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AUSTERITY BRITAIN, POVERTY MANAGEMENT AND THE MISSING GEOGRAPHIES OF MENTAL HEALTH

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In : Health and Place

ABSTRACT: This paper presents the lived experiences of individuals with mental illness as they navigate the benefits landscape in an age of welfare reform in the UK. We focus on the impacts upon their well-being and daily geographies. We articulate the relationship between welfare reform and mental health using the concept of poverty management and its 'missing geographies', in which everyday well-being and routines are dismissed by the restructuring welfare system. We liken this dismissal to a shift towards a narrower and more unforgiving mode of poverty management, where even the smallest misstep can unravel the entire edifice of everyday survival and well-being.

KEYWORDS: welfare reform; benefits system; mental health geographies; poverty management

INTRODUCTION

In this paper, we explore the lived experiences of self-identified and/or diagnosed individuals with mental illness as they navigate the benefits landscape in an age of welfare reform in the UK, and particularly its impacts upon their daily geographies and their mental health. We articulate the relationship using the concept of an increasingly narrow and unforgiving state-imposed poverty management (Wolch & DeVerteuil, 2001), which in turn creates 'missing geographies' by which the lived experiences of benefits reform overlap with mental health in largely hidden, dismissed and imposed ways. We aim to tease out both the missing geographies that this welfare restructuring may create, and the impacts upon mental well-being.

The paper is organized as follows. We first examine the broad relationship between disability and the benefits system, using a poverty management frame. More specifically, we focus on how the current welfare reform in the UK (since 2010) has squarely threatened the stability of certain key benefits for individuals with mental illness: Incapacity Benefit, Disability Living Allowance and housing benefits. Empirically, we tease out both the missing geographies that this may create – including the various impositions, neglect and misunderstandings that benefits reform creates - and the impacts upon mental well-being. The relationship between welfare reform and mental illness (and disability more generally) is framed through within the larger urge to control very poor and disabled people.

WELL-BEING, DISABILITY, THE BENEFITS SYSTEM AND POVERTY MANAGEMENT

Well-being can be defined as both the absence of infirmity and disease, but also the capacity to thrive within society. With these components in mind, there is a well-

established literature in health geography on the precarious well-being of populations deemed disabled (e.g. Hall, 2000, 2005; Hall & Kearns, 2001; DeVerteuil et al., 2007; Power, 2008; Hall & Wilton, 2017). It is also well-established that many disabled populations are disproportionately reliant on a variety of state-provided benefits, given their sustained exclusion from the labor market (Dear & Wolch, 1987; Wilton, 2003; Mifflin & Wilton, 2005; Power & Bartlett, 2018). This is particularly true for the mentally-unwell population – those medically diagnosed via WHO's International Classification of Disease, or those who self-identify – and whose reliance on welfare is typically deep and pervasive (Boardman and Rinaldi, 2013; Gewurtz et al, 2019; Mattheys et al., 2018; Wilton, 2003, 2004). Large-scale governmental social policies have long bounded the individual and collective geographies of people with mental health problems, particularly with regards to their residential circumstances: decanted from asylums into communities that sought their spatial filtering into particular parts of the urban realm; as actors in a deinstitutionalised landscape of homelessness and precarious and circulatory living; as recipients of a re-stigmatisation that sought pushback against 'care in the community' and which posited various forms of re-institutionalisation as a solution; as users of a large but unequal and fragmentary set of services provided by public, private and voluntary sector organisations; and now, as benefit-reliant individuals experiencing the rough edges of welfare reform.

