Staff experiences of working within mental health services in a socially deprived city: An Interpretative Phenomenological Analysis.

Thesis submitted for the degree of Doctorate in Clinical Psychology at the University of Leicester

by

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2014
Declaration

I Leah Clatworthy confirm that this thesis and its contents are my own original work. This thesis has been written and submitted as part fulfilment of the Doctoral degree in Clinical Psychology. I also confirm that this thesis and its contents have not been submitted for any other degree or academic qualification.
Thesis Abstract

Title: Staff experiences of working within mental health services in a socially deprived city: An Interpretative Phenomenological Analysis.

Author: Leah Clatworthy

Section One: Literature Review
The literature review investigated the association between income inequality and mental health within Britain. Eight quantitative studies were included within the review. All studies showed support for the notion that there is an association between income inequality and mental health. The results demonstrated the complexity of the relationship between income inequality and mental health. Future research is required to specifically examine the validity of Kawachi & Kennedy’s (1997) conceptual model of income inequality and mental health.

Section Two: Research Report
The research report explored mental health staff members’ understandings of the impact of social deprivation on mental health and also how these understandings influence their clinical practice. Data was collected using focus groups and individual interviews. Five focus groups and two individual interviews were conducted. Twenty-seven participants took part in the study. Interpretative phenomenological analysis was used to analyse the data. Three super-ordinate themes emerged from the data which were: ‘unjust circumstances’, ‘division’ and ‘survival’. The findings highlighted the complex nature of working within socially deprived areas. Recommendations were made in relation to how mental health services should address the challenges that working in deprived areas brings for team members and how to ensure that service users receive the most effective care from mental health services.

Section Three: Critical Appraisal
The critical appraisal focussed on a trainee clinical psychologist’s experience of conducting this research project. This included a reflection on the overall research process including a critique of the methodology used and the limitations of the research. The critical appraisal also included the trainee’s personal and professional development in relation to completing the research project.
Acknowledgements

Firstly, I would like to thank all of the participants who agreed to take part in this research study. I would also like to thank my research supervisor Dr. Steve Melluish for his continued support and encouragement throughout the process of completing this research project.

Thank you also to my partner Kate for her patience and support over the last few years.
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Section One: Literature Review

The association between income inequality and mental health within Britain: A review

by

Leah Clatworthy

To the Department of Clinical Psychology

University of Leicester

In partial fulfilment of the degree of Doctorate in Clinical Psychology

In April 2014
The association between income inequality and mental health within Britain: A review

Leah Clatworthy

Abstract

Background:
It has previously been reported that there is a strong negative association between inequality and mental health within economically developed countries. For example in economically unequal countries there are a higher proportion of people that have mental health difficulties. The UK has previously been reported as one of the most economically unequal countries in the world.

Purpose:
This paper aimed to review recent published literature that has specifically focussed on the association between income inequality and mental health within Britain. The current paper also aimed to provide an overview of the recent literature within this field.

Method:
A systematic review of the published literature that explored the association between income inequality and mental health was conducted using electronic databases (Medline, PsychInfo, Scopus and Web of Science).

Results:
Eight studies were included in the current review as they were considered to meet the specified inclusion criteria. All of the included studies used a quantitative methodology. All the included studies used a cross-sectional survey design. All studies showed support for the notion that there is an association between income inequality and mental health in Britain.

Conclusion:
The current review demonstrated that there is a complex relationship between mental health and income inequality. The complexity of this relationship therefore shows some support for Kawachi & Kennedy’s (1997) conceptual model, which describes three possible ways that income inequality may negatively affect health. Future research should aim to specifically examine the validity of Kawachi & Kennedy’s (1997) conceptual model.
Introduction

Social inequalities are a complex area of healthcare to research due to there being a number of established different key social inequality indicators that overlap each other. Examples of such indicators include: income inequality, social class, socioeconomic status and social deprivation.

Income inequality relates to the unequal distribution of income amongst a population. It may be argued that a certain level of income inequality is necessary to drive a country’s growth and progress by rewarding those people who have talent and entrepreneurial skills (Oxfam, 2014). However, the increasing evidence and concern within governments is that high levels of income inequality are damaging for a population’s health and well-being (Oxfam, 2014).

Income inequality worldwide

A recent report by Oxfam (Oxfam, 2014) stated that seven out of ten people currently live in countries where economic inequality has increased over the last 30 years; and that almost half of the world’s wealth is currently owned by 1% of the population. These are some of the reasons that ‘severe income disparity’ was rated as the fourth most concerning global risk by the World Economic Forum (World Economic Forum, 2014).

There is variation between countries in terms of income inequality and in 2011 The Organisation for Economic Co-operation and Development (OECD) reported that in OECD countries the average income of the richest 10% of the population was approximately nine times that of the poorest 10% (OECD, 2011). However, they also reported that this varies widely between countries. For example this ratio was lower than the OECD average in the Nordic countries but it was 10 to 1 in the United Kingdom and 27 to 1 in both Mexico and Chile.
**Income inequality in Britain**

*The Marmot Review* demonstrated that there is a social gradient in health in England: the lower a person’s social position, the worse his or her physical and mental health. For example, the review found that people living in the poorest areas of England would, on average, die seven years earlier than people living in the most affluent parts of the country. The report recommended that action should be taken to reduce this health gradient (Marmot, 2010).

Following the publication of *The Marmot Review* a White Paper was published in Britain named ‘Healthy Lives, Healthy People’ (Department of Health, 2010) which described the public health strategy for England. This highlights the significance of the findings of *The Marmot Review* for the British Government.

Also in 2010 the National Equality Panel reported that income inequality in Britain was at its highest in a generation (Hills, 2010). Their report also found that the level of income inequality within Britain was considered high compared to other developed nations.

In addition to this Parekh *et al.*, (2010) showed that over the last decade the richest tenth of the population of Britain accounted for a disproportionate share of growth in income. For example 39% of the increase in income over the last ten years went to the top income decile.

Recently a report demonstrated that inequality in Britain has risen sharply over the last 30 years (The High Pay Centre, 2013). The report states that the share of the national income that goes to the top 1% of the population has more than doubled since 1979 as it has risen from 6% to 14.5%. These findings show that within Britain the difference in income between the rich and the poor is continuing to grow.

**Income inequality and health worldwide**

*The Guardian* recently highlighted that income inequality has been a concern for governments worldwide over the last three decades, particularly as there is an ever growing body of evidence that supports the notion that income inequality has an adverse effect on the health of a population (Hutton, 2014).
For example Dorling et al. (2007) reported that income inequality appears to have a negative impact on health worldwide. The study found that income inequality was associated with higher mortality levels in all nations worldwide.

As well as its impact on health it has also been reported that income inequality impacts on well-being. Layard (2005) reported on the link between happiness and income reporting that countries will achieve a higher average level of happiness when income is more equally distributed.

Wilkinson and Pickett (2006) reviewed 155 studies worldwide and found that 70% supported an association between income inequality and poor population health. Their book, titled the Spirit Level (Wilkinson & Pickett, 2010) reported that more equal societies enjoy better health, less mental illness, less obesity and lower rates of infant mortality compared to more unequal societies. Wilkinson and Pickett (2010) also found that inequality affects everyone in a society and that it is not just poorer people but also educated, middle class people who fare better in more economically equal societies.

These findings were supported in 2011 by The Joseph Rowntree Foundation who published an independent review of the evidence about the impact of inequality on health (Rowlingson, 2011). The report found that there is evidence to suggest that people who live in countries that have high levels of income inequality fare worse in terms of life expectancy than people who live in countries with lower levels of income inequality. People who have high incomes that live in unequal countries also fare worse on a range of indicators (including the prevalence of diabetes, heart disease and hypertension) compared to people who have high incomes that live in more equal countries.

Similarly, a study by Franklin (2012) that was conducted in America suggested that socioeconomic factors have the largest impact on health (40%) compared to clinical care and quality of care (20%), health behaviours (30%) and the physical environment (10%).
As a result of the growing evidence about the link between income inequality and health, governments across the world have pledged to reduce income inequality and also to improve the health of their populations.

In relation to this a recent report by the British Academy for the Humanities and Social Sciences proposed nine local actions that could be implemented to reduce health inequalities in Britain (The British Academy, 2014).

**Income inequality and mental health**

Mental health difficulties are common in areas of social deprivation and poor mental health is consistently associated with unemployment, poor education, low income or material standard of living (Friedli, 2009). In 2003 Fryers *et al.* conducted a systematic review of epidemiological studies of the prevalence of common mental disorders in disadvantaged socio-economic groups. The review indicated that low income was the most salient factor when explaining the differences between socio-economic groups. Further to this a meta-analysis showed a strong dose-response relationship between the prevalence of depression and income (Lorant *et al.*, 2003).

Ahern and Galea (2006) explored the association between neighbourhood income inequality and depression among those with different levels of income. This study was conducted in New York, USA following the September 11th terrorist attack in 2001. Their results indicated that income inequality was significantly associated with depression.

This finding was consistent with a recent study that was conducted in Brazil that found that people living in areas with high income inequality were more likely to have mental disorders (Filho *et al.*, 2013). However, the results showed that although this relationship was statistically significant for depression it was not always statistically significant for anxiety. In addition to this, a recent longitudinal study that was conducted in the USA showed that living in a state with high income inequality increased the risk of depression amongst women (Pabayo *et al.*, 2014).
Kahn et al. (2000) conducted a study in the USA to examine the association of state income inequality and individual household income with the mental and physical health of women with young children. Their results demonstrated that high income inequality was related to an increased risk of poor mental and physical health.

In addition to this, Pickett and Wilkinson (2007) conducted a study within the USA and their results demonstrated that income inequality at state level was significantly correlated with rates of: teenage births; juvenile homicides; infant mortality; low birth weight; overweight children; and mental health problems.

Wilkinson and Pickett (2010) found a positive correlation between the prevalence of mental illness and income inequality in rich societies. They reported that in unequal countries there is a higher population of people that suffer from poor mental health. It is of note that the UK was one of the most unequal of the countries studied. These results support Blazer et al. (1994) who found that a high prevalence of mental health disorders was found within low-income groups in the USA.

**A conceptual model of income inequality**

Kawachi and Kennedy (1997) devised a conceptual model of the ways that high income inequality could affect the health of a population. Their model is shown in Figure 1. The thick arrows show potential causal pathways between income inequality and health. The thin lines represent confounders and downward arrows show the effects of area local covariates on individual outcomes. Finally, upward arrows demonstrate aggregation effects.
The conceptual model described above identifies three possible ways that income inequality may negatively affect health (Kawachi & Kennedy, 1997). The first suggests that areas that have high levels of income inequality are associated with poor health for individuals living in these areas. This has a consequence for the community as a whole as the model suggests that these areas would have a high number of people living in those communities who have poor mental health.

In addition to this, Kawachi and Kennedy (1997) suggested that high levels of income inequality may lead the rich people to withdraw support for public services as they can afford to pay to use private facilities. This then results in these services having less custom which can have a negative impact on these services and they can suffer as a result of this.
This can consequently affect poorer individuals who want to use those facilities, in terms of the stigma attached to use public services. However, it can also affect the community as a whole as the services can become undesirable and can fall into disrepair if they are not used.

Finally areas of high income inequality can be detrimental to people’s well-being if people are given increased opportunities to compare their situation to other people. For example Frank (1999) described the term ‘luxury fever’ to explain this concept. He reported that in areas of high income inequality, affluent people spend a lot of their money on luxury goods. The poorer people living in those areas also have the desire to possess these goods but struggle to be able to compete with the richer people to afford them.

This concept is supported by Pickett and Wilkinson (2010) who reported that greater income inequality increases both status competition and status insecurity for people living in areas with high income inequality. This has a consequence for the community as a whole as it can affect both the low and high-income people within the area.

Aim of the current review
As stated previously social inequality is a difficult area of healthcare to research due to the number of overlapping key social inequalities. Therefore the current review aimed to specifically focus on income inequality rather than any other measure of social inequality.

The results from the studies that are described above demonstrate that the association between income inequality and mental health is complex. Therefore the current paper therefore aims to systematically and critically review the published literature that has specifically focused on the association between income inequality and mental health in Britain.
Method

A systematic review of the published literature that explored the association between income inequality and mental health was conducted using electronic databases (Medline, PsychInfo, Scopus and Web of Science). The rationale for selecting these databases is outlined in Appendix B. The search terms that were used in the current review are stated in Table 2 and the rational for using these terms are stated in Table 3.

Table 2: Search terms used

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<td>Income Inequality AND mental illness</td>
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Table 3: Rationale for terms used in the search

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<td>Inequality</td>
<td>To limit the search to articles that focused on inequality</td>
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<td>Mental Health</td>
<td>To limit the search to articles that focused on mental health</td>
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<td>To capture articles that used the term mental illness instead of mental health</td>
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<tr>
<td>Mental Disorders</td>
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In total 503 articles were retrieved from this search, not excluding duplicates. All retrieved articles were collated using reference management software (Refworks) and duplicates were subsequently removed. After the duplicates had been removed the total number of articles was 283, please refer to Appendix C for further details in relation to this.

The abstracts of the remaining articles were then manually screened for relevance and those that were not considered to be relevant to the current review were excluded. The remaining articles that were considered relevant to include in the current review were selected for further analysis against the set inclusion and exclusion criteria. The following inclusion and exclusion criterion was applied within the current review:
Inclusion Criteria
Studies were required to be retrieved from peer reviewed English language journals. Only articles that specifically focused on the association between income inequality and mental health were included. Studies were required to have been published with the last fifteen years (1998-2013) to ensure that only recent articles were included within the current review. Only studies that were conducted within Britain were included due to the different healthcare systems that are in place worldwide. In addition to this only adult participants were included in the current review.

Exclusion Criteria
Any articles that were published before 1998 where deemed unsuitable for inclusion, as were articles that were not published in peer reviewed journals. Articles that were conducted outside of Britain were excluded as well as professional opinions and letters.

In addition to this papers that focussed on the association between other key social inequalities indicators (e.g. social class and socio-economic status) and mental health were not included within the current review. This was due to the fact that the current review aimed only to focus on the association between income inequality and mental health.

Measuring the Quality of Articles
Da Costa et al. (2011) reported that the use of The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) as a tool to assess the methodological quality of research studies was inappropriate and therefore STROBE was not used within the current review.

However, each remaining article was systematically reviewed and examined for its aims, sampling methods, method and participants, design, outcome measure, results and limitations. Please refer to Appendix E for further details relating to the articles that were selected to be included in this review.
From the search a total of 17 articles were examined further for possible inclusion in the current review. Of these articles nine were not considered to be appropriate to be included on one or more grounds when they were examined in detail. Please refer to Appendix D for a description of the reasons for this decision.

Eight studies were not considered relevant to the current review as they did not specifically examine the association between income inequality and mental health. A further study was not considered relevant as it focussed on the impact of income inequality on a global scale and it did not have any data relating to income inequality in Britain (Pickett et al., 2006).

**Results**

Eight studies were included in the current review as they were considered to meet the specified inclusion criteria. All of the included studies used a quantitative methodology. All of the studies used a cross-sectional survey design. Each study was ordered using the date of publication and allocated an ID code from one to eight. Please refer to Appendix E for further details in relation to this.

Two studies used the Gini coefficient to examine the association between income inequality and the prevalence of common mental health disorders. A further two studies used the 20:20 ratio measurement of income inequality to explore the association between income inequality and the prevalence of mental illness. The remaining four studies used the concentration index to specifically examine income-related inequality in mental health. Please refer to Appendix F for further details in relation to these outcome measures.

Therefore the studies within the current review were categorised in to three groups: those that used the concentration index, those that used the Gini coefficient and those studies that used the 20:20 ratio measure of income inequality. This decision was made with the aim of ensuring clarity for the reader and to reduce any potential confusion between these three types of studies.
a) **Studies that used the Gini coefficient**

Two studies examined the association between income inequality and mental health disorders using the Gini coefficient (Fone *et al.*, 2013; Weich *et al.*, 2001).

**Participants**

Participants were all respondents to national surveys of private households. Sample sizes within these studies ranged from 8191 (Weich *et al.*, 2001) to 88623 (Fone *et al.*, 2013). All participants were at least 16 years old.

**Measures used**

1. **Measures of common mental disorders**

   Fone *et al.* (2013) used the Mental Health Inventory (MHI-5) as a measure of common mental health disorders. This measure has been reported as being a robust measure of mental well-being in the general population (Ware, 1998).

   Similarly, Weich *et al.* (2001) used the 12-item General Health Questionnaire (GHQ; Goldberg & Williams, 1988) as a measure of psychological distress. The GHQ-12 is a self-administered questionnaire that has been widely used in research studies as a measure of common mental disorders.

2. **Measures of income**

   Fone *et al.* (2013) used validated gross household income estimates for 2001 to estimate the neighbourhood income (Fone *et al.*, 2007). Similarly, Weich *et al.* (2001) collected gross income data (pounds sterling per week) from participants and this was aggregated for households. Net income data were then validated against data from the Family Expenditure Survey (FES) which is used by the Department of Social Security (1992) to enable official income distribution figures for the UK to be complied.

   Income data was adjusted using the McClements Equivalence Scale (Taylor, 1995) to account for differences in the composition of households and household size.
Participants were collated in two ways according to their income. Individuals were allocated to one of eleven income bands and classified by income rank by quintile group within region.

**iii) Measure of income inequality**

Both studies used the Gini coefficient as a measure of income inequality (Fone et al., 2013; Weich et al., 2001). This measure has been reported as being the most widely used summary measure of income inequality (Weich et al., 2001). Weich et al. (2001) also reported that the Gini coefficient is advantageous as it is relatively insensitive to outlier incomes at both the top and bottom of the income distribution.

**Results**

Fone et al. (2013) found a significant association between income inequality at a regional level and poor mental health. Relatedly, Weich et al. (2001) found that income inequality was associated with poor mental health. Their results showed that in areas of large income inequality mental health difficulties were more frequent. However, it is of note that this finding only applied to the people who had the highest incomes that were living in these areas.

**Reliability of findings/ limitations**

Both studies described above used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be made, which is a weakness. However, a particular strength of the study conducted by Fone et al. (2013) was the large sample size.

Relatedly, a strength of both studies was their use of appropriate outcome measures to assess common mental health disorders. However, it is of note that the mental health scores were self-reported and they were not validated with clinical interviews which is a weakness.

A weakness of both studies was their decision to choose the Gini coefficient to measure income inequality. For example this measure has previously been criticised for not reflecting the socioeconomic dimension to inequalities in health (Wagstaff et al., 1991).
b) Studies that used the 20:20 ratio measure

Two studies used the 20:20 ratio measure to explore the association between income inequality and mental health (Pickett & Wilkinson, 2010; Wilkinson & Pickett, 2007).

