“The industry died… the towns went right down”: Structural Violence and Deaths of Despair in North East England

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Abstract

The rise in mortality in high-income countries from drug, suicide, and alcohol-specific causes (DSA), referred to collectively as 'deaths of despair', has received growing interest from researchers since 2015. While this increase in mortality has been most pronounced within the United States (US), there is growing concern about deaths by these causes in the United Kingdom (UK). In both the US and the UK, mortality rates from deaths of despair are higher in deprived, deindustrialised communities and follow pre-existing patterns of geographic health and wealth inequality. In this qualitative study, I sought to learn how people living and working in areas with above-average prevalence of DSA mortality understand and explain the prevalence of deaths from these causes locally. Data were collected through in-depth, semi-structured interviews with 54 professional stakeholders and community members in Middlesbrough and South Tyneside. Participants identified several individual, cultural, and structural level determinants that they believed drove DSA mortality in their communities.

I make the argument that the existence and influence of these determinants are best understood through the theoretical lens of structural violence. The theoretical framing of the determinants of DSA mortality as a product of structural violence provides a novel perspective of how individual, cultural, and structural determinants influence DSA mortality. It also underscores the need for approaching the problems presented by 'deaths of despair' as issues rooted in social injustice. The findings from this study constitute a novel contribution to the literature surrounding 'deaths of despair' in the UK, which is currently dominated by research using quantitative methods. In this thesis, I demonstrate that 'deaths of despair' are a manifestation of broader social inequality; interventions seeking to prevent deaths from these causes must address the structural violence that has given rise to the conditions in which people initiate DSA behaviours.

Dedication

This thesis is dedicated to my friends, family, and everyone who has supported me over the years. I couldn't have done it without you.

Acknowledgements

First and foremost, I would like to thank everyone who participated in this study. Your willingness to speak with me and openness while doing so was invaluable. It was a great privilege to hear your stories and learn from your experiences. In the most literal sense, this research could not have happened without you. I cannot thank you all enough.

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Declaration

I declare that this thesis is my original work. The sections of Chapter 4 related to the history of Middlesbrough and South Tyneside have been published as part of a report on child poverty in the North East to which I was a contributing author. These sections have been expanded for use in this thesis. Findings related to the views of stakeholders in Middlesbrough have been used to produce a paper that has been submitted to the journal *Health and Place* (currently under review). While there were multiple authors on both the report and the paper, I was the only author to contribute to the sections used in this thesis and they constitute independent work.

Relevant Citation

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List of Abbreviations

DSA	Drug, suicide, alcohol-specific
DoD	Deaths of Despair
UK	United Kingdom
US	United States
NHS	National Health Service
GP	General Practitioner
ONS	Office for National Statistics
DWP	Department for Work and Pensions
DHSC	Department of Health and Social Care
PIP	Personal Independence Payment
IMD	Index of Multiple Deprivation
ACE	Adverse Childhood Experience

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Chapter 1: Introduction

It is widely recognised that some places in England, often in the north, experience higher rates of drug, suicide, and alcohol-specific (DSA) morbidity and mortality, commonly referred to as 'deaths of despair', than other places do. Similarly, one does not need to undertake years of study to recognise that many of those same areas are often home to stark health and wealth inequalities—that is to say, they are poorer and less healthy than their counterparts elsewhere in the country. To the casual observer outside of the affected areas, these inequalities often appear natural. Some explain these differences as the just outcome of poor decision-making and behaviour by individuals, others, somewhat more generously, understand them to be the unfortunate product of chance or circumstance. Rarely, however, do we pause to consider what underpins these inequalities in DSA morbidity and mortality. For the people who live and work in these communities, however, the question of what underpins these inequalities is hardly novel. People in affected communities have years of first-hand experience with these inequalities and have watched the suffering and death from DSA behaviours unfold; they know what determinants have led to the inequalities in DSA morbidity and mortality in their areas, and they are ready to explain if we are ready to listen.

This thesis presents an in-depth qualitative study investigating inequalities in DSA morbidity and mortality, which sought to learn how people living and working in areas with above-average prevalence of these outcomes understood and explained the inequalities in their communities. The findings reported here are novel, as this was the first study to use qualitative methods to explore the determinants of DSA morbidity and mortality in England. Participants in this study provided insight into how these inequalities have been created through the complex interaction of individual, cultural, and structural determinants and that their continued existence is a reflection of deeper societal inequity. After assessing participants' beliefs in relation to the existing empirical and theoretical literature, I argue that addressing inequalities in DSA morbidity and mortality is a matter of social justice, rooted in the need to rectify

fundamental inequities within society.

1.1 Deaths of Despair

Since the early 1900s, life expectancy has generally risen in high-income countries (Ho and Hendi, 2018). While many high-income countries saw a decline in life expectancy in 2014-15, most resumed the trend of increasing life expectancy in 2015-16, with the US and UK being two notable exceptions (Ho and Hendi, 2018). Anne Case and Angus Deaton, economists from Princeton University in the US, observed that the decline in US life expectancy was attributable to increasing mortality rates for 45–54-year-old non-Hispanic whites between 1999 and 2013. Case and Deaton (2015, 2017, 2020) found that the increase in mortality was driven primarily by DSA mortality. They proposed that changes in social norms and the US labour market (e.g. rising age at marriage, increased childcare responsibilities, low educational attainment, wage stagnation, and the cost of housing) had caused cumulative disadvantage from one birth cohort to the next and given rise to a sense of despair and ultimately increased the likelihood of DSA mortality.

While there is a long history in the literature of studying the factors driving drug, suicide, and alcohol-specific mortality as separate phenomena, Case and Deaton (2020) were the first to suggest that deaths by these causes are driven by the same underlying forces and that they should be treated as a single entity, which they called 'deaths of despair'. The suggestion that these causes of death all share a common cause – despair – has been a point of contention, with some researchers suggesting that Case and Deaton had failed to adequately account for the role of the US opioid crisis on premature mortality (Ruhm, 2021). Since they published their initial papers and their 2020 book *Deaths of Despair and the Future of Capitalism*, trends in DSA mortality rates in the US have broadened to include non-white demographics and people with a college degree, further complicating Case and Deaton's narrative (Ruhm, 2021). Case and Deaton's findings and criticism thereof are discussed in greater detail in Chapter 2, but while their findings are subject to academic debate there is no question that they have been influential on both public and academic discourse. The 'deaths of despair' label is frequently

used in news media and academic publications (Aspholm, 2022, Beseran et al., 2022, Walsh et al., 2021, Angus et al., 2023).

While the increase in DSA mortality in the US was initially understood to be a uniquely American phenomenon, recognition of increasing mortality from these causes has driven research interest in the UK (Leon et al., 2019). Although the available evidence suggests that the stagnation in life expectancy in the UK before the COVID-19 pandemic was only partially attributable to DSA mortality (Ho and Hendi, 2018), drug overdoses in men have increased substantially in England since 2012 (Hiam et al., 2017), and suicide mortality has been rising in England since 2016 (Augarde et al., 2022). The evidence base surrounding DSA mortality in the UK is largely consistent with that in the US, where these deaths have risen significantly since the early 2000s and have primarily affected people of middle age (Case and Deaton, 2015, Case and Deaton, 2017). Increases in DSA mortality in both the UK and the US have been primarily driven by significant increases in drug-related mortality, with alcohol-specific mortality and deaths by suicide increasing at a more moderate rate (Augarde et al., 2022). Within England, patterns of DSA mortality are not evenly distributed geographically, with northern regions bearing a greater burden than their southern counterparts (Camacho et al., 2024). This is a reflection of broader regional health and wealth inequalities in the UK, often referred to as the North-South divide (Bambra, 2016).

1.2 Health Inequalities

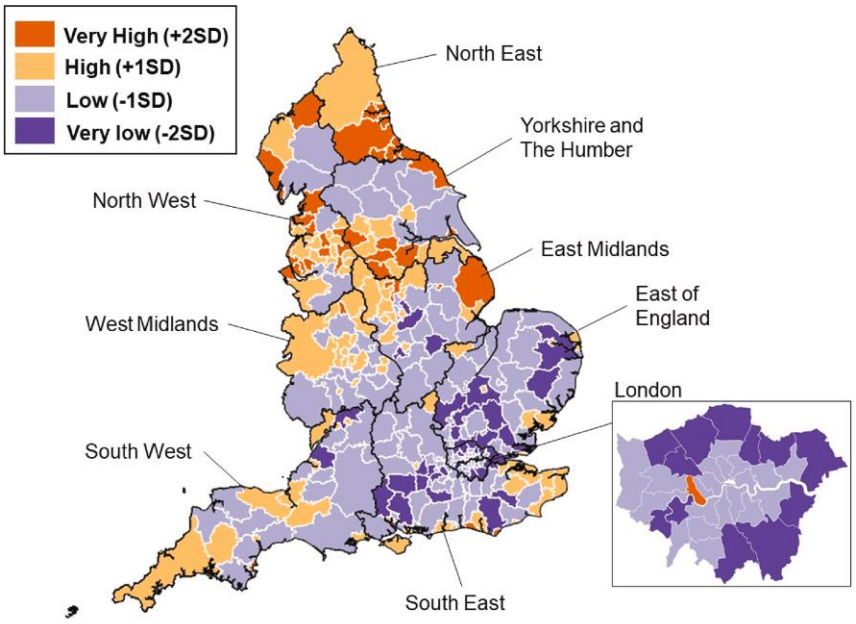
The term health inequalities refers to differences in health status or outcomes between different populations (Bartley, 2016). While it is natural that some populations experience better health status and outcomes than others (e.g. it is inevitable that elderly people are more likely to die than young adults), researchers in Europe routinely use the term health inequalities to refer to *unfair* differences in health where there is an issue of social injustice (McCartney et al., 2019, Krieger, 2024). While the terms ‘health inequities’ and ‘health disparities’ are sometimes used to refer to unfair differences in health, and are arguably more linguistically correct, this thesis will use the term health inequalities to refer to these differences, as this is

the language most commonly used in the UK (Krieger, 2024). Health inequalities are intrinsically linked to the social determinants of health, the conditions in which people are born, grow, live, and work (Bartley, 2016). The social determinants of health have a significant influence on one's health and well-being and are the fundamental causes of health inequalities, as they create and maintain differences in health status and outcomes between populations (Marmot, 2005).

Research surrounding health inequalities in the UK dates back to the 19th century when social reformers such as Edwin Chadwick and Joseph Rowntree highlighted the poor living conditions and health of the working class during the Industrial Revolution (Green et al., 2018, Pearce and Dorling, 2009). Early research into these class-based health and well-being inequalities laid the groundwork for later investigations into the social determinants of health. The Black Report, published in 1980, was a seminal text in the field of health inequalities research in the UK (Bartley, 2016, Townsend et al., 1992). It highlighted stark health inequalities within British society, which had persisted since the 1950s despite the establishment of the National Health Service (NHS) (Department of Health and Security, 1980). The report attributed health inequalities in British society to inequalities in income, education, and living conditions (Department of Health and Security, 1980). Despite the interest in health inequalities generated by the Black Report, by the early 1990s little progress had been made towards addressing them and in some cases, they had worsened (Townsend et al., 1992). In 2010, the Marmot Review, *Fair Society, Healthy Lives*, highlighted the continued existence of significant health inequalities in the 21st century and advocated for action to address the social determinants of health that perpetuate health inequalities (Marmot, 2010). As with the Black Report, a ten-year follow-up of the progress made since the publication of the Marmot Review found that health inequalities had continued to grow in the years following publication (Marmot, 2020); these inequalities would then be worsened by the COVID-19 pandemic (Bambra et al., 2020b).

Health inequalities in the UK are geographic in nature—that is to say, they affect some areas more than others. There are stark health inequalities between the constituent countries of the UK; for example, people in Scotland experience significantly poorer health outcomes and lower life expectancy than their English counterparts (Schofield et al., 2016, Walsh et al., 2010). Within England, health inequalities persist between regions, cities, and towns, with the North

East bearing some of the most dramatic inequalities in health and life expectancy relative to other English regions (Bambra, 2016, Corris et al., 2020). The geographic pattern observable in health inequalities extends to inequalities in DSA morbidity and mortality specifically, and these are the focus of this thesis. According to the latest available data, the North East had the highest rate of DSA mortality of all English regions (ONS, 2023a, ONS, 2023e, ONS, 2024a). Figure 1 shows age-standardised mortality rates from DSA causes in England by local authority. While the inequalities in DSA mortality in England are striking, they are not unique. The North East has a strong industrial legacy and a history of rapid deindustrialisation (Beatty and Fothergill, 2020) and former industrial regions in the US, such as the Rust Belt, also experience significantly higher rates of DSA mortality than other US regions (Chetty et al., 2016). Similar patterns in DSA mortality have been observed in former industrial areas in Eastern Europe (King et al., 2022).



Rank	Local Authority	Region	ASMR
	Highest Age Standardised Mortality Rate for Deaths of Despair		
1	Blackpool	North West	83.8
2	Middlesbrough	North East	71.6
3	Hartlepool	North East	70.5
4	Barrow-in-Furness	North West	63.4
5	Redcar and Cleveland	North East	62.1
6	Sunderland	North East	60.4
7	Carlisle	North West	59.8
8	Preston	North West	59.4
9	Scarborough	Yorkshire and The Humber	58.2
10	Wakefield	Yorkshire and The Humber	56.7
11	Kingston upon Hull, City of	Yorkshire and The Humber	56.7
12	Stoke-on-Trent	West Midlands	55.6
13	Torbay	South West	54.3
14	South Tyneside	North East	54.2
15	Copeland	North West	53.8
16	Lincoln	East Midlands	53.2
17	Eastbourne	South East	52.2
18	Newcastle upon Tyne	North East	52.2
19	Burnley	North West	52.1
20	Liverpool	North West	51.8

Figure 1.1: Age-standardised mortality rates for DSA mortality in England by local authority. Graphic from:(Camacho et al., 2024) .