Thus, any restructuring of the benefits system, in the form of so-called welfare 'reform' that tightens up eligibility and/or reduces benefits (amount, reliability), can have profound impacts on these already-bounded geographies (DeVerteuil et al, 2002; Power, 2014). An existing literature on the overall reach of reforms and their impact for health and health inequalities (Garthwaite et al, 2014;

Gewurtz et al, 2019; Pearce, 2013; Schrecker and Bambra, 2015; Warren et al, 2014) has also focused on impacts to particular vulnerable populations in specific places, including those in the UK receiving 'out of work' sickness benefits (Barr et al, 2015a, 2015b; Garthwaite 2014; Garthwaite et al, 2014; Patrick, 2014), disability benefits (Mattheys et al., 2018; Power, 2016; Roulstone, 2015), and those being penalised by the bedroom tax (Moffatt et al, 2015).

While empirically rich, the current literature lacks conceptual depth in terms of understanding the disability/welfare reform relationship that goes beyond issues of dependency to examine the long-term politics (and geographies) of managing vulnerable populations, including those with mental illness. In response, we use what Wolch and DeVerteuil (2001) termed 'poverty management', in which the presence of populations in poverty are managed through a variety of structures and motivations, ranging from purely punitive (displacing homeless people from prime urban space) to more ambivalent and supportive (providing benefits). For the mentally un-well, these structures have varied over time, from rural-based asylums to deinstitutionalization and community care designed to minimize the spillover costs associated with populations deemed societally disruptive. The current welfare system acts both as a way to support the mentally un-well in their everyday lives, but limits their lived experiences by paying only poverty-level benefits that severely restricts everyday circumstances and geographies, as well as imposing multiple conditions. In particular, we want to underscore the lived experiences of benefits reform among the mentally un-well, especially gaps around their mental well-being, daily routines and access to everyday resources. These lived experiences represent *missing geographies* and provide a vital counterweight to hegemonic government/media/policy debates on 'welfare' (Patrick, 2014). In effect, *any* welfare

reform presents particularly acute challenges for people with mental health problems, who are more likely to be unemployed than the general population (Boardman and Rinaldi, 2013), and thus disproportionately reliant on a number of interlinked welfare benefits and services for support (Mattheys, 2015). They are crucial if we are to make sense of the human cost of austerity, but also how the current benefits reform fits into the poverty management framework (or not), or if in fact poverty management is shifting as part of welfare reform. It is therefore this paper's aim to tease out both the missing geographies that this may create, and the impacts upon mental well-being, using the context of recent UK welfare reform.

BENEFITS REFORM IN AUSTERITY BRITAIN

Especially since 2010, restrictions on entitlement to sickness and disability benefits (including reassessments for ongoing entitlement), combined with a focus on 'work-led' recovery, and fundamental changes to the system of housing support for low-income people, presage both an overhaul of the UK welfare state and a recasting of its relationship with those most reliant upon it. We underline three benefits that are especially important to individuals with mental health issues, and how they have changed since 2010 – not just in terms of actual payments, but the shift in the underlying ideologies and language about who is 'deserving', which is a key component of poverty management.

First, Incapacity Benefit (IB) is the primary income substitute for those with long-term illness or disability that prevented participation in the labor market, eligibility for which was ordinarily determined by the claimant's doctor certifying them 'unfit to work' (DWP, 2010; Lowe, 2016). Despite its whiff of paternalism ('incapacity'), IB did nonetheless seek to front-load individuals' (ill) health as the dominant factor in the assessment of entitlement - what we might now think of as a

'health first' approach and one which sought to balance questions of health as well as unemployment (Warren et al, 2013). Since the early 2000s, however, the UK government has set out to determine whether the criteria for assessing both initial and ongoing eligibility to IB were sufficiently rigorous to distinguish long-term and substantive *ill-health* from long-term and substantive *unemployment*, the latter of which involved the far more conditional, lower paying and means-tested 'Jobseeker's Allowance'. This process culminated in 2008 with the abolition of IB for new claimants and the introduction of its replacement, Employment Support Allowance (ESA) (Houston and Lyndsay, 2010). Included was the requirement for all existing IB claimants to in future be reassessed for eligibility for the new benefit, the primary mechanism for which was the Work Capability Assessment (WCA). The WCA evaluated claimants on their capability for either immediate participation in the labor market or for work-related activities in preparation for future participation. The assessment assigned individuals to three groups: those who were found fit to work and could thus be transferred onto Job Seeker's Allowance (JSA); those judged capable of some work in the near future, subject to appropriate support and assistance, and who could be allocated to a work-related activity group; and those found unlikely ever to be able to work because of ill-health or disability, and who would be assigned into a 'support group'. The WCA was presented by the post-2010 Coalition government as a crucial tool for both its imminent reassessment of all existing IB claimants and its wider ambitions for a leaner welfare state.