Participants

Both studies recruited participants from data that was already obtained from previously conducted World Health Organisation (WHO) surveys. The ages of the participants and the exact number of participants that were included was not described in either of these studies.

Measures Used

i) Measures of common mental disorders

Both studies used data from the 1998 World Mental Health Survey Consortium (Pickett & Wilkinson, 2010; Wilkinson & Pickett, 2007). This survey was designed by the World Health Organisation (WHO) to estimate the prevalence of mental illness in different countries worldwide. No further details about this survey are given.

ii) Measures of income

Both studies focussed on the relationship between income inequality and mental health on a global scale. Therefore they did not report whether or not individual participants’ income was obtained as part of the WHO study.

iii) Measure of income inequality

Both studies used the 20:20 ratio measure to assess income inequality (Pickett & Wilkinson, 2010; Wilkinson & Pickett, 2007).

Results

Both studies found a significant relationship within the rich countries that were analysed in their study (including Britain) between income inequality and the prevalence of mental illness (Pickett & Wilkinson, 2010; Wilkinson & Pickett, 2007). This finding indicated that income inequality is positively associated with the prevalence of mental health difficulties within Britain.
Reliability of findings/limitations

A specific weakness of both studies was that they did not describe the data obtained that was specific to Britain in detail as their studies focussed on a global scale (Pickett & Wilkinson, 2010; Wilkinson & Pickett, 2007).

In addition to this both studies described the demographics of the participants and the outcome measures that were included in their studies in limited detail. For example it is unclear how valid the 20:20 ratio measure of income inequality is and therefore it is unclear to the reader how reliable the results obtained from these studies are. Therefore it is unclear how valid the outcome measures are that were used in both of these studies and consequently how this might have had a negative impact on the results obtained from these studies.

Another weakness to both of these studies was that the cross-sectional design used in the studies does not enable a cause and effect of the association between income inequality and mental health to be ascertained.

c) Studies that used Concentration indices

Four studies used the concentration index to specifically examine income-related inequality in mental health (Gravelle & Sutton, 2003; Mangalore et al., 2007; Mangalore & Knapp, 2012; Wildman, 2003). All of these studies used a cross-sectional survey design.

Participants

All four studies recruited participants from data that was obtained from large household surveys. All participants were at least 16 years old and the total number of participants ranged from 3565 (Mangalore & Knapp, 2012) to 299,968 (Gravelle & Sutton, 2003). All studies used a representative sample of participants from across the age span, a range of social classes and from different occupations.
Measures Used

i) Measures of common mental disorders

Gravelle and Sutton (2003) used the EuroQol ED-5D health assessment to measure anxiety and depression in their study. Two studies used the Clinical Interview Schedule- Revised (CIS-R) to measure neurotic symptoms and disorders (Mangalore & Knapp, 2012; Mangalore et al., 2007).

Relatedly Mangalore and Knapp (2012) also used the Psychosis Screening Questionnaire (PSQ) to measure psychosis, whilst Mangalore et al., (2007) used the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) to measures psychosis.

Wildman (2003) used the General Health Questionnaire (GHQ-12; Goldberg, 1988) to measure mental distress. Bowling (1991) reported that the GHQ was a reliable screening test for mental illness. The GHQ is also considered to have good predictive validity and content validity compared to other measures (Bowling, 1991). In addition to this Pevalin (2000) found that the GHQ is robust against retest effects and therefore it is considered suitable to use in repeated measures designs.

However Wildman (2003) reported that the health variable within the GHQ is slightly skewed it is less so for female participants. Wildman (2003) reported that despite this the health variable is useful as a measure of mental well-being.

ii) Measures of income

Both Gravelle and Sutton (2003) and Mangalore and Knapp (2012) used equivalised household income to measure income. Similarly, Mangalore et al. (2007) obtained information in relation to participant’s income using the living standards measure although they reported that using the participants’ equivalised household income would have been more preferable to increase the validity of the measurement of income in their study. Further to this Wildman (2003) used annual household income to measure income in their study.
iii) Measures of income inequality

All four studies used the Concentration Index (CI) to measure income inequality in relation to mental health difficulties. The CI is a widely accepted standardised tool for summarising health inequality (Kakwani et al., 1997).

Results

All four studies found that Britain does suffer from income related inequalities in mental health. For example Wildman (2003) found significant inequalities in mental health when individuals were ranked by income. The negative concentration indices found suggested that poor mental health is highly concentrated in lower income groups.

Related to this Mangalore et al. (2007) found marked inequality that was unfavourable towards lower income groups in relation to mental health disorders. Therefore their results showed that income inequality in relation to mental health disorders is present in Britain. This result supported Mangalore and Knapp (2012) who found that inequality in mental health morbidity both between and within ethnic groups in Britain is at least partly associated with income.

Further to this Mangalore and Knapp (2012) found that the burden of mental health disorders was greater for the lower income groups amongst Irish, White and African Caribbean communities.

Similarly Gravelle and Sutton (2003) found that of the three countries studied (England, Scotland and Wales) the effect of income inequality on health was most prominent in Wales and the least prominent in England.

Reliability of findings/limitations

A particular strength of all of the studies described above was their large sample sizes. Another strength of the studies was the appropriateness of the outcome measures that were used to assess both income inequality and mental health disorders.
However, a weakness of all four studies was that the results obtained from the questionnaires used within the four studies were self-reported and there was no follow up clinical interview to valid the results obtained. Therefore it is possible that people may not have answered accurately and this may have skewed the results obtained from these studies.

Another weakness was the fact that the cross-sectional designs used made it difficult to ascertain the cause and the effect of the results that were obtained from the studies.

Mangalore and Knapp (2012) only focussed on income- related inequalities in common mental disorders among ethnic minorities in England. Therefore their results may not be generalizable to people among ethnic minorities living in other parts of Britain. Further to this, as Mangalore and Knapp (2012) focused on the differences in the prevalence of mental disorders between ethnic groups it is unclear as to whether or not ethnic minorities in England experience a higher or lower prevalence of mental disorders than other ethnic groups living in this area.

This would be interesting to explore further and therefore further research should be conducted in this area. A final criticism of Mangalore and Knapp’s (2012) study was that due to the specific nature of their study their sample was the smallest of all the studies used within the current review.

A weakness of both Mangalore et al (2007) and Wildman (2003) was that neither of these studies used equivalised household income to measure income. This may have decreased the validity of the results obtained from these studies.
Discussion

The current review aimed to systematically examine the relationship between income inequality and mental health. From reviewing the recent published literature in this area it appears that the relationship between income inequality and mental health is particularly complex.

It is of note that all of the papers that were included within the current review demonstrated that in Britain income inequality is associated with poor mental health. For example all four studies that used the concentration index found negative results that indicated that poor mental health is more prevalent in areas of low income (Gravelle & Sutton, 2003; Mangalore & Knapp, 2012; Mangalore et al., 2007; Wildman, 2003).

Weich et al. (2001) found that income inequality was only associated with poor mental health amongst affluent participants which contradicts the above findings. Weich et al. (2001) suggested that this surprising result may be due to affluent participants from these areas being placed under more stress than affluent people living in more equal areas of Britain.

For example, Weich et al. (2001) tentatively hypothesised that affluent people living in unequal areas may feel that they have to work harder to maintain their social position and that this may consequently lead to them experiencing more mental health difficulties than lower income participants. In addition to this, affluent participants living in areas of high income inequality may feel uneasy or guilty in relation to their wealth (Weich et al., 2001).

A Conceptual Model of Income Inequality

The current review demonstrated that there is a complex relationship between mental health and income inequality within Britain. The complexity of this relationship therefore shows some support for Kawachi and Kennedy’s (1997) conceptual model which describes three possible ways that income inequality may negatively affect health.
Kawachi and Kennedy’s (1997) conceptual model could therefore be used to explain the relationship between income inequality and mental health in Britain as follows: Britain currently has high levels of income inequality and this then may lead to poor mental health on both an individual and a community level. For example this is detrimental for the individuals living in high areas of income inequality as they are more likely to suffer from mental health problems. It is also detrimental to the community as a whole to have a high concentration of people that experience mental health problems in terms of the strain that this may have on mental health services in the area.

In addition to this, the Kawachi and Kennedy’s (1997) conceptual model suggests that the high level of income inequality in Britain may have led the rich to withdraw support for public services which consequently has a decline in individual and community health. This relates to affluent people choosing to use private services (e.g. health clubs) rather than using the services that the local authority provides. This may lead to a stigma being developed in relation to using these facilities: only people who can’t afford to pay for a private gym use these services.

This can make these services undesirable and consequently individuals may choose not to use them. However this not only affects the individuals who may struggle to afford to use a private service and also the community as a whole. For example, the community suffers if these services are not used over a long period of time as they can fall in to disrepair or even be removed from areas in Britain where they are not considered to be needed.

Finally, the model suggests that high level of income inequality in Britain may have increased the opportunity for people to compare their situation to others, which may have led to a decline in health at both an individual and community level (Kawachi & Kennedy, 1997).
The latter point is related to Oliver James’ notion of ‘Affluenza’. James (2007) suggested that in affluent societies people can place a high value on acquiring money and material possessions. He reported that these values can increase a person’s vulnerability to experiencing mental health difficulties.

In relation to this, De Botton (2004) reported that if people fail to maintain their position in a social hierarchy then they may experience shame which can consequently lead to mental health difficulties.

Limitations of the current review
Further to this two studies that were included within the current review specifically focused on specific areas within Britain and therefore their results may not be generalizable to other areas of Britain. For example Fone et al. (2013) examined an area in Wales, whilst Mangalore and Knapp (2012) specifically focused on England.

Relatedly, the current review only included studies that were conducted within Britain and therefore it is possible that the findings obtained may not be generalizable to other countries. However, the current review does have clinical implications for health care services within Britain.

Another limitation of the current review was that it only focussed on the association between income inequality and mental health. Income inequality is only one indicator of social inequality and therefore it is unclear as to whether other confounding variables such as other social inequality indicators e.g. social deprivation, may have biased the results obtained from the studies included within this review.

However, it was considered appropriate when conducting the current review to only include studies that specifically focussed on income inequality and mental health to be able to effectively appraise studies that researched the same area of social inequality.
Clinical Implications

The results of the current review suggest that the association between income inequality and mental health is complex and this should be acknowledged when planning the provision of health care services within socially deprived areas of Britain.

An example of how this could be operated was highlighted in a recent report written by The British Academy for the Humanities and Social Sciences. Within the ‘If you could do one thing’ report (The British Academy, 2014) Clare Bambra described taking a ‘health first’ approach to addressing socioeconomic health inequalities by reducing health –related worklessness. This would therefore require both the National Health Service (NHS) and Local Authorities to work together to establish ways to address this issue at a local level.

Pickett and Wilkinson (2010) suggested that to reduce income inequality within Britain, income should be redistributed more equally through taxes and benefits. They also suggested that trade unions may play a key role to enabling this strategy to be implemented.

Future Research

In spite of good evidence of a link between income inequality and psychological distress, mental health services with Britain are still based around a ‘social’ and a ‘mental health’ dichotomy. However, the way that professionals who are currently working within deprived areas conceptualise the relationship between inequality and mental health would be of clinical significance consequently it ought to be explored.
References

* denotes which references form the basis of the current review.


Section Two: Research Report

Staff experiences of working within mental health services in a socially deprived city: An Interpretative Phenomenological Analysis.

by

Leah Clatworthy

To the Department of Clinical Psychology
University of Leicester

In partial fulfilment of the degree of Doctorate in Clinical Psychology
In April 2014
Staff experiences of working within mental health services in a socially deprived city: An Interpretative Phenomenological Analysis.

Leah Clatworthy

Abstract

Purpose
The study aimed to explore MDT staffs’ experiences of working in deprived communities and to explore how these understandings influenced their clinical practice.

Method
A qualitative methodology design was used within the current study. Data was collected using both focus groups and individual interviews. Five focus groups and two individual interviews were conducted. Interpretative Phenomenological Analysis was used to analyse the data. Twenty-seven participants took part in the study.

Results
Three super-ordinate themes emerged from the data which were: ‘unjust circumstances’, ‘division’ and ‘survival’.

Conclusion
The findings highlighted the complex nature of working within socially deprived areas. Recommendations are made in relation to how mental health services should address the challenges that working in deprived areas brings for team members and how to ensure that service users receive the most effective care from mental health services.
Introduction

Inequality and mental health
Issues surrounding inequality and mental health have been widely researched over recent years and as a result of this there is a significant literature base within this area. For example a number of studies have found evidence in relation to the social determinants of mental health problems (Lewis et al., 2003; Weich et al., 2001; Wiggins et al., 2004).

There has also been a wealth of published studies that have focussed on access to mental health services. Examples of recent studies in this area include: Soomro et al., 2002 and Sundquist and Ahlen, 2006.

However, the current debate in relation to inequality and mental health has specifically focussed on ‘inequality’ in terms of how the social determinants impact differentially on people and in terms access to mental health services (Friedli, 2009; Marmot, 2010; Rowlingson, 2011).

The Sainsbury Centre for Mental Health (2009) reported that mental health conditions are consistently associated with the following factors: unemployment; poor education; low income and poor standard of living; poor physical health; and adverse life events. The report also stated that mental health stigma and discrimination can exacerbate wider social and health inequalities.

In addition to this research has demonstrated that income inequality is associated with poor mental health (Fone, et al., 2013; Lang et al., 2011; Mangalore et al., 2007). These results support Lewis et al., (1998) who found that higher rates of mental disorder were associated with lower socio-economic status.

There is also evidence that social position has an impact on a person’s mental health. Marmot (2010) found a positive association between higher occupational social class and better mental health. They also found that steeper social hierarchies have a greater negative impact on people’s well-being.
Wilkinson and Pickett (2010) demonstrated that there is a strong positive association between income inequality and the prevalence of mental illness in economically rich countries. This finding was supported by Rowlingson (2011) who conducted a review of the evidence that focussed on the impact of income inequality on health and social problems.

Research has also demonstrated that there is a high prevalence of mental disorders amongst people living in areas of social deprivation (Power et al., 2002). Pickett et al., (2006) found that socio-economic disadvantage was associated with higher rates of mental illness.

Relatedly a recent study by Vallée et al. (2011) examined the relationship between social deprivation and mental health in Paris. They found that people living in deprived areas of Paris were significantly more depressed that those living in more affluent neighbourhoods.

**The subjective experience of living in socially deprived areas**

Research has also focussed on the experience of living in poverty. In 2013 the charity Barnardo’s interviewed a number of service users who had accessed either family support services or Barnardo’s children’s centres within the UK. Their results showed that low-income families increasingly felt that the rising costs of food, energy bills, transport and childcare were putting a strain on their household budget (Smith & Mathers, 2013).

The results also demonstrated that service users were buying unhealthier foods because healthy food, such as fruit, was deemed as being too expensive. Service users also reported that they had tried to cut back on heating their house. Therefore many of the ways in which service users were trying to save money was at the detriment to their health and/ or wellbeing.

One participant was quoted in the report as feeling tired as a result of living in poverty. She reported that she managed this situation by reminding herself that her and her family will cope and that they will be fine. However, she also reported that it was particularly hard to cope when the whole community was feeling tired and experiencing the same difficulties.
In relation to this Ridge (2009) conducted a review of qualitative research studies that focused on the ‘lived experience’ of poverty. This indicated that for people who live in socially deprived areas, the experience affects every aspect of their lives. Ridge (2009) also found that living in socially deprived areas can be particularly damaging for children. The effects of living in poverty are not only restricted to economic and material disadvantage but also limit children’s’ opportunities for social and relational development.

In addition to this, Ridge (2009) found that children reported feeling shame and sadness and that family life can be uncertain for low-income parents living in areas of social deprivation. The review also found that a family’s equilibrium is often destabilised by other internal or external factors such as unemployment and these additional pressures increase the family’s vulnerability to debt and homelessness.

CMHT or mental health practice in deprived areas
Very little research that has been conducted previously has specifically focussed on the clinical practice of CMHTs within socially deprived areas. However, many studies have been conducted that have focussed on particular aspects of how mental health service delivery is related to social deprivation such as hospital admission, referral patterns and attrition.

The majority of research that has been conducted in this area has used a quantitative design and has predominately focussed on correlations between social deprivation and the prevalence of mental health disorders, psychiatric admission rates and referral rates to CMHTs.

Self et al. (2005) studied the relationship between social deprivation and attrition from therapy. Their results showed that social deprivation was associated with attrition from therapy at two stages of the treatment pathway: attendance at the first appointment; and the early stage of attending therapy. However, it is of note that this relationship was not found in the other stages of the treatment pathway. This indicates that social deprivation may be a barrier to service user engagement during the two identified stages of therapy.
Kingsford et al. (2010) explored the association between social deprivation and treatment outcome for a Crisis Resolution and Home Treatment (CRHT) intervention. Their results showed that social deprivation was associated with poor treatment outcome. Their results also demonstrated that service users who were referred from the local enhanced CMHT to the CRHT service were significantly more likely to live in a socially deprived area than other participants.

The link between social deprivation and referral to CMHTs has been extensively researched over recent years. For example Soomro et al. (2002) found a low positive correlation between outpatient referral rates to a CMHT in London and a social deprivation index. This suggests that there is an association between living in a deprived area and being referred to a CMHT.

In addition to this Sundquist and Ahlen (2006) found that neighbourhood socio-economic deprivation was associated with a first psychiatric hospital admission, after adjusting for both individual demographic and income characteristics.

Little research has specifically focussed on the experience of health and social care staff who work within socially deprived areas, CMHT staff understandings of the relationship between social deprivation and poor mental health, and how this understanding influences both individual clinical practice and team clinical practice.

The impact on staff who work in socially deprived areas

Whilst there has been substantial research into the lived experience of people in poverty, how social deprivation affects mental health professionals who work in such areas has not been explored to date.

The impact of social deprivation on staff is of particular importance for members of health and social care teams working in such areas. A number of research studies have looked at the impact that working in community settings has on staff (Burnard et al., 2000, Edwards et al., 2000; Wynn & Low, 2008).
Prosser et al. (1996) compared levels of mental health, burnout and job satisfaction amongst hospital and community-based mental health staff within a socially deprived area and they found that community based staff scored significantly higher on the General Health Questionnaire-12 (GHQ-12) and the Maslach Burnout Inventory emotional exhaustion component. This difference was significant even when other job characteristics and demographic variables were accounted for.

