteristics such as race, gender and class in mental health. This section will begin by examining participant perceptions of causal factors for discrimination experienced by Black, Asian and minority ethnic (BAME) service users. However we will also consider concerns about escalating use of compulsory legal powers and coercive forms of intervention in psychiatric settings. These concerns have taken on an unprecedented prominence in light of the announcement by the British government in October 2017 of a high-profile review of the current Mental Health Act (Samuel, 2017).

2.5.2.1 BAME service users and coercive interventions

There has been longstanding concern regarding the role of overt and institutional forms of discrimination in mental health services in England leading to the over-representation of BAME service users in the population subjected to involuntary forms of psychiatric treatment (Bradby, 2010; McKenzie & Bhui, 2007). For Adam (social worker) a failure to address institutional discrimination and workforce demographics were significant contributory factors in these processes:

'Equality and diversity, it's no longer a priority [...] so you go across the country and you will come across an all-white British workforce and particularly in the health service, whenever I sit in meetings, I am the only non-white person and it's not seen as a challenge or an issue anymore. [...] Recently our Prime Minister pledged to dismantle [...] the current Mental Health Act because of its, well, alleged discrimination, particularly in relation to the proportion, number of BME service users [...] It's not about legislation, it's about what's behind it, you know, have you considered the workforce and have you considered providing the relevant training across health and social care professionals.' (GRP08: 38-9).

2.5.2.2 Increased use of Mental Health Act and Community Treatment Orders

In addition to issues of institutional discrimination, there have been concerns about a significant increase in involuntary forms of intervention in recent years. The number of detentions under the Mental Health Act

in England and Wales has risen from 46,600 in 2009/10 to 63,622^[16] in 2015/16 with a concomitant increase in the number of Community Treatment Orders (CTOs) since 2011/12 (NHS Digital, 2016; EHRC, 2017b). There is some evidence to suggest powers to detain under the Mental Health Act have been deployed as a means to secure access to in-patient facilities in the context bed scarcity (Buchanan, 2014b).

Though none of our participants specifically articulated this rationale, a relationship between austerity cuts and the rise in detentions was widely acknowledged. Hugh (social worker) explained how, as an AMHP, he would reluctantly resort to hospital admission because of a lack of community alternatives:

'We have responsibility between looking at the bed or [...] the least restrictive alternative and there is no doubt that there are less and less least restrictive alternatives. It's not for want of us wanting to keep people out of hospital [...] but we do not have the resources to look at alternatives, [... we] look to acute settings to manage stress a lot of the time, that we could quite easily support in the community if we had the resources.' (GRP07: 3).

Mary (social worker/AMHP) also described the relationship between declining resources for preventive forms of practice in the community and an escalation of the use of involuntary mechanisms such as admission but also CTOs:

'The 1983 Mental Health Act, [is] a very longstanding draconian piece of legislation, but the amendments to it in 2007, so the Community Treatment Order in particular, is such a draconian piece of legislation and that [...] has gone hand in hand with the management of decline [...]. So you've got the decline of resources and services and then what you're saying is, we're going to get you in at the hospital, [...] but there's not many beds now, so they've reduced all the beds in acute crisis, so people who really need help don't get it and then they get it much later on and then they're more likely to end up [...] under The Mental Health Act. Then [...] when you come out, we're going to keep you on that Mental Health Act in a different way [CTO] and then usually what it means is, you're going to have to see us and you're going to have to have that injection.' (GRP06: 15).

However Mary (social worker/AMHP) also described how, in the context of increasingly scarce bed resources, the CTO itself functions as a substitute for in-patient admission:

'[Psychiatrists] will recommend CTOs 'cause there's a lack of beds, so they'll put as part of their recommendation 'try in the community with a CTO.' (GRP06: 52).

The ethical tension at the heart of CTO use is the balance between the service users' rights to autonomy and the right of access to support and treatment to improve quality of life (Taylor, 2010). Overall, our data and the wider literature indicate a worrying trend towards *both* reduced autonomy *and* declining access to resources and support (other than biomedical interventions).¹⁶

We will conclude this section on non-discrimination with brief reference to one further issue. This is the failure of the UK government to meet its much-heralded commitment to parity of esteem between physical and mental health services contained in the Health and Social Care Act 2012 and later reiterated by the Mental Health Taskforce (Mental Health Taskforce, 2016). Instead there is widespread evidence of continued underfunding of mental health services by clinical commissioning groups (CCGs), the bodies responsible for planning and commissioning local NHS services, in the context of wider NHS resource constraints (Gilburt, 2016; EHRC, 2017a).