Second, Disability Living Allowance (DLA) was a financial contribution towards the costs associated with disabled peoples' care and/or mobility needs, and was intended to assist them to live as independently as possible (DWP, 2010; Lowe, 2016). It was supplementary to other benefits - or indeed to earned income - and in

2011 was being received by 3.2m claimants, 500,000 of whom were doing so on grounds of mental ill-health. The Coalition government announced in 2010 its intention to replace DLA with a new payment entitled Personal Independence Payment (PIP). Like IB, the government promoted its reforms as being founded on the principles of fairness and sustainability. The expressed intention of the policy changes was applied in ways that maximised the opportunities for independent living for recipients, and which took into account the changing nature of disabilities over time (DWP, 2010). As with IB, the concept of independence being applied here is closely aligned with the idea of paid employment as a pathway out of welfare dependency.

PIP was introduced for new claimants from 2013, with existing DLA claimants subject to an ongoing process of reassessment (Lowe, 2016). This was conducted by Atos, the company similarly contracted to undertake the WCA, with the government explaining the requirement for reassessment of existing claimants on the following grounds:

- The conditions for which people have been awarded DLA change over time, often imperceptibly, yet there is no process to systematically check that the awarding of the benefit remains correct
- DLA offers too many automatic entitlements
- The consequence is a system that rising caseloads and expenditure have rendered unsustainable
- Thus DLA is confusing, complex and poorly understood
- Reassessment of all recipients, with periodic reviews thereafter, will rationalize the system, make it more efficient, and better targeted to those who have greatest need and will gain the maximum benefit (DWP, 2010)

Third and finally, Housing Benefit (HB) remains the principle rental assistance programme for low-income tenants, operating in both the private and social rented housing sectors (Hamnett, 2010; Lowe, 2016). The origins of the present system reflected the shift in the state's responsibility away from 'brick and mortar' social housing toward a programme of personal housing allowances and subsidies (Kemp, 2000; DeVerteuil & Manley, 2017). Expenditure on HB rose significantly from £4.65bn in 1989/90 to £20bn by 2009/10, by which time it covered 4.766m recipients (by May 2012 this had climbed to 5.03m) (Lowe, 2016). These rising costs were a consequence of both the increase in the number of households obliged to rent in the more expensive private sector, and the rapid growth in the numbers of in-work households becoming eligible (Gibb, 2015). Elements of the HB system could be seen as providing an open-ended system of financial assistance – both to tenants and their landlords (particularly in the private sector) - with insufficient checks and balances (Gibb, 2015). As part of their wider welfare reform programme, the post-2010 Coalition government announced its intention to cut £1.75bn from total HB spending by 2014/15. This would involve reducing further the maximum amounts payable locally, substantially lowering the cap for existing HB recipients¹, and, most controversially, the imposition of an under-occupancy penalty – the so-called 'bedroom tax' – in which tenants in the social-rented sector deemed to reside in a property with surplus bedrooms would be penalized by having between 14% for one bedroom and 25% for two or more bedrooms of their housing benefit withheld². Overall then, the three benefits have not only seen important financial restrictions – they have also shifted their language to further narrow those deemed 'deserving' and

¹¹ The cap does not apply to a household in which a person is in receipt of DLA

² Recipients of DLA will not be exempt from the bedroom tax

worthy of a supportive poverty management approach, and those that now must turn to the labor market and a more unforgiving poverty management.