O’Brien et al. (2011) interviewed both general practitioners (GPs) and practice nurses (PNs) in Scotland to gain an understanding of their experiences of managing multi-morbidity in deprived areas. Although this study is not directly related to mental health it is one of the few studies which have focussed on members of staffs’ experiences of working in deprived areas. O’Brien et al. (2011) also found that some staff working in deprived areas described their work as being ‘exhausting,’ ‘demoralising’ and ‘overwhelming’.

However, other staff reported feeling ‘energised rather than de-energised’ by working in a deprived area and that it was a ‘privilege’ to be able to work in this area (O’Brien et al., 2011). This indicates that although working in a socially deprived area can be complex and difficult at times, it can also be rewarding for practitioners.

The practitioners reported that they managed the difficulties of working in a socially deprived area by maintaining appropriate boundaries with their clients, exploring the positive aspects of the client’s life with them and trying to accept that at times the practitioner is unable to change a person’s life (O’Brien et al., 2011). The study also highlighted the need for developing appropriate support for practitioners working in deprived areas.
There have been few qualitative research studies conducted in this area and therefore little research has specifically focussed on the experience of healthcare staff who work within socially deprived areas, CMHT staffs’ understandings of the relationship between social deprivation and poor mental health and how this understanding influences both their individual clinical practice and the clinical practice within the team as a whole.

In addition to this the power imbalance between service users who live in socially deprived areas and mental health professionals who work within these areas may contribute to the service user feeling that the professional is an ‘outsider’ who will not be able to adequately understand the context of their difficulties and therefore be unable to help them. For the mental health professional, there may be a similar sense of feeling like an ‘outsider’ who does not know how to fully understand the person’s difficulties, particularly if they themselves are from a more affluent background.

**Current study**

Contemporary mental health services in Britain may discuss issues of social inclusion/exclusion; however they appear to fail in both their practice and their theoretical understandings to address the wider social context of those who present with mental health needs. For example Carpenter and Sbaraini (1997) found that mental health service users consistently reported the importance of social factors such as housing and finances, but that mental health services consistently failed to address their social needs.

In the past the community mental health movement of the 1960s and 1970s attempted to work using a social model. It is of note that social models are also incorporated within the voluntary sector but less so within NHS services. An example of this is the Women’s Therapy Centre, which is a charity in London.
However, it is unclear how staff working within contemporary CMHTs in Britain that cover socially deprived areas make sense of the relationships between social determinants and mental health problems, and how these relationships impact on their clinical practice. Few published research studies have specifically investigated mental health professionals’ understanding of the association between mental health and social deprivation.

Aim of the current study
In the past many studies (Lewis et al., 1998; Pickett et al., 2006; Power et al., 2002) have focused on the complex association between mental health and social deprivation. However, few studies have specially focused on the experiences of clinical staff who work in mental health teams within socially deprived areas of the UK.

Therefore the current study aimed to explore: healthcare professionals’ understandings of the association between social deprivation and poor mental health and how it influences both their clinical practice and the practice of the wider team. The current study therefore aimed to explore the views of multi-disciplinary staff members working within three city CMHTs and Social Care teams in a city that was located within the Midlands in the UK.

Therefore the main objective of the current study was to explore clinical staffs’ understandings of social deprivation and to ascertain how this knowledge influences their current clinical practice. The results of the current study aimed to inform how future practice may be changed to help CMHT staff to incorporate this knowledge into their own clinical practice.

It was anticipated that the results of the current study would inform future practice by raising the awareness of the association between poor mental health and living in socially deprived areas and also encourage professionals to use this knowledge to inform both their and their team’s clinical practice when working in socially deprived areas.
Research Questions
The current study focussed on the following two research questions: what are multidisciplinary team (MDT) members’ understandings of the impact of social deprivation on mental health; and how do MDT team members’ perceptions of social deprivation influence mental health clinical practice within city CMHTs?

Method

Study Design
The present study used a qualitative design to explore staff members’ understanding of social deprivation and the impact that this has on clinical practice using focus group and individual interviews. A qualitative design was considered to be appropriate to allow the study to develop a rich description of both phenomena and process. For example, a qualitative design enabled a deeper description of staff members’ understandings of the impact of social deprivation on mental health to be analysed than could have been achieved using a quantitative methodology.

A focus group methodology was used to provide an opportunity to gain a rich understanding of how the multidisciplinary teams’ approaches the issue of social deprivation and how this understanding influences the clinical approach of the teams and of the individual staff within it.

Five focus groups were conducted in the present study. It is of note that one focus group (Region 3) was a mixed social care and CMHT group as unfortunately it was not possible to arrange two separate focus groups for these teams. For further details in relation to this, please refer to the critical appraisal chapter.

Focus groups were chosen as they were felt to facilitate members of the team to discuss the issue together and allow for new ideas to be co-constructed by the participants. It has also been reported previously that a group discussion may also elicit more experiential reflection than an individual interview (Palmer et al., 2010).
Further to this Palmer "et al." (2010) found that the use of a natural group of participants in their study had a positive impact on participants’ engagement in the research.

Flowers "et al." (2001) stated that focus group dynamics added an extra part of their analysis which would have been missed if individual interviews had been conducted. These latter points appeared relevant to the current study as all focus group participants were colleagues and therefore knew each other relatively well. However, the potential problem with focus groups is that the relationships between staff in the focus groups may have prevented frank and open discussions taking place during the sessions.

Two individual interviews were conducted to enable team members that had expressed an interest in taking part in the study but were not available to attend the focus group sessions to take part in the study. Despite attempts to make the focus group sessions as accessible as possible for team members, it was not possible for all team members who had expressed an interest in taking part in the study to meet at the same time on two separate occasions during the current study.

It was considered appropriate to conduct individual interviews rather than exclude the two team members from the study as it was anticipated that their contributions would be valuable to the study. This was considered to outweigh the difficulties of having a mixture of focus group and interview data which was acknowledged by the researcher as not being ideal. However, it is of note that a combination of individual interview and focus group data has previously been used within published studies (Flowers "et al.", 2000; Flowers "et al.", 2001; Flowers "et al.", 2003).

**Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis (IPA) has a history of being used within health and clinical psychology research (Smith "et al." 2009). IPA is concerned with meaning and processes instead of incidents and causes.
Therefore the intent of IPA is exploratory rather than explanatory (Larkin & Thompson, 2011). As the nature of the present study was exploratory IPA was considered to be an appropriate type of analysis to use. IPA is focussed on the ‘lived experience’ (phenomenology) of participants and this was considered to be relevant to the current study as it focused on staff members understandings’ of the relationship between social deprivation and mental health and also how this relationship influences their clinical practice. IPA has previously been used within a CMHT context to explore CMHT staff members’ perceptions of complex clinical presentations (Donnison et al., 2009).

IPA is concerned with individual subjective experience and therefore semi-structured individual interviews have previously been reported to be the preferred method of data collection using IPA (Smith et al., 2009). Individual interviews are suited to in-depth and personal discussion as they allow for a rapport to be developed between the researcher and the participant.

Combining subjective experiences in a focus group setting is complex and potentially problematic. It has previously been reported that using IPA within a focus group methodology requires recognition of the difficulty involved in applying experiential analyses to complex social interactions (Smith et al., 2009).

Similarly, Tompkins and Eatough (2010) provided an in-depth reflection on the use of IPA with focus groups and reported that adjustments to the data analysis process, away from traditional IPA, need to be made when using focus groups. For example being aware of the group dynamics that are present within the focus group and including this in the data analysis.

However, it is of note that several published studies have used IPA within a focus group methodology (Dunne & Quayle, 2001; Flowers et al., 2000; Flowers et al., 2001; Flowers et al., 2003; Palmer et al., 2010). Therefore IPA was considered to be appropriate to use for focus group data, although on these occasions it is important for the researcher to appreciate and recognise the additional complexities of analysing focus group data (Smith et al., 2009).
IPA researchers usually attempt to use a reasonably homogenous sample to ensure that all participants have an understanding of the topic being studied and that the research study will be meaningful to the participants (Larkin & Thompson, 2011; Smith et al., 2009). The current study was considered to use a homogenous sample as all participants were staff members working within city CMHTs/ Social Care teams within the area that was studied.

It is acknowledged that other methods of qualitative analysis, such as narrative psychology, could have been used within the present study. The use of narrative psychology would have focussed on the stories that the participants told about their experiences of working in mental health services within socially deprived areas. However, IPA was chosen as it was considered to be the best method of capturing the participants’ shared lived experience of working in socially deprived areas, for example, participants’ shared understandings of the role that social deprivation had on the mental health of their service users and how social deprivation had influenced their teams’ clinical practice.

The present study focussed on how the participants experience the concept of social deprivation and how this influences their clinical practice. Therefore, IPA was used to interpret the salient themes that arose from the data obtained from both focus groups and individual interviews.

**Transparency and Reflexivity**

The transparency of the results and the reflexivity in relation to the process of analysis was prioritised by the researcher to ensure the quality of the research. Yardley (2000) previously reported that providing a transparent and coherent account of the research was important when assessing the quality of a qualitative research study. Therefore, the researcher aimed to provide a clear and coherent account of how the research was conducted to support the reader in understanding how the results were derived (Smith et al., 2009).
Self-reflexivity relates to how sensitive the researcher is in relation to how they influence the research process. It is of note that the researcher is not able to completely separate their beliefs and perceptions from the research and therefore qualitative researchers should aim to ‘bracket’ their own values (Elliott et al., 1999).

Therefore, during the research process the researcher attempted to ‘bracket’ her own beliefs and values by keeping a reflective diary and utilised supervision to aim to ensure that as far as possible the interpretations that were made were not biased. An example of this was the researcher’s frustration when interviews were cancelled. The researcher made a note of her feelings in relation to this issue and recorded them in her reflective diary. This was done to remind the researcher of her own biases and therefore to reduce the likelihood of these biases affecting her interpretation of the data obtained from those teams.

**Researcher’s background**

The researcher in the present study was a trainee clinical psychologist and the research was conducted as part of her Doctorate in Clinical Psychology course training requirements.

The researcher had an interest in social inequality due to her previous experience of undertaking a placement within a CMHT environment within a socially deprived area. The researcher observed many staff members commenting on the difficulties of working with service users who have complex health and social care needs. As a result of this, service users’ social needs and their environment (e.g. housing, income) may also have to be addressed by mental health services before any traditional therapeutic work can be undertaken successfully. The researcher consequently became interested in understanding how clinicians may alter their practice when working in socially deprived areas.

The researcher’s epistemological position can be described as ‘critical realist’. Critical realism argues that individuals attach different meanings to experiences because each person experiences different parts of reality (Fade, 2004).
This is relevant to the current study as critical realism would argue that each participant would attach a different meaning to their experiences of working within a socially deprived area as each participant would experience a different reality. Please refer to Appendix G for further discussion on the researcher’s epistemological position.

Research Context
The present study was conducted within a city in the Midlands in the UK. There were three CMHTs and three corresponding Social Care teams that covered this city, and clinicians from all six teams were offered the opportunity to participate.

In 2010 the Index of Multiple Deprivation (IMD) demonstrated that this city had a high level of social deprivation (Department for Communities and Local Government, 2011). The IMD includes seven domains: employment, health and disability; education; skills and training; barriers to housing and services; crime; income; and living environment. It is of note that the county that surrounded the city scored as less deprived on the IMD (Department for Communities and Local Government, 2011).

Participants
A purposive sample of staff members working within the three CMHTs and the three corresponding Social Care teams from the same city in England was obtained. These teams covered the whole of the city. The sample was considered to be homogenous as all participants worked within mental health services within the city and therefore had an understanding of the impact that social deprivation has on mental health. The current study was also relevant to participants as it focussed on their clinical practice.

There is currently a debate within the field of qualitative research in terms of sample size. At present the general consensus appears to be that the ideal sample size will depend on the individual research question, the type of qualitative methodology used and practical aspects such as the time that the researcher has to obtain data.
This debate is summarised by Baker and Edwards (2012) in their review paper. In relation to the current study, three to six interviews have previously been reported as being sufficient for a research project using IPA (Smith et al., 2009).

It has also previously been reported that four to five people is an appropriate size for a focus group using IPA (Smith et al., 2009). Within the current study each focus group included between four and eight participants (mean = 5.0, s.d. = 1.73).

**Inclusion and Exclusion Criteria**

*Inclusion Criteria:* Mental health professionals working within one of the three CMHTs or the three corresponding Social Care teams.

*Exclusion Criteria:* Mental health professionals working in CMHTs and social care teams within the county were excluded from the study. Non clinical staff members were also excluded as the present study focussed on clinical practice.

**Final Sample**

Participants were recruited for the current study from members of clinical staff working within all three CMHTs and the corresponding social care teams within a specified city. In total 27 participants took part in the study. Table 7 demonstrates the demographic characteristics of the final sample.

The teams were multi-disciplinary and therefore the present study included members of staff from the following professions: Community Psychiatric Nurses (CPNs); Clinical Psychologists; Occupational Therapist; and Social Workers. Unfortunately none of the teams’ Psychiatrists chose to participate in the current study without stating their reasons for this.
### Table 7: Aggregated demographics of the final sample

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number of participants of this profession</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Number of years working in current service</th>
<th>Number of years working within mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>3</td>
<td>44-50</td>
<td>Males=2 Females=1</td>
<td>White British=3</td>
<td>0-15</td>
<td>16-30</td>
</tr>
<tr>
<td>CPN</td>
<td>7</td>
<td>27-59</td>
<td>Males=3 Females=4</td>
<td>White British=7</td>
<td>0-30</td>
<td>8-30</td>
</tr>
<tr>
<td>Team Manager</td>
<td>3</td>
<td>49-59</td>
<td>Males=3 Females=0</td>
<td>White British=2 Indian=1</td>
<td>14-27</td>
<td>17-33</td>
</tr>
<tr>
<td>Social Worker</td>
<td>8</td>
<td>43-60</td>
<td>Males=2 Females=6</td>
<td>White British=4 British Asian=3 Pakistani=1</td>
<td>1-21</td>
<td>7-39</td>
</tr>
<tr>
<td>Social Care Assistant</td>
<td>3</td>
<td>26-41</td>
<td>Males=0 Females=3</td>
<td>White British=1 British Asian=2</td>
<td>0-2</td>
<td>0-11</td>
</tr>
<tr>
<td>Other CMHT staff members</td>
<td>3</td>
<td>36-45</td>
<td>Males=1 Females=2</td>
<td>White British=3</td>
<td>0-26</td>
<td>0-26</td>
</tr>
</tbody>
</table>

### Procedure

#### Ethical Approval

The researcher obtained ethical approval and permission to access participants from a UK NHS Trust in January 2013. During the research process two additional amendments were made to the research proposal (to increase the number of focus groups to enable the three Social Care teams to be included, and to use individual interviews on occasions where focus groups could not be facilitated). Ethical approval and permission to access participants was obtained on both these occasions. Please refer to Appendices H, I, J and K for the relevant documentation in relation to this.

All participants were made aware that: the data collected would be kept confidential; audio and video-recordings would be password protected; and all identifying characteristics would be removed during the transcription process. Participants were informed that they would be able to withdraw from the study if they chose to do so and informed consent to take part in the study was obtained from all participants.
Informed consent was obtained from each participant before the interviews began. Please refer to Appendix M for a copy of the consent form. Participants were given the researcher’s contact details and advised to contact them after the session if they felt distressed by the content of the session.

In addition to this, participants were informed that they could withdraw their consent to take part in the study until the point of transcription when the data was made anonymous by the researcher. Each participant was given a number and any information that could potentially lead to their identity being discovered was removed.

All data was stored securely and demographic data was stored in written form only and kept separately from typed interview transcripts and video and audio files. Also, as participants in any one focus group were likely to be acquainted with each other they were advised that all comments made during interview were private and were not to be shared outside the interview in a way that identifies another participant.

**Initial feasibility discussions**

The researcher initially discussed the feasibility of the present study with the CMHT team managers prior to the application for ethical approval. After ethical approval was obtained further discussions took place between the researcher and the team managers.

**Recruitment**

Recruitment took place between May 2013 and January 2014. Following the preliminary discussions with team managers the researcher introduced the present study to the teams by presenting the research proposal at team meetings (one per team).

After this meeting had taken place the team managers circulated the participant information sheet to all members of their teams which explained the purpose of the research and what would be involved if participants decided to take part. Please refer to Appendix L for a copy of the participant information sheet.
Data collection method and interview schedule

The present study used semi-structured interviews to collect the data. Interviews were conducted in either a focus group format or individual interview. Each interview was approximately an hour in duration. The interview schedule was developed to guide the interviews and a copy of this can be found in Appendix N. All interviews were conducted at each team’s base as this was considered the most convenient location for participants.

All interviews were conducted by the researcher and were audio-recorded. All focus group sessions were video recorded in addition to being audio-recorded to ensure that each participant’s contribution to the interview was accurately recorded by the researcher when transcribing the data. Following each interview the researcher used a reflective diary to increase reflexivity as stated previously.

Analysis of data

After each focus group interview had been conducted the researcher watched the video-recording (where appropriate) and transcribed the content verbatim. Any pauses in conversation were noted. The researcher then listened to the audio-recording to check for accuracy as this recording was clearer than the video-recording. After the individual interviews the researcher transcribed the data using the audio-recording because no video-recording was available. This process enabled the researcher to become fully immersed in the raw data.

The data was then analysed using IPA. The researcher followed a published protocol for using IPA when analysing focus group data due to the additional complexities that are involved with this type of data (Palmer et al., 2010). The first stage involved highlighting any objects of concern that the participants reported and any experiential claims. Please refer to Appendix O for an example of a stage one coding sheet. The second stage focussed on positionality, which explored the researcher’s role and the function of statements that were made by participants.
The third stage involved examining the roles and relationships that were present within the data, whilst the fourth stage focussed on exploring the organisations and systems that were discussed. The fifth stage then focussed on the stories that the participants told and the sixth stage examined the type of language that participants used.

The seventh stage involved adapting the emergent themes that had arisen from stage one of the analysis, whereas the final stage (stage eight) involved integrating themes. Please refer to Appendix P for further details in relation to the final stage of analysis.

It is of note that the two individual transcripts were also analysed following this protocol for consistency. The researcher acknowledged that it was not ideal to analyse the individual data following this protocol as it differed from traditional IPA analysis for individual interviews. However it was considered appropriate in this instance to analyse all seven transcripts using the same protocol.