2.5.3 Accessibility

Our data suggest that recent reconfigurations and financial retrenchment within services has reduced access to support. In this section we will examine two key dimensions, economic and physical accessibility, that were articulated by our participants.

¹⁶ This is borne out in recent research findings that suggest that, in terms of social outcomes, there are minimal longer term benefits to service users from CTOs (Vergunst et al, 2017).

2.5.3.1 Physical (geographical) accessibility

The UK Equality and Human Rights Commission has expressed concern about the dramatic increase in the number of out-of-area placements (OAPs) and its detrimental impact on service users and their families (EHRC, 2017a; Trewin, 2017). There has been an increase of almost 40% in the number of people sent out of area for mental health treatment from 4,213 adults in 2014/15 to 5,876 in 2016/17 (BMA, 2017). As a result of increased public scrutiny and concern regarding these practices the government-appointed Mental Health Taskforce recently committed to ending OAPs (Mental Health Taskforce, 2016).

A number of participants recounted the harmful impact of OAPs. Service user Pete (GRP10: 6) described being placed in an out of area bed 70 miles (100 km) from his home which left him isolated from family networks of support. Bridget (CMHN) described a service user with whom she worked being briefly admitted to an in-patient unit 140 miles (225 km) away from home. She expressed concern not only about the personal costs for the service user but also the financial implications of these practices such as revenue generation for private sector transport and healthcare providers:

'There were three Police with her and from 12 o'clock, when their shifts ended, they were with her 'til half past six in the morning, when she was put in a private ambulance, on overtime, so that's 18 hours Police overtime. Then, a private ambulance for 3 hours up to Darlington, she was in Darlington for 5 hours, when they found her a bed in East-town [home borough], a private ambulance for 3 hours, which brought her back again and then admitted to a ward in East-town, at what cost?'

The issue of public versus private funding was also raised by Abi (service user) who argued:

'[with] the money they're paying out for [private sector providers], they could fund and bring back the [local] closed wards.' (GRP10: 6).

However in spite of the human rights implications, Leah (social worker) described with regret that NHS providers' primary motivation for return of patients to their local area seemed to be financial rather than ethical:

'If you've got someone in an out of area bed, the pressure is on [... you], if you're [...] care co-ordinator, to be badgering West-town bed management every day to remind them, we need to get this person back from out of area. [...] Yeah, not to get them closer to their family [ironic laughter].' (GRP08: 40).

2.5.3.2 Economically accessibility: Charges

Our participants described reductions in economic as well as physical accessibility of services in the context of austerity. Pete (service user) noted that a number of service users were no longer able to attend his local authority day centre for support due to charges introduced since 2013/14. Emma (service user) concurred, explaining: 'it's from £ 17 a day now [...] which is a lot of money out of benefits' (GRP10: 14). She went on to describe the detrimental impact on the mental health of her partner (also a service user) both due to the stress generated by the debt he incurred through day centre charges and the restricted access and increased isolation he experienced as a consequence of his inability to afford to pay for this support.

This illustrates how, in the mixed economy of mental health service provision, out of pocket payments for non-NHS services have become more common. This trend towards introducing or increasing charges for local authority-delivered services has been one means to address the funding gap caused by swingeing real terms reductions in central government allocations to local government since 2010 (Local Government Association, 2014; National Audit Office, 2014). Moreover, the interaction between fiscal retrenchment and liberalisation/commodification of services should also be noted.

2.5.4 Availability

Availability refers to the quantity of mental health service provision. As noted above, there has been an extended period of NHS and local authority mental health service funding retrenchment and this has

prompted cost-reduction programmes that have negatively impacted on levels of both staffing and service provision (Gilbert, 2015; Moth et al 2015).

Emma (service user) summed up the overall experience of service users as follows

'There were [...] far, far more services available [15 years ago]. I think the change now is [...] everything seems to be time limited and more difficult to access.' (GRP10: 1).

She described the funding cuts to a third sector community outreach support service that affected 'about 120 service users' including her partner who used to be supported weekly but no longer receives a service (GRP10: 47). In addition to the third sector, Emma noted increased pressure to discharge service users from statutory services:

'It's almost impossible to get a psychiatrist. They're desperately trying to turf [throw] everyone long term off their books now. They wanted [my partner] to be taken off the psychiatric services, it's the only help he's got.' (GRP10: 1).