1.3 Research Aims

In this thesis, I present the findings of a qualitative study examining how stakeholders and community members in South Tyneside and Middlesbrough, two local authorities with above-average rates of DSA morbidity and mortality, understand and explain the factors underlying DSA morbidity and mortality in their areas. This research attempts to fill an existing gap in the literature surrounding DSA morbidity and mortality in England, where previous research in this area has, thus far, only used quantitative methods. With its grounding in the lived experience of people in affected areas, this study provides critical insights into the social determinants underpinning inequalities in DSA morbidity and mortality that cannot be provided through quantitative analysis. Examining the underlying determinants of DSA morbidity and mortality is timely, as the most recent data suggests that these outcomes are increasing in frequency, both in England (ONS, 2023a, 2023b, 2024), and in the US (Dowd et al., 2023). This study had two research aims:

1. To explore how stakeholders and community members in areas with a high prevalence of DSA morbidity and mortality understand the causes of DSA morbidity and mortality locally.

2. To learn how stakeholders and community members understand and explain the inequalities in DSA morbidity and mortality present in their areas.

1.4 Thesis Structure

This thesis is comprised of eight chapters. Chapters 2-4 present background literature, methods, and the study settings. Chapters 5-7 comprise three results chapters which incorporate a discussion of related literature. Chapter 8 concludes the thesis. These chapters

are briefly outlined below.

Chapter 2: Literature Review

In this chapter, I review the empirical literature surrounding: deaths of despair as a unified concept, the determinants of drug, suicide, and alcohol-specific morbidity and mortality as individual phenomena and the theoretical literature surrounding the concept of structural violence, which will be used to frame the findings of this study.

Chapter 3: Methods

This chapter provides an overview of the philosophical assumptions underpinning this research, the methods used to conduct this study, and a reflection on my positionality as a researcher.

Chapter 4: Study Settings

This chapter describes the settings in which this study was conducted. I discuss the histories of Middlesbrough and South Tyneside from the Industrial Revolution to today, with a focus on their principal economic activities and labour relations. This discussion provides an important backdrop that allows the findings of this study to be understood within their geographic and historical context.

Chapter 5: "If you don't want to take drugs you don't have to." Individual Level Determinants of DSA Morbidity and Mortality

In this first results chapter, I present the findings that relate to individual-level determinants, those individual choices, feelings, and experiences that participants believed led to DSA morbidity and mortality. The findings are presented and discussed alongside relevant theoretical and empirical literature and are supported by illustrative quotes from participants. In this chapter, I show that individual-level determinants are heavily influenced by both cultural and structural level factors.

Chapter 6: "I think morals and values have to come into this." Cultural Determinants of DSA Morbidity and Mortality.

Here I present the second results chapter, which discusses the findings of this study that relate to cultural determinants of DSA morbidity and mortality. Cultural determinants are constituted by the belief systems, values, and social norms that influence one's social environment and shape economic participation, help-seeking, and health behaviours. The discussion of cultural determinants places these findings in the context of the existing empirical and theoretical literature and highlights the need to account for the role that cultural forces have in shaping both individual behaviours and structural forces.

Chapter 7: "They're not mentally ill, their lives are just shit." Structural Determinants of DSA Morbidity and Mortality.

In this final results chapter, I discuss the structural determinants, the political and economic structures that govern society, that participants believed had created the social environment in which DSA morbidity and mortality occur. Participants' beliefs surrounding the importance of structural determinants in leading to DSA morbidity and mortality are presented in the context of the existing health inequalities literature. The findings of this chapter emphasise the need for understanding the upstream forces that lead to ill-health for individuals.

Chapter 8: The Cycle of Structural Violence

Chapter 8 concludes the thesis with a discussion of how the findings of this study can be understood through the theoretical lens of what I describe as a cycle of structural violence. The cycle of structural violence is a novel theoretical approach that combines theories of violence to describe how health inequalities, including those of DSA morbidity and mortality, are created and maintained within society. In this chapter, I also discuss the strengths and limitations of this study and the implications my findings have for future research.

1.5 Chapter Summary

This chapter has provided a brief overview of the fields of research in which this thesis sits—deaths of despair and health inequalities. I have outlined my research aims and objectives and provided an overview of the structure of this thesis. With this context in mind, the next chapter provides a detailed analysis of the relevant existing literature and identifies the gap in the literature that my study fills.

Chapter 2: Literature Review

This chapter presents a review of the literature surrounding deaths of despair (DoD), drug, suicide, and alcohol-specific morbidity and mortality in the UK, and the concept of structural violence. I begin by providing an overview of DoD research from its origins with economists Anne Case and Angus Deaton in the US to its current applications in the UK. I also discuss the academic criticisms of the concept and areas for future research. Next, I provide an overview of the available literature examining the structural determinants of DSA morbidity and mortality in the UK, as the body of research examining the outcomes of these phenomena separately dates back much further than the DoD concept. Finally, I introduce the concept of structural violence and explore how it has been applied within the fields of health equity research. In doing so, I demonstrate that structural violence is an appropriate theoretical framework through which to investigate the determinants of DSA morbidity and mortality.

2.1 Deaths of Despair

2.1.1 Deaths of Despair in the US

DoD as a concept began to appear in public discourse in 2015, following the publication of Anne Case and Angus Deaton's landmark article *Rising Morbidity and Mortality in Midlife among white non-Hispanic Americans in the 21st Century (Deaths)* (Case and Deaton, 2015). While Case and Deaton did not initially use the term 'deaths of despair' in their academic publications to describe the causes of death driving the decline in American life expectancy, the term was used in articles from non-academic sources (Case, 2015). In their article, the authors identify that in the US mortality rates of 45–54-year-old non-Hispanic whites rose from 1999 to 2013; an increase that was not identified in other demographics or other countries (Case and Deaton, 2015). While people of all educational backgrounds saw some increase in overall mortality, people without a college education were particularly impacted. Case and Deaton identified suicide, alcohol-related conditions, and accidental poisoning (which are almost

entirely made up of drug overdoses) as driving the increase in mortality (Case and Deaton, 2015).

Case and Deaton (2017) published *Mortality and morbidity in the 21st century* as a follow-up to their 2015 article. In the 2017 article, the authors broadened their analysis to include a wide range of age categories, and to focus on the mortality trends for those with a wider range of educational backgrounds. The authors found significant differences in mortality by race and education, with mortality rates falling year-on-year for non-Hispanic whites with a college degree and rising year-on-year for those without one (Case and Deaton, 2017). Their 2017 article was the first time that Case and Deaton proposed possible explanations for the relatively sudden increases in DoD. Specifically, the authors propose that worsening labour market conditions (among other factors including age at marriage, increased childcare responsibilities, and declining religious participation) cause cumulative disadvantage from one birth cohort to the next for white Americans with below college-level educational attainment and that this disadvantage ultimately increases the likelihood of DSA mortality.

Deaths is Case and Deaton's (2020) bestselling book in which they present and discuss their findings for a popular audience. The book discusses the findings of the author's 2015 and 2017 articles and further develops Case and Deaton's explanation for the observed increases in DSA mortality. Particular attention is given to the challenging socio-economic conditions, such as declining union membership and the decline in real wages, facing white Americans without a college education and the deterioration of informal support systems such as declining rates of religious participation and increasing divorce.

Case and Deaton (2020) also use *Deaths* as an opportunity to discuss chronic pain, which they argue may drive the use of opioid-containing medications, and ill-health more generally, which was absent from their previous publications (2015, 2017). The authors explain that since 1990, the likelihood that middle-aged white Americans will report their health as fair or poor has increased (rather than good, very good, or excellent) and that the decline in health has been particularly notable in those with less than a bachelor's degree education. Chronic pain has also increased for people aged 40-65 years old (although less dramatically for those with a bachelor's level education or higher) and is more common in the US than in 19

comparison countries. The authors propose that this combination of rising ill health and chronic pain is the morbidity that precedes the death of despair.

Since Case and Deaton (2015, 2017, 2020) popularised the DoD concept, a wide body of research on the subject has developed in the US. Academics within the US have compared rates of DoD in the US to those abroad and have found that while rates remain significantly higher in the US, DoD are a growing problem in other Western countries (Bastiampillai et al., 2021, Benny et al., 2023). Researchers have continued to refine and expand Case and Deaton's analysis of mortality trends, identifying broader demographic patterns and regional variations in DoD. Recent studies have highlighted that these deaths are no longer confined to middle-aged white Americans as Case and Deaton initially identified (2015, 2017, 2020) and are increasingly affecting younger populations and various racial and ethnic groups (Friedman and Hansen, 2024, Friedman et al., 2023). Analysis of midlife mortality patterns in the US across racial and ethnic groups found that midlife mortality had increased across racial groups, and noted that this increase had severe consequences for racial groups with high baseline mortality rates, such as non-Hispanic Blacks, American Indians and Alaskan Natives (Woolf et al., 2018, Friedman and Hansen, 2024, Friedman et al., 2023).

Recent spatial analysis has demonstrated that deaths from these causes are not distributed evenly throughout the US, but appear most often in geographic clusters, namely Appalachia and the Rust Belt (e.g. Ohio, West Virginia, western Pennsylvania), the South West (e.g. Arizona, western Texas, New Mexico), and the South (e.g. Florida, Georgia, Alabama) (Monnat, 2017, Steelesmith et al., 2023, DeVerteuil, 2022). These areas of the US tend to have rural populations, a history of deindustrialisation (particularly Appalachia and the Rust Belt) and high rates of poverty and unemployment (DeVerteuil, 2022). DoD are particularly prominent in areas on or near Indian reservations (areas of land held and governed by federally recognised tribal nations), which are some of the most economically precarious and isolated communities in the US (Bjorklund, 2023, Davis et al., 2016). Many of the states in these regions lack robust social safety nets, such as unemployment and disability benefits and subsidised health insurance programmes and have high levels of economic precarity, highlighting the importance

of considering the social and economic context in which DoD occur (Bjorklund, 2023).

2.1.2 Deaths of Despair – Criticism of the Concept

As the DoD concept grew in prominence, the discourse surrounding the shortcomings of Case and Deaton's body of work began to emerge. In 2021, Christopher Ruhm published a working paper (Ruhm, 2021) in which he articulated several concerns about the content of *Deaths of Despair and the Future of Capitalism* (Case and Deaton, 2020) and some of the shortcomings of Case and Deaton's academic publications (Case and Deaton, 2015, Case and Deaton, 2017). Rhum (2021) noted that *Deaths* relied heavily on counterfactual mortality rates to describe the number of lives lost as a result of DoD between 1999 and 2017 and that the assumptions underpinning these counterfactuals were not fully convincing. For example, Case and Deaton assumed that had DoD not increased mortality rates for midlife whites, the 2% mean annual reduction in all-cause mortality seen between 1970 and 1999 would have continued into the 21st century (Case and Deaton, 2020); however, Rhum (2021) notes that the reduction in all-cause mortality for US whites seen at the end of the 20th century was largely attributable to declining smoking rates and the introduction of hypertension medications which would not have continued to improve life expectancy into the 21st century. Rhum (2021) stresses that the counterfactuals that Case and Deaton (2020) rely on are not necessarily erroneous, but that empirical testing is needed before they can be reliably cited as evidence for the effect of DSA mortality on all-cause mortality rates for white Americans.

Rhum (2021) also raised concerns about the 'deaths of despair' label and its potentially misleading implications (Ruhm, 2021). Their 2017 article was the first time that Case and Deaton used the term 'deaths of despair' in a peer-reviewed publication (Case and Deaton, 2017). The term itself is applied inconsistently. First, Case and Deaton (2020) refer to the term as a "convenient label" which indicates "the link with mental or behavioural health, and the lack of any infections agent" (p. 40). Later in the same book, the definition shifts; no longer just a "convenient label" for these causes of death, the authors state that it "captures a common underlying cause – despair – that is not easily captured when they are treated separately" (p. 96). The inconsistency in how the DoD label is applied creates confusion about how the label

should be interpreted. If 'deaths of despair' is merely a convenient label, then it is problematic in that it seems to have a clear implication that these deaths all share a similar cause (i.e. despair), while this proposition has not yet been empirically tested (Ruhm, 2021). Indeed, recent evidence that rates of DSA mortality have diverged both in the US and UK questions whether these causes of death are as closely related as Case and Deaton (2017, 2020) suggest, and indicates that they may be best approached as distinct phenomena (Angus et al., 2023, Dowd et al., 2023, Allik et al., 2020).

Researchers have also raised concerns about the role of drug overdose deaths in explaining the decreases in life expectancy that Case and Deaton observed. In 2018, Masters et al. re-examined the increases in mortality among middle-aged whites in the US that were identified by Case and Deaton (2015, 2017). Using US mortality data, the authors examined trends in all-cause and cause-specific mortality rates between 1980 and 2014. (Masters et al., 2018). Masters et al. (2018) found that while trends in middle-aged mortality for US whites varied considerably by cause and gender, the contributions from suicide and alcohol-related deaths remained stable throughout the study period; only the contribution from drug-related deaths increased significantly since the 1990s.

Masters et al's (2018) study failed to replicate the findings of Case and Deaton (2015, 2017) and provided evidence that undermines the DoD hypothesis. The authors found that there were gender differences in mortality trends among US whites which had previously been noted elsewhere (Gelman and Auerbach, 2016, Masters et al., 2017). There were also notable differences between the effects of drug-related deaths on mortality rates for men and women, mainly that increases in drug-related deaths in women started after those in men and primarily affected different age groups. These gender differentials call into question Case and Deaton's (2017) claim that the increase in all-cause mortality for middle-aged US whites was driven by 'the same underlying epidemic', as one would expect to see similar trends among white men and women had the underlying cause of the increases been the same. They found that while rates of drug-related deaths for US whites began increasing in the 1990s and continued to increase throughout the study period, rates of suicide only began to increase in the late 2000s, and alcohol-related deaths remained stable across the study period. The marked differences in

the timing of changes to rates of deaths from these causes (or in the case of alcohol, the absence thereof) and the finding that only the contribution of drug-related deaths increased over the study period further calls into question whether these causes of death share a similar underlying cause (Masters et al., 2018).