**Results**

Three superordinate themes arose from the systematic analysis of the transcripts that was described previously. These themes were identified from the subordinate themes that are described in Table 8. Each superordinate theme is described in detail below and direct quotations from the transcripts are used to demonstrate how these themes arose.
Table 8: Superordinate and subordinate themes

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Corresponding subordinate theme</th>
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<tbody>
<tr>
<td>'Unjust Circumstances'</td>
<td>a) Within mental health services:</td>
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<td></td>
<td>• Lack of support</td>
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<td></td>
<td>• Lack of resources</td>
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<td></td>
<td>b) Within the communities that mental health services serve:</td>
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<td></td>
<td>• Lack of resources: service user’s income</td>
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<td></td>
<td>• Services disempower service users</td>
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<td></td>
<td>• The current welfare system is unjust</td>
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<td></td>
<td>• Other services can make unjust decisions</td>
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<td></td>
<td>• Lack of housing provision</td>
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<tr>
<td>'Division'</td>
<td>a) Division between mental health services and other agencies:</td>
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<tr>
<td></td>
<td>• Division between mental health services and Housing and Immigration services</td>
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<td></td>
<td>b) City and county division</td>
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<td></td>
<td>c) Social Care and CMHT division</td>
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<td></td>
<td>d) Division between service users’ and staff members’ worlds</td>
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<tr>
<td>'Survival'</td>
<td>a) Staff experienced frustration towards both services and service users.</td>
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<td></td>
<td>b) Staff need to be tough</td>
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<td>c) Staff support each other</td>
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<td>d) Staff break the rules</td>
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<td>e) Staff need to set realistic expectations for therapy</td>
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Superordinate theme one: Unjust Circumstances

The theme 'unjust circumstances' arose from all seven interviews that were conducted. Unjust circumstances refer to the participants’ perception that the current situation is unfair for both them and for the service users that they work with.

Therefore this theme was considered to have two subordinate themes: unjust circumstances within mental health services; unjust circumstances that are present within the communities that mental health services serve. Both of these are described in further detail below.
a) Unjust circumstances within mental health services

i) Lack of resources
Participants consistently reported their belief that there was currently a lack of resources within mental health services and how unfair this felt. An example of this is described below:

“I don’t think working in a deprived area is necessarily a problem if you are efficiently resourced, backed up etc. etc. and you are sufficiently backed up and you have enough time to get things done I think it can work very well. I think the problem is that we are not sufficiently resourced” (Region 2 CMHT Interview: 835-839).

In addition to this participants reported that there was not enough staff within the teams to manage the high level of referrals that the teams receive. This resulted in staff members working with large caseloads and consequently some service users had less contact with members of the team than previously:

“I think criticisms would be that people aren’t seen as frequently as they used to be. Again that’s due to service pressures and increasing demands. People carrying ridiculous caseloads which mean that um actually clients are only seen sort of every three or four weeks.” (Region 3 CMHT Individual Interview: 167-170).

ii) Lack of support
Participants also voiced their frustration at how their services were being managed. It was felt by the researcher that the participants believed that mental health services were currently too focused on targets. It was also felt that participants did not feel supported by their management teams. Both of these issues are highlighted by the quotes below:

“I’m not against being answerable for what I’m doing, the trouble is what they seem to measure are (..) things that are easily measurable. Things that someone who doesn’t really know how the world works thinks are important.” (Region 2 social care: 768-770).
“They are frustrated because [the job] prevents them from doing it properly…. it’s sort of like a pandemic frustration amongst all of us.” (Region 2 CMHT: 862-866).

b) Unjust circumstances within communities that mental health services serve

i) Unfair welfare system

Many participants appeared to believe that the current welfare system within Britain was unjust. For example participants reported their belief that there were too many barriers for service users in relation to accessing benefits that were entitled too and that the income obtained from benefits was too low for service users to live comfortably on. Examples of these issues are demonstrated below:

“They can't afford to put the heating on because the benefits have changed. Now they are paying for the extra bedroom that they've got that they don't use and they are paying council tax, which I understand that they've lost about a hundred pounds a month out of their benefits” (Region 1 CMHT: 236-240).

ii) Lack of housing provision

However it was not just the welfare system that was considered to be unjust. For example participants reported that there was a lack of adequate housing provision in the city which was considered unfair as the standard of living offered to service users was considered to be poor.

Relatedly, other agencies such as housing agencies and immigration authorities were considered to be unjust due to the perceived unfairness of the decisions that these agencies made. These agencies were considered to be very powerful as the decisions made by these agencies have direct implications for service users. The quotations below aim to illustrate this point:

iii) Local Authority

“I've got a lady whose house is like damp, she has to buy pillows once a month because they go black because the damp is that bad in her house.” (Region 1 CMHT: 229-230).
The quote above demonstrates the staff member’s view that is unjust that a service user should have to live in such appalling conditions whilst waiting for the local authority to address this issue.

iv) Immigration Authorities

“Actually giving her decision where she has leave to stay, she’s got leave to engage with services and work on things, sort out her accommodation as she is now eligible for council housing or housing benefit um and thankfully the decision was that she can stay, full bells and whistles. Actually the improvement was massive so was that a psychological intervention? You bet your arse.” (Region 3 Individual Interview: 357-361).

The quote above highlights the important role that mental health services can have in addressing service user’s immigration status. For example this quote illustrates the staff member’s view that the service user’s mental health improved following the immigration authorities decision that she could stay in Britain and that only then could she implement the strategies that she had been taught during her work with the staff member.

v) Housing Agencies

The quotes below demonstrate how frustrated some of the staff members felt in relation to the local housing agencies. The quotes illustrate the staff members’ views that everyone is entitled to a place to live.

The second quote also describes the stigma that was still prevalent in relation to mental health service users. It was suggested that the local housing agencies may make inaccurate judgements about mental health service users which was unjust.

“It’s almost like you are asking them for a kidney or something. Someone should have a basic right to a roof over their head.” (Region 3 Focus Group: 248-249).
“You know the perception of people with mental health problems remains you know, I think very much, particularly people who don’t work in it so housing officers will have a view about what housing someone with mental health problems means and it’s not usually a positive picture to be fair.” (Region 3 Focus Group: 254-256).

vi) **Services disempower service users**

In addition to the issues stated above participants also appeared to feel that mental health services (Social Care services in particular) were disempowering service users. This was due to an increasing drive from these services to commission other agencies to provide service users with support rather than clinicians undertaking direct work with the service users themselves.

This is highlighted in the quote below as the staff member reported his frustration that he wasn’t able to work with the service user directly to explore the cause of the service user’s depression and the function of the avoidant behaviour (cleaning the house).

The staff member felt that if the direct work had occurred he would then have been able to identify solutions to this difficulty. However, he felt that his current role restricted him from undertaking this work and only enabled him to commission a cleaner for the service user. This frustrated the staff member as the service ultimately maintained the service user’s avoidant behaviour and increased the service users’ dependence on mental health services.

“You know we shouldn’t just be accepting that someone says ‘Oh I’m too depressed to clean my house,’ therefore we should give them send in home care to clean their house for them. We should be working with them on the causes of their depression.” (Region 2 social care: 324-328).
Superordinate theme two: Division

Division was a theme that consistently arose from the interviews. There were four main areas of division: division between mental health services and other agencies, division between city and county mental health services, division within mental health services (CMHTs and Social Care services), division between the clinicians’ ‘world’ and the ‘world’ which service users live within. Each of these areas are discussed below and quotations are used to illustrate these themes.

a) Division between mental health services and other agencies

The teams appeared to feel that mental health services were completely separated from other agencies (e.g. housing agencies and immigration services). It seemed that participants’ felt that some other agencies did not have an adequate understanding of mental health difficulties and also that the stigma of mental health was still present within some of these agencies.

This appeared to be frustrating for participants when trying to provide service users with additional support and therefore this division added to the complexity of working within mental health services within a socially deprived area.

“Historically we were joined and it was a proper discussion about whether it was Social Care dominant needs or health dominant needs and it was an informed discussion.” (Region 3 Focus Group: 300-303).

b) City and County division

From the data it appeared that the city and county mental health services were considered by participants as being entirely different entities. For example, participants frequently reported their views that mental health teams within the county were more sufficiently resourced than city teams, which consequently appeared frustrating for some participants.

“I think it depends all over, there are a lot of um prejudices I think about which areas have more problems and I think the problem with the city is it’s just more concentrated.” (Region 3 Individual Interview: 54-56).
“It can leave you feeling quite resentful as I’ve always worked in the city…. I can see the difference very clearly but apart from that it’s always been the city teams.” (Region 2 CMHT: 246-248).

Participants also acknowledged that the service users living in the county may experience different difficulties (e.g. social isolation) to those service users who live in the city. It is also possible that there is more hidden poverty in the county due to the fear of being considered poor when living in a relatively wealthy area. These issues are demonstrated below:

“I think that they probably have their own problems like social isolation maybe more of an issue there”. (Region 3 Focus Group: 501-502).

c) Social Care and CMHT division
Division was also apparent within mental health services within the city. All of the teams that were interviewed discussed their frustration that CMHT and Social Care teams had recently separated after many years of working together. This structural division had been difficult for all of the teams to adjust to. Many participants commented on how inconvenient the new process was for clinicians and some discussed ways in which they had attempted to overcome this separation. The quotations below attempt to demonstrate this divide:

“If it was one of my people and I was the only one involved um I would breach the invisible divide between us and social services because they are just in that office and I know them. Um and I would say ‘Who do I need to speak to, to get this sorted out?’ I wouldn’t go through the single point of access and make a referral.” (Region 3 Individual Interview: 317-320).

d) Division between service users’ and staff members’ ‘worlds’
The last aspect of division that was clear from the interviews was how different some participants perceived their lives to be from their service users’ lives. For example some participants reflected on how privileged their lives were compared to some of the service users’ lives and that this made them feel ‘lucky’.
This point was interesting as it suggested that staff consider that their comfortable lives are fragile and therefore they may fear the notion that they too could be in the same situation as their service users.

Other participants reported feeling shocked at the conditions that some service users were forced to live in and reflected on how different this was from their own homes. The quotes below show examples of how staff members distance themselves from the service users that they work with. This distance appears to be a coping strategy for staff who, as stated above, may fear that they too could be in a similar social context to their service users.

Therefore if staff members considered their lives to be completely separate and different from their service users, this may help to reduce their fear. This distance may also enable staff to deal with the emotional and physical demands of working within a socially deprived area with service users who have complex health and social needs.

“If they get burgled they get burgled, they haven’t got any house insurance and they just replace it if and when they can with you know loan sharks and God knows what to fund it. That is very different to the world that I live in personally.” (Region 3 Focus Group: 203-206).

“When I clear off to my nice little middle class house and enjoy the weekend with my children I don’t think that I spend a lot of time thinking about this world back here and you know I think that that would be overwhelming.” (Region 2 Individual Interview: 480-483).

**Superordinate theme three: Survival**

The final superordinate theme was ‘survival’. This related to how the participants coped with working within a socially deprived area. The following five subordinate themes were identified within the theme of ‘survival’: staff experienced frustration towards both services and service users, staff members need to be tough, staff members support each other, staff members break the rules and staff members need to set realistic expectations for therapy.
Each of these themes are discussed in detail below to illustrate the theme ‘survival’ and the notion that due to the austerity measures in place the situation is going to get worse.

a) Staff frustration
i) Staff frustration directed at services
Participants reported feeling a range of emotions in relation to their clinical work. For example some participants reported feeling angry or frustrated at the way in which mental health services were operated.

“Historically social work was about working with people. Over time there has been a shift ….. which has reached the point now that we are glorified benefit clerks um expected to fill in a form with people to allocate them a budget.”
(Region 2 Social Care: 181-184).

ii) Staff frustration directed at service users
Participants also reported their frustration that was directed towards their service users. Examples that were discussed were when service users chose not to follow advice given to them by team members and when service user chose to make unwise choices in relation to how they spent their benefit money. An example of the latter situation is described below:

“You know they’ve got no food in the cupboard but they’ve got all the designer labels you know or the latest computer system and they tell me that they’ve got no money.” (Region 2 CMHT: 716-719).

b) Staff members need to be tough
Participants frequently reported the need to be ‘tough’ and strong to work within this area of health and social care to enable them to manage the poverty that they observed within their work and also to manage the large demands that are placed on them by their service. The quotes below demonstrate the staff members’ view that they had developed a high tolerance of social deprivation and poverty due to their frequent exposure to these issues within their clinical work. There was an acknowledgement amongst staff that they had become desensitised to witnessing many manifestations of social deprivation.
“I think the thing is that you’ve got to be quite thick skinned.” (Region 1 Social Care: 280-280)

“My threshold for what is really grim is probably quite high.” (Region 3 Individual Interview: 478-479).

c) **Staff members support each other**
The most frequent strategies that participants reported using were seeking support from their colleagues. The quote below demonstrates the importance that the participants placed on the support that they received from their colleagues.

“Yeah we like all support each other. That’s what the, I’ve noticed that the good thing about here is (...) if you need anybody they are there.” (Region 1 CMHT: 700-701).

d) **Staff members break the rules**
The quotes below illustrate how staff members consider themselves to have broken the rules of the service on occasions to meet the needs of their service users. For example some participants reported giving service users money whilst other participants reported providing furniture or other practical solutions to meet service users’ social needs.

This is an interesting point as it implies that for staff to follow the rules of the mental health services that they work for, they have to overlook service users’ real material needs. Also, the last quote used the term ‘old fashioned’ which indicated that recently there has been an shift in the way that mental health services provide care for service users with mental health difficulties. The quote suggests that this new way of working is unhelpful as it has moved away from offering people practical/ material support in an unsuccessful attempt to separate a person’s mental health difficulties from their social context.

“Sometimes you just you know go out of your way and bend the rules a bit and sort the benefits out, sort the furniture out, sort out everything you can.” (Region 1 Social Care: 311-313).
“Well, you know one of the consultants here, he’s left now, used to (...) he used to give people money you know.” (Region 1 CMHT: 277-278).

“I don’t know if I should say it when my manager is here, but I have a case now that in theory I shouldn’t be holding but that person just needs some old fashioned short term social work.” (Region 3 Focus Group: 393-395).

e) **Staff members need to set realistic expectations for therapy**

Two of the clinical psychologists that were interviewed reported their view that when working in a socially deprived area it is particularly important to set realistic expectations for therapy. This is to ensure that the service user is clear as to what they can expect to gain from commencing psychological work.

However, ensuring that the expectations for psychological work were realistic was also considered to be important for the psychologists’ wellbeing in order to ensure that they were not being over ambitious in relation to what they could achieve when working within the service users’ social context.

“That is part of an assessment process, trying to work out what is real and realistic and what is um something that could be altered psychologically.” (Region 2 Individual Interview: 363-365).

**Discussion**

The aim of the current study was to explore how healthcare professionals understood the relationship between social deprivation and poor mental health and how this knowledge influenced their clinical practice. The current study used IPA to explore these aims. Similar experiences were reported by participants even though they worked within different teams that covered different parts of the city.

In the current section of the report the research findings are summarised and discussed in relation to the wider research literature as well as the clinical implications of these findings. This section also details the limitations of the current study and offers ideas for future research.
Summary of research findings

Whilst one of the aims of the current study was to explore staff members’ understandings of the relationship between social deprivation and poor mental health, the data obtained did not support such an analysis. This was due to the participants appearing to find this association obvious and they appeared to lack the language to be able to elaborate on this debate in more depth.

However the data provided useful and interesting information in relation to the stressors of working in socially deprived communities. For example many participants discussed how different their clinical work was compared to staff members that work in the more affluent county teams.

The data also provided findings that were not anticipated, for example the data identified a number of the stressors (e.g. a perceived lack of resources) for staff members working in mental health and social care teams. This finding reflects how inductive qualitative studies can produce results that are not necessarily directly related to the research question. However such findings can still be both useful and relevant to the area being studied.

Superordinate Themes

Three superordinate themes arose from the data. The three themes were: unjust circumstances; division and survival. Please refer to Figure 2 for a diagram of how the researcher felt that the three superordinate themes were connected.

a) Unjust circumstances

The results suggested that participants felt that there were unjust circumstances both within mental health services (e.g. not enough resources) and within the communities that mental health services serve (e.g. service users being forced to live in substandard living conditions). These unjust circumstances were considered to be outside of participants control (e.g. a lack of funding for mental health services).
b) Division

Division was the second superordinate theme that arose from the data. For example the divide between mental health services and other organisations, the divide between city and county teams, the divides within mental health services (e.g. the recent separation of health and social care services) and also the divide between service users and staff members working within mental health services.

Within the current study many participants reflected that working in the county may be easier than working in the city because the participants that are referred to mental health teams in the county are likely to have their basic needs met such as housing. This division also reflected the real differences in the resources within these areas: the urban- rural divide. For example, the county is less socially deprived than the city (Department for Communities and Local Government, 2011).

The division between the CMHTs and Social Care teams was particularly interesting. The reason behind this separation of the teams was not explored in detail within the current study; however participants did express their frustration at the irony of the recent combined Health and Social Care Act (Department of Health, 2011) when the CMHTs and Social Care services have recently separated.

This division reflected the way that mental health is currently being conceived within Britain. The separation between the services suggests that a biological conception of mental health maybe becoming more prevalent compared to a biopsychosocial model. A biopsychosocial model of mental health suggests that mental health cannot be separated from a person’s social context, however mental health services currently appear to be attempting separating these factors.
Further to this another division that was highlighted in the current study was the division within mental health services. For example both health and social care teams appeared to highly regard clinicians whilst their service managers were frequently criticised. This was considered to be an example of the psychodynamic defence ‘splitting’ being played out within mental health services.

Splitting is a primitive defence whereby a person’s feelings are divided into different elements to avoid internal conflict (Klein, 1946). Splitting aims to enable people to identify with the good and to protect what is considered to be good from being destroyed by the bad.

The example above suggests that the participants considered other health and social care clinicians to be ‘good’ whilst their service managers were ‘bad’. This may have protected them from experiencing the internal conflict of anxiety in relation to being considered as part of the same team as their managers who they are currently frustrated at for making decisions that they don't agree with.

The divisions highlighted in the current study appeared to make working within a mental health service within a socially deprived area even more complex more staff members. It is of note however that these divides are a reflection of the national picture regarding mental health services in Britain.

c) Survival
Therefore participants sought survival strategies such as emotionally distancing themselves from service users to help them to cope with the demands of working within these unjust circumstances. The notion of the need for staff members to set their own boundaries to enable them to cope with the demands of working in a socially deprived area supports the findings from a recent study by O’Brien et al., (2011).