This is consistent with the emergence of gaps in provision for 'chronic' service users noted in Section 2.4.4.2. In addition to cuts in worker support, Pete (service user) described diminishing buildings-based provision:

'There ha[s] been a decrease in day centres, [...] buildings have been sold off [...] within the Council, [...] the three or four that were left [...] one of them is working on a couple of days a week and this [day centre] is the only other one apart from that, which is open five days a week, but there's a six week enablement [reablement].' (GRP10: 46).

The short-term approach identified by Pete and Emma, known as 'reablement', is a relatively new organisational model utilised, in particular, by local authority providers to achieve cost reductions. This practice approach, which has affinities with the recovery approach, claims to restore independent functioning through a period of intensive but time-limited intervention (Reidy et al, 2013; Tew et al, 2016). Leah (social worker) described the post-assessment support options she could offer as frequently limited to reablement even if longer-term support seemed to her to be more appropriate. She noted that this time-limited approach could be disruptive to emerging therapeutic relationships with the service user making:

'A relationship with one person, knowing that it's short term and then they've got to make a relationship with another one, [...] it's not the way I'd choose to do it if it wasn't restricted in that way.' (GRP08: 8).

As well as issues of reduced availability, the fraught relationship between rights and resources was a related issue articulated by Hugh (social worker). He described the contradictory dynamics opened up by the Care Act 2014, with nominal rights established but severe constraints on the resources to facilitate their realisation:

'I thought [the Care Act] would be an opportunity for the Government to kind of rail back a lot of the welfare state, which is what I think kind of post 2010 or 2015 that's what the whole Government agenda was, here we've got an opportunity to smash that. [However] the Care Act in itself raised expectations but they cut back money. [They say] we're going to put the carer at the centre of things, we're going to make safeguarding a core part of it, but in terms of the resources about what you can do with it. I think a lot of why they keep social workers is not to kind of distribute or find resources but to tell people there aren't any.' (GRP07: 37).

2.5.5 Quality

The significant negative impacts of austerity have not only been felt in the reduced *availability* of support but also in its *quality*. We noted above in Section 2.4.4.1 that in some areas there is a crumbling mental health buildings infrastructure as a result of funding constraints and disinvestment under austerity.

Louise (service user) also described how cuts led to inconsistency in staffing that undermined relationship-based practice with negative implications for mental health recovery:

'[T]here's not enough consistency in mental health support anymore because of the cuts to social care, I could say since my, I had a psychiatrist, the same one, for years and that consistency helps support and nurture and you recover, [...] consistency is everything [...] you build a relationship [...]. As the cuts came into social care, so the professionals engaging with us, suddenly

it became a merry-go-round, you would see a locum, the next time you'd see someone else again [...], never the same person twice [...] I would start to feel, and friends similarly, [...] I'm not going to engage with you, 'cause you could be gone now. [...] so there was not enough consistent relationships to [...] aid recovery.' (GRP02: 11-12).

There is extensive evidence of the importance of relationships and their quality for recovery (Mental Health Foundation, 2016). A recent survey of service user experiences of care indicated declining levels of satisfaction in relation to indicators such as being listened to by and engagement from workers (Care Quality Commission, 2017).

Another process with negative implications for service quality is downskilling of practitioners. There has been a 12% drop in FTE-equivalent NHS mental health nurses between 2010 and 2017 (Care Quality Commission, 2017), with evidence of a particular decline amongst more experienced nurses with potential implications for quality of support (Gilbert, 2015). As a consequence of this, there is both an increase in responsibility for more junior staff in statutory services, and devolving of very high levels of need to less specialist third sector services and staff (as we noted above in Sections 2.4.2.1 and 2.4.3.1). Bridget (CMHN) explained:

'A lot of people are being [...] stepped down now, with [...] major problems that are not being addressed in any way [...] Recently I've been working with somebody who was expected to go to victim support for counselling over an incident, when actually she's got major mental health problems and victim support, as we know, very good organisation, but they would not have the ability or the skills to deal with somebody who's been unwell for 35 years, who's got all sorts of other factors.' (GRP09: 19).

Another related trend is the 'downbanding' of staff pay and conditions. We mentioned earlier (Section 2.4.3.1) how Ben's support worker role was outsourced from the NHS to the third sector resulting in a significant pay cut. In a context of deteriorating pay and conditions he described it less likely that staff would 'go the extra mile' in their practice with service users.