Furthermore, the dramatic increase in drug-related deaths that occurred in the US beginning in the late 1990s is a product of the US opioid epidemic and is largely unrelated to population-level despair. In *Deaths*, Case and Deaton (2020) propose a demand-side explanation for the increase in prescriptions for opioid-containing medications-- that the increase in prescriptions in the late 1990s – early 2000s was a response to increased levels of pain, which were caused by worsening economic conditions (Case and Deaton, 2020). However, a supply-side explanation – that the increase in prescriptions was due to poor regulation, highly targeted, aggressive marketing of opioid-containing drugs by Purdue Pharma and overprescribing by doctors— is better supported by the evidence (Macy, 2018, Rudd et al., 2016, Ruhm, 2019, Fischer et al., 2020). Opioid overdose rates were consistently lower in states that had programmes in place to monitor how many prescriptions for controlled substances (including opioids) prescribers were writing; when these programmes were removed overdose rates increased (Alpert et al., 2021). Changes to the formulation of OxyContin in 2010 to make it resistant to tampering (e.g. by crushing it before ingestion) encouraged many opioid users to switch to heroin and later, to fentanyl, which was associated with a dramatic increase in opioid-related mortality (Beheshti, 2019, Evans et al., 2019, Alpert et al., 2021). This supply-side origin for the increase in drug overdose mortality suggests that Case and Deaton (2020) may be incorrect in their assessment that all three causes of death share despair as a causal agent and highlights the importance of investigating how structural determinants influence deaths from these causes.

While the field of DoD research has expanded significantly since Case and Deaton's (2015, 2017, 2020) initial publications, there is a growing concern amongst researchers that it has largely neglected to investigate social determinants underpinning deaths from these causes. Current literature indicates that while numerous studies have explored individual and economic factors, there is a paucity of research focusing specifically on the broader social

conditions that underpin these outcomes. A 2022 scoping review of the literature concluded that there was limited evidence surrounding the structural and intermediate determinants of DoD and encouraged future research to identify the structural causes and related social mechanisms (Beseran et al., 2022). While this review was focused on DoD literature in the US, similar concern has been raised by researchers investigating these deaths in the UK (Allik et al., 2020).

I share the concern that DoD research has neglected the social determinants that underpin these deaths and my concerns extend to the term "deaths of despair" itself. In my view, the DoD label is problematic in that it shifts the collective focus away from structural drivers of these deaths and towards individual feelings and experiences. At its core, despair is an individual experience, and framing these deaths in terms of despair implies that the factor that leads to these deaths resides within the individuals who die. However, despair is not the cause but is itself an outcome of deeper, structural issues. By focusing on individual despair, the DoD label absolves social structures of accountability and reinforces a narrative that obscures the structural factors—such as economic inequality, community disintegration, and labour market changes—that actually drive these deaths. In this way, the term "deaths of despair" is itself part of a broader social force that deflects attention from the structural roots of the problem; this is an example of symbolic violence, which will be discussed later in this chapter. Given my concerns around the DoD label, I have elected to use the term "DSA" (drug, suicide, and alcohol specific) to refer to these deaths in this thesis, as I believe it is somewhat more neutral and avoids the implication that individual feelings and experiences underpin these deaths.

2.1.3 Deaths of Despair in the UK

As Case and Deaton's work in the US rose in prominence, researchers began to investigate DoD around the world. The rise in DoD was initially believed to be a phenomenon unique to the US, but growing rates of death due to drugs, suicide, and alcohol have led to wider acknowledgement that these problems affect the UK (Joyce and Xu, 2019, Marmot et al., 2020, Leon et al., 2019). Since Case and Deaton popularised the term 'deaths of despair',

research examining DSA morbidity and mortality in the UK has frequently adopted this label (Walsh et al., 2021, Allik et al., 2020, Augarde et al., 2022). I conducted a review of the existing DoD literature in the UK to understand how the concept has been adopted in this setting. I searched Ovid Medline, Embase, Psychinfo, SCOPUS and Web of Science for articles that used the terms "deaths of despair" and "UK, England, Scotland, Wales or North Ireland"**.** After duplicates were removed, 120 articles were identified. After title and abstract screening, 8 studies were included (Angus et al., 2023, Augarde et al., 2022, Dowd et al., 2023, Dowd et al., 2024, Koltai et al., 2020, Walsh et al., 2021, Camacho et al., 2024, Allik et al., 2020).

Two studies (Dowd et al., 2023, Dowd et al., 2024) sought to compare how rates of DoD in the UK and US had changed over time, and whether mortality from these causes had influenced life expectancy in the UK. Dowd et al. (2023) found that Scotland had experienced increases in drug-related mortality comparable to those in the US, while other UK constituent nations saw less significant increases. Alcohol-specific and suicide mortalities generally followed different patterns to drug-related deaths across the UK over time, although both had increased in England and Wales in recent years (Dowd et al., 2023). The second study found that the US is increasingly falling behind high-income countries in terms of mid-life life expectancy due to DoD (primarily drug overdoses) (Dowd et al., 2024). While the increases in DoD and midlife mortality in the UK have been less significant, the UK is worsening in both regards relative to Western Europe (Dowd et al., 2024). One study by Angus et al. (2023) investigated whether the COVID-19 pandemic had coincided with an increase in DoD in the US and UK. Their findings suggested that concerns that the COVID-19 lockdown measures would increase rates of suicide were unfounded, but that alcohol-specific mortality had increased in both the US and UK (Angus et al., 2023). In combination, these studies demonstrated that while rates of DoD remain uniquely poor in the US, these problems are nonetheless worsening in the UK.

Five studies (Augarde et al., 2022, Camacho et al., 2024, Koltai et al., 2020, Walsh et al., 2021, Allik et al., 2020) examined rates of DoD in England and Wales, England, or Scotland. Augarde et al. (2022) examined temporal trends in DoD mortality across England and Wales. The authors found that between 2001 and 2016, the DoD mortality rate increased by 21.6% for men and 16.9% for women and, as in the US, mortality from DoD was highest among middle-

aged people (Augarde et al., 2022). Walsh et al (2021) investigated rates of mortality from DoD by birth cohort, and similarly to Augarde et. al (2023), found that mortality was highest amongst those of middle age, with the exception of drug-related deaths, that were highest amongst those aged 30-34 years. The findings of these studies generally reflect the findings of DoD literature in the US, where deaths from these causes have increased dramatically since 2001 and have predominantly affected those in middle age (Case and Deaton, 2017, 2020). It is important to note however, that as discussed in the previous subsection, the rates of mortality from these causes in the UK, and in England and Wales specifically, are significantly lower than those observed in the US.

Camacho et al. (2024) aimed to identify the spatial distribution of DoD and the socioeconomic factors that increase DoD risk in England. The authors found that DoD were highest in the North and in coastal areas of the country, with the North East having the highest rate of all English regions (Camacho et al., 2024). Risk factors for DoD included living in the North, unemployment, White British ethnicity, living alone, economic inactivity, and living in urban areas (Camacho et al., 2024). The spatial pattern of DoD uncovered by Camacho et al. (2024) mirrored the pattern of health inequalities in England more broadly.

One study investigated the association of local authority rates of DoD with support for the 2016 Brexit referendum (Koltai et al., 2020). Koltai et al. (2020) found that worsening mortality correlated with Brexit votes, although these associations were reduced to non-significance when controlling for socioeconomic factors. Koltai et al.'s (2020) findings are similar to those of a study conducted in the US, which found an association between DoD mortality and support for Donald Trump in the 2016 US presidential election (Monnat, 2016). The findings of that study, like those of Koltai et al. (2020), were mediated when controlling for socioeconomic factors (Monnat, 2016).

Allik et al. (2020) calculated age-standardised DoD mortality rates for men aged 15-44 between 1980 and 2018 for men in Scotland. The authors found that between 1980 and 2018, drug-related deaths increased dramatically and are now the leading cause of death for that demographic (Allik et al., 2020). Allik et. al. (2020) conclude that reducing mortality from these causes, or inequalities in mortality between Scotland and other constituent nations of the UK

requires action to address the social determinants of health and reduce socioeconomic inequalities.

This review of the literature surrounding DoD in the UK has found a general lack of available literature. While researchers have raised concerns about the increasing prevalence of DoD in the UK (Walsh et al., 2021, Allik et al., 2020, Augarde et al., 2022), relatively little research has been conducted to examine the underlying determinants of deaths from these causes. Instead, much of the research has been focused on international comparisons to the US, where deaths from these causes are significantly more prevalent (Angus et al., 2023, Dowd et al., 2023, Dowd et al., 2024), or in mapping the prevalence of these deaths in one or more UK constituent countries over time (Walsh et al., 2021, Augarde et al., 2022, Allik et al., 2020). Only one study has examined deaths from these causes in England specifically and attempted to identify their risk factors (Camacho et al., 2024). Given the concern about the increasing prevalence of deaths from these causes, and the available quantitative evidence that they are heavily influenced by socioeconomic factors, it is prudent for future research to focus on identifying the determinants that increase the risk of death from these causes.

2.1.4 Deaths of Despair Summary

Case and Deaton's work has been influential and has introduced a new frame through which to approach the relationship between changing economic conditions and deaths from drug overdose, suicide, and alcohol-related conditions. While the term 'deaths of despair' has been widely adopted, many of the claims that are central to Case and Deaton's work remain untested. In the US, future research will need to settle questions about the role of drug-related deaths in causing the changes in mortality that Case and Deaton observed and establish whether and to what extent rates of DSA mortality are related to their underlying causes. In the UK, Case and Deaton's work has done little to further develop the understanding of the association of changing socioeconomic conditions with DSA mortality, but research into their prevalence has revealed that deaths from these causes follow pre-existing geographic patterns of ill health.

This review of the literature has found that, as in the US, the existing DoD literature in

the UK lacks qualitative evidence. To the best of my knowledge, there are no existing studies that have used qualitative methods to investigate deaths from these causes anywhere in the UK. The absence of qualitative research means we currently lack in-depth, contextual insights into the lived experiences and social factors contributing to DoD. Conducting qualitative research on this subject is essential to uncovering nuanced understandings and personal narratives that quantitative data alone does not provide, thereby offering a more comprehensive picture of the determinants of DoD. As Camacho et al. (2024) found, deaths from these causes are spatially patterned in England, with some areas (e.g. the North East), experiencing significantly higher rates than others. Thus, the available evidence suggests that North East England is an ideal setting in which to undertake qualitative research seeking to explore the determinants of DSA mortality. The study I have conducted as part of this thesis fills this critical gap in the literature and will contribute to a relatively limited body of literature surrounding deaths of despair in England. It is also noteworthy that none of the DoD literature in this literature review investigated structural determinants of DoD. My study addresses this significant gap in the literature by investigating the structural determinants of DoD and in doing so will make a novel contribution to this field of study that is of relevance both within the UK and elsewhere.

2.2 Empirical Literature on DSA Morbidity and Mortality

While the phrase ‘deaths of despair’ is relatively novel, there is a long history of research investigating determinants of DSA morbidity and mortality as separate phenomena. It is prudent to briefly summarise the existing literature in this field to ascertain what is already known on this subject. To that end, I reviewed the literature examining the determinants of drug, suicide/self-harm, and alcohol-specific morbidity and mortality. An overview of common themes in the available literature on these subjects is provided in this subsection.

2.2.1 Drug-Related Morbidity and Mortality

In reviewing the literature, I identified sixteen studies examining the determinants of drug use in the UK, the overwhelming majority of which were focused on heroin and other opiates. Among these, three studies employed qualitative methods (Pearson and Patel, 1998, Payne, 2007, MacDonald and Marsh, 2002), using thematic analysis of interviews to explore the lived experiences of heroin users. The qualitative studies revealed common themes of escapism and self-medication as primary reasons for initiating heroin use (Pearson and Patel, 1998, MacDonald and Marsh, 2002). Payne (2007) found that women in North Cumbria turned to heroin to escape daily struggles in a deprived area. Similarly, MacDonald and Marsh (2002) found that socially excluded youth in Teesside used heroin to self-medicate and distract from their harsh realities. Pearson and Patel (1998) highlighted that Asian men in Bradford, despite existing in separate drug cultures, initiated heroin use for similar reasons, including limited job opportunities and discrimination.

Quantitative literature in this area has largely focused on the association between opioid prescribing rates and socio-economic deprivation. Six studies found a positive association between deprivation and opioid prescription rates, indicating that higher levels of deprivation correlate with increased opioid prescribing (Vandoros et al., 2020, Ruscitto et al., 2015, Mordecai et al., 2018, Nowakowska et al., 2021, Chen et al., 2019, Bing et al., 2016). Other related topics that have been explored using quantitative methods include, predictors of long-term opioid prescriptions (Naughton et al., 2022), the impact of social service spending cuts on opioid-related hospitalisations and mortality (Friebel et al., 2021), whether regional inequalities in opioid usage are explained by socioeconomic deprivation (Cairns et al., 2017), and the longitudinal trajectory of opioid utilisation and its associated factors (Chen et al., 2020). Three of these studies found an association between deprivation and the outcome of interest (Naughton et al., 2022, Cairns et al., 2017, Chen et al., 2020). Naughton et al. (2021) found that local authorities that experienced the largest social service spending cuts also saw the largest increases in opioid misuse and found that unemployment increased the rate of opioid-related deaths.