The current study also provided some support for the social defence system (Menzies Lyth, 1960). The social defence system is thought to protect people from feeling overwhelmed by feelings of anxiety and helplessness. One example of how a social defence system is enacted is the use of detachment.
This suggests that any clinician that works with people needs to develop an adequate level of professional detachment to enable them to control their own feelings and to work in an appropriate manner (Menzies Lyth, 1960).

The findings obtained from the current study indicate that the social defence system was enacted to help members of staff manage their feelings of helplessness in relation to the potentially overwhelming nature of their service users’ difficulties. A specific example of professional detachment was a member of staff describing a service user as living in a different ‘world’ to her.

**How the research findings are linked to previous research literature**

The findings from the current study indicated that parallel processes were occurring between mental health services and the communities that the mental health services serve.

It has previously been reported that parallel processes can occur when two or more systems (which can be organisations, groups or individuals) develop significant relationships with each other and they develop similar affects, cognitions and behaviours (Smith et al., 1989). Bloom and Farragher (2010) stated that applying the notion of a parallel process to organisations can be a useful framework to help staff to think ‘outside of the box’ about situations.

Parallel processes were considered to be occurring across all three superordinate themes (unjust circumstances, division and survival). An example of this is that participants within the current study reported that they felt dissatisfied and frustrated with how mental health services were currently being operated.

However, participants also reported their opinions that the service users that they work with were also dissatisfied and frustrated with the service that they had received from mental health services (e.g. long waiting lists and not able to be seen by a professional as frequently as they would like).
This finding supports Harris’ (2014) study which suggested that staff members were affected by their empathy for clients as well as feeling let down by the organisations that they worked for. Harris (2014) reported that staff experienced a double loss: they shared in the loss of services that their clients experienced; but staff also experienced a loss of trust in their organisation as they felt that the situation was unfair. This relates to the current study as the staff members reported feeling dissatisfied and frustrated at mental health services.

Meeting the needs of service users
The findings of the present study also provide support for Maslow’s theory of motivation (1954). Maslow’s ‘hierarchy of needs’ argued that before humans can focus on their growth needs (need for self-actualisation, need for self-esteem and need for love and belonging) their deficiency needs (need for survival, need for safety) must be met.

Maslow’s theory (1954) therefore can be used to explain why some participants felt so dissatisfied with their current role within mental health services. For example participants frequently discussed their frustration at spending their time completing benefit forms for service users instead of undertaking clinical work that directly focussed on service users’ mental health.

However, many participants also acknowledged that this work was often considered the most valuable work to their service users as it had a direct impact on their lives (e.g. receiving benefit money). Some participants also acknowledged that teams that work within socially deprived areas will frequently receive referrals from service users who do not have their basic needs met and therefore the support they require from services may be to enable these needs to be met.

This finding is related to a recent report by the Midlands Psychology Group (2014) which stated that a person’s social circumstances should always be taken in to account when addressing their mental health difficulties.
Staff members in the current study also reflected that it is for this reason that service users often seem unmotivated to work towards meeting their growth needs, particularly in relation to undertaking psychological therapy until their basic needs have been met.

**Methodological Issues**
The current study had a number of limitations. One limitation of the current study was that the data obtained was a mixture of focus group and individual interview data, which was not ideal as it meant that the participants who were individually interviewed had a greater voice than those participants that took part in the focus group sessions.

In addition to this it was unfortunate that individual focus groups could not be facilitated for the health and social care teams within Region 3. This possibly resulted in less in depth data being obtained from the Region 3 focus group session as both teams were present.

The current study included participants from both health and social care teams. However, as health and social care services have different roles in supporting service users living in socially deprived areas it is possible that including both teams may have had a negative impact on the homogeneity of the sample.

Further to this, a limitation of the current study was that the original aims of the current study were required to be adapted due to the data that was obtained from the interviews. For example participants did not appear to have a discourse to discuss the relationship between social deprivation and mental health. Therefore data obtained from the interviews focussed on the staff members’ struggles and emotions in relation to their working conditions.

Although this was considered to be an interesting finding in itself it did not meet the original aims of the current study and consequently the aims of the current study had to be adapted in response to the data that was obtained. This was considered necessary in order to proceed with the study. However, it was acknowledged that this unexpected change in research direction may have had a negative effect on the quality of the conclusions drawn from the current study.
It is also possible that both the researcher’s preconceptions and prior experience of working within a CMHT within the city that was studied may have led her to misinterpret other meanings within the data that was obtained. However the data obtained from the current study was intended to be experience close rather than an accurate representation of the truth and therefore the data was dependant on the interpretation of the researcher. Therefore it is possible that if the data was analysed further new meanings and themes may arise.

Further to this, as an additional quality measure, the researcher sent all participants a summary of the three superordinate themes that arose from the data and asked for their feedback. This was a form of respondent validation to ensure that the researcher’s understanding corresponded to the participants’ understanding of the phenomena being studied (Bishop & Yardley, 2007). Two participants responded to this and gave positive feedback in relation to the researcher’s interpretation of the data.
‘Unjust circumstances’ refers to the perception that the current environment is unfair and the impact that this has on both staff who work within mental health services and the community that mental health services serve.

**Within mental health services**
Staff members within mental health services felt that there was a lack of resources in the city in terms of service provision (e.g. not enough staff to manage the demand) compared to the county teams which felt unjust considering the higher population of people that they serve in the city compared to the county.

Staff members felt that this impacted on their clinical work as it resulted in them having to manage large caseloads. Having such large caseloads then ultimately led to a barrier for some staff attending supervision sessions as they felt that they did not have enough time to attend these groups which felt unfair.

Staff also felt that their working environment was unfair as despite the lack of resources available to the team they felt that there had been an increase in the demands and pressures placed on them by the managers of their corresponding services and consequently this left them feeling unsupported by their service managers.

**Within communities that the mental health services serve**
Many staff referred to the welfare system as being unfair and the impact that this has had on service users. Therefore many service users also appeared to be living within ‘unjust circumstances’ such as having a lack of resources e.g. a low income due to the changes to their benefits and many have no choice but to live in the poor accommodation that service offer.

It was also acknowledged by staff that other agencies e.g. housing, DWP and immigration authorities appear to make unfair decisions at times which directly impacts on service users’ lives.

Some staff commented that they felt that the current service models (particularly within social care) disempower service users by commissioning other services to provide them with support rather than undertaking the direct work with service users to empower them to make changes to their own lives with support from services.

**Division**
Two forms of division were present from the data: division between organisations and division between people.

**Within mental health services**
Divides were apparent between the CMHTS and the Social care teams due to the recent separation and between city and county teams.

Divides were also present between mental health services (CMHTS and Social care teams) and the following: GPs; housing; immigration authorities; and the Department for Work and Pensions.

There also appeared to be a divide between staff and their service managers.

**Within communities that mental health services serve**
Divides were present between service users and clinicians. Staff felt that they lived in a completely different world to service users which both shocked and angered them at times. When staff felt angry towards service users (e.g. blaming them for their own circumstances) this appeared to perpetuate this division.

A similar divide was also apparent between rich and poor service users. Staff felt that richer service users also lived in a completely different world to poorer service users due to the increased resources that wealth brings (e.g. housing, income, financial security and independence).

**Survival**
Survival refers to strategies that staff members appear to use to enable them to cope with working within these unjust circumstances. These are summarised below:

- Staff experienced strong emotions: dissatisfaction, anger, frustration and distress.
- Staff felt that due to the lack of resources they are firefighting which is stressful.
- Staff felt that they need to be tough to survive working in these unjust conditions.
- Staff felt vulnerable due to the threat of redundancy.
- Staff supported each other as their colleagues understand the working conditions.
- Staff used supervision to cope with the emotional impact of the work wherever possible.
- Staff broke the rules to support service users to live in unjust circumstances e.g. low income.
- Staff set realistic expectations for therapy (so that they don’t feel that they have failed).
- Staff were critical of management decisions and the lack of support that they received from management.
Clinical Implications and Recommendations

The findings from the current study are relevant to health and social care professionals that undertake clinical work with clients living in deprived areas. The results of the current study indicate that reflective practice sessions may be particularly beneficial for Health and Social Care staff members working in socially deprived areas to provide an opportunity to reflect on the wider issues of health inequality and how it affects daily practice within mental health services in these areas.

This is of relevance to clinical psychologists working within deprived areas as they may take a lead role in facilitating reflective practice sessions for teams. In addition to this, clinical psychologists may also supervise multi-disciplinary colleagues within the teams that they are working in.

Therefore clinical psychologists could incorporate the theory and practice links (including discussions about any psychological defences that may be being played out) in relation to undertaking clinical work in socially deprived areas within supervision sessions when appropriate to do so. Supervision would consequently be another avenue to draw clinicians’ attention to these broader issues of health inequality.

The results of the current study indicated that staff members’ perceived social deprivation to have an impact on their clinical practice. This finding will be useful to add to the published literature in this area particularly as identified previously there is no published literature within the field to date that had specifically explored this issue.

However, due to the nature of the current study the findings should not be generalised to other areas of Health and Social Care. Instead the results of the current study should only be used to highlight the staff members’ experiences of working within a socially deprived area.
Clinical Recommendations

1. The findings of the current study indicated that staff members’ perceived social deprivation to impact on their clinical practice. For example, staff reported spending time addressing people’s social needs such as housing and immigration status. Staff also reported their view that working in socially deprived areas adds an additional layer of complexity to service users’ difficulties as they often do not have their basic needs met which reduces the likelihood of psychological interventions being successful.

Research should be conducted in this area to further explore the association between social deprivation and clinical practice. Healthcare providers should also aim to address the potential challenges that working in socially deprived areas may bring for team members to ensure that service users living in deprived communities receive the most effective care from mental health services. This could be achieved by ensuring that health and social care services use a biopsychosocial model of mental health rather than attempting to separate mental health difficulties from social factors.

2. Staff members reported their perception that both service users and members of staff felt ‘depowered’ due to having fewer material resources because of the austerity measures that were in place. Feeling de-powered can result in feeling depressed and hopeless about the situation (Gilbert, 2006) due to a belief that it will not change.

Therefore further research should be conducted to further explore the association between social deprivation and psychological distress. However, if an association is found between social deprivation and psychological distress then working together in solidarity can gain power. For example if staff members return to ‘old fashioned’ ways of working that focus on the needs of the community by working alongside service users, this may be helpful to both them and to their service users.
3. Adequate support should be available to members of staff working within socially deprived areas due to the additional complexities that this environment has compared to other areas of health and social care within mental health. This could be in the form of reflective practice and/or supervision sessions being made available to team members to enable them to have a space to reflect on how social deprivation could potentially impact on their clinical practice for example.

The results from the current study also indicate that staff perceived encouragement or ‘permission’ from senior management within mental health services is required to enable staff to feel confident in prioritising these sessions despite working with high caseloads.

Conclusion and Further Research

The findings from the current study highlighted that members of staff working within mental health services within a socially deprived city perceived social deprivation to impact on their clinical practice.

There have been few recent published research studies that have focussed on social deprivation within the area of mental health and no published research has been previously conducted which has specifically focussed on the impact of social deprivation on clinical practice. Therefore future research should be conducted to explore the association between social deprivation and clinical practice in more depth.

Relatedly further research should be conducted in relation to the association between social deprivation and psychological distress for both staff members working in this area and service users that live in socially deprived areas. The findings from such research studies would be beneficial to potentially strengthen the evidence obtained from the existing literature within this field.

Further research should also be conducted to explore the experiences of staff members working within county teams within socially deprived areas to ascertain what similarities and differences are present.
It would also be beneficial for future research to be conducted that focussed on other aspects of mental health, for example the experiences of staff working within a Children and Adolescent Mental Health Team (CAMHs) within the UK to explore how social deprivation influences clinical practice within child services.
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Section Three: Critical Appraisal

by

Leah Clatworthy

To the Department of Clinical Psychology

University of Leicester

In partial fulfilment of the degree of Doctorate in Clinical Psychology

In April 2014
Introduction

This section of the report is an account of my personal reflections in relation to conducting the current research study. Therefore it is an opportunity for me to critically reflect on the whole research process. The reflections described below are derived from my reflective diary recordings which were made throughout the entire research process.

Background to the current study

My first year placement during clinical training sparked my interest in community work as I was placed within an older adult CMHT within a socially deprived city. This was my first experience of undertaking clinical work within a community setting as prior to training I had only worked in in-patient, mainly forensic settings.

The differences between community and in-patient work really struck me and I was particularly shocked at how independently each professional group (clinical psychologists, community psychiatric nurses, psychiatrists and occupational therapists) worked, which I felt to be very different from the multi-disciplinary team working that I had encountered within a range of in-patient settings.

I was also struck by the terms that staff members gave for socially deprived areas and the 'jokes' that were made about certain areas within the teams. This last point was particularly interesting to me as a trainee clinical psychologist as I observed that although many informal conversations took place within the team about issues of social deprivation (e.g. the conditions that people lived in and how staff members dreaded going to certain areas of the city) these issues were not regularly included within referral letters to the clinical psychology service or within other formal letters to other professionals and/or organisations in relation to the service user's care.

However, this was not the only difference that I encountered. I was also shocked to discover the poor conditions that some service users lived in and how little money they had to survive on.
The notion of inequality is one that is particularly important to me in terms of both my personal and professional life. It is my personal view that everyone should be treated fairly and equally. Therefore this placement highlighted to me the unfairness of the current welfare system as I felt that service users’ were being penalised for experiencing mental health difficulties by the state due to having access to such a limited income.

Further to this, during the placement I worked with a number of service users who had no choice but to live in very poor local authority housing and who had a very limited income. This experience made me aware of the effect that poor living conditions has on people’s mental health.

For example service users often reported feeling anxious in relation to how they were going to be able to afford to pay their central heating bills during the winter months along with their other household bills. As a result of this some of the service users that I worked with limited themselves to a couple of hours of central heating per day to reduce their heating bills. This resulted in them living in very cold conditions for a large amount of time, which I thought could not be beneficial to either their physical or mental health.

In addition to this at the time of conducting the research project I felt that service users were being blamed for their current economic situation by the media, which also reinforced my belief that service users were being treated unfairly. The notion that service users are being increasingly blamed for their social circumstances has been highlighted in a recent article by Riddell (2014). Riddell reported that the right-wing media has attempted to vilify people who are in receipt of benefits in Britain by calling them derogatory names such as ‘skivers’ and ‘shirkers’.

Wiggan (2012) reported that there has been a discourse within government policy documents that has implied that poverty and unemployment is a consequence of poor choices made by individuals.
This finding may explain why public attitudes towards unemployed people in Britain indicate a growing indifference (The Midlands Psychology Group, 2014). For example, there may be less public empathy in Britain for unemployed people than previously as people who are in receipt of welfare benefits are being increasingly blamed by society for their social difficulties.

In terms of choosing a research question to study I found this particularly difficult as I had not completed any formal research since completing my undergraduate dissertation five years prior to commencing clinical training. The notion of undertaking a research project therefore felt daunting to me and I was anxious that my research skills may not have been sufficient for me to complete this task.

However, due to my interest in the conversations that I had witnessed between professionals during placement I undertook a scoping literature search to ascertain what research had been conducted within this area of health and social care. I was interested to discover that very little recent qualitative research had been undertaken within this area. Therefore with the support of my research supervisor I was able to shape my initial ideas into a relevant research question.

**Choice of methodology**

The research question was exploratory and therefore a qualitative methodology was deemed appropriate to use. Qualitative analysis enabled me to explore team members’ experiences of social deprivation in more detail than a quantitative methodology would allow. Conducting a qualitative research study initially appeared daunting as I had no experience of undertaking this type of research. However, after familiarising myself with various methods of qualitative methodology and having discussions with my research supervisor I felt ready to take on this challenge.
I initially thought that Thematic Analysis would be an appropriate choice for the current study so as to explore what common themes arose from the data. However, following discussions with my research supervisor I felt that IPA (Smith et al., 2009) was more appropriate to use as it enabled the participant’s experiences to be analysed in greater depth than thematic analysis would enable.

**Ethics**
I felt incredibly nervous completing my applications for ethical approval and permission from the NHS Trust to conduct the study. Despite having had teaching during my clinical training on this process it initially felt overwhelming due to the amount of forms that had to be completed. However, I found out that as I was exploring staff understandings rather than service users’ understandings I was able to go through a proportionate review for ethical approval. From discussions that I had had with other trainees during this time, this route appeared much easier in comparison to the traditional pathway and the whole process was much less stressful than I had anticipated.

**Recruitment**
As all members of clinical staff from the six city teams (three CMHTs and three Social Care teams) were invited to take part in the study I did not anticipate that there would be too much difficulty recruiting participants to take part in the current study. From my previous experience of working within a CMHT I was aware of how busy these teams were and how high clinical staff caseloads could be. However as only six to eight members of staff were required for each focus group, which was an hour and a half in duration, I did not think that this would be too much time for participants to commit to.

In reflection I think that I was quite naive as to how little importance is sometimes placed on conducting research studies within teams who are stretched due to high referral rates and not enough resources to meet the demands placed upon them.
Therefore I soon realised that I was actually expecting quite a lot from participants by requesting them to give up an hour and a half to take part in a research study. This point became particularly clear to me during my first visit to one of the CMHTs in February 2013. I attended one of the team’s meetings to introduce myself and the research study, where I was met by a somewhat overwhelming sense that the team did not consider the research to be meaningful. Consequently no one at the meeting stated that they would be interested in taking part in the research.

At the time this shocked me as this was the first team that I had introduced myself to and I felt both disappointed and scared that they did not appear to want to take part in the study. However this fear soon disappeared when I met another two CMHTs in February & March 2013 respectively. Both of these teams appeared keen to take part in the research study and reported their beliefs that it would be a useful study to conduct. This definitely eased my initial anxieties in relation to the recruitment of participants.

On reflection I found it interesting that the first team did not have a psychologist working within their team at that time, unlike the other two teams. Therefore it was possible that the team’s resistance may have been politically driven: the staff may have felt bitter towards my profession due to the lack of psychology provision within their team. Alternatively, the other two teams may have been more willing to participate as they were more familiar with working with psychologists.

Following these initial meetings with the three CMHTs I arranged to conduct a focus group session with one team in May 2013. However, only five staff members reported that they would be able to take part in the study and on the day only four staff members were able to participate. Although this was fewer participants than expected I felt that it was enough participants to obtain meaningful focus group data and therefore the session was facilitated.
I felt relieved after conducting the first session, which increased my motivation to encourage as many other people to participate in the current study as possible. I was also encouraged by the positive feedback that I received from the participants who took part in the session. The participants stated that it was a useful experience for them to have an opportunity to reflect on how social deprivation influenced their clinical practice.