METHODS

Within this context of reform, our sample frame of 25 was developed in late 2014 via connections to voluntary sector services that worked with individuals with mental illness, with a focus on London given its dense service provision and large population of service users. Using a snowball approach, the aim was to recruit sufficient numbers of ‘information-rich’ (Mifflin and Wilton, 2005) participants whose experiences with the benefits system could shed light on both their individual life trajectories while at the same time combining with the larger structural changes inherent in welfare reform. Notwithstanding attrition, each interviewee was re-interviewed after six and then twelve months in order to create a biographical picture that would help elucidate both the longitudinal and episodic aspects (May, 2000) that capture their mental health well-being status as it related to (changing) welfare benefit payments, but also their current mental health and everyday survival patterns. The longitudinal element of the research and personal life stories served to cement individual “outcomes within a larger suite of personal, familiar, health and welfare contexts” (DeVerteuil, 2005: 397). As a consequence of delays in participant recruitment, and the knock-on effects on the overall time allowed for the completion of the fieldwork, it only proved workable to re-interview eight participants across three different occasions. A further thirteen were interviewed twice (initially and again at the six month stage), with the remaining five being questioned once. The maximum time captured by the data collection spanned 1.5 years. Ethically, the research was done in a way to minimize intrusion into daily lives while generating a

politically-sensitive record of the impacts of welfare reform (Parr, 2000). Finally, there were five mental health service providers who had assisted in the recruitment of participants and who were themselves keen to contribute by setting their experiences of reassessment processes alongside those of participants.

All 25 service users self-identified as having mental illness, with 80% having a medical diagnosis, and all had suffered long-term effects. Four of the 25 service users interviewed were in paid employment (probably not coincidentally all in mental health) at the time of the first interview (note that all were women), one was in full-time education and claiming DLA, and five were of retirement age and in receipt of state (and, in some cases, private) pensions. The remaining fifteen were unemployed and claiming welfare benefits³. Each had experienced paid employment in the past, with the most recent instances ranging from under a year to over three decades prior to the first interviews in 2014. Without exception, all fifteen interviewees unemployed at the time of the interview related both their original loss of employment and their present status as being primarily a consequence of their poor mental health.

Table 1 summarises the principle benefits received by the twenty interviewees who were either working or below pensionable age at the time of first interview.

Table 1: Participants' benefits

	Paid employment	Incapacity Benefit or Employment Support Allowance	Job Seekers Allowance	Disability Living Allowance or Personal Independence	Housing Benefit
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³ Despite not being in paid employment many of the fifteen nevertheless undertook unpaid voluntary work which provided them with some of the 'benefits' propounded by supporters of reform (activity, structure, routines, taking 'responsibility', putting 'something back') and which they were able to manage alongside their health needs.

				Payment	
Anthony			✓		*
Christine		✓		✓	✓
David		✓		✓	✓
Donna		✓		✓	✓
Faisal		✓		✓	✓
Hannah	✓			✓	✓
Harry		✓		✓	✓
Jessica		✓		✓	✓
Jonathan		✓		✓	✓
Katherine		✓		✓	✓
Laura	✓			✓	**
Liam		✓		✓	✓
Paula	✓			✓	**
Richard		✓		✓	✓
Ruth	✓			✓	**
Simon			✓	✓	✓
Stephen		✓			✓
Susan	***			✓	*
Trevor		✓		✓	✓
Yann		✓		✓	✓
Total	5	13	2	18	15