I identified six studies examining the determinants of deaths from drug poisoning, all of

which used quantitative methods. Five of these studies utilized publicly available data from the ONS or death certificates to calculate drug-related deaths and correlated these with census data on deprivation in the decedents' areas (Yoganathan et al., 2021, Shah et al., 2001, Fiddler et al., 2001, Cassidy et al., 1995). These studies consistently found that drug overdose deaths followed an economic gradient, with higher mortality rates in more deprived areas. Additionally, two studies reported significantly higher rates of drug-related mortality among men compared to women (Cassidy et al., 1995, Shah et al., 2001). Another study investigated the impact of cuts to disability-related spending on drug mortality, finding that larger austerity cuts in the 2010s were associated with increases in drug-related deaths (Koltai et al., 2021).

Overall, the literature, whether it be qualitative or quantitative, highlights the significant influence that socioeconomic factors have on drug use. The qualitative research provides in-depth insights into the lived experiences of people who use drugs, emphasising themes of escapism and self-medication in response to socioeconomic hardships. Quantitative research supports these findings by demonstrating a statistical relationship between socioeconomic deprivation and higher rates of opioid prescribing and misuse. These studies collectively emphasise the importance of considering the socioeconomic context in which drug use occurs and the need to address socioeconomic inequality as a critical component in reducing drug use.

2.2.2 Suicide and Self Harm

I identified seven articles that examined the relationship between socioeconomic factors and non-fatal self-harm in the UK. These studies employed a mix of quantitative, qualitative, and mixed methods approaches. Quantitative studies utilized Townsend Deprivation scores to measure area-level deprivation, finding a consistent positive association between deprivation levels and nonfatal rates of self-harm rates (Ayton et al., 2003, Barnes et al., 2016, Hawton et al., 2001, Gunnell et al., 2000). Notably, three studies found significant associations that were consistent across age and gender, while one study highlighted a stronger effect among women aged 15-34. A mixed-methods study confirmed the deprivation-self-harm link but noted an absence of this association in certain deprived areas of London, prompting a further qualitative investigation (Polling et al., 2019).

Qualitative studies provide additional context to the quantitative findings, with one study supporting the existing quantitative evidence by reporting that socioeconomic factors such as low income and unemployment, compounded by vulnerabilities like sexual orientation and chronic disease, led to incidents of self-harm (Barnes et al., 2016). Two of the studies that used qualitative methods investigated rates of self-harm that were below expected given the levels of deprivation observed in the areas of interest (Polling et al., 2021, Polling et al., 2019). Participants in these two studies reported experiencing acute socioeconomic stressors, in addition to experiences with violence and symptoms of mental health conditions but reported that self-harm and mental illness were viewed by their (majority Black and Caribbean) communities as shameful and signs of weakness. As a result, participants in those studies did not self-harm or seek services for their mental health problems and undertook behaviours that were not typically associated with mental illness in their communities (such as drug and alcohol consumption and reckless behaviour), but that are nonetheless harmful (Polling et al., 2021, Polling et al., 2019). Overall, these findings highlight the complex nature of the determinants of self-harm, emphasising the role of deprivation and community perceptions in shaping self-harm behaviours. The studies highlight the need for a nuanced understanding of how socioeconomic determinants and cultural contexts influence mental health and self-harm.

There is also a significant body of evidence examining the social determinants of, and the association of socioeconomic factors with, suicide. Numerous studies have demonstrated an effect between rates of suicide and one or more socioeconomic indicators (Aschan et al., 2013, Coope et al., 2014, O'Reilly et al., 2008, Wetherall et al., 2015). While deprivation was consistently associated with increased rates of suicide, in one case the effect was more pronounced in men (Rezaeian et al., 2007), and two studies failed to demonstrate an association between deprivation and rates of suicide in women (Rezaeian et al., 2005, Coope et al., 2014). While O'Reilly et al. (2008) did find a positive association between household-level deprivation and rates of suicide, the authors did not observe an association with area-level deprivation (O'Reilly et al., 2008). This finding stands in contrast to the 10 other studies that examined area-level deprivation. Also of note are the findings of Wetherall et al. (2015) who investigated whether the relationship between income and suicidality is accounted for by the

income rank comparison within groups. The authors found that income rank was more significant than deprivation in affecting suicide rates, which suggests that psychosocial elements of deprivation, rather than experiences with material deprivation, may drive the association between deprivation and suicide (Wetherall et al., 2015).

Two studies failed to demonstrate an effect of deprivation on suicide rates (Middleton et al., 2004, Congdon, 2012). Middleton et al. (2004) found that social fragmentation was more strongly associated with the risk of suicide than area-level deprivation was and Congdon et al. (2012) found that a combination of deprivation and social capital explained suicide risk better than either factor alone. These findings suggest that in some contexts social fragmentation and isolation may be important contributors to the risk of suicide.

The studies in this subsection provide a clear consensus; deprivation is positively associated with rates of suicide in the UK. This finding is consistent with the consensus of the broader body of literature surrounding the relationship between deprivation and suicide in other contexts. The consistent association between deprivation and higher suicide rates, particularly among men, underscores the profound impact of socioeconomic conditions on mental health and well-being. The findings that social fragmentation and psychosocial aspects of deprivation, such as income rank within groups, are critical contributors to suicide risk further emphasize the need to look beyond material deprivation alone. Future researchers examining the determinants of self-harm and suicide should adopt approaches that examine the upstream forces that create socioeconomic inequality and lead to self-harm and suicide in deprived areas. It is also noteworthy that the literature on this subject is dominated by studies that have used quantitative methods. This makes a degree of sense, given the highly sensitive nature of suicide and self-harm and the practical difficulties of conducting interviews with people at high risk of suicide or self-harm. Despite these challenges, future research using qualitative methods could provide valuable insight into how the association between socioeconomic factors and suicide and/or self-harm is understood by people living in deprived areas.

2.2.3 Harmful Alcohol Use and Alcohol-Specific Mortality

While reviewing the available literature surrounding the determinants of alcohol-related morbidity in the UK I found thirteen relevant articles. As was the case with drug and self-harm/suicide-related morbidity and mortality, the majority of the available literature used quantitative methods, with only one study adopting a qualitative approach.

The study that used qualitative methods (Neale et al., 2017) investigated the socio-demographic characteristics of people who repeatedly attended A&E for alcohol-related harm. Data were collected through semi-structured interviews with 30 individuals who had been admitted to A&E in London 10 or more times in the year proceeding the study. The authors used thematic analysis and a framework approach to analyse and interpret their findings (Neale et al., 2017). Participants in the study reported experiences with years of harmful drinking, poor mental health, unemployment, reliance on state benefits, and housing challenges (Neale et al., 2017). Neale et al. (2017) concluded that participants had multiple complex needs and that sociodemographic factors, in addition to behavioural factors, contributed to the repeat episodes of harmful drinking observed in this population.

The remaining 12 studies examined elements of the relationship between socioeconomic factors and potentially harmful levels of alcohol consumption. Five studies (Batty et al., 2012, Batty et al., 2008, Bellis et al., 2010, Garnett et al., 2021, Manca and Lewsey, 2021) collected primary data while the other seven used secondary data from longitudinal (Fone et al., 2013, Harhay et al., 2014, Katikireddi et al., 2017, Melotti et al., 2013, Beard et al., 2019) or cohort (Maggs et al., 2015, Caldwell et al., 2008) surveys. The available quantitative literature presents mixed results about the relationship between socioeconomic factors and harmful drinking behaviours. Batty et. al. (2008) found that socioeconomic disadvantage during childhood and adulthood was positively associated with the risk of harmful drinking for both men and women, as did three other studies (Caldwell et al., 2008, Katikireddi et al., 2017, Maggs et al., 2015). These findings are in contrast to those of Fone et. al. (2013) who found that people living in deprived areas were less likely to drink at harmful levels than those in less deprived areas. Additionally, several studies found that socioeconomic factors had opposing effects between men and women. Batty (2012) found that while low socioeconomic status

conferred a higher risk of harmful drinking for men, the opposite was true for women; Garnett et al. (2021) and Melotti et al. (2013) found similar results. Finally, two studies (Beard et al., 2019, Fone et al., 2013) found that lower income or living in deprived areas were associated with lower overall alcohol consumption, but higher rates of binge drinking.

There is no obvious explanation for why low socioeconomic status would be associated with harmful drinking in men but has the opposite association in women (Batty et al., 2012, Garnett et al., 2021, Melotti et al., 2013). The differential effect of socioeconomic status on rates of harmful drinking by gender may indicate that material deprivation is not the root cause of low socioeconomic status' impact on alcohol consumption; rather, it may indicate social and/or structural forces that lead deprived men and high-socioeconomic status women to harmful alcohol consumption. The relationship between gender, socioeconomic status, and harmful alcohol consumption may be an area that could effectively be explored with qualitative methods.

There is relatively little literature that examines the association of socioeconomic factors with alcohol-specific mortality in the UK. In conducting my literature review I was only able to identify four relevant studies, all of which used quantitative methods. Three of the studies (Connolly et al., 2011, Erskine et al., 2010, Harrison and Gardiner, 1999) examined the effect of one or more socioeconomic indicators on alcohol-related mortality risk, all of which found deprivation to have a positive association with mortality risk. The effect of deprivation on alcohol-related mortality varied from population; one study (Erskine et al., 2010) found the effect to be greatest for people aged 50-54 years, while another (Harrison and Gardiner, 1999), found the effect to be most pronounced for men aged 25-39 years. One study (Siegler et al., 2011) investigated socio-economic inequalities in alcohol-related mortality in England and Wales. They found that differences in alcohol-related mortality rates between socioeconomic classes increased in the early 1990s and were significantly greater for those in deprived socioeconomic classes, particularly men and women aged 25-49 (Siegler et al., 2011).

2.2.4 Empirical Evidence Summary

There is a wide body of literature examining the risk factors for DSA morbidity and mortality. Despite the existing evidence, important questions remain about how people living in communities with high rates of morbidity and mortality from these understand and explain their determinants. While extensive quantitative evidence exists examining the social determinants of DSA morbidity and mortality, there is a relative lack of qualitative research in this area. This gap in the literature justifies the need for qualitative investigation, as these methods would facilitate the exploration of lived experiences and social contexts that quantitative methods often fail to fully capture. Qualitative research would provide rich, detailed insights into how social determinants like socioeconomic status, community support, and cultural norms impact individual behaviour and influence DSA outcomes. There is overwhelming evidence that DSA morbidity and mortality are heavily influenced by social determinants such as poverty, low educational attainment and lack of access to services, all of which are also factors proposed by Case and Deaton (2017, 2020) to explain the increase of DoD in the US. Given this evidence for the influence of structural determinants, future qualitative research must adopt an appropriate theoretical framework that will allow for an in-depth investigation of the influence of structural factors on DSA outcomes. As I will demonstrate in the next subsection of this chapter, the concept of structural violence is one such framework.

2.3 Structural Violence

2.3.1 Background

The concept of structural violence was developed within the field of peace studies; an interdisciplinary field that draws on elements of history, sociology, political science, philosophy, and others. Peace studies emerged as a distinct academic movement in the early 1960s (Lawler, 2008). While closely related to other fields, such as conflict analysis and international relations, peace studies has a clear distinction. Conflict analysis and international relations focus on examining the sources of conflict and strategies for de-escalation but generally treat violent

conflict as inevitable (Lawler, 2008). The field of peace studies is principally interested in the eradication of war and violent conflict and the concept of peace itself (Samaddara, 2004). Johan Galtung was a prolific researcher working in the field of peace studies who founded the field's leading journal, the *Journal of Peace Research* (Lawler, 2008). While the term 'violence' recalls images of physical conflict or warfare, Galtung (1969) described it as the avoidable impairment of fundamental human needs or life.

Galtung was responsible for establishing many of the concepts that would become central to the field of peace studies, including the concepts of positive and negative peace (Lawler, 2008). Negative peace refers to the absence of war and violent conflict, while positive peace refers to the complete integration of human society (Galtung, 1964). Negative peace is what one might describe when asked to define a 'peaceful' society, but Galtung (1969) argued that this definition was incomplete. A negative peace, while absent of the physical violence associated with warfare and violent conflict, is still capable of causing tremendous harm to members of society (Galtung, 1969). To explain how a society that has achieved a negative peace could still perpetuate violence, Galtung (1969) advanced the concept of structural violence. Structural violence explains how political and economic systems in a society can perpetuate violence and cause unintended, yet significant, harm to individuals or groups of vulnerable people. As an example of his concept of structural violence, Galtung said: "If a person died from tuberculosis in the eighteenth century, it would be hard to conceive of this as violence since it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present according to our definition" (Galtung, 1969 p.169). Building on the Galtung's definition, Banerjee et. al. (2012) described structural violence as "the roll that institutions and social practices play in preventing people from meeting their basic needs or realizing their potential" (p.390). Achieving a positive peace would require the restructuring of social and governmental systems to end structural violence, and promote integration of formerly ostracised members into society (Galtung, 1969).

From the earliest days of the field, peace studies' interdisciplinary nature and broad view of what constitutes peace have facilitated the diffusion of theories and concepts from peace studies into other academic fields (Lawler, 2008). The concept of structural violence has

been widely adopted across a range of social sciences to examine how systems perpetuate violence across a range of subject areas. For example, structural violence has been adapted and used to explore topics such as urban trauma (Pain, 2019), the disproportionate impact climate change will have on the global south (Nixon, 2011), and gun violence in the United States (Zakrison et al., 2017). Since the mid-2000s, structural violence has increasingly been used within the combined fields of health research to examine and explain inequalities in health (De Maio and Ansell, 2018).