Surprisingly the first team that I had met changed their mind and agreed to participate in a focus group session in May 2013. This felt positive up until the team manager contacted me a few weeks later to say that the session had to be cancelled due to a ‘lack of interest’ from the team. This was both disheartening and frustrating as I thought that the team had changed their minds by agreeing to take part in the research.

The other CMHT agreed to take part in the current study in July 2013. This session appeared to be well received by the team and five people participated in the session. Although this was fewer than I expected I was pleased that this many staff members attended.

Unfortunately the team clinical psychologist was unable to attend this date and therefore it was agreed that I would facilitate an individual interview with him in October 2013. This was due to the limited availability of staff over the summer months and therefore it did not seem appropriate to cancel the focus group session for one participant.

I then became aware that a clinical psychologist had joined the CMHT that had not yet participated in the study and asked her if she thought that other team members would participate if the focus group session took place during one of her monthly supervision sessions with the team.

The feedback was positive and a focus group session was arranged for September 2013, however this was cancelled due to staff availability on that day. Therefore the clinical psychologist agreed to take part in an individual interview in November 2013 to at least gain some insight into the staffs’ understanding of social deprivation within that area of the city.
During August and September 2013 I met with two of the three Social Care teams to introduce the current study. I conducted the focus group sessions for these teams in October 2013. Each session had four participants; however one participant in one team had to leave the session early due to a clinical commitment.

During this time I had attempted to contact the remaining Social Care manager to introduce the current study to him and to ascertain whether he thought that his team would be interested in participating. However, I struggled to make contact with the manager despite leaving several answerphone messages and sending several emails. This process was frustrating as I didn’t know how else to contact the manager and it felt important to offer all clinicians from the six teams an opportunity to participate in the current study. In reflection it was interesting that this team covered the same area of the city as the CMHT that had not yet participated.

In December 2013 my research supervisor wrote to the two team managers (Social Care and CMHT) to highlight the importance of the current research project with the aim of encouraging the teams to participate.

As a result of this a joint Health and Social Care team focus group session was arranged that took place in January 2014. It was unfortunate that the teams were not able to take part in separate focus groups like the other team, however I felt grateful to the team managers for their support in ensuring that a focus group session was facilitated.

I was particularly nervous when facilitating this focus group as I was aware of the teams’ previous resistance to the research study and anticipated that some participants may be critical of the study. Luckily this was not the case, although the session was difficult to facilitate on my own. This was due to there being eight participants, which was more than in previous sessions. However, despite this I was pleased that the session was so well attended. The participants engaged in the discussion and once the session started my anxiety eased.
It is of note that one participant did not contribute to the discussions during the session despite appearing to listen to the points that other people made. I attempted to engage this participant in the discussion on a couple of occasions but she did not choose to contribute.

In reflection it may have been beneficial if I had directly asked this participant a question as she may have contributed to the group discussions. However I did not do this as I was concerned that it may have felt intimidating or uncomfortable for her.

Overall despite less participants taking part in the current study than initially anticipated, I am pleased with the number of participants who were able to participate in the study (N=27). In reflection I think that I was too ambitious expecting up to eight people to attend every focus group. Unfortunately I don’t think that this would realistically have been achievable, particularly during the current economic climate where mental health services are under pressure to meet many demands with little funding available to them.

I was pleased that the sample included participants from a range of professions (occupational therapy, clinical psychology, community psychiatric nurses and social workers). It was disappointing however that no members of the medical profession chose to take part in the current study.

Facilitating the interviews
Initially I found conducting the interviews quite anxiety provoking, particularly the focus group sessions as I had no previous experience of this. However, I found it helpful liaising with another clinician who had facilitated focus group sessions previously as he gave me some advice on this issue. In addition to this I familiarised myself with focus group literature to ensure that I was able to confidently facilitate these sessions (Kitzinger, 1995; Smith et al., 2009). I found the interview sessions both enjoyable and interesting, especially the anonymous case examples that were discussed. These case studies in particular furthered my passion for conducting a research study within this area to contribute to the wider literature on health inequality.
The interview data

It became apparent when conducting the interviews that the teams did not appear to have a discourse to discuss the relationship between social deprivation and mental health. For example the data obtained from the interviews implied that the participants’ felt that the association between social deprivation and poor mental health was obvious and participants did not appear to have the language to discuss these ideas in depth. This surprised me as I had not considered that the teams would struggle to articulate their understanding of the relationship between social deprivation and mental health.

I also felt disappointed when I realised that as a result of this I would not be able to effectively answer one of the research questions: what are MDT members’ understandings of the impact of social deprivation on mental health? Therefore I realised that I had to be flexible and adapt my original aims of the current study in order to proceed with the data that I had obtained.

Unfortunately I was also aware that this unexpected change in the direction of the current study may have comprised the results obtained and consequently it may have had a negative effect on the quality of the conclusions that can be drawn from the current study. This felt disheartening at the time, however I was reassured by the fact that the data obtained from the interviews remained important and relevant despite not being directly related to the original research question.

Data transcription and analysis

Yardley (2000) developed criteria for assessing the quality of qualitative research based on four principles. The second of these principles was ‘commitment and rigour’ from the researcher. This can be in the form of being attentive to participants during both data collection and the analysis process (Smith et al., 2009).
I feel that one way in which I demonstrated my commitment to the current study was through the transcription process where I transcribed each interview. This was a tedious and time consuming but in reflection it was a valuable process as it enabled me to become more familiar with the data compared to the use of a transcription service. Further to this I believe that transcribing the data on my own speeded up the data analysis process as I was already familiar with the content of the obtained data. It is also of note that self-transcription is recommended practice for IPA studies.

The analysis process was challenging as I had not undertaken IPA analysis before. The process was also quite complex due to the mixture of individual interview and focus group data obtained during the current study. However, familiarising myself with the stages of analysis for both individual interview (Smith et al., 2009) and focus group data (Palmer et al., 2010) eased my anxiety in relation to this. In addition to this the support and advice from my research supervisor was particularly helpful during this time.

**Articulating my epistemological position**

The section that I found hardest to write was articulating my epistemological position. Initially I found it tough to establish what my epistemological position. I believe that this difficulty was due to the fact that previously I had never considered either my stance on the nature of reality or how knowledge about reality is acquired.

Therefore establishing my epistemological position appeared daunting at first. However, after attending lectures throughout the training course that discussed many different epistemological positions I felt that my personal epistemological position started to become clear to me. In addition to this, after reading relevant literature within this area (Fade, 2004; Watkins, 2004) and having many discussions with my research supervisor, I eventually came to the conclusion that a critical realist position best reflected the epistemological stance I took during the research process.
I felt that a critical realist position suited me as I believe that reality is shaped by a number of factors (e.g. social and political factors). I also believe that knowledge about reality will be shaped by my values as the researcher and consequently my values would have influenced the research findings.

However ascertaining my epistemological position was just the beginning of the process as I then found that articulating my epistemological position in written form was far more difficult than I had imagined it would be. For further details in relation to my epistemological position please refer to Appendix G.

**Personal and professional development**

**Professional Development**

When I commenced clinical training conducting a research project appeared a very daunting concept to me. I doubted my research ability and questioned whether my research skills were advanced enough to meet a doctoral standard. Therefore the notion of completing a thesis was very anxiety provoking for me at that time.

However, now that I have prepared the thesis I feel incredibly proud that I have managed to overcome these anxieties and that I have conducted a research study. I feel that my confidence in my research skills has increased over the last three years and the prospect of conducting research in the future does not fill me with dread as it would have done previously.

** Undertaking research within the public sector**

Conducting the current research study has enabled me to see first-hand the complexities of undertaking research within the public sector. I was struck by how stretched services were currently due to the implementation of ‘austerity measures’. I was also aware of how this had impacted on clinical practice and consequently had directly affected the care received by service users.
I feel that this experience has taught me the importance of prioritising research studies despite these difficulties as otherwise there is a danger that ‘real-life’ research conducted within clinical settings could become a rarity. This would be a shame as it can be difficult to develop clinical recommendations from research studies that are conducted within artificial laboratory settings.

**Personal impact of the research process**

The findings of the current study have reinforced my personal belief that inequality is associated with mental health. This belief stems from the findings from previous research studies (Friedli, 2009; Marmot, 2010).

Prior to commencing the current study I do not think that I was aware of the extent that social needs can have on a person’s mental health if they are not met adequately. However, from completing the current study I can now appreciate how a person’s social circumstances can affect their mental health. Therefore, if someone is living in a deprived area and experiencing social difficulties such as having a low income or poor living conditions, then it is likely that their mental health would be negatively affected by these factors. Therefore, in relation to the current study I believe that for mental health services to work effectively with people who experience mental health difficulties, staff members need to address service users’ social needs in addition to undertaking traditional mental health treatments (e.g. psychological therapy and medication).

The main emotion that I experienced during the research process was anxiety. However, from speaking to clinicians within the field of clinical psychology who have been through this process and with my trainee peers I was reassured to hear than anxiety appears to be a common aspect of completing a doctoral thesis. Further to this, clinical psychology training has previously been reported as being a stressful process (Cushway, 1992).
I managed my anxiety by being organised and by planning my time efficiently to ensure that I had enough time to meet the deadline. I also sought regular supervision to discuss any issues that arose during the research and to discuss my anxieties whenever appropriate.

Despite my anxiety I feel that I maintained a suitable work/life balance by ensuring that I had at least one day a week where I did not work on the research project. On my day off every week I ensured that I spent time completing fun activities with friends and family to distract me from the research which I feel was an adaptive strategy.

I feel that maintaining this work/life balance will prepare me for working as a qualified clinical psychologist within the NHS in the future as it is likely that I will have many demands placed on me. Therefore, it will be important for me to manage my time effectively and efficiently to ensure that I do not become too consumed with the work as this would not be beneficial for my mental and physical health. For example, Hobson et al. (2001) found that an employee’s failure to manage both life and work demands can lead to negative consequences for both the individual (e.g. high stress levels) and for the organisation (e.g. increased absenteeism and reduced productivity).

However, it is of note that towards the latter stages of the research process my anxiety did reduce and it was replaced by a sense of achievement in relation to what I had accomplished over the last three years.

I feel that being aware of my strengths as well as my weakness will also prepare me for working as a qualified clinician within the NHS as it could be detrimental to my mental health if I became pre-occupied with my personal weaknesses.
References


Appendix A: Guidelines to authors for target journal for literature review

Journal of Community & Applied Social Psychology

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Edited By: Flora Cornish

Impact Factor: 0.763

ISI Journal Citation Reports © Ranking: 2012: 47/60 (Psychology Social)

Online ISSN: 1099-1298

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All papers must be submitted via the online system.

Manuscript Style. JCASP publishes articles in a range of formats, including reports of empirical studies, theoretical articles, review articles, commentaries and reports of community practice. Submissions should be as concise as is consistent with clear exposition of the subject matter. Manuscripts should not normally exceed 5,000 words, with 7,000 as an absolute maximum. The word count includes abstract, references and tables. Editors may ask authors to reduce their article’s length as part of the review process, in the interest of maximising the number of articles published in the limited space of the journal. Short Papers of no more than 2,000 words in length are encouraged. Research papers, Innovations in practice and Commentaries are all welcome in the Short Paper section. Submissions will be reviewed in the usual way but it is anticipated that the reviewing and publication process will be of shorter than average duration than for longer papers.

The title page must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page. The title page is not sent to reviewers. In the interest of maintaining anonymity, acknowledgements should be placed on the title page rather than in the main text. Sponsor(s) of the research, if any, and grant number(s) should be included here.

Supply an abstract of up to 200 words for a full-length article, or around 50 words for a Short Paper. No abstract is needed for a book review. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. Include up to ten key words that describe your paper for indexing purposes.

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Normally reviews will be between 1,200 and 1,500 words and should be submitted to Associate Professor Darrin Hodgetts via email dhodgetts@waikato.ac.nz.

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4. Strengths of the text
5. Critical comment / limitations of the book
6. Overall recommendation and assessment
7. References
8. Reviewer contact address

Potential authors should also refer to book reviews previously published in the journal, via Wiley Online Library:


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Title and Abstract Optimisation Information. As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Journal of Community and Applied Social Psychology at the same time please visit Optimizing Your Abstract for Search Engines for guidelines on the preparation of keywords and descriptive titles.

Reference Style. The APA system of citing sources indicates the author’s last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author’s name and the year of publication.

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.

Example: In a 1989 article, Gould explains Darwin’s most successful. . .

D. Specific citations of pages or chapters follow the year.

Example: Emily Bronte “expressed increasing hostility for the world of human relationships, whether sexual or social” (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author’s last name followed by et al. (meaning "and others”).
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas et al., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by et al. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas.

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:
Journal Article


Book


Book with More than One Author


The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials*. Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website:
http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)


Journal Article from Database

Abstract from Secondary Database


Article or Chapter in an Edited Book


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**Cite EarlyView Articles:** To link to an article from the author’s homepage, take the DOI (digital object identifier) and append it to "http://dx.doi.org/" as per following example: DOI 10.1002/hep.20941, becomes http://dx.doi.org/10.1002/hep.20941.
### Appendix B: Table 1: Databases searched and rationale

<table>
<thead>
<tr>
<th>Database</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsycInfo</td>
<td>To cover psychology-related articles</td>
</tr>
<tr>
<td>Scopus</td>
<td>To cover psychology-related articles</td>
</tr>
<tr>
<td>Web of Science</td>
<td>To cover the broader field of science</td>
</tr>
<tr>
<td>Medline</td>
<td>To cover articles from the broader field of science.</td>
</tr>
</tbody>
</table>
### Table 4: Articles returned

<table>
<thead>
<tr>
<th>Database/Inclusion</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsychInfo</td>
<td>54</td>
</tr>
<tr>
<td>Scopus</td>
<td>65</td>
</tr>
<tr>
<td>Web of Science</td>
<td>32</td>
</tr>
<tr>
<td>Medline</td>
<td>352</td>
</tr>
<tr>
<td>Total articles retrieved from database search</td>
<td>503</td>
</tr>
<tr>
<td>Total after duplicates were removed</td>
<td>283</td>
</tr>
<tr>
<td>Total after removal of articles that did not appear relevant from scanning the individual abstracts</td>
<td>17</td>
</tr>
<tr>
<td>Total after relevance criterion applied</td>
<td>8</td>
</tr>
</tbody>
</table>
### Appendix D: Table 5: Why nine studies were excluded from the review

<table>
<thead>
<tr>
<th>Author, year and title of study</th>
<th>Reason for exclusion from the current review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Allanson &amp; Dennis (2013). On the choice of health inequality measure for the longitudinal analysis of income-related health inequalities.</td>
<td>This study did not specifically focus on the impact of income inequality on mental health.</td>
</tr>
<tr>
<td>2. Jokela et al., (2013). Socioeconomic inequalities in common mental disorders and psychotherapy treatment in the UK between 1991 and 2009.</td>
<td>This study did not specifically focus on income inequality.</td>
</tr>
<tr>
<td>3. Kearns et al., (2013). The psychosocial pathway to mental well-being at the local level: investigating the effects of perceived relative position in a deprived area context.</td>
<td>This study did not specifically focus on income inequality.</td>
</tr>
<tr>
<td>4. Lang et al., (2011). Income and the midlife peak in common mental disorder prevalence.</td>
<td>This study did not specifically focus on income inequality.</td>
</tr>
<tr>
<td>5. Pickett et al., (2006). Income inequality and the prevalence of mental illness: a preliminary international analysis.</td>
<td>This study examined income inequality on a global scale. It was not considered to be relevant to the current review as it did not include Britain in the analysis.</td>
</tr>
<tr>
<td>7. Macintyre et al., (2005). Are rich people or poor people more likely to be ill? Lay perceptions, by social class and neighborhood, of inequalities in health.</td>
<td>This study focussed on perceptions of health inequality in relation to income.</td>
</tr>
<tr>
<td>9. Lewis et al., (2003). Socio-economic status, standard of living and neurotic disorder.</td>
<td>This study did not specifically focus on the impact of income inequality on mental health.</td>
</tr>
</tbody>
</table>
### Appendix E: Table 6: A data extraction table for the eight studies included in the review