2.5.6 Acceptability

There is extensive evidence that service users tend to value holistic and social approaches for understanding and responding to mental distress (Beresford et al, 2010; Tew, 2005). The need for this orientation to assume greater prominence and challenge biomedical dominance has been strongly advocated in a recent report by the UN Special Rapporteur (UN Special Rapporteur on the right to health, 2017).

When describing a helpful therapeutic experience in a day hospital, Emma (service user) identified the eschewal of a reductively biomedical perspective as an important factor in her satisfaction with the service: *'Although there were [...] medically trained staff there, your diagnosis wasn't really pushed or, you really were just helped ... You know, to interact, to feel better, you know, it wasn't like a horrendous diagnostic [approach].'* (GRP10: 4).

However, after a shift in services towards a more holistic approach in the de-institutionalisation period from the 1990s, Bridget (CMHN) argued that the medical model has recently regained prominence:

'I think that the expectations on secondary care patients are much greater now than they were [...] to be well and stable in a relatively short space of time [...] There was a time when the job changed [...] I was a nurse and then I was a care co-ordinator and [...] it made sense to me to be more holistic, you're looking at people's, [...] housing benefits, family issues, kids, whatever, employment, but actually now, it's become very medical again, it's a medical model, people are acutely unwell, they may be post-admission, they may be coming out, they're referred to a team, 6 months, boom, boom, that's it, back to work.' (GRP09: 29).

Denise (CMHN) pointed to the mechanism generating this reductionist medicalisation:

'You revert to a medical model when you have less time, because non-medical models in the short term take more time.' (GRP09: 59).

This reductive orientation in neoliberal mental health practice towards defensive risk management and checking of ‘meds, mood and sleep’ has been termed ‘biomedical residualism’, with liberalising and market-oriented reforms tending to reinforce this orientation (Moth, 2018).

More recently an approach to recovery underpinned by a so-called ‘work-cure’ philosophy has been deemed unacceptable by some service users. As Emma notes, new service initiatives such as recovery colleges are:

‘Very much not about people’s welfare and alleviating distress and more about getting them in the right mind-set to get themselves off benefits and get, or voluntary work.’ (GRP10: 10).

An emergent alternative to this position, known as ‘unrecovery’, will be considered in the next section.

2.5.7 Rights to recover versus right to be ‘unrecovered’

This report has drawn attention to decreasing rights to access mental health support, and coercive elements of psychiatric intervention. It is necessary to add one further dimension of rights. Emma (service user) articulated this in her description of the way discourses of recovery have been utilised in neoliberal policy reforms to delegitimise the illness experience itself:

‘I think that’s the downside [of the] recovery [model...] there’s like this terrible onus now on service users, on mentally distressed people, to recover ‘cause you’re fucking telling us you can do it and all the research is saying you can do it, so do it. That’s what I find so frustrating about it now, the way it’s been colonised by services and that is then reflected in services, in the time limit [...] so that’s the whole ethos now, is not of care for as long as you need or helping people along... it’s like you almost feel like a failure if you do that [don’t recover].’ (GRP10: 8).

Emma’s perspective suggests an articulation of the ‘right to be unrecovered’ formulated by survivor activist network Recovery in the Bin (Recovery in the Bin, no date a). This approach may be considered a form of experiential rights¹⁷ (Cresswell, 2009) emergent from the challenge by survivor movements and their allies to the neoliberal colonisation of recovery. As Recovery in the Bin (no date b) emphasise, the concept of unrecovery is not intended to signify a demand to remain unwell but rather a rejection of neoliberal appropriations or withdrawals of mechanisms of support. Mainstream recovery approaches, Spandler and Calton (2009) argue, have directed attention away from the development of supportive contexts embodying relations of solidarity in which the expression of mental distress and exploration of its meaningfulness can be envisaged and realised. In Section 2.5.1 above, Pete (service user) described therapeutic day centre environments where peer and sensitive professional support mutually interact. Such alternatives to paternalistic provision where collective, egalitarian and democratic approaches to therapeutic support are available may constitute one prototype for spaces of ‘unrecovery’.