Infectious disease doctor and medical anthropologist Paul Farmer was among the first to integrate the concept of structural violence into health research, writing extensively on the subject throughout the 2000s (Farmer, 2004a, Farmer, 2020, Farmer, 2001, Farmer, 2004b, Farmer et al., 2006). Farmer co-founded the non-profit organization Partners in Health, which works to address social inequalities and promote health in resource-poor settings around the world. Farmer saw structural violence as playing a key role in causing the health inequalities that he observed through his work in Haiti, Peru, and a number of West African nations affected by the 2014 Ebola epidemic (Farmer 2001, 2004, 2020). Structural violence in the context of global health, Farmer explained, is "a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestably human rights abuses, some of them punishment for efforts to escape structural violence."(Farmer 2004b, p.8). Farmer did not empirically define structural violence, or propose a testable theory regarding how it manifests and what its impacts are; instead, he uses the concept as a way of providing context and an analytical lens through which to approach health inequalities (De Maio and Ansell, 2018).

2.3.2 Structural Violence and Health

Structural violence is related to the concept of structural determinants of health. Structural determinants of health is a phrase adopted by the World Health Organization (WHO) Commission on Social Determinants of Health (Solar and Irwin, 2010). Structural determinants of health refer to forces within the social order that create stratified social hierarchies and class divisions (Solar and Irwin, 2010). Both structural violence and the structural determinants of

health attempt to identify the upstream forces that set the stage for ill health, the 'causes of the causes' (De Maio and Ansell, 2018) While there are clear commonalities between these two concepts, structural violence more deliberately implicates political, economic, and social structures as the causes that create the conditions that allow for ill health. The framing of health inequalities as *violent* is evocative and facilitates a direct reconciliation with the fact that the structures that govern modern life are responsible for tangible suffering and death.

Structural violence's focus on the *structural* causes of ill health, rather than behavioural causes, is of particular significance in the context of this dissertation, particularly surrounding the issues of drug and alcohol addiction. Research examining the neurobiological causes and indicators of addiction has, thus far, failed to meaningfully advance treatments for addiction (Sinha et al., 2011). One reason for the failure of neurobiology to develop effective strategies to treat addiction may be that research has neglected social forces, such as social exclusion, criminalisation, and the marginalization of people living with addiction (Heilig et al., 2016). Using structural violence as a theoretical framework through which to approach the issues of drug and alcohol addiction could generate critical insights into what social structures are associated with the risk of drug and alcohol dependence. Identifying the role of social forces in promoting addiction would be an important contribution to the literature within the field of addiction studies.

As a concept, structural violence is not without its limitations. In the context of health research, structural violence is a nebulous term that is difficult to observe objectively. Currently, there is no widely accepted metric that identifies and quantifies structural violence, as there are for other forces that impact health such as income inequality (De Maio, 2007). As a result of the ambiguity surrounding the term, structural violence can serve as a sort of catch-all to describe health inequalities that occur in virtually any situation (De Maio and Ansell, 2018). For some, the ambiguity surrounding what precisely constitutes structural violence is a fundamental liability of the theory that limits its explanatory power (Janes and Corbett, 2009). Given the lack of specificity in the definitions provided by Galtung (1964, 1969) and Farmer (2001, 2004a, 2004b) and the wide range of contexts to which the concept of structural violence has been applied, it is unlikely that a unified measure of structural violence can be

established. Nor, do I think, is it necessary that a concept be empirically testable or perfectly defined to be useful to researchers. The criticism of structural violence as "untestable" is ultimately rooted in a positivist worldview, whereas researchers working with a constructivist paradigm (as I do, discussed further in Chapter 3), would find significant value in its ability to describe how individuals experience the world.

Despite its limitations, structural violence is a useful framework through which to approach investigations of the broader forces that impact health. While it may not be possible to develop a singular metric to quantify structural violence, that does not mean the theory lacks explanatory power altogether. As we will see in the following section, structural violence has been widely adopted in qualitative research and a limited number of attempts have been made to quantify and measure its effects. As a concept, structural violence encourages researchers to look at the upstream forces that allow for the development of ill health and to consider how these forces can be changed.

2.3.3 Applications in Existing Health Inequalities Literature

The concept of structural violence has been extensively applied within health research to explore how societal structures and institutional practices harm marginalised populations. In studies examining health issues related to gender and sexuality, structural violence has been applied to understand the experiences of women and gender non-conforming people. These studies, conducted in diverse settings such as North America, South America, Africa, and Asia, consistently highlight issues like stigma, inadequate access to healthcare, poverty, and gender-based discrimination (Basnyat, 2017, Dutta et al., 2019, Gamlin and Holmes, 2018, Neely et al., 2020). The use of structural violence as a theoretical lens revealed the intersectional nature of these experiences, showing how overlapping identities, such as gender and socioeconomic status, exacerbate health inequalities. The structural violence framework also facilitated the examination of the legacy of colonialism and how it continues to shape the social order of post-colonial countries. Several studies (St. Cyr et al., 2021, Solnes Miltenburg et al., 2018, Shannon et al., 2017, Hufstedler et al., 2020) discussed the intersectional nature of participants and how their intersectional identities contributed to their vulnerability to violent structures within the

social order. The intersectional nature of the qualitative findings highlights one of the central tenets of structural violence as a theory, that violent political and economic structures often cause disproportionate harm to members of the social order who are already vulnerable, such as those living in poverty or in conflict areas.

Structural violence has also been applied to the experiences of immigrants and migrants in high-income countries to describe how institutional discrimination impacts health. Studies conducted in the USA (Konczal and Varga, 2012, Page-Reeves et al., 2013) and France (Larchanche, 2011) found that immigrants and migrants often face institutional discrimination, lack of services in their native languages, and stigma from healthcare providers. A systematic review focusing on young migrants in the European Union highlighted how these people experience stigmatisation, marginalisation, poverty, and suboptimal living conditions (Mason-Jones and Nicholson, 2018). While much of the literature that has utilised the concept of structural violence has examined the health of people living in the global south, these European studies are an exception to the trend. The application of structural violence within high-income countries is of particular interest because it demonstrates that the concept is a useful theoretical framework through which to understand health inequalities across a range of settings.

Researchers documenting the lived experience of people who use drugs have also framed their findings through the lens of structural violence. In this context, structural violence manifested through stigma, discrimination, poverty, and fear of law enforcement, all of which deterred individuals from seeking help (Beckerleg and Hundt, 2005, Sarang et al., 2010, Yu et al., 2018). Participants in one study reported “a fatalistic acceptance of risk associated with drug use” (Sarang et al., 2010) while participants in another emphasised individual-level behaviours as the most important factors in causing their use of drugs and in determining whether they would continue to use drugs in the future (Yu et al., 2018). While similar to the stigma experienced in other populations, these findings may suggest that the impacts of structural violence can be internalised in this population (i.e., that people who use drugs are taught by the social order that they are responsible for their drug addiction and that it is ultimately their responsibility to stop or experience the consequences of continued use),

highlighting the importance of both structural and cultural forces in perpetuating structural violence. Overall, the application of structural violence in health research highlights the importance of addressing systemic and institutional inequities to improve health outcomes for marginalized populations. This framework helps to identify and analyse the root causes of health inequalities, providing a holistic understanding of how social structures perpetuate harm and highlighting the need for systemic change.

It is noteworthy that a large portion of the literature that has used the concept of structural violence has also used qualitative methods. This is perhaps unsurprising, given the inherent limitations in establishing an agreed-upon metric through which to measure structural violence (see the previous subsection); however, the extent to which the concept has been used by qualitative researchers demonstrates that structural violence is a useful concept through which qualitative researchers can understand the influence of structural factors on individuals' lived experiences. One notable strength of structural violence as an analytical framework in the available literature was that it clearly identified the intersectional nature of participants' experiences. As discussed in section *2.3.1: Background*, one of the premises of the concept of structural violence is that it has a differential impact based on existing vulnerabilities within a social order. The qualitative literature I have discussed here has demonstrated that structural violence as an analytical framework effectively captures the intersectional nature of participants' lived experiences with health inequalities.

While the structural violence and health literature spans a wide range of populations and phenomena, some common themes may serve as hallmarks of structural violence. Poverty, discrimination and stigma, lack of access to healthcare services, and services that were not optimised to serve populations in need were frequent themes in studies from both high- and low-income settings. Poverty and a lack of access to health services were noted by Farmer (2001, 2004) as forms of structural violence that frequently impact health in low-income countries (Farmer, 2001, 2004). Further research using a structural violence framework in the English context will need to identify the mechanisms by which structural violence drives inequalities in the social determinants of health and how these shape the landscape in which

DSA morbidity and mortality occur.

2.3.4 Structural Violence Summary

Originating in the field of peace studies, structural violence has been adopted into health research fields. Thus far, its use has been primarily as a theoretical framework through which to approach qualitative research. Structural violence is highly relevant to health inequalities and is particularly compatible with qualitative inquiry, as it provides a robust framework for identifying and analysing the structural causes of health inequality. By applying the concept of structural violence to DSA morbidity and mortality, my study will contribute to the existing literature and offer new insights into the structural factors underpinning these public health issues. This study will also constitute a novel theoretical contribution to the literature, as the concept of structural violence has not yet been applied within the field of DoD research.

2.4 Other Concepts of Violence

Structural violence is not the only theory of violence. Two other theories of violence are relevant to the findings of this study and are briefly introduced here; these are slow and symbolic violence. Slow violence builds on the concept of structural violence to describe how the effects of structural violence can persist for years after the structurally violent act has occurred. Symbolic violence explains how dominant groups impose social norms to give the appearance that a harmful social order is just and legitimate.

2.4.1 Slow Violence

The concept of slow violence originates from the field of environmental humanities and is rooted in postcolonial ecological research (Nixon, 2011). Rob Nixon introduced the term in his 2011 book, *Slow Violence and the Environmentalism of the Poor*, where he sought to highlight the gradual, often invisible environmental degradation that disproportionately affects

marginalized communities, particularly in the Global South. Nixon (2011) describes slow violence as a form of violence that occurs gradually and out of sight, a delayed destruction that is dispersed across time and space. The concept of structural violence as constructed by Galtung (1969) has an inherent temporal element due to its emphasis on understanding how past injustices influence present living conditions, but it is often implicit and not directly examined (Banerjee et al., 2012, Galtung, 1969, Galtung, 1964). Slow violence builds on the concept of structural violence by placing greater emphasis on the tendency for violence to go on for an extended period of time without notice (Nixon, 2011, Pain, 2019). While Nixon's concept of slow violence has predominately been applied within fields concerned with the impacts of environmental degradation on human health (Davies, 2022, Davies, 2018b), it has been applied to studies examining the impacts of neoliberal economic policies on urban environments (Kramer and Remster, 2022, Pain, 2019)

The concept of slow violence is significant because it highlights forms of harm that are often overlooked in mainstream discourse due to their protracted and diffuse nature. By drawing attention to these subtle forms of violence, the concept challenges traditional understandings of violence as immediate, visible, and event driven. This framework has been particularly valuable in examining how systemic inequalities—whether through environmental degradation, neoliberal economic policies, or urban disinvestment—produce long-term, cumulative harm to vulnerable communities. Its application underscores the importance of understanding violence not just as a momentary act but as a process deeply embedded in societal structures, shaping lived experiences across generations (Pain, 2019; Nixon, 2011). In the context of this thesis, the concept of slow violence allows for a greater understanding of how events that occurred decades previously (such as deindustrialisation) continue to shape the lived environment in Middlesbrough and South Tyneside today.

2.4.2 Symbolic Violence

Symbolic violence is a concept advanced by sociologist Pierre Bourdieu that explains the ways in which power and dominance are maintained through cultural, rather than physical, force (Bourdieu, 1977). Bourdieu explains that within society, dominant groups impose norms, values, and perceptions upon a subordinate group through language, education, and social institutions, which leads the latter to perceive the social order as just and legitimate (Bourdieu, 1977, Bourdieu, 1990). Symbolic violence emphasises how power operates subtly and pervasively, shaping perceptions, behaviours, and social hierarchies without overt coercion. This concept has been widely applied in a number of fields to explore how inequalities are reproduced through everyday practices and ideologies (Recuero, 2015, Martin et al., 2021). By focusing on the internalisation of domination, symbolic violence underscores the role of cultural and symbolic systems in sustaining social stratification, often rendering inequality invisible or giving it an appearance of naturalness (Bourdieu, 1990).

The concept of symbolic violence has been applied in health-related research to examine how social hierarchies and power dynamics influence health outcomes, access to care, and patient-provider interactions (Thapar-Björkert et al., 2016, Araújo et al., 2009). For instance, studies have explored how symbolic violence operates in healthcare by reinforcing class, gender, or sexual orientation-based inequalities (Araújo et al., 2009). In public health research, symbolic violence has also been used to critique how health promotion campaigns and policies may unintentionally blame individuals for poor health outcomes, rather than addressing systemic barriers. For example, weight stigma in obesity interventions or maternal health campaigns that focus exclusively on individual behaviors without acknowledging socioeconomic determinants are instances where symbolic violence can manifest (Monaghan, 2013, Lupton, 1995). This is of particular importance in the context of deaths of despair research, where, as discussed in section 2.1.3 of this chapter, the term itself emphasizes the role of individual feelings in producing these deaths. Additionally, symbolic violence can provide important context for how the harms resulting from other forms of violence, such as structural and slow violence, can be overlooked and perceived as natural.

2.5 Chapter Summary

This review of the relevant literature indicates that further research in the UK is essential to deepen our understanding of factors underpinning DSA morbidity and mortality. While previous research has been instrumental in highlighting that DSA morbidity and mortality are closely tied to structural forces and socioeconomic conditions, there remains a notable gap in the literature in that these issues are rarely explored using qualitative methods. Qualitative research on DSA morbidity and mortality would provide nuanced insights into the lived experiences and social contexts influencing DSA related outcomes. This gap in the literature is particularly pronounced in the UK where very little research examining these outcomes as separate phenomena, and none examining them under the DoD label, has yet been published. My study will make a novel contribution by addressing this gap in the literature. The concepts of structural, slow, and symbolic violence can offer a robust theoretical framework for such qualitative inquiry, allowing critical analysis of the structural causes of health inequalities. By applying these concepts to the determinants of DSA morbidity and mortality, my study will contribute valuable new insights into the determinants underpinning DSA morbidity and mortality that will be of interest to researchers in the UK and those studying the determinants of DoD in other contexts.