<table>
<thead>
<tr>
<th>Author, year, title &amp; ID code</th>
<th>Aim of study</th>
<th>Sampling &amp; participants</th>
<th>Study Design</th>
<th>Outcomes measures</th>
<th>Results</th>
<th>Strengths &amp; Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fone <em>et al.</em>, (2013). Common mental disorders, neighbourhood income inequality and income deprivation: small area multilevel analysis.</td>
<td>To investigate the hypothesis that income equality was associated with individual mental health.</td>
<td>The study used a multistage probability sampling design. The sample comprised of 88,623 respondents aged 18-74 from the Welsh Health Survey, 2003/04-2010.</td>
<td>The study used a cross-sectional survey design.</td>
<td>The Mental Health Inventory (MHI-5) scale of the Short Form Health Survey (SF-36) version 2 as a measure of common mental disorders. Income was measured using validated gross household income estimates. Income inequality was measured using the Gini coefficient.</td>
<td>The Gini coefficient ranged from 0.39-0.45 for the unitary authorities used in the study (mean 0.41, s.d. = 0.018). This demonstrated that income inequality was present within the regions that were studied. At a regional level income inequality was significantly associated with poor mental health (parameter estimate -1.35 (s.e. = 0.54), P=0.012; odds ratio = 1.13, 95% CI 1.04-1.22).</td>
<td>1. The study used a large sample. 2. Appropriate mental health outcome measure used. 3. However the Gini coefficient has limitations. 4. The findings are based on a self-report measure of mental health which was not validated by a clinical interview 5. The study used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be established.</td>
</tr>
<tr>
<td>Author, year, title &amp; ID code</td>
<td>Aim of study</td>
<td>Sampling &amp; participants</td>
<td>Study Design</td>
<td>Outcomes measures</td>
<td>Results</td>
<td>Strengths &amp; Limitations</td>
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<tr>
<td>2. Mangalore &amp; Knapp (2012). Income-related inequalities in common mental disorders among ethnic minorities in England.</td>
<td>To calculate and compare income-related inequalities in common mental disorders among ethnic groups. IV: Ethnic groups and household income (obtained from EPIRIC survey) DV: Concentration indices obtained from income and mental health measure (CIS-R score)</td>
<td>The study used a representative sample of 3,565 obtained from the (EMPIRIC) 2000 survey.</td>
<td>The study used a cross-sectional survey design.</td>
<td>Income was measured using equivalised (for household size) household income from data obtained by the EMPIRIC survey. The concentration index was used to measure income inequality in relation to mental health. Common mental disorders were measured using the Clinical Interview Schedule-Revised (CIS-R).</td>
<td>The concentration indices were negative which suggests that a high proportion of people with poor mental health live in areas of low income. Among groups that have income inequality, within-group inequality is highest for the Irish (-0.1370), White (-0.1268), African Caribbean (-0.1158) and Pakistani (-0.0595) populations. These concentration indices are all statistically significant.</td>
<td>1. The study used a relatively large sample. 2. Appropriate outcome measures were used. 3. The findings are based on a self-report measure of mental health which was not validated by a clinical interview 4. The study used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be established.</td>
</tr>
<tr>
<td>Author, year, title &amp; ID code</td>
<td>Aim of study</td>
<td>Sampling &amp; participants</td>
<td>Study Design</td>
<td>Outcomes measures</td>
<td>Results</td>
<td>Strengths &amp; Limitations</td>
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DV: Mental health score | Representative sample was used of adults living in different countries. The sample were respondents from a 1998, World Health Organisation (WHO) study. However, no further details were given. | The study used a cross-sectional survey design. | No detail of the outcome measure that was used was given in the article.  
Income inequality was measured using the 20:20 ratio measure of income inequality. | No data in relation to 20:20 ration measure was presented.  
A significant association was found in rich countries between income inequality and the proportion of adults that were mentally ill in the year before being interviewed ($r= 0.73, P < 0.01$). | 1. The study looked at the relationship between income inequality and mental health on a global scale.  
2. The study used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be established.  
3. The study used a large sample.  
4. No information about validity of outcome measures. |
<table>
<thead>
<tr>
<th>Author, year, title &amp; ID code</th>
<th>Aim of study</th>
<th>Sampling &amp; participants</th>
<th>Study Design</th>
<th>Outcomes measures</th>
<th>Results</th>
<th>Strengths &amp; Limitations</th>
</tr>
</thead>
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<tr>
<td>4. Mangalore et al., (2007). Income-related inequality in mental health in Britain: the concentration index approach.</td>
<td>To measure income-related inequality in the distribution of psychiatric disorders. IV: Individual income obtained from the psychiatric morbidity survey. DV: The concentration indices obtained from income data and the mental health data (CIS-R and SCAN scores).</td>
<td>A representative sample of 8580 respondents from the Psychiatric Morbidity survey 2000 aged 16-74 was used.</td>
<td>The study uses a cross-sectional survey design.</td>
<td>The Psychiatric Morbidity survey included the Clinical Interview Schedule Revised (CIS-R) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) as measures of mental health. The living standards measure was used as a measure of individual income. The Concentration Index (CI) was used to measure income inequality in relation to mental health.</td>
<td>The results indicated that there was a significant income-related inequality in health (CI = -0.0129). The concentration index was a negative value which indicated that poor mental health is more prevalent in areas of low income indicating that income inequality was present within the region that was studied. Psychosis was associated with the highest level of income-related inequality (CI = -0.439).</td>
<td>1. The study used a large sample. 2. The study used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be established. 3. Appropriate outcome measures were used for income inequality and mental health. 4. Equivalised household income would have been a more valid measure of income. 5. Scores were based on self-report measures and not validated with clinical interviews.</td>
</tr>
<tr>
<td>Author, year, title &amp; ID code</td>
<td>Aim of study</td>
<td>Sampling &amp; participants</td>
<td>Study Design</td>
<td>Outcomes measures</td>
<td>Results</td>
<td>Strengths &amp; Limitations</td>
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<tr>
<td>5. Wilkinson &amp; Pickett (2007). The problems of relative deprivation: Why some societies do better than others.</td>
<td>To assess the association between income inequality and the prevalence of both serious and any mental illness. IV: Income inequality score using the 20:20 ratio measure. DV: mental health scores</td>
<td>Representative sample was used of adults living in different countries. The sample were respondents from a, World Health Organisation (WHO) study. However, no further details were given.</td>
<td>The study used a cross-sectional survey design.</td>
<td>No details of the measures that were used were given to measure mental health. Income inequality was measured using the 20:20 ratio measure of income inequality.</td>
<td>No data was presented in relation to the 20:20 ratio measure of income inequality for the UK. A statistically significant correlation was found between income inequality and the prevalence of both serious and any mental illness (r= 0.79, P=0.002).</td>
<td>1. The study looked at the relationship between income inequality and mental health on a global scale. 2. The study used a cross-sectional design and therefore the causality of the association between income inequality and mental health cannot be established. 3. The study used a large sample. 4. No information about the validity of the outcome measures.</td>
</tr>
<tr>
<td>6. Gravelle &amp; Sutton (2003). Income related inequalities in self-assessed health in Britain: 1979–1995.</td>
<td>To measure income related inequalities in health in England, Scotland, and Wales between 1979 and 1995. IV: Household Income. DV: Concentration indices obtained from income data and the EuroQol ED-5d11 score.</td>
<td>Representative sample of the adult population living in private households in Great Britain 1979–1995. The total sample was 299,968 people.</td>
<td>A cross-sectional survey design was used.</td>
<td>The Health Survey England (HSE) was used which incorporated the EuroQol EQ-5D11 measure of health that has an anxiety and depression scale within in to assess mental health. Equivalised household income was obtained from the HSE survey. The partial concentration index was used to measure income inequality.</td>
<td>The difference in income related health inequality in the three countries was attributed to the effect of income on health. Health inequality was greater in Wales (PCI= 0.0135) and Scotland (PCI= 0.0119) than England (PCI= 0.0112) because the effect of income on health is larger in these areas.</td>
<td>1. A large sample was used. 2. The causality of the association cannot be established. 3. Appropriate outcome measures used. 4. It may have been preferable to use the concentration index rather than the partial concentration index. 5. Scores were self-reported and not validated with interviews.</td>
</tr>
<tr>
<td>Author, year, title &amp; ID code</td>
<td>Aim of study</td>
<td>Sampling &amp; Study Design</td>
<td>Outcomes measures</td>
<td>Results</td>
<td>Strengths &amp; Limitations</td>
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<tr>
<td>7. Wildman, J. (2003). Income related inequalities in mental health in Great Britain: analyzing the causes of health inequality over time.</td>
<td>To explore the nature of income related inequalities in health over time in Great Britain. IV: Annual household income. DV: Concentration indices of mental health (GHQ score)</td>
<td>A representative sample of 5234 participants who responded to the British Household Panel Survey (BHPS). All participants were adults. A cohort design was used.</td>
<td>A short version of the General Health questionnaire (GHQ) was used was a measure of mental health. Annual household income was obtained from the BHPS survey. Income inequalities in mental health were measured using the concentration index.</td>
<td>The concentration indices in both waves 1 (men = -0.022; women = -0.02) and 7 (men = -0.016; women = -0.010) were negative which suggests that poor mental health was more highly concentrated amongst those in lower income groups.</td>
<td>1. A large sample was used. 2. Appropriate outcome measures were used for mental health and income inequality. 3. Income would have been more accurately measured using equivalised household income. 4. Scores were self-reported and not validated with interviews. 5. No cause and effect could be ascertained.</td>
<td></td>
</tr>
<tr>
<td>8. Weich et al., (2001). Income inequality and the prevalence of common mental disorders in Britain.</td>
<td>To investigate the hypothesis that income inequality is associated with a high prevalence of common mental disorders after adjusting for individual income. IV: Gini coefficient (income inequality) DV: GHQ score</td>
<td>A representative sample of 8191 participants was used in the study. All participants were aged between 16-75. Data was obtained from the British Household Panel Survey (1991) A cross-sectional survey design was used.</td>
<td>Income was measured using annual household income. Gini coefficients for each region were calculated as a measure of inequality by region. Common mental disorders were assessed using the General Health questionnaire (GHQ).</td>
<td>No statistically significant association was found between Gini coefficient and common mental disorders (odds ratio = 0.99, 95% CI 0.87-1.13; P=0.88). However, income inequality was associated with poor mental health among the most affluent individuals (adjusted Odds ratio 1.31, 95% CI 1.05-1.65. P=0.02).</td>
<td>1. The study used a large sample. 2. The causality of the relationship between inequality and mental health cannot be ascertained. 3. The Gini coefficient has limitations. 4. Appropriate outcome measures used. 5. Scores were self-reported</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: A Description of the income inequality measures used within the current review

The Gini Coefficient
The Gini coefficient is a widely used measure of income inequality. A Gini coefficient of 0.0 represents perfect equality of income, whereas a Gini coefficient of 1.0 relates to maximal income inequality. The Gini coefficient has a close relationship with the Lorenz curve. The Gini coefficient measures the area between the Lorenz curve and a hypothetical line of absolute equality, expressed as a percentage of the maximum area under the line.

The Concentration Index
The Concentration Index (CI) is a standardised tool and it builds on both the Lorenz curve and the Gini coefficient. It provides a method of quantifying the degree of income-related inequality in a specific health variable. The CI therefore measures the inequality in the health variable being studied in relation to the distribution of income.

The concentration curve plots on the horizontal axis the cumulative percentage of the income of the sample beginning with the poorest and the vertical axis shows the cumulative percentage of the health variable that is being studied. The minimum and maximum values of the CI are -1 to +1. If it takes a negative value then it is indicated that there is a disproportionate concentration of the health problem among the poor.

The 20:20 Ratio Measure of Income Inequality
The 20:20 ratio measure of income inequality compares how much richer the top 20% of populations are to the bottom 20% of a given population. The 20:20 ratio is a direct measure of income inequality and is more sensitive to variation in the distribution of income that the Gini coefficient.
Appendix G: Researcher’s statement of epistemological position

Interpretative phenomenological analysis (IPA) was used in the current study to explore how members of staff working within mental health teams perceived social deprivation to influence their clinical practice.

Staff experiences were interpreted by the researcher from a critical realist perspective. Critical realism argues that knowledge is subjective and accepts conflicting alternative perspectives (Watkins, 1994). Therefore even though staff members may have experienced the same reality (e.g. social deprivation) within their clinical work, critical realism argues that each individual staff member would have attached a different meaning to this experience. This is due to staff coming from different backgrounds (e.g. social class) and having different: values; ethics; beliefs; and personal experiences of poverty.

A critical realist perspective acknowledges that the researcher’s own social class, values, ethics, beliefs and personal experiences of poverty would have influenced the results that are presented, through the process of interpreting the participants’ understanding of the phenomena studied (social deprivation).

For example, the researcher was aware that she was from a working class background and during the study it became apparent that some participants were from middle-class backgrounds. However, the researcher used reflexive practices such as the use of a reflective diary to reduce the likelihood of inappropriate bias occurring. The researcher was also aware that the data obtained from the present study may not reflect a direct access to the true reality (Willig, 2008).
Appendix H: Favourable opinion ethics

Health Research Authority

NRES Committee North East - Sunderland
Room 002
TEDCO Business Centre
Viking Business Park
Jarrow
Tyne & Wear
NE32 3DT
Telephone: 0191 4283563
Facsimile: 0191 4283432

14 January 2013

Miss Leah Clatworthy

Dear Miss Clatworthy

Study title: The understanding and experience of social deprivation on mental health for staff working within Community Mental Health Teams (CMHTs): An exploratory study.

REC reference: 12/NE/0422
IRAS project ID: 115331

Thank you for your email of 10 January 2013, responding to the Proportionate Review Sub-Committee’s request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Helen M Wilson, nrescommittee.northeast-sunderland@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.
Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved by the Committee are:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Leah Clatworthy</td>
<td>04 December 2012</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>Other: CV</td>
<td>Dr Stephen Melluish</td>
<td>04 December 2012</td>
</tr>
<tr>
<td>Other: Service User Reference Group Evaluation of Trainee Research</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A Research Ethics Committee established by the Health Research Authority
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/NE/0422 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.
R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

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12/NE/0422: Please quote this number on all correspondence

Yours sincerely

[Signature]

Mr Paddy Stevenson
Chair

E-mail: nrescommittee.northeast-sunderland@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to:
Appendix I: Research and development letter of approval

Miss Leah Clatworthy
Trainee Clinical Psychologist
104 Regent Road
Leicester
LE1 7LT

Dear Leah

25 January 2013

Re: The Impact of Social Deprivation on Members of staff working within Community Mental health Teams (CMHTs): An exploratory study

SPONSOR: 
INDEMNITY: NHS Indemnity Scheme
Trust Ref: ADMH0604

Thank you for applying for NHS Permission to conduct the above study in the Trust. I am now in receipt of confirmation of a favourable ethical opinion (Ref 12/NE/0422 dated 14 January 2013), and have undertaken a full governance review (and have noted all subsequent amendments). This includes confirmation of the arrangements for full indemnity cover for your study against any negligence that might occur during the course of your project.

This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. has granted you full approval to conduct this research within the Trust on the condition that the Trust suffers no additional costs as a result of this study being undertaken. Your research has been entered onto the Trust's Research Database.

Study documents that have been approved are listed below (not exhaustive):

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Leah Clatworthy</td>
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</tr>
<tr>
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<td>Version 8</td>
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</tr>
<tr>
<td>Other: CV</td>
<td>Dr Stephen Melluish</td>
<td>04 December 2012</td>
</tr>
<tr>
<td>Other: Service User Reference</td>
<td>Group Evaluation of Trainee Research</td>
<td></td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>Protocol</td>
<td>Version 8</td>
<td>10 January 2013</td>
</tr>
<tr>
<td>REC application</td>
<td>Version 3.4</td>
<td>04 December 2012</td>
</tr>
</tbody>
</table>
Please note that all research with an NHS element is subject to the Research Governance Framework for Health and Social Care 2005. If you are unfamiliar with the standards contained in this document, or the policies that reinforce them, you can obtain advice from the R&D Office, or from http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentA Z/ResearchGovernance/fs/en.

You must stay in touch with the R&D Office during the course of the research project, particularly if/when:

- There is a change of Principal Investigator;
- The project finishes (please complete a summary report form);
- Amendments are made, whether minor or substantial;
- Serious Adverse Events have occurred (must be reported within 24 hours of becoming aware of the event).

This is necessary to ensure that your indemnity cover is valid. Should any untoward events occur it is **essential** that you contact the R&D Office immediately. If patients or staff are involved in an incident, you should also contact the Clinical Risk Manager.

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Regards,

Copy to:
Appendix J: Favourable opinion ethics amendment 1

NHS

Health Research Authority

NRES Committee North East - Sunderland
Room 002
TEDCO Business Centre
Viking Business Park
Jarrow
Tyne & Wear
NE32 3DT
Tel: 0191 4283563

27 June 2013

Miss Leah Clatworthy

Dear Miss Clatworthy,

Study title: The understanding and experience of social deprivation on mental health for staff working within Community Mental Health Teams (CMHTs): An exploratory study.

REC reference: 12/NE/0422
Amendment number: 1 Amendment 13.06.13
Amendment date: 13 June 2013
IRAS project ID: 115331

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>Version 9</td>
<td>13 June 2013</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>1 Amendment 13.06.13</td>
<td>13 June 2013</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

A Research Ethics Committee established by the Health Research Authority
R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

| 12/NE/0422: | Please quote this number on all correspondence |

Yours sincerely

[Signature]

Mr Paddy Stevenson
Chair

E-mail: nrescommittee.northeast-sunderland@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: [Redacted]

A Research Ethics Committee established by the Heath Research Authority
Appendix K: Favourable opinion ethics amendment 2

17 September 2013

Miss Leah Catatworthy

Dear Miss Catatworthy

Study title: The understanding and experience of social deprivation on mental health for staff working within Community Mental Health Teams (CMHTs): An exploratory study.

REC reference: 12/NE/0422
Amendment number: Amendment 2, 14/08/13
Amendment date: 14 August 2013
IRAS project ID: 115331

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td>Email</td>
<td>22 August 2013</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>Amendment 2, 14/08/13</td>
<td>14 August 2013</td>
</tr>
<tr>
<td>Protocol</td>
<td>Version 10</td>
<td>14 August 2013</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

A Research Ethics Committee established by the Health Research Authority
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R&D staff at our NRES committee members’ training days – see details at [http://www.hra.nhs.uk/hra-training/](http://www.hra.nhs.uk/hra-training/).

12/NE/0422: Please quote this number on all correspondence

Yours sincerely

Pp

Mr Paddy Stevenson
Chair

E-mail: nrescommittee.northeast-sunderland@nhs.net

**Enclosures:** List of names and professions of members who took part in the review

**Copy to:**
Appendix L: A copy of the participant information sheet

Participation Information Sheet

1. Study Title
The impact of social deprivation on members of staff working within mental health services: An exploratory study.

Ethics Number: 12/NE/0422

Researcher: Leah Clatworthy, Clinical Psychologist Trainee, University of Leicester

Contact: E. lc255@le.ac.uk

2. Invitation to participate
As a member of clinical staff working within an Adult CMHT within the city you are being invited to take part in this study. The following information will explain why the research is being done and will help you to decide whether you want to take part. If you have any further questions after reading this document, please feel free to contact the researcher.

3. What is the purpose of the study?
In the past research studies have focused on the complex association between mental health and social deprivation. However, few studies have specially focused on the experiences of clinical staff who work in mental health teams within socially deprived areas of the UK. Therefore, the main objective of the proposed study is to explore clinical staffs' understandings of social deprivation and to ascertain how this knowledge influences their current clinical practice. The results of the proposed study will then be used to inform how future practice may be changed to help CMHT staff to incorporate this knowledge into their own clinical practice.

4. What will you be asked about?
You will be asked about your understanding of the term 'social deprivation'. In addition to this, you will be asked in what ways (if any) do you consider social deprivation to influence your clinical practice.
5. What will this entail?
The study will involve taking part in one focus group with other multi-disciplinary members of your clinical team. The entire session will last for one and a half hours. Your service has agreed for you to take part in this study during work hours. You will not have to engage in discussion or answer questions about topics you do not wish to talk about. The interviews will be audio recorded and transcribed for analysis.

6. Confidentiality and Anonymity
Your comments will be anonymised, so that any information shared in the communication of the project findings cannot be traced back to you. Transcription of interviews will be produced in a completely anonymous format, removing any participant names, references to places etc. Anonymous extracts from interviews may be incorporated into the final publication.

7. What will happen if I agree to take part?
If you agree to take part you can contact the researcher directly and they will give you details of when the focus group will take place. The researcher will liaise with your line manager to schedule the session. Further instructions and the opportunity to ask questions will be scheduled in the actual session. You will be asked to sign a consent form before the interview. If you choose to participate, you retain the right to withdraw up when data is anonymised.