2.6 Impact on individual capabilities

In this section we address the extent to which valued capacities and freedoms to choose and to act may be achieved by mental health service users and practitioners. In the capabilities approach (CA) framework, two key dimensions underpinning the capacity to act are: a) the individual and contextual (e.g. economic and social) means to convert resources into this capacity and, b) the freedom to use such capacity to act in the way one chooses and values (Orton, 2011). In the following discussion we consider the extent to which these criteria are met in relation to promoting claimants’ capacities to engage with support services (access);

¹⁷ First generation are political rights (‘negative’ freedom from repressive state intervention/control), second generation are social or welfare rights (‘positive’ rights to economic, health and social support from the state), while third generation are solidaristic rights to self-determination or ‘experiential rights’ (Vasak, 1982; Spandler and Calton, 2009; Cresswell, 2009). The critiques of coercive state intervention in Section 2.5.2 above align with first-generation rights, the analysis presented in the remaining sections (2.5.1 and 2.5.3 – 2.5.6) pertain to second-generation rights to forms of welfare support.

managing mental distress in ways consonant with user preferences (therapeutic options); negotiating the dependence-independence continuum in services; maintaining positive mental health and wellbeing (prevention); and realising valued forms of social participation (social inclusion).

2.6.1 Accessing and engaging support

We have already examined a number of constraints on the availability and accessibility to service users of supportive resources. These include reductions in the size and type of community teams, as well as reduced physical and economic accessibility to them due to service closures and charges.

Adam (social worker) argued that unnecessary mental distress and hospital admissions arose from a failure to provide timely access to support or forms of early intervention:

People come in to us at crisis more now than ever before, you know and often had we interviewed earlier, [it] would have made a difference, but they're coming to us [...] at a desperate stage and the only option you've got, [is] admission [...]. Because of diminishing, [...] community resources, limited early intervention and support, we [...] just respond to crisis.' (GRP08: 27).

This may negatively impact the capabilities of service users who are subjected to more restrictive and involuntary forms of intervention and treatment as a result of this delayed access.

2.6.2 Maintaining positive mental health and wellbeing

As Adam's comments in the previous section suggest, diminishing access and provision has significant negative implications for *preventative* forms of support. Louise (service user) described in Section 2.5.5 how cuts in support led to inconsistent and fragmented interventions that jeopardised her recovery by undermining therapeutic and supportive relationships.

Such difficulties are likely to be further intensified by the proliferation of short-term delivery structures rooted in recovery and reablement principles. This was an issue highlighted by Denise (CMHN). She described 'review teams whose only interest, [was to] downgrade' support packages. As a result:

People who are perfectly stable under a community mental health team [were destabilised]. The fact that you might be stable because you're under them doesn't seem to have occurred to [reviewers]. The fact that you're in a residential place and you might be stable because you're in there... [it is assumed that] you don't need that anymore [...] And it might be true [...] there might be a discussion [to be bad], but it isn't a discussion, it's a, you know, the worker going in will [...] have to downgrade a load of people, [...], and so there's an instability for staff, for users, for the support, for the residential places and all that just leaves everybody more anxious and then there's more mental illness.' (GRP09: 48).

This illustrates a diminishing acknowledgement at the policy level of the role of services in supporting users to maintain stable mental health. Moreover, as Pete (service user) noted, emotional pressures were placed on and experienced by service users as a result of a shift to time-limited service models:

It's difficult to turn around and say, I'm not ready, 'cause you feel like a failure then. You want to be positive about your own health and when someone's encouraging you by saying what they think you're capable of.' (GRP10: 6).

This highlights how an emphasis on self-reliance can, in itself, exacerbate distress, thereby negatively impacting users' capacities and capabilities.

2.6.3 Negotiating the dependence-independence continuum in services

The assumption underpinning neoliberal reablement and recovery models is that earlier more comprehensive models of service provision necessarily created and reinforced passive dependency (CSIP, RCPsych and SCIE, 2007). Emma (service user) acknowledged that there is sometimes a difficult balance to strike

between dependence and independence within services. She described a period of mental distress in the 1990s that was helped by activities and support in a day hospital:

'[It] really helped [...] Your medication was sorted out there and you did groups, but then you could go home, so it was amazing [...] you'd just want to go there forever, that's the problem, you know.' (GRP10: 2).

However she noted, in positive terms, how the service would, 'level the support for what you needed, [over time] they cut your days down, [... to] sort of wean you off' (GRP10: 2). This description of support tapering challenges the assumption that earlier service models did not seek to promote service user recovery and increased independence over time.

Similarly, in the period before short-term models were introduced to community services, Bridget (CMHN) described working with service users towards the goal of discharge:

'Our expectations were that [users'] support needs would vary as time went on. You would get to the point where people were able to move on, you would get to that point, but it would be a mutual decision, it wasn't dictated for you.' (GRP09: 10).