Chapter 3: Methods

This chapter provides an overview of the methods used to meet the research aim and objectives. I discuss the philosophical assumptions underpinning my research paradigm and my justification for utilising a qualitative approach. I provide an overview of the study timeline, discuss the ethical considerations necessitated by this study, and reflect on my positionality as a researcher and how this may have influenced the data.

3.1 My Research Paradigm and Study Design

Research paradigms are the assumptions made by researchers, characterised by their ontology, epistemology, and methodology that guide how a study is conducted, interpreted, and understood (Grix, 2019, Sławecki, 2018). Paradigms represent a researcher's worldview and are underpinned by philosophical assumptions about the nature of existence, how individuals interface with the world, and how knowledge can be discovered or generated (Guba and Lincoln, 1994). As these paradigms shape the way that researchers approach every phase of the research process, it is important to consider their philosophical underpinnings and how these have influenced the study (Sławecki, 2018).

Ontology is the branch of philosophy that deals with the nature of existence and what can be known about the world (Scotland, 2012). Research in fields of social science has been shaped by two major ontological perspectives, realism and constructivism (Ritchie et al., 2003). Realism is a philosophical perspective rooted in the idea that reality is objective and exists independently of a researcher's experience or interpretation (Jenkins, 2010). Constructivism (also known as social constructivism or interpretivism) is essentially the opposite philosophical position of realism. Constructivism is based on the idea that reality is constructed by individuals through their perceptions and interpretations of, and interactions with, the world and those around them. To that end, constructivism argues that no reality exists independent of human interaction (Guba, 1990, Ritchie et al., 2003). Researchers working in fields that study human behaviour and culture (e.g. anthropology and sociology) frequently hold constructivist

ontologies and they are most often associated with qualitative research methods (Lee, 2012), while realist ontologies are more common in the natural sciences and when adopted by researchers in the social sciences are associated with the use of quantitative methods (Johnson and Onwuegbuzie, 2004). It should be noted that realism and constructivism are broad categories within which there is significant nuance and debate surrounding the internal consistency of different ontological positions (Lee, 2012, Sider, 2009). Ontological assumptions are one component that influences researchers' theoretical perspectives and informs their choice of methodology (Guba and Lincoln, 1994).

Epistemology is related to, but distinct from the concept of ontology. Epistemology is the branch of philosophy focused on the nature and validity of knowledge and the rationality of belief (Roots, 2007). Ontological philosophy asks questions about what exists, while epistemological philosophy asks *how people know* what exists and how they know it is true. Epistemological assumptions influence the ways that a researcher believes knowledge about the subject they are studying can be acquired or generated (Scotland, 2012) As with ontology, there are two common epistemological perspectives in social sciences research, positivism and interpretivism (Guba and Lincoln, 1994). Positivism relies on the scientific method to test hypotheses and thereby generate knowledge or fill gaps in current knowledge and frequently relies on the use of quantitative methods (Park et al., 2020). Interpretivist paradigms believe that there is no universal truth because knowledge is socially constructed and is more conducive to research using qualitative methods (Ritchie et al., 2003). It is important to note that as with ontological perspectives, there is significant nuance within these broad epistemological paradigms (Allen, 1994). Every research paradigm has strengths and weaknesses, and the principal determining factor when designing a study should be the researcher's aims and objectives (Cassell and Johnson, 2006).

Methodology refers to the ways through which a researcher acquires or generates knowledge about the phenomenon they are studying (Ritchie et al., 2003). In this study, my research aims were centred around exploring how participants' perspectives and experiences living and/or working in communities with above-average prevalence of DSA morbidity and mortality shape their explanations for the above-average prevalence of these problems in their

area. As the purpose of the research was to gain a deeper understanding of participants' perceptions and experiences, I adopted a constructivist ontology and interpretivist epistemological approach. Qualitative methods were the most appropriate approach to collect the required data as they allowed for an in-depth exploration of participants' perspectives and how their subjective experiences living in their communities had informed their understanding of the factors underpinning DSA morbidity and mortality (Al-Busaidi, 2008).

When I initially proposed this research, I aimed to conduct a mixed-methods study in which, I would have conducted qualitative research with stakeholders and community members in one case study site. The quantitative portion of the proposed study would have examined the factors driving inequalities in DSA morbidity and mortality at the regional and local authority levels. I decided to switch from a mixed-methods study design to focus on qualitative research at the end of the first year of my PhD. I decided to drop the quantitative portion of my project and expanded the qualitative portion based on four major factors:

1. The qualitative data I had generated up to that point were yielding rich findings that covered a broad range of topics. I felt that further qualitative research would add significant depth to the data and allow me to generate meaningful novel insights into how DSA morbidity and mortality were understood by stakeholders and community members.

2. My literature review revealed that research on 'deaths of despair' in the UK had exclusively used quantitative methods and that no qualitative research investigating perspectives on the prevalence of DSA morbidity and mortality had yet been published, so there was a clear gap in the literature that my qualitative research could help fill.

3. The quantitative data surrounding DSA morbidity and mortality were disparate in their geographic units (some data were only available at the regional level, others at the local authority level, and still others at the level of Lower Super Output Areas) and of varying quality. Higher quality datasets, such as the Crime Survey for England and Wales and the

Health Survey for England, required the use of protected research environments which I did not have access to due to a lack of funding and logistical constraints.

4. As my project progressed, my research interests shifted, and I was increasingly drawn to the use of qualitative methods because of their grounding in participants' lived experiences.

After discussing my rationale with my supervisors and review panel, I decided to drop the quantitative portion of my project and expand the qualitative portion to include the recruitment of participants from a second case study site.

3.2 Methods

Participants in this study were recruited from two local authorities in North East England, Middlesbrough and South Tyneside. Details about these local authorities and how they were selected as the setting for this study are discussed further in Chapter 4. Recruitment and data collection were carried out in four phases, as shown in the Gantt chart below. As there was variation in the recruitment methods used and ethical considerations required for the phases of the study involving stakeholders versus those required for community members, these phases are discussed separately in the following subsections.

	October 2022-December 2022	March 2023 – June 2023	July 2023-September 2023	October 2023 – December 2023
Middlesbrough Stakeholders				
South Tyneside Stakeholders				
Middlesbrough Community Members				
South Tyneside Community Members				

Table 3.1: Study timeline

3.2.1 Stakeholders

Recruitment and Sampling

Stakeholders were eligible to participate in this study if their work involved people living in Middlesbrough or South Tyneside and if their work pertained directly or indirectly to drug, self-harm, or alcohol-specific morbidities and mortalities. Data collection stopped when I deemed that data saturation had been reached i.e., that continuing to generate additional data would not yield additional themes relevant to my topic (Fusch and Ness, 2015).

Recruitment was conducted using a variety of approaches to maximise variation in the sample. Purposive sampling, a form of non-random sampling in which the researcher selects participants based on a particular characteristic relevant to the study, was used to recruit participants. This approach ensures the sample is well matched to the research aims and objectives and thereby improves the rigour of a study (Palinkas et al., 2015). Several recruitment techniques were used in this study to maximise variation in the sample. First, a short description of the study and an invitation to participate was distributed via an established professional network email mailing list for stakeholders working in a range of professional areas across Middlesbrough. Individual stakeholders deemed relevant to the study were approached directly via email and invited to participate. Stakeholders were approached directly if they worked in a sector that had been frequently discussed in previous interviews but was as yet unrepresented in the sample; for example, multiple participants discussed the role that town councillors have in setting policies that affect people living in deprived wards, so town councillors from particularly deprived wards were emailed directly and invited to participate.

Snowball sampling, a method in which participants are asked to refer other members of the target population to participate in the study, was used to further the reach of recruitment materials. All email invitations and social media posts included a request for participants to forward the invitation to any colleagues or contacts they thought may be relevant to the study. Snowball sampling is an appropriate recruitment technique when the target population is difficult to access, as was the case given my limited existing connections to stakeholders in my case study sites (Naderifar et al., 2017).

In South Tyneside, no professional network for stakeholders was identified, so recruitment was carried out through snowball sampling and direct approaches to relevant stakeholders. The impact of this difference in recruitment techniques between case study sites was minimal, as most stakeholders recruited in Middlesbrough were recruited through a direct approach or referred to the study by a colleague. Purposive sampling was used to ensure that the sample from South Tyneside was comprised of stakeholders from similar sectors as the sample from Middlesbrough. In Middlesbrough, 28 invitations to schedule an interview were sent, of which 13 agreed to participate and completed an interview.

In South Tyneside, 61 invitations to schedule an interview were sent of which 11 agreed to participate and completed an interview. Significantly more invitations were sent in South Tyneside due to difficulty securing participation from local councillors. All local councillors in South Tyneside were invited to participate in the study, of which one agreed to complete an interview. Low councillor participation in South Tyneside may be due in part to recruitment taking place around the time of the 2023 UK local elections. Councillors were initially contacted during the pre-election period – a period in the lead-up to an election in which the law restricts government officials from many forms of public communication to avoid influencing the election outcome. While participation in this study was anonymous and would not have constituted a violation of pre-election period regulations, councillors may have been hesitant to speak to a member of the public on the record at that time. A small number of councillors agreed to be interviewed after the election but were not re-elected; I tried to contact these former councillors but was not able to reach them. All standing councillors were re-contacted via email after the 2023 elections were finished; most did not respond to the initial invitation or follow-up, although several responded to decline the invitation. Local Conservative, Labour, and Green Party organisations were contacted and asked to nominate one of their elected members to participate; no response was received from these organisations. As a result, the sample from South Tyneside consists of fewer elected officials than the sample from Middlesbrough.

Individuals interested in participating in the study were asked to complete an expression of interest survey which gauged their eligibility for participation and collected demographic information (age group, gender, and highest level of education) as well as professional

background information (years in current position, job title, professional responsibilities). Three people were excluded from participation due to their current role not being in a related sector; these people indicated on their expression of interest survey that their work did not relate directly or indirectly to DSA morbidity and/or mortality. Two of the three people deemed ineligible to participate in the stakeholder portion of the study were referred to participate as community members. One person did not live in either Middlesbrough or South Tyneside and their work was in an unrelated sector, thus they were ineligible to participate in either portion of this study. Figure 3.1 outlines the recruitment process.

Sample Composition

The expression of interest survey collected demographic information from participants. Stakeholders who were contacted directly by me were asked to complete the expression of interest survey before their interview so that their demographic information could also be captured. Table 3.2 presents participant demographic information.

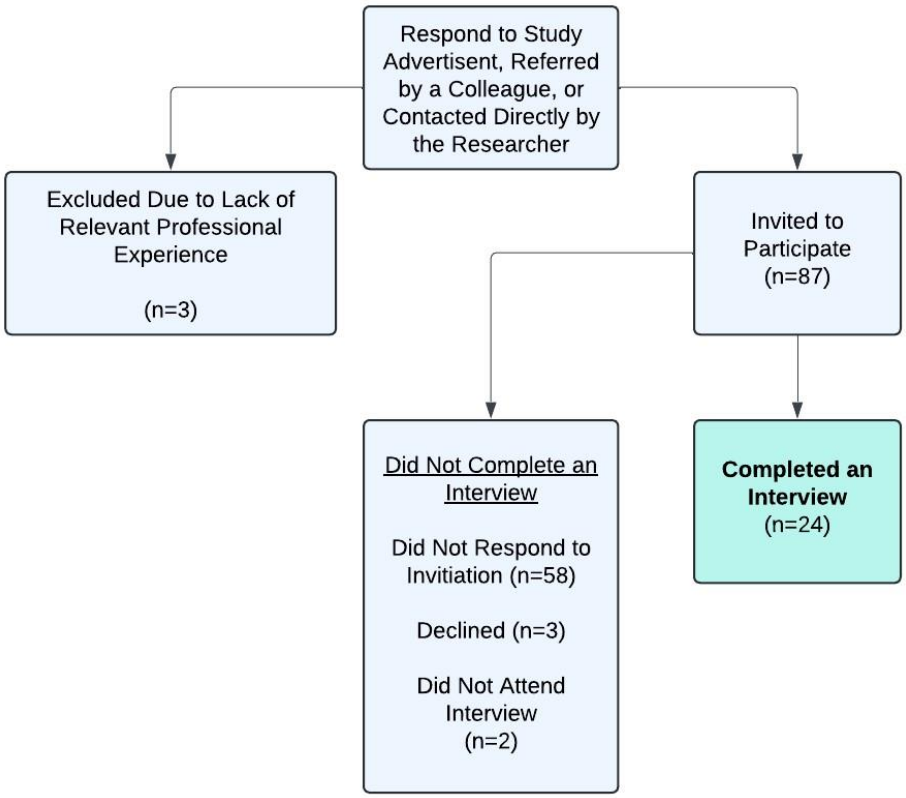


Figure 3.1: Stakeholder recruitment flowchart.