8. Are there any risks in taking part?
No significant risks have been identified in this study.

9. What are the potential benefits in taking part?
The results of the study aim to inform future practice and potentially highlight areas of training that may be useful for staff members who work in socially deprived areas. You may also benefit by reflection on the topics discussed and the practices of your colleagues, which in turn may influence your clinical practice.

10. How will the findings of the study be used?
A report will be disseminated to the Community Mental Health Teams involved in the study. The study will be submitted for publication to selected journals in Autumn 2014. You will not be identifiable in any of the proceeds. A copy of the final report will be available from the researcher in Autumn 2014 if you request it.

11. Who is funding the research?
The research is being funded by the University of Leicester and is sponsored by Leicestershire Partnership Trust.

Further Information
If you require any more information now or in the future you may contact the researcher Leah Clatworthy (E: lc255@le.ac.uk).

Thank you for taking the time to consider participating.
Appendix M: Participant consent form

Ethics Number:
Participant Identification Number:

CONSENT FORM
Title of Project: The impact of social deprivation on members of staff working within Community Mental Health Teams (CMHTs): An exploratory study.

Name of Researcher: Leah Clatworthy, Clinical Psychologist Trainee, University of Leicester

Thank you for agreeing to take part in this research project. Please read this consent form, and ask any further questions you would like to about what will be involved.

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that I will be taking part in a focus group, which will be recorded, and that the data will then be transcribed.
4. I understand that my identity will remain anonymous throughout the study and that if quotations are used from my interview, that my identity and the identities of other people I may mention will also be anonymised.
5. I understand that if the researcher is concerned about my safety or the safety of anyone that I might mention during the interview, that the researcher has a duty to break confidentiality.
6. I understand that data from the interview will be kept securely at the University of Leicester, and destroyed after one year.
7. I understand that the data from the focus group will be included as part of a Doctoral thesis, and that the results will be published in academic journals and fed back to Participants.

8. I agree to take part in this study.

____________________                                   _________
Name of Participant                                      Date        Signature

____________________                                   _________
Researcher                                              Date        Signature
Appendix N: Interview schedule

Introduction to the session
During the introduction it will be stressed that participant/s should keep what they hear in the discussion as confidential. The researcher will also explain that the first half of the session will focus on participants’ understanding of the term social deprivation, whilst the last half of the session will focus on how social deprivation influences their current clinical practice.

Space for questions

Part one of the interview

1) What is your understanding of the term ‘social deprivation’?

2) What is your understanding of the association between mental health and social deprivation?

3) Are issues of social deprivation (such as poverty and low income) highlighted when working with someone living in a deprived area? If so, in what ways are they discussed? If not, what do you think are the reasons for this?

Part two of the interview

1) Now let’s begin to consider in what ways (if any) social deprivation influences your clinical practice. Do you regularly work with people who live in deprived areas?

   (i) If not, have you ever worked with someone who lives in a deprived area?
   (ii) If so, what (if any) are the differences in the work that you undertake with people who live in deprived areas compared to working with people who do not?

2) How does it make you feel as a professional who is working with people who live in areas of deprivation?

3) Have you ever had to visit socially deprived areas as part of your work? If so, how did this make you feel? If not, would you feel comfortable visiting these areas?

4) Is there an opportunity within your service to discuss these issues within your team? If so, do you feel comfortable discussing these issues? If not, what do you think would make you feel more at ease to discuss these issues?

Debrief
Thank participant/s for taking part in the study and to provide an opportunity for participant/s to reflect on the experience of taking part in the interview (ten minutes).

Space for questions
Appendix O: An example of a coding sheet

Table 9: Tracking experiential claims and identifying emergent themes for individual interview 2 (Step 1)

<table>
<thead>
<tr>
<th>From Line</th>
<th>Object</th>
<th>Experiential Claims</th>
<th>Emerging Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>448</td>
<td>Impact of changes to the welfare system on service users</td>
<td>&quot;People are pretty desperate and that one of the things that you do need to be able to do these days is to provide a cast iron case for your ill health before you can access any kind of disability allowance.&quot;</td>
<td>Benefits: pretty desperate</td>
</tr>
<tr>
<td>458</td>
<td>Team are stretched</td>
<td>&quot;A part of that it might be because of more people needing those sorts of supporting letters but it’s also part of the push down because of other people being too busy. The last one I wrote they said could you write it because we have been asking so and so for two weeks and he’s not got it and we’ve got a deadline so could you just write something.&quot;</td>
<td>Service is struggling: other people being too busy</td>
</tr>
<tr>
<td>481</td>
<td>How to cope with the emotional impact of the work</td>
<td>&quot;You know when I clear off to my nice little middle class house and enjoy the weekend with my children I don’t think that I spend a lot of time thinking about this world back here and you know I think that that would be overwhelming.&quot;</td>
<td>Divide: I don’t think that I spend a lot of time thinking about this world</td>
</tr>
<tr>
<td>486</td>
<td>How to cope with the emotional impact of the work</td>
<td>&quot;I suppose I have a belief that to be helpful to people there has to be a level of distance. If I became emotionally engaged to the extent that you could if you really felt for those people’s lives then I wouldn’t be able to do this job for very long. So yeah it’s a nodding awareness rather than a fully-fledged engagement with it.&quot;</td>
<td>Divide: helpful to people there has to be a level of distance</td>
</tr>
</tbody>
</table>
### Appendix P: Table 10: Integrating data from multiple interviews (Data Analysis Stage 8)

<table>
<thead>
<tr>
<th>Stage of Analysis</th>
<th>Region 1 CMHT</th>
<th>Region 1 Social care</th>
<th>Region 2 CMHT</th>
<th>Region 2 Psychology</th>
<th>Region 2 Social care</th>
<th>Region 3 CMHT &amp; Social care</th>
<th>Region 3 Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steps 1: Emergent Themes</strong></td>
<td>• Divide between City and County.</td>
<td>• Divide between City and county.</td>
<td>• Divide between city and county.</td>
<td>• Divide between city and county.</td>
<td>• Divide between city and county.</td>
<td>• Divide between City and county.</td>
<td>• Service users are struggling to live on benefit money.</td>
</tr>
<tr>
<td></td>
<td>• Divide between service user and staff member’s homes.</td>
<td>• Divi...</td>
<td>• Not enough resources in the city.</td>
<td>• Benefit system is unfair for service users.</td>
<td>• Benefit system is unfair for service users.</td>
<td>• Benefit system is unfair at the service.</td>
<td>• Divide between the city and county.</td>
</tr>
<tr>
<td></td>
<td>• Staff members need to be ‘thick skinned’.</td>
<td>• Staff members need to be ‘thick skinned’.</td>
<td>• Staff members are frustrated with the management of the service.</td>
<td>• Staff members are frustrated with the management of the service.</td>
<td>• Staff members are frustrated with the management of the service.</td>
<td>• Staff members are frustrated with the management of the service.</td>
<td>• Divide between staff and service users’ living conditions.</td>
</tr>
<tr>
<td></td>
<td>• Staff members break the rules of the service</td>
<td>• Staff members break the rules of the service</td>
<td>• Team is frustrated with changes in benefit system</td>
<td>• Team is frustrated with changes in benefit system</td>
<td>• Team is frustrated with changes in benefit system</td>
<td>• Team is frustrated with changes in benefit system</td>
<td>• Frustrated at service.</td>
</tr>
<tr>
<td></td>
<td>• Divide between CMHT and Social Care.</td>
<td>• Divide between CMHT and Social Care.</td>
<td>• Poor housing provision in the city.</td>
<td>• Poor housing provision in the city.</td>
<td>• Poor housing provision in the city.</td>
<td>• Poor housing provision in the city.</td>
<td>• Not enough resources in team.</td>
</tr>
<tr>
<td></td>
<td>• Staff members talk to each other about difficult situations.</td>
<td>• Staff members talk to each other about difficult situations.</td>
<td>• Peer support is important.</td>
<td>• Peer support is important.</td>
<td>• Peer support is important.</td>
<td>• Peer support is important.</td>
<td>• Need for clear expectations of change following therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Staff members are frustrated at service users.</td>
<td></td>
<td></td>
<td></td>
<td>• Divide between immigration services and the CMHT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Staff members are supportive.</td>
</tr>
<tr>
<td>Stage of Analysis</td>
<td>Region 1 CMHT</td>
<td>Region 1 Social care</td>
<td>Region 1 Social care</td>
<td>Region 2 Psychology</td>
<td>Region 2 Social care</td>
<td>Region 3 CMHT &amp; Social care</td>
<td>Region 3 Psychology</td>
</tr>
<tr>
<td>-------------------</td>
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<td>----------------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td><strong>Step 2:</strong> Positionality (P); Facilitator Role (FR) &amp; Statement Function (SF)</td>
<td>P: Frustration at the separation of services; shock of the difference between service users' world and their own; lots of examples of breaking the rules; team is described as supportive.</td>
<td>P: Frustration at the separation of services; dissatisfaction of changes to role over time; difference between service users' world and their own; frustration directed at other agencies; breaking the rules; importance of staff support.</td>
<td>P: Defeated; frustration at the separation of social care and the impact that this has had on the team; resentful of resources in the county; empathy for service users</td>
<td>P: Welfare system is unfair and the recent changes impacted on the CMHT which is also unfair; service users live in a different world; lack of service provision in city and county</td>
<td>P: Frustration at service; dissatisfaction at current role; service users world is different from staffs' world; team are united in their own philosophy of how service should be operated.</td>
<td>P: Frustration at current service provision; difference in service user life to own; staff support each other; staff need to be tough.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FR: Curious stance: guides conversation, provides links to theory, encourages quieter participants to participate</td>
<td>FR: Curious stance; guides conversation, provides links to theory, asks for clarification on issues</td>
<td>FR: Curious stance, asks questions, guides conversation more due to individual interview, links to theory, seeks clarification on issues at times.</td>
<td>FR: Curious stance; guides conversation, provides links to theory.</td>
<td>FR: Curious stance; guides conversation, provides links to theory, encourages quieter participants to participate.</td>
<td>FR: Curious stance; guides conversation, provides links to theory.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SF: Encouraging each other to discuss case examples and be critical of service. Validating each other's experiences</td>
<td>SF: Encouraging each other to discuss case examples and describe occurrences where rules have been broken and describing the history of the service.</td>
<td>SF: Encouraging each other to discuss case examples and validating service users' and staff's frustrations with the lack of resources and mainly descriptive. Shares personal views of world.</td>
<td>SF: Validating each other to discuss case examples and validating each other's experiences. Examples given of breaking the rules and justification for this.</td>
<td>SF: Encouraging each other to discuss case examples and validating each other's experiences.</td>
<td>SF: Encouraging each other to discuss case examples and validating each other's experiences.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 3:</strong> Roles &amp; Relationships</td>
<td>• Service users: seen as completely separate from staff; 'they', 'chap'</td>
<td>• Social care team: 'we'</td>
<td>• CMHT: we</td>
<td>• CPN: 'they'</td>
<td>• Team: 'we'</td>
<td>• Service users: 'they', 'them', 'powerless people', 'chap'</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• People who live in the county are seen as 'different'.</td>
<td>• Service users: 'them' or 'they'</td>
<td>• Service users: 'them' or 'they'</td>
<td></td>
<td>• Psychologists: 'we are a bit different from psychologists'</td>
<td>• Teams: 'we'</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMHT: 'our colleagues'</td>
<td></td>
<td></td>
<td>• Social care team: 'them' or 'they'</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CPNS: 'they are very creative'</td>
<td></td>
<td></td>
<td>• Doctors: still wear a suit and tie, nurses don't.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Stage of Analysis

#### Step 4: Organisations & Systems

<table>
<thead>
<tr>
<th>Region 1 CMHT</th>
<th>Region 1 Social care</th>
<th>Region 2 Psychology</th>
<th>Region 2 Social care</th>
<th>Region 3 CMHT &amp; Social care</th>
<th>Region 3 Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical of recent changes to the welfare system.</td>
<td>Praise for manager: ‘knows what he is doing’</td>
<td>Critical of management of service and NHS as a whole: pressures, lack of resources, separation from social care</td>
<td>Perception that service is struggling</td>
<td>Critical of NHS management</td>
<td>Critical of how both services are operated</td>
</tr>
<tr>
<td>Critical of the management decision to separate the CMHT from social care.</td>
<td>Critical of housing service: unjust</td>
<td>Critical of social care service: ‘emphasis on money’</td>
<td>Critical of recent changes to the welfare system</td>
<td>Critical of social care managers</td>
<td>Critical of the housing service</td>
</tr>
<tr>
<td></td>
<td>Critical of recent changes to the welfare system</td>
<td>Critical of recent changes to the welfare system</td>
<td>Critical of social care referral team</td>
<td>Critical of social care referral team</td>
<td>Critical of recent changes to the welfare system</td>
</tr>
</tbody>
</table>

#### Step 5: Stories

<table>
<thead>
<tr>
<th>Region 1 CMHT</th>
<th>Region 1 Social care</th>
<th>Region 2 Psychology</th>
<th>Region 2 Social care</th>
<th>Region 3 CMHT &amp; Social care</th>
<th>Region 3 Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>The separation from social care was difficult.</td>
<td>The separation from CMHT was difficult.</td>
<td>The separation from social care has been difficult for the team</td>
<td>The separation from social care was difficult.</td>
<td>Dissatisfaction directed at both services.</td>
<td>Dissatisfaction directed at both services.</td>
</tr>
<tr>
<td>Empathy for service users</td>
<td>Current situation is unjust for staff and service users</td>
<td>Current situation is unjust for staff and service users</td>
<td>Current situation is unjust for staff and service users</td>
<td>Staff break the rules quietly</td>
<td>Staff break the rules quietly</td>
</tr>
<tr>
<td>Staff break the rules</td>
<td>Staff break the rules</td>
<td>Empathy for service users</td>
<td>Service users are struggling</td>
<td>Staff support each other</td>
<td>Staff support each other</td>
</tr>
<tr>
<td>Staff support each other</td>
<td>Staff support each other</td>
<td>Staff are struggling; firefighting</td>
<td>Lack of resources in city and county</td>
<td>Staff do not feel supported by the service</td>
<td>Service users lives very different from own</td>
</tr>
<tr>
<td>Reminiscing about how the service operated previously</td>
<td>Reminiscing about how the service operated previously</td>
<td>Staff support each other</td>
<td>Barriers to undertaking therapeutic work</td>
<td>The separation from the teams was difficult</td>
<td>Staff live in a different world from service users</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Live in a different world to service users</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Steps 6: Language

- Informal: ‘I’ve got a chap’.
- Moderately Emotional: ‘People have fallen over the edge now and services’
- Jargon: professional guidelines, NSF
- Language of anger & frustration

### Steps 7: Adaptation of Emergent Themes

<table>
<thead>
<tr>
<th>Stage of Analysis</th>
<th>Region 1 CMHT</th>
<th>Region 1 Social care</th>
<th>Region 2 Psychology</th>
<th>Region 2 Social care</th>
<th>Region 3 CMHT &amp; Social care</th>
<th>Region 3 Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 6: Language</strong></td>
<td>Divide between City and County.</td>
<td>Divide between service user and service users’ worlds.</td>
<td>Informal/flippant language: ‘we don’t do useful things like that anymore.’</td>
<td>Divide between staff members and service users’ living conditions.</td>
<td>Divide between CMHT and Social Care.</td>
<td>Highly emotional: ‘I almost like you are asking [the housing service] for a kidney’</td>
</tr>
<tr>
<td><strong>Step 7: Adaptation of Emergent Themes</strong></td>
<td>Divide between CMHT and Social Care. Staff members support each other.</td>
<td>Divide between service user and service members’ worlds. Staff members are ‘thick skinned’. Staff members break the rules.</td>
<td>Highly emotional: ‘fighting the same battles every week with no rewards’</td>
<td>Frustration directed at service pressures.</td>
<td>Frustration directed at the service and service users.</td>
<td>Benefit system is unfair.</td>
</tr>
<tr>
<td></td>
<td>Divide between City and County.</td>
<td>Reduce between service user and service users’ worlds.</td>
<td>Language of anger &amp; frustration</td>
<td>Staff members break the rules.</td>
<td>Staff members need to be tough.</td>
<td>Divided between the city and county.</td>
</tr>
<tr>
<td></td>
<td>divide between service user and service members’ worlds. Staff members are ‘thick skinned’. Staff members break the rules.</td>
<td>Divide between CMHT and Social Care. Staff members support each other.</td>
<td>Supervision provides support.</td>
<td>Staff members need to be tough.</td>
<td>Staff members need to be tough.</td>
<td>Divided between city and county teams.</td>
</tr>
<tr>
<td></td>
<td>Divide between City and County</td>
<td>Staff members support each other.</td>
<td>Supervision provides support.</td>
<td>Staff members support each other.</td>
<td>Staff members support each other.</td>
<td>Divided between city and county teams.</td>
</tr>
<tr>
<td></td>
<td>Emotional: ‘no furniture, a filthy mattress and nothing else’</td>
<td>Staff members support each other.</td>
<td>Supervision provides support.</td>
<td>Staff members support each other.</td>
<td>Staff members are supportive towards each other.</td>
<td>Benefit system is unfair.</td>
</tr>
<tr>
<td></td>
<td>Jargon: professional guidelines, NSF</td>
<td>Team is frustrated with changes in benefit system. Poor housing provision in the city. Peer support is valued.</td>
<td>Supervision provides support.</td>
<td>Staff members need to be tough.</td>
<td>Staff members need to be tough.</td>
<td>Divided between city and county teams.</td>
</tr>
<tr>
<td></td>
<td>Jargon: professional guidelines, NSF</td>
<td>Staff members support each other.</td>
<td>Supervision provides support.</td>
<td>Staff members need to be tough.</td>
<td>Staff members need to be tough.</td>
<td>Divided between city and county teams.</td>
</tr>
</tbody>
</table>
Appendix Q: Chronology of research process

1. January 2012: Submission of three research topics to the University of Leicester
2. January 2012: Allocation of research Supervisor
3. February 2012: Development of research question
4. March - May 2012: Development of the research proposal and submission of proposal to the University of Leicester for peer review
5. May 2012 - November 2012: Amendments to research proposal
6. December 2012: Submission to Ethics committee
7. December 2012: Amendments made to research proposal following ethics committee review
8. January 2013: Favourable ethical opinion received from ethics committee and R&D approval awarded
9. February - April 2012: Recruitment
10. May 2013 - January 2014: Interviews conducted and transcription of data. Both amendments to research proposal were submitted during this time and favourable opinions were received.
11. February 2014: Data Analysis