Bridget presents a contrast between current short-term approaches that impose time constraints with earlier community care models where mutual decision-making in relation to discharge played a greater role. Ben (support worker) also problematised the way independence promotion was deployed in the context of austerity. When significant funding cuts to the social inclusion project in which he worked were announced, the reductions were:

'[D]ressed [...] up in progressive language. Rather than money, [...] this was about self-inclusion [...] They said that we were more or less ghettoising people and [...] people with mental health difficulties had got to access mainstream provision [...] in the community.' (INT14: 2).

This has parallels with the comment by Louise (service user) in Section 2.4.4.3, that the deployment of progressive rhetoric to justify cuts and responsabilise service users has a corrosive effect on trust in public institutions (cf. Mladenov et al, 2015).

These perspectives challenge a simplistic binary that constructs earlier community care services as reinforcing dependency and institutionalisation whilst more recent neoliberal service reforms underpinned by recovery and reablement increase user autonomy and control and promote independence. Our respondents problematised limited consumerist conceptions of 'choice and control' that inform recovery-oriented service reforms. Instead a more complex and nuanced picture emerges in which it is recognised that the actualisation of greater user voice and independence requires facilitation of the enabling conditions and infrastructure for such outcomes. An alternative to retrenchment and responsabilisation of service users is to realise these goals by democratisating provision through challenges to inequities in social and political power relations both within services and in the wider society (Spandler & Calton, 2009; Lewis, 2009).

2.6.4 Managing mental distress in ways consonant with preferences

An important dimension of capability enhancement concerns not only access to resources but that these are of a type that is valued by recipients. A high proportion of participants in the study, both service users and workers, identified social and relational mechanisms as important in healing and recovery from mental distress (Mental Health Foundation, 2016). For Emma (service user):

'It's always the peer support [...] I find that's the therapeutic thing. That's the important thing, it's just getting you back to mix with other people and feel safe with other people [...] I've found in every situation, even on an acute ward, even though you're all really poorly, you still gain a lot from interacting with other [users], more so than the staff.' (GRP10: 3).

This contrasts with the tendency towards biomedical residualism in the context of practitioner time constraints that we have already examined in detail earlier.

2.6.5 Engaging in valued forms of social participation

A strong theme that emerged from participants was that resources to enhance social inclusion had diminished. Ben (support worker) described the pre and post-2012 period working in mental health community support services. Before 2012:

'You had long pieces of work. You might get somebody on a course, you might give somebody some job seeking skills, you might give people a bit more confidence, you might give people a new interest or a hobby, you know, it could be art, drama, whatever, photography, basically building up people's self-esteem and self-worth again after they've been through a really bad traumatic period in their life.' (INT14: 5).

He noted this construction of social inclusion did not reduce the concept to labour market re-engagement, 'it weren't just like employability and courses and qualifications, it was also building them culturally as well' (INT14: 10). However after a restructuring of services in 2012 he expressed concern that the focus had moved away from social inclusion to what he called 'self-inclusion' or self-management, and an emphasis on work. Emma (service user) echoed this, describing the 'contradictory effect' of a 'work-cure' orientation:

'You've got to be so poorly to access services and to stay in them, so you're not going to try to get a job and you're not going to show any keenness for voluntary work, because they'll say, oh, look at you, you're bloody marvellous, so [...] you can't win. [It's a] catch 22.' (GRP10: 8).

This highlights the perception amongst many of our participants that short-term recovery and work-focused models in contemporary service reform have paradoxical effects, promoting mechanisms that, whilst purporting to enhance service user independence and capabilities, in practice undermine these goals.

2.7 Impact on 'collective capabilities'

The report has indicated multiple ways in which processes of liberalisation and disinvestment have impacted negatively on the collective capacity of providers of mental health services in NHS, local authority and third sector (NGOs) to promote comprehensive mental health support. There has been an ongoing failure of funding earmarked for mental health services to reach its intended target in recent years (Lafond et al, 2017), with only independent (private) sector providers seeing a significant upturn in resources (LaingBuisson, 2016). These overarching trends are visible in rapidly declining in-patient bed provision and mental health nurse numbers (Gilbert, 2015; Care Quality Commission, 2017).

However our participants described a number of forms of collective agency in response to these processes. These ranged from the development of alternative mechanisms of provision to acts of contestation and resistance, and resulted in outcomes that included increased service capacity and promoted users' rights.