* Anthony and Susan owned their own homes

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

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

For these twenty service users, their personal priority was the maintenance of relative stability in their mental health, as opposed to the government's one of spurring entry into the labour market. Indeed, forced entry into the labour market

represented not an escape route from benefit dependence – as government policy purportedly intends - but rather a threat to both their stability of health and their finances. Indeed, fully twelve out of the thirteen recipients of IB/ESA also qualified for the entire suite of sickness, disability, and housing benefits. Even for those in employment, benefits either as a top up to income (i.e. Housing Benefits for Hannah) or as assistance to the maintenance of employment or education (DLA/PIP for Hannah, Laura, Paula, Ruth, Susan), formed a core part of their finances. Noteworthy too is that the only two interviewees not to receive DLA or PIP – Anthony and Stephen - were also the only two service users who had not engaged with statutory mental health services and had not received a formal health diagnosis. With the exception of the five interviewees in employment or education, and Simon, who has access to additional financial support via a trust fund established by his mother, none of the other 14 service users had any sources of regular income outside of their benefits, and given this dependency, their experiences form the focus around benefits reform and missing geographies.

Benefits reform as re-assessment: Service users' experiences of well-being

The evidence from the interviews lends credence to findings from other recent studies of benefits reform (Barr et al, 2015; Garthwaite, 2014; Garthwaite et al, 2014; Gewurtz et al, 2019; Mattheys et al., 2018; Moffatt et al, 2015; Patrick, 2014; Power, 2016; Roulstone, 2015; Warren et al, 2013): that the re-assessment process is not just flawed for people with mental health problems, but is actively damaging. There was substantial reflection on the part of service users that the assessment processes simply did not appear to regard them as people with particular needs, ones that

perhaps could not always be 'seen'. This could be demonstrated in relation to the bedroom tax, whereby

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

The failure of the assessment processes to grasp the distinctive requirements of people with mental health problems, thereby rendering both overlooked and invisible, is a picture that mental health service providers recognise too on behalf of their clientele:

One of our members here [at a mental health drop in centre] that I support, I mean she actually went for an ESA assessment without any support, got bumped off it, put onto Job Seekers. And just seeing somebody who has borderline learning disabilities, has mental health issues, got physical health issues, being, you know, forced to jump through these hoops, and being threatened with being penalised because she couldn't prove that she'd done the necessary number of [job] applications that week. This is a person who has been stable for quite a period of time, coming back from each interview at the job centre more stressed and more destabilised...I managed to help her get back on ESA, and went with her for the assessment for ESA, and I did a fair bit of prompting in the interview as I knew that otherwise she'd just sit there and be flummoxed by the whole thing and be bumped back on to Job Seekers. (mental health service provider, Home Counties market town)

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

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

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

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

The delay- and backlog-prone reassessment schedule was felt to operate against people by ensuring the process was a drawn-out affair. Worse, little time would pass until service users were once again required to start preparing for another assessment:

Then, just before Christmas, I had another [letter] to say I was to be reassessed for ESA only nine months after being told I had been accepted for

it. I rung up about it and asked if it was a mistake. She said no, it's not a mistake and you've got to do it all again. I said 'surely, if you read my form, you'll see I have a long-standing condition and I've been on the thing for years and years, and I've been awarded a life award for DLA, and it shows you the things I struggle with', but she wasn't interested. (Harry)

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

I applied for DLA and then it was refused, and then I had to appeal it – which took ages and ages – and in between that I'd had my gastric bypass and I'd lost loads of weight. So I was going into the appeal with the form saying I was 24 and a half stone but, of course, I am bloomin' size twelve and so straight away it looks as if I am a lying fraud! Some of the most embarrassing things I'd had to put on the form, like toilet needs and stuff - when you weigh so much you're more likely to be incontinent - things like that. And I was mortified that I'd put in things that I hadn't even told the doctor. And I think the other trouble with personality disorder is that whole polarised, black and white thing, so if you're having a day where you're feeling good it's actually very difficult to even be reminded that a week ago, or two weeks ago, you were feeling [so much worse] ... I was almost desperately wanting – this will sound bizarre – to show them how well I was. When you actually feel good, you feel that you want to shout about it. (Hannah)

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

Both Christine and Donna spoke about the way they had been advised to behave at their next hearings, with the recommendation that they answer every

question as if it were their 'worst day'. Christine talked about feeling obliged to put on an act in order to maximise her chances of being found eligible for ESA:

This time I was primed that you have to behave in a certain way. I had to basically perform, because I don't understand why they don't believe what you say. I find it demeaning and humiliating that I have to present in a way that makes me seem worse than I really am, or that it's my absolute worst day when it's not my worst day. So I didn't make eye contact, didn't speak very much, took an advocate with me, um, all the things that they expect to see so that you tick the boxes. (Christine)

Christine and Donna's experiences are supported by mental health service providers who have sufficient experience of shepherding fearful clients through the assessment process. Along the way, they also confirm the extent to which the WCA is a hopelessly inadequate tool, and inevitably poorly administered:

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

The WCA is therefore viewed as a device in which the quotidian rhythms of mobility – such as the occasional ability to visit the local shops – are seen not as practices anchored in individuals' finely-honed methods of stability and safety, but are de-contextualised, up-scaled, and presented as evidence of individuals' capability for re-entry to the labour market. More broadly, benefits reform in the guise of re-assessment 'misses' a host of everyday, pre-existing geographies of coping, survival

and routine that stitch together the lives of service users, bounded and protective to ensure mental well-being. In the next section we recast the empirical material to think about these missing geographies, as well as tying them into the larger notion of poverty management.

The missing geographies of benefits reform: Impositions and dismissals

The sharp end of benefits reform was primarily experienced via the re-assessment process, raising key points around how the welfare system misses and misunderstands the importance of daily routines and everyday resources among service users. This in turn disrupts their bounded and protected geographies that had previously ensured a modicum of mental well-being. As a first example, if service users are able to travel a certain distance for their appointment, then according to the system they surely are not suffering from debilitating mental illness: “I do get the impression that if you manage to turn up at your assessment in [name of town] on your own that’s a mark against you because you can manage to travel to get there in the first place” (mental health service provider, Home Counties market town). The benefits system clearly misses the mundane mobility of many service users, assuming instead that they are very much house-bound.

Moreover, the entire re-assessment process invades service users’ personal geographies: service users occupy *too much* residential space; they are ‘dragged’ through the WCA process; the suggestion that service users’ competent use of public space through accurate way-finding is potentially suspect and will likely count against them in any assessment of their ‘capabilities’; even in the flesh they are unseen and uncouneted. This imposed, involuntary mobility by the WCA upon service users manifested itself in a variety of ways. For some, it was the bewilderment of “...being called into a place where they don’t know the person and all of a sudden

they're making all kinds of judgments about you" (Richard). This was compounded by compelling them into unsafe places - "...a big room full of lots of people..." in the words of Trevor, mirrored in official decision-making over the 'bedroom' tax. In these cases, benefits reform squarely dismisses the personal geographies of service users as unimportant or even wasteful.

Let us unpack this blanket dismissal in more detail, as these impositions are based on an inability to understand the different life-worlds inhabited by people with mental health problems, especially the ways through which practices of stability and security are strongly *emplaced*:

I know a lady who did make the decision she had to move [as a result of the bedroom tax], and did get support to move and did move. And she survived the move but it was... an incredibly traumatic experience, and she is very angry about it. The place where she had lived, that was her home, the place where the spare bedroom was extremely small anyway, and she's got a daughter with children who lives some distance away so it's now far harder for her family to visit her. Conversely, there is a member here who is being hit by the bedroom tax but who does not feel in a place – she does not feel robust enough to move. And, yet, she's being hit with a financial debt that she can't afford. And she is far less well than she was a year ago. And potentially she's going to get ill, and she's going to end up in hospital, which costs £400 a night, so where's the saving? (mental health service provider, Home Counties market town)

Again, the mobility here is experienced as a form of 'trauma' or violence, in which people are either uprooted, their practices of stability and safety destroyed, or remain in place but are destabilised to the point where the prospect – and cost - of hospitalisation looms. In addition to the perceived inadequacy of the WCA, service providers also spoke about its incompetent administration whereby even when

people had been found unfit to work the 'system' ensured that any respite was of short duration:

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

Individuals become entrapped across a dizzying circuit of assessment, appeal, and reassessment, in which the time and space for them to (re)locate their stability becomes ever more fleeting. Service users (and providers) have been at pains to stress the extent to which they are precariously balanced at all times between 'wellness' and 'illness'. They are acutely aware that one false move by them or, increasingly, by the state apparatus responsible for administering to their needs, could have them fall back into places darker and more troubling than the twilight world of the reassessment process. And so with varying ability to manage – hope, determination, defiance, anger, pain, bewilderment – individual service users can be seen re-orientating their practices of stability in order to cope as best they can in circumstances which are largely outside of their control.

All of these top-down dismissals, misunderstandings and impositions threaten the well-honed practices of bounded geographies by the service users even before they experienced benefits reform. As the results showed, service users worked to keep the familiar and the unfamiliar, and the safe and the unsafe, apart spatially, temporally, and emotionally so far as possible. This is typical of many people 'in recovery' (Love et al, 2012), in which place becomes highly bounded in order to

avoid feelings of doubt, fear and relapse. The fear of 'one false move' operated as a threat to the mental well-being of those reliant on benefits, making the experience of the system a constant effort to restore bounded geographies, a key discussion point for the next section within a context of an increasingly unforgiving poverty management.

DISCUSSION AND CONCLUSIONS

An overarching theme to the process of benefits reform via the process of re-assessment is how it represents a narrowing of (supportive) poverty management through its restrictive language as to who is deserving, alongside a narrowing of actual benefits and, ultimately, increasingly overlooked and dismissed everyday geographies. In effect, the top-down impositions connect not only to the wilful 'blind spots' of the welfare state, but also to the increasingly unforgiving conditions upon which support may be acquired in terms of time, space and moral integrity (DeVerteuil et al, 2002). These conditionalities speak to an increasingly 'high-altitude' poverty management, largely overlooking the lived experiences of those who must endure it, at best grudgingly supportive to some. The tightening up of the benefits system through national-scale welfare reform, whether in the UK or elsewhere, also has a tendency to be irreversible once the new system is entrenched in the bureaucracy.

More empirically, we have demonstrated how interviewees attempted to develop personal coping strategies for managing the gap between the government's expectation of an easy and ostensibly 'supported' passage into work, and their own excruciating fears of a bruising transition into something they feel ill-equipped to endure. These fears are evident whether they are actively involved at a particular stage of the reassessment process, or are continuing claimants caught up in an

atmosphere mediated by harsh political rhetoric and service user alarm. As such, these strategies take the form of protective tactics that are predicated on upholding their own 'everyday equilibrium' (Pinfold, 2000), and allude to the ways in which service users can be seen as active agents working in a multiplicity of ways at a series of different scales to determine and have control over their own pasts, presents and futures (Parr 2006, 2008). Yet this judicious balancing act can be upended by enforced movement – to an assessment, to a job centre, to a tribunal, back to an assessment, and so on - or through the menace of a 'brown envelope' dropping through the letter box (Garthwaite, 2014). Either way, new spaces of stability have to be sought or eked out of potentially unforgiving terrain.

Future research would need to pursue the longer-term effects of benefits reform beyond the immediate re-assessment period, and with what impacts upon mental well-being and personal geographies. Further, the administration of benefits reform is never straightforward – frontline workers can bend the rules to favour or punish clients. However, most of the time this 'street-level bureaucracy' imposes scarcity and even greater distancing from clients' lives and circumstances (DeVerteuil et al, 2002), particular as the UK moves towards Universal Credit and its rigid caps on overall benefits. A further factor adding complexity is the introduction of the voluntary sector in the delivery of mental health services as the welfare system recedes (DeVerteuil et al, forthcoming). While the voluntary sector can never hope to replicate the universality of the welfare system, it does offer a way to access the system and perhaps even outflank it. How the sector enables this, and crucially where it enables this, would tap into a rich vein of future research.

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