Category	Middlesbrough (Number of Participants)	South Tyneside (Number of Participants)
Gender		
Male	6	7
Female	7	4
Age		
18-24	0	1
25-34	1	1
35-44	1	3
45-54	7	4
55-64	4	2
Highest Level of Education		
Higher or secondary or further education (A-levels, BTEC, etc.)	4	2
University	6	6
Postgraduate Degree	2	3
Prefer not to say	1	0
Years in Current Professional Role		
Less than 1 Year	4	2
1 to 2 Years	3	0
2 to 5 Years	0	4
5 to 10 Years	1	4
More than 10 Years	4	1
Prefer not to say	1	0
Total Participants	13	11

Table 3.2: Stakeholder demographic information

Data Collection

Data were collected through semi-structured, in-depth interviews. Semi-structured interviews allow for the exploration of ideas that participants believe to be important that may not be covered in the topic guide (Gill et al., 2008). Interviews were the most appropriate data collection method for this topic as I was seeking to explore individuals' thoughts, opinions, and perceptions that were grounded in their own professional experience. The one-to-one interview format ensured that participants could freely voice their opinions on controversial topics, such as policy failures and ineffective approaches to service provision, that they may not

have felt comfortable sharing in a group setting. Interviews were guided by a topic guide (Appendix A) informed by my review of the existing literature around DSA morbidity and mortality and loosely modelled after a discussion guide used in a qualitative study investigating communal perceptions of diseases of despair in the United States (George et al., 2021). The topic guide was peer-reviewed by my supervisors and by classmates and instructors at the University of Essex Summer School in Social Science in July 2022.

Interviews were conducted in-person (n=17) or online (n=7), depending on participant preference. In-person interviews were conducted at the time and place of participants' choosing, which in all but three cases were their places of work. Three participants preferred to have their interviews conducted in a more public setting, such as a café or coffee shop. Online interviews were conducted using Microsoft Teams during normal office hours. All interviews were audio-recorded, either using a digital voice recorder or, in the case of online interviews, using the in-app recording feature. Audio recordings were transcribed by me; these transcriptions were checked for accuracy, and anonymised, and audio recordings were subsequently deleted.

Ethical Considerations

This study was approved by the Newcastle University Faculty of Medical Science (FMS) Research Ethics Committee (REC). The portion of this study relating to stakeholders was determined to be ethically low risk by the FMS REC online ethics assessment form. Ethical approval was secured on 01/05/2022 (Ref: 22812/2022).

When stakeholders were invited to take part in an interview, they were provided with a virtual copy of the participant information sheet. The participant information sheet provided them with details about the purpose of the study, how their information would be collected, used, and stored, and informed them that they were free to withdraw from the study at any time before or during the interview. The information sheet informed participants that they would have up to one month from the date of their interview to withdraw from the study; this limitation was implemented to prevent significant disruption to the study should a participant wish to withdraw after the analysis was complete and findings generated from their data.

Before each interview, participants were provided with another copy of the information sheet and asked to complete a written consent form; when an interview was conducted virtually, these sheets were emailed to the participant, and consent was secured through an online consent form. Upon completion of their interview, participants were provided with a participant debrief sheet. Participation in this study was completely voluntary; stakeholders were not offered any incentive for participation or compensation for their time.

Data Availability

While I have made every reasonable effort to anonymise the transcripts (such as removing all names, references to specific employers, job titles, and areas of residence), it remains possible that participants may be identifiable from the transcripts. The possibility of identification from the transcripts arises from the fact that participants drew heavily from their professional experiences and their first-hand knowledge of service commissioning and delivery within the community. The service provision landscapes in Middlesbrough and South Tyneside are relatively tight-knit; service providers may be familiar with one another's experiences and may be able to identify participants on this basis. During their interviews, participants shared both positive and negative thoughts and experiences with specific funders, government organisations, and service providers within the community. If participants who voiced negative perceptions were identified based on their transcript, they may be subjected to reputational damage or at risk of reprisal. Identification of participants in this study could also hamper the ability of future researchers to conduct other studies with stakeholders in Middlesbrough and South Tyneside. Given these risks, transcripts of stakeholder interviews will not be made available to the public and direct quotes are not attributed to specific participants.

3.2.2 Community Members

Recruitment and Sampling

The goal of recruiting community members to participate in this study was to learn how people living in Middlesbrough and South Tyneside understand and explain the problems of

DSA morbidity and mortality in their areas. To achieve this goal, eligibility criteria for participation in the community member portion of this study were deliberately kept as broad as possible. To be eligible to participate, community members needed to be over the age of 18, able to complete an interview in English, be a resident of Middlesbrough or South Tyneside, and be comfortable discussing DSA outcomes.

Community members in Middlesbrough and South Tyneside were recruited through several convenience sampling approaches. In both communities, the study was advertised by displaying flyers in community spaces (e.g. libraries and community centres) and through engagement with key stakeholders that had access to the public (i.e. food banks, welfare-to-work organisations, and housing providers). While these methods were effective in recruiting a small number of participants who saw flyers advertising the study and reached out to me to participate, most community members who participated in the study were people I met at community drop-ins and directly invited to take part.

I identified several community drop-ins in Middlesbrough and South Tyneside that were open to the public. These groups were aimed at creating opportunities for socialisation and peer connection in the interest of promoting general health and wellbeing, rather than providing support for specific issues (as would be the case for formal peer-support groups like Alcoholics Anonymous). The organisations responsible for hosting the drop-ins were contacted to request permission for me to attend and to recruit participants from their group. Once permission had been granted, I started attending these groups regularly. I introduced myself to group members as a researcher but did not initially request to interview anyone. My goal in attending the groups was to build rapport and trust among group members to facilitate open conversations once I began the interview process. After building rapport with the group members, I explained my study in more detail, described what participation would entail, and asked any group members interested in participating to schedule an interview. All the attendees at the drop-ins were invited to participate.

The sample of community members consisted of 30 people (16 from Middlesbrough, and 14 from South Tyneside). Figure 3.2 outlines the recruitment process.

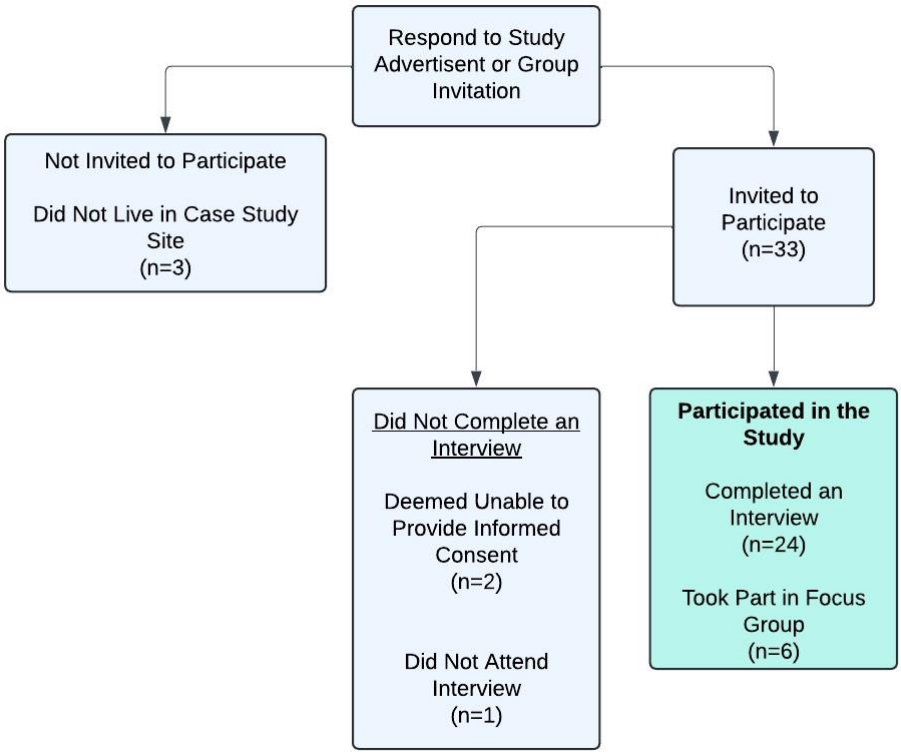


Figure 3.2: Community Member Recruitment Flowchart

Data Collection

Participants were offered the option to take part in an interview online or in person; all chose to be interviewed in person. Interviews were scheduled at a time and public place that was convenient for the participants; venues included coffee shops, privately booked rooms in community centres, restaurants, and cafes. Participants who had been recruited from a drop-in were typically asked to do their interviews in the same place that the drop-ins were held; in these cases, I coordinated with the relevant group's host organisation for the use of the drop-in space outside of the scheduled drop-in hours.

Interviews with community members followed a similar structure to those of stakeholders. Data were collected through semi-structured, in-depth interviews which typically lasted between 45 and 90 minutes. They were guided by a topic guide (Appendix A) similar to the one used for stakeholders, with minor adjustments made to make the questions more

accessible to a lay audience. While participants were not recruited based on having lived experience with a problem related to drugs, suicide, alcohol, or their mental health more generally, and were never asked to share any related personal experiences, participants frequently volunteered these experiences during their interview, nonetheless. This is perhaps not surprising as it is relatively common among the general public to have experienced a DSA or mental health-related problem or to know someone who has, so they were naturally going to be present in some participants' lives.

Members of one community drop-in in South Tyneside expressed the desire to do their interviews as a group. To accommodate that request, data were collected from these participants via a focus group using the same topic guide that was used for interviews. Focus groups are a form of group interview where a small group of people discuss a specific topic under the guidance of a moderator to gather insights and opinions. As with all qualitative data collection methods, there are strength and weaknesses to focus groups, but a key strength in the context of this study was that they can encourage participation from those who are reluctant to be interviewed individually (Kitzinger, 1995). Six people participated in the focus group. All interviews and the focus group were audio-recorded (with consent) using a digital voice recorder. Audio recordings were transcribed by the researcher; these transcriptions were checked for accuracy, and anonymised, and audio recordings were subsequently deleted.

Sample Composition

At the start of their interview or focus group, participants were asked to complete a short demographic survey, either in writing or verbally according to their preference. This survey collected information such as their age, gender identity, employment status, highest level of education, and length of time they had lived in their town. Table 3.3 presents participants' demographic information.

Category	Middlesbrough (Number of Participants)	South Tyneside (Number of Participants)
Gender		
Male	9	9
Female	7	5
Age		
18-24	1	0
25-34	2	1
35-44	2	0
45-54	3	1
55-64	3	8
65+	5	4
Highest Level of Education Completed		
Primary school	5	2
Secondary school up to 16 years	4	8
Higher or secondary or further education (A-levels, BTEC, etc.)	2	3
College, university, post-graduate degree	2	1
Prefer not to say	3	0
Employment Status		
Unemployed	7	9
Part-Time	2	0
Full-Time	2	1
Retired	5	4
Years Lived in Town		
1 to 5 Years	1	1
6 to 10 Years	2	3
11 to 15 years	2	0
15+	11	10
Total Participants	16	14

Table 3.3: Community member demographic information.

Ethical Considerations

Due to the sensitive nature of some of the discussion topics and the fact that some participants were recruited via a gatekeeper, the portion of this study relating to community

members was deemed ethically high-risk and required full ethical approval. Ethical approval was received from FMS REC on 23/02/2023 (Ref: 2443/26851).

Before beginning participation in an interview or the focus group, participants were provided with a physical participant information sheet. This provided them with details about the purpose of the study, how information would be collected, used, and stored, and informed them that they were free to withdraw from the study at any time before or during the interview. The participant information sheet informed participants taking part in an interview that they would have up to one month from the date of their interview to withdraw from the study. Participants in the focus group were not able to withdraw their data from the study after the focus group had concluded. These limitations were implemented to prevent significant disruption to the study should a participant wish to withdraw after data had been anonymised and analysis had begun. I would also offer to read the information sheet out loud to them; this was done to accommodate participants who may have struggled to read and understand the information sheet because of physical disability or low reading comprehension skills. Participants were then given the opportunity to ask questions and asked to provide written consent to participate in the study. Consent sheets were similarly read aloud to participants, and written consent was secured.

Upon completion of their interview or focus group, participants were provided with a debrief sheet which reiterated the information on the participant information and consent sheets. They were also provided with a resource sheet which provided contact information for local organisations that provide support for issues relating to drugs, suicide, and alcohol.

Participation in this study was completely voluntary. Participants were provided with a £25 supermarket shopping voucher (either ASDA or ALDI according to their choice) as a thank-you for their participation. The voucher amount was set in line with the guidance for researchers provided by the Wellcome Trust.

As previously discussed, some participants chose to disclose information about their own mental health and/or experiences with substance use during their interview. When participants raised these issues, they were reminded that they were not required to share such information if they did not wish to do so and that we could stop the interview or change the

subject at any time. Most participants who shared these experiences did so without becoming upset, expressed that it felt good for them to talk about these things, and believed that by sharing their experiences they were contributing to research efforts to better understand the problems affecting people in their areas. One participant chose to disclose details of their own experience with mental illness and became visibly distressed during their interview to the point that I deemed it inappropriate to continue. In this case, I stopped the interview immediately, debriefed with the participant, and ensured they were going to a supportive and safe environment after leaving the interview location. Upon immediate consultation with my supervisory team after the interview, we deemed that no further safeguarding action was necessary to ensure this participant's safety. In the days following the interview, I re-contacted the participant to confirm their well-being and enquire whether they wished for the data that they had provided before me stopping the interview to be destroyed. The participant strongly believed that their data should be included in the study so that their experiences could have a positive impact for others; as such, the data provided before stopping the interview was included and used during analysis.

In two cases, individuals volunteered to participate in the study who I believed were not capable of providing informed consent. Before starting their interview, one person disclosed to me that they were under the influence of drugs at the time of our meeting. The other person was a frequent attendee at a community drop-in who volunteered to participate in the study; the person had a disability which required the support of a carer who advised me that the individual was not able to provide informed consent due to the nature of their disability. In both cases, I knew I could not ethically interview these people as they were unable to provide informed consent but did not want to cause harm by creating feelings of stigmatisation or exclusion by refusing to meet with them. Instead of an interview, I chose to have an informal conversation, which did not involve securing written consent, with these would-be participants about how they liked living in their town. These informal conversations were very broad, did not discuss any sensitive topics, were not audio recorded, and were not incorporated into the findings of this study in any way. I gave both of these would-be participants a voucher to thank

them for their time and willingness to participate.

3.3. Data Analysis

All participant data were pooled and analysed together. Data analysis was conducted using the Iterative Categorization (IC) technique developed by Neale (2016) and findings were interpreted through thematic analysis (Braun and Clarke, 2006). IC is a technique for analysing qualitative data that was first published in 2016 and has previously been used to support qualitative research investigating addiction (Neale et al., 2012, Neale et al., 2017). IC is not a stand-alone method of analysing qualitative data; it is a technique for managing data analysis that is rigorous and transparent while remaining compatible with other common forms of qualitative analysis, such as thematic analysis (Neale et. al, 2016). IC outlines eight steps of data analysis (Neale, 2020). Table 3.4 outlines each of the steps of IC and the actions taken in this study to complete each step.

Step of Iterative Categorization	Action Taken
1. Transcription	Audio recordings were transcribed by the researcher using a denaturalised transcription approach.
2. Familiarisation	Transcripts were re-read to ensure the researcher was familiarised with their content.
3. Anonymisation	All directly identifiable information, such as names, dates, family information, job titles, and places of work were removed. Participants were assigned a participant ID number.
4. Logging	Documents were stored in a folder filing system saved to the researcher's university H:// drive and backed up to a passphrase-protected OneDrive account.
5. Coding	A deductive coding framework was developed based on the questions asked in the topic guide. Codes were merged and new codes were generated inductively as coding

	progressed. Coding was conducted using the MAXQDA 2022 software package.
6. Analyses Preparation	All coded data extracts were exported to Microsoft Word documents. Raw codes, analysis files, and summary files were generated and stored in a folder filing system. All coded extracts were reviewed by the researcher.
7. Descriptive Analysis	Coded extracts were reduced to short sentences and phrases. Similar summarised extracts were grouped and merged into groups with headings and subheadings. All reduced coded extracts were summarised.
8. Interpretive Analysis	Themes present within the data were identified. Findings were externalised by relating them to the existing literature and identifying policy implications within the findings.

Table 3.4: Steps taken during each of the eight steps of Iterative Categorization as outlined by Neale (2020).

Transcripts were generated from the audio recordings of interviews as soon as possible, with transcription often beginning within one day of completing the interview. A denaturalised transcription approach, in which involuntary vocalisations and pauses were omitted from the transcript but the substance and meaning of the interview were preserved, was adopted (Oliver et al., 2005). Coding was conducted using the qualitative analysis software MAXQDA 2022. An initial coding matrix was generated deductively based on the interview topic guide; codes were merged, and the matrix was supplemented with codes generated inductively as coding progressed. The coding matrix and a sub-sample of coded transcripts were reviewed by another PhD student (Amber Sacre) in the Population Health Science Institute to ensure reliability and rigour. Once coding was completed, the analysis followed the stages of IC outlined by Neale (2016, 2020).

The final stage of IC, interpretive analysis, seeks to identify patterns, associations, and explanations within the data (Neale, 2020). Interpretive analysis involves identifying themes that appear in the data and exploring how these themes corroborate, expand, or refute existing

constructs and theories. Interpretive analysis within IC can comprise three processes: conceptualising, differentiating, and externalising. In this study, conceptualising was undertaken inductively and involved the identification of three distinct themes within the data (individual, social, and structural determinants). Data differentiation involves checking descriptive themes and categories for similarities, differences, and outliers within participant accounts. Differentiation of participant accounts is conducted based on inclusion in subgroups and characteristics relevant to the study; in this case, participants were differentiated based on gender, age, town of residence, and professional capacity (e.g., service provision, administration, policy setting, etc). Emerging themes were differentiated to investigate whether participants who expressed similar beliefs shared any discernible characteristics. After differentiation, there were few clear differences between the themes present in participant narratives based on any identifiable characteristics. These differences were relatively minor (e.g. all participants agreed that crisis lines were largely ineffective at improving mental health, but stakeholders felt this was because crisis lines were misunderstood while community members felt it was because they do not provide ongoing mental health support). Most participants' narratives contained elements of a wide range of themes relating to individual, cultural, and structural level determinants of DSA morbidity and mortality. Once identified and fully developed, themes were externalised by assessing them in relationship to the existing literature on the causes of DSA morbidity and mortality. The three processes involved in interpretive analysis were not conducted sequentially; rather, they were conducted iteratively with each process being revisited as new findings were generated.

3.3.1 Rigour and Transparency

Selected quotes have been integrated into the findings chapters of this thesis to illustrate themes as they are discussed. To ensure participants' privacy, these quotes are not attributed to specific participants. There are 101 illustrative quotations included in this thesis derived from 44 separate participants. While this decision is somewhat unusual in qualitative

research, in the context of this study, this approach is both necessary and justifiable for two key reasons.

Firstly, ensuring participants' privacy was essential. The community groups I engaged with were relatively small, close-knit settings where individuals were familiar with one another. Similarly, stakeholders were recruited from service provision landscapes that are tightly interconnected (as evidenced by the effectiveness of snowball sampling during stakeholder recruitment). In this context, participants could potentially recognize one another's patterns of speech and their lived/professional experiences. Given the deeply personal nature of the insights shared—including criticisms of specific services, groups, and institutions—it was essential to take all possible precautions to prevent harm through reidentification. Secondly, the rigour of the analysis process following IC ensures the validity of the themes presented, regardless of the lack of participant attribution. In IC, all participant data is systematically analysed to generate themes. Narratives that are less frequent or involve fewer participants are naturally downplayed or synthesized into broader categories, ensuring that the themes presented reflect a wide range of participants' perspectives. Consequently, the quotes included in the findings chapters are illustrative of overarching concepts shared across multiple narratives, rather than tied to individual accounts. Additionally, given that there were few meaningful differences in participants' narratives based on discernible characteristics (as discussed in the previous subsection), it was unnecessary to provide information such as age or gender alongside specific quotations.

3.4 Researcher Positionality

As an international student from the United States who has lived in the North East for a relatively short period, I had very little cultural familiarity with Middlesbrough and South Tyneside before beginning my research. As a result, I was largely unaware of many of the social forces and norms that are important to people in these areas. Before beginning my fieldwork, I did significant reading and research on background to gain a better understanding of the history of my case study sites and an appreciation of their current political, social, cultural and

economic circumstances.

My position as an American offered some distinct advantages in speaking with both stakeholders and community members. Participants often assumed that I did not know relatively basic facts about their towns and UK politics more generally. For example, several participants asked me if I knew what austerity was, or if I had ever heard of Margaret Thatcher. While I had spent a significant amount of time learning about the relevance of such things in relation to Middlesbrough and South Tyneside, participants' assumptions that I did not know about them afforded me the chance to ask them to explain them to me. When asked if I knew about the history of the town, or how different policies had affected the community, I often provided a vague answer, implying that I had no significant understanding. This response encouraged participants to provide explanations and context, thus providing insight into how they understood these things and the effect they had had on their towns. My perceived lack of knowledge also permitted participants to share their opinions on potentially contentious issues, such as politics, without fear of judgement or disagreement, since they assumed I had no real opinion on these matters to begin with.

My American identity also helped me avoid preconceptions based on social class while working with community members. I speak with an American accent, and participants generally had no knowledge whatsoever of where I am from, two important signifiers of class in the UK (Donnelly et al., 2022). Without these class-based signifiers, participants struggled to 'put me in a box', so to speak. While I was not one of "us", that being people from their town or one of similar socioeconomic position, I also was not one of "them", those from more wealthy communities, often in the South of England. I leaned into this when doing field visits and conducting interviews by ensuring that I dressed and behaved in a way that did not signal a particular socioeconomic background (e.g. casual dress and an absence of visibly branded clothing). I think the absence of these easily observable class-based signifiers made it difficult for participants to have a strong preconceived idea of how I viewed them and their communities, which allowed me to establish rapport more quickly than I would have had I been from another area of the UK.

While I was able to avoid many class-based signifiers because of my American identity,

the fact that I was a PhD student from a well-regarded University was itself an indication that I was of a different socio-economic background than my participants, very few of whom had any experience with higher education. It was clear to me that my experience in education conferred a degree of authority and that this impacted how participants interacted with me. Participants frequently started their interviews by providing a sort of disclaimer that they were not “clever” or “brainy”, that they would likely be of little help to me, and that I might be wasting my time by interviewing them. I responded to such statements by reassuring participants that they were experts by experience and thus were more qualified than I was to talk about the problems in their towns. While this reassurance probably helped to an extent, it did not erase participants' perception that I was an authority figure by virtue of my education. I had to be mindful during interviews when asking follow-up or clarifying questions to avoid phrasing that could be construed as challenging or contradicting anything participants had said, as I found they would often defer to my judgement on the basis that I must know “the statistics” or “the facts” better than they did.

Other aspects of my identity, such as the fact that I am a cis-man and present as such, likely influenced the way stakeholders and community members spoke to me about certain topics, particularly gender roles and how they affect people in these towns. When men spoke to me about aspects of masculine identity, such as the desire for men to be the ‘breadwinner’ of their household or the reluctance of men to use mental health services, they did so with a degree of camaraderie, a sort of “you get how it is” attitude that often left a lot unspoken. While our shared gender identity was a point of connection, this attitude was problematic from a research perspective as I wanted participants to be as explicit as possible during their interviews to avoid misinterpretation or misunderstanding during analysis. This was something that I had to be very conscious of as I often really *did* get how it is for men, so I had to be deliberate in mitigating this by asking for participants to explain further and avoid implications. My gender identity may have also made me more approachable to men and increased men’s willingness to participate in my study. When women spoke to me about masculine gender roles, they often expressed a concern that they might offend me by pointing out what they saw as negative aspects of masculinity. While I tried to mitigate this by reassuring participants I

would not be offended, it is possible that these women would have been more open while speaking to another woman than they were with me.

The locations in which interviews and the focus group were conducted may influence the data produced while speaking with participants. When meeting with community members, I encouraged them to choose the time and place (as long as it was a location other than their home) of our meeting. Allowing the participant to control the setting in which their interview was conducted ensured they felt comfortable while speaking with me. Community members recruited through community groups most frequently chose to have their interviews held in the same location that the community groups were held (typically this was a private area of a community centre). The organisers of these community groups were gracious in allowing me to rent their space at a low cost for these interviews, which ensured I had easy access to a convenient interview location. The focus group in South Tyneside was similarly conducted in a private area of a community organisation.

The locations of stakeholder interviews varied considerably. A small number of stakeholders preferred to have their interviews online. While my personal preference is to hold interviews in person, as I believe it allows for easier rapport building and a more in-depth conversation, I adapted to accommodate participants' preferences. I was surprised to find that there was little difference between the length and depth of online vs. in-person interviews. It may be that because these participants typically worked from home, they had become comfortable having extended conversations via. video calls. It may also be a product of the fact that data collection occurred in the wake of the COVID-19 pandemic, so participants likely had extensive experience using video call technology. That there was little difference between in-person and online interviews highlights the importance of accommodating participants and allowing them to set the terms of the interview.

When I met with stakeholders in person, the interview setting varied. We typically met at their workplace, but many of these workplaces were not convenient venues to conduct an interview; for example, many spaces were quite small, or noisy, and interruptions were not uncommon. While I was often able to make the available space work by falling back on my skills as an interviewer (e.g. being deliberate in adopting open body language, making use of

extended silence to prompt further speaking from the participant and taking notes to ensure I did not lose my train of thought if interrupted), it was still not always an ideal setting. I think this is an inherent limitation to interviewing stakeholders during their normal working hours, as we had to meet in their workplace and thus were limited to whatever space they had available. Despite my best efforts, in a small number of stakeholder interviews, the setting became problematic. In one interview, we were interrupted quite frequently, which disrupted the flow of our conversation. In another case, I interviewed a member of law enforcement in a police interview room (what I would call an interrogation room); the setting made the interview feel adversarial and I struggled to build any sort of rapport with the interviewee. Perhaps unsurprisingly, that was the shortest interview of the study (it lasted just over 33 minutes) and generated relatively thin data.

3.5 Chapter Summary

This chapter has discussed the philosophical assumptions that underlie this study and guided my decision-making in determining my overall study design. I have provided an overview of the qualitative methods used in collecting, analysing, and interpreting the data. My reflection on my positionality as a researcher facilitates a holistic understanding of this research and my experience and influence therein. The following chapter expands this understanding of my research by providing a detailed overview of my selected case study sites and my justification for selecting them.

Chapter 4: Study Setting

The North East is the English region with the highest rates of DSA morbidity and mortality. As it was the region I was based in, it was both a relevant and convenient setting for this study. To select the local authorities from which I would recruit participants, in the early phases of this research I reviewed the available data surrounding morbidity and mortality from DSA-related causes. I found that data surrounding morbidity from DSA-related causes was disparate and often incomplete (for example, rates of admissions for in-patient alcohol detox programmes can serve as a proxy for alcohol-related morbidity but will always provide a significant undercount as most people who use alcohol at a harmful level do so without ever entering in-patient treatment). As such, I relied on mortality data for case study selection. In 2021, Middlesbrough was the North East local authority with the highest rates of suicide and drug-related mortality, while South Tyneside was the local authority with the highest rate of alcohol-specific mortality (ONS, 2022b, ONS, 2022a, ONS, 2023e), so Middlesbrough and South Tyneside were selected as my research sites. The following sections provide an overview of the history of these places, as well as some of the basic demographic and economic factors that affect everyday life there.

4.1 Middlesbrough

Middlesbrough is a town in North Yorkshire, England, situated south of the river Tees and just north of the North York Moors National Park. This area of England, which borders the river Tees and spans County Durham and North Yorkshire is known as Teesside. In 2021, Middlesbrough had a population of 143,900 people; a growth of 4% from 138,400 in 2011 (ONS, 2023c). The median age in the town in 2021 was 37, compared to 42 for the North East and 40 for England as a whole (ONS, 2023c). Figure 4.1 shows the percentage of Middlesbrough residents by age group in 2021 compared to England as a whole.