Our first set of examples indicates strategies adopted by service users and practitioners to enhance networks of support and social connection.¹⁸

2.7.1.1 'Under the radar' 1: Community and group work within services

Some practitioners described how, in a practice environment dominated by performance indicators and assessment and individual casework models, it was increasingly difficult to engage in forms of creative and community work that are often valued by service users. Leah (social worker) described the necessity of a 'stealth' strategy to implement such approaches:

'[It] is quite rare really that social workers do [groupwork], but we've had, [...] more funding with psychology into our CMHT [...] so there's me and three psychologists, another social worker, another OT [occupational therapist], who've worked on developing a group [...] that wasn't directed by management, it's almost like stealth groups.' (GRP08: 14).

18 This strategic orientation represents an 'interstitial' logic of transformation in Olin Wright's (2012) terms.

Similarly, Ben (support worker) described the need to work ‘under the radar’ to engage in creative community work models:

I will have some Syrian refugees, I’m also working with the Afro Caribbean community and [...] young Afro Caribbean men [...] I’ve got some funding [...] to pay for two tutors that belong to a theatre group and [...] they’re going to get service users to tell their stories in creative ways, so [they] can then go out and talk to people about the possibilities of recovery. So my job, [...] a lot of stuff, I just deliver under the radar.’ (INT14: 09).

He explained the importance of support from his line manager that enabled him to work in a way that circumvented the predominant target regime.

2.7.1.2 ‘Under the radar’ 2: Mutual support outside the formal sector

Bridget (CMHN) also advocated working outside the constraints imposed by the mainstream performance indicator and funding regime. In the context of the increasing wider difficulties in accessing support noted above, she described working alongside service users since her retirement to set up and facilitate peer support groups. She described why the groups had not sought formal funding:

No, we’re not funded [...] the reason why the group [...] is a voluntary group is [to have] no criteria, no attendance criteria, no referral criteria [...] I didn’t want any interference [from mainstream services] because we’re all equals there and I didn’t want people to not be allowed to come if they don’t turn up for a week [...] I don’t want people to say, oh well, you go to the [groups] therefore you don’t need a [NHS] service, because we’re not instead of, we are as well as. I think it’s really important that Trust don’t interfere with that, because it isn’t enough to assume that other people with illnesses or a couple of volunteers will be able to actually take over instead of what should be a statutory service.’ (GRP09: 34).

As this quote illustrates Bridget was at pains to emphasise that these groups were seeking to supplement not replace statutory provision. However their democratic ethos and lack of eligibility criteria challenged some of the more hierarchical and restrictive elements of mainstream provision. What these examples all share in common is the embodiment of a more non-hierarchical, community-focused and social-relational approach to support.

Our second set of examples illustrates diverse strategies of collective resistance to challenge the escalating use of CTOs and prevent austerity cuts to day centre provision.¹⁹

2.7.1.3 Pushing back the frontier of coercive control

Mary (social worker) explained how her community team had seen escalating use of CTOs in the context of bed cuts. However rather than constituting a lower level of deprivation of liberty than hospital admission, she felt this development actually constituted a coercive extension of ‘psychiatric tentacles [...] into the community’. She described how, there had been concern about the negative implications for the rights of service users, with social workers (AMHPs) being asked by psychiatrists to:

‘Come along and basically rubberstamp the CTO. [The team decided] we’re not doing that, you [psychiatrist] are going to have to come to the team [...] to argue your case for why you think [it’s justified] [...] We’ve tried to operate some kind of mitigation in a collective way, in a team meeting that isn’t medically driven, ‘cause you’ve got all those other [...] people [the wider team] in a room to give their opinion.’ (GRP06: 52).

She described this collective strategy as being effective in reducing the number of CTOs. In this way the community team and AMHPs were successful in improving accountability for decisions that result in deprivations of liberty, thereby pushing back the frontier of control in the medically dominated hierarchy of NHS mental health services.

¹⁹ This strategic orientation represents a ‘symbiotic’ logic of transformation in Olin Wright’s (2012) terms.

2.7.1.4 Mitigating resource reductions: action strengthens hope

Service user participants described their involvement in a campaign to save a local mental health day centre from outsourcing. Pete (service user) described what the service meant to him:

'It was [...] such a valuable service [...] that even people who'd only been there a short time or people who'd been there a long time, they knew it was special and we wanted to fight as much for the staff's jobs, as well as [...] for our own dignity and support and our lives really.' (GRP03: 29).

The protests were successful, and Pete shared his view of the benefits of this type of community campaigning:

'We had people on [local] radio, we had numerous articles in the [local newspaper], we also had [campaign] stalls, [...] Standing up [against cuts], it makes people think [and] change[s] ideas [...] And individually, we also brought each other [together] by taking those steps, [...] to organise and to [...] fight.' (GRP03: 28)

Emma (service user) described the effects of engagement in the campaign for her own mental health:

'I think that's the positivity about campaigning and being involved in things like that, is it does reduce that sense of isolation [...] and that sense of powerlessness and helplessness. And I think anything you do along those lines and even though [...] part of it [is] stressful [...] but it's still worth it, it's still worth the price [...] because you've got to have hope, that's the key thing, hope for the future, or there really isn't anything. The more voices you can add and the more alliances you can build and the more powerful you can become, then there's hope and that's what we all need, at the end of the day.' (GRP03: 28).

2.8 Conclusion: policy recommendations to counter the impact of social disinvestment

The discussion above has indicated multiple mechanisms through which the logics and practices of liberalisation have become more deeply embedded in mental health services since the 1990s. Moreover the interaction and imbrication of these processes with more recent social disinvestment trends in the post-2008 era of austerity has accelerated and intensified the reconfiguration of this arena of service provision. In particular we have noted the reshaping of the role of practitioners from providers of support to managers of care packages, with an increasing emphasis on bureaucratic demands and meeting performance indicators to secure income streams and realise market imperatives. This has served to undermine opportunities for relationship-based practice, reinforce medicalised interventions and fragment processes of care provision. Meanwhile, the devolution of accountability within provider organisations has led to more defensive forms of practice and negative risk management by frontline professionals and workers.

In the period since the implementation of austerity measures, these emergent liberalisation trends have been amplified in new short-term delivery models such as reablement and in recovery-oriented services. This is part of a wider reconfiguration of provision that has led to retrenchment of whole layers of community-based support, particularly services oriented to longer-term needs. Overall the effect of these changes has been to intensify the responsibility placed on service users to self-manage mental distress in a context of diminishing access to formal service provision. Moreover there appears to be a relationship between reduced access to preventative forms of support and escalating use of involuntary forms of treatment.

One area of increased investment has been the IAPT programme of short-term therapies in primary care settings. However there is an increasing focus on labour market activation within IAPT reflecting a growing trend towards integration of healthcare and welfare policy goals. In the context of a punitive welfare regime there are concerns about the ethical implications of both an emphasis on employment as a goal of psychological intervention and the potential for claimants to feel pressure to engage with psychological programmes.

These intersecting health and welfare policy agendas are rooted in ontologically individualist assumptions emphasising service user autonomy, choice and control delivered via market mechanisms. However these fail to recognise the constitutive interdependency between the reflexive individual and the social-relational

contexts (Van der Maesen & Walker, 2012; Archer, 2012) within which individual and collective capacities towards recovery and wellbeing may be realised. We therefore conclude by proposing specific delivery mechanisms and reforms:

- Develop comprehensive and universal provision of mental health support by the public sector, and end costly processes of competition, marketisation and performance management that fragment care and lead to biomedical residualism in practice.
- Promote a relationship-based and dialogic approach to support, underpinned by a democratic and egalitarian philosophy, with an infrastructure to support a range of peer-led and professional interventions.
- Develop collective and community-based forms of service provision that complement and underpin individualised care and therapy interventions.
- Implement new mechanisms of performance review based on service user experience and voice that are process not event-driven (to avoid perverse incentives and priority distortion).
- End the development of an active labour market-focused integration of mental health with welfare policy in light of evidence that the current punitive approach to activation is exacerbating the mental health needs of service user claimants through 'benefits distress'.
- Refocus service philosophy from individualised dependency reduction to facilitation of collective interdependencies that support community as well as individual wellbeing.
- Shift in service philosophy from the current emphasis on crisis management and coercive involuntary treatment in the context of funding retrenchment to increased social investment. However the increased funding should be directed towards addressing the wider the social determinants of mental distress from a preventative perspective utilising a public mental health approach rather than an individualised medical model.

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RE-InVEST - Rebuilding an Inclusive, Value-based Europe of Solidarity and Trust through Social Investments

In 2013, as a response to rising inequalities, poverty and distrust in the EU, the Commission launched a major endeavour to rebalance economic and social policies with the Social Investment Package (SIP). RE-InVEST aims to strengthen the philosophical, institutional and empirical underpinnings of the SIP, based on social investment in human rights and capabilities. Our consortium is embedded in the 'Alliances to Fight Poverty'. We will actively involve European citizens severely affected by the crisis in the co-construction of a more powerful and effective social investment agenda with policy recommendations.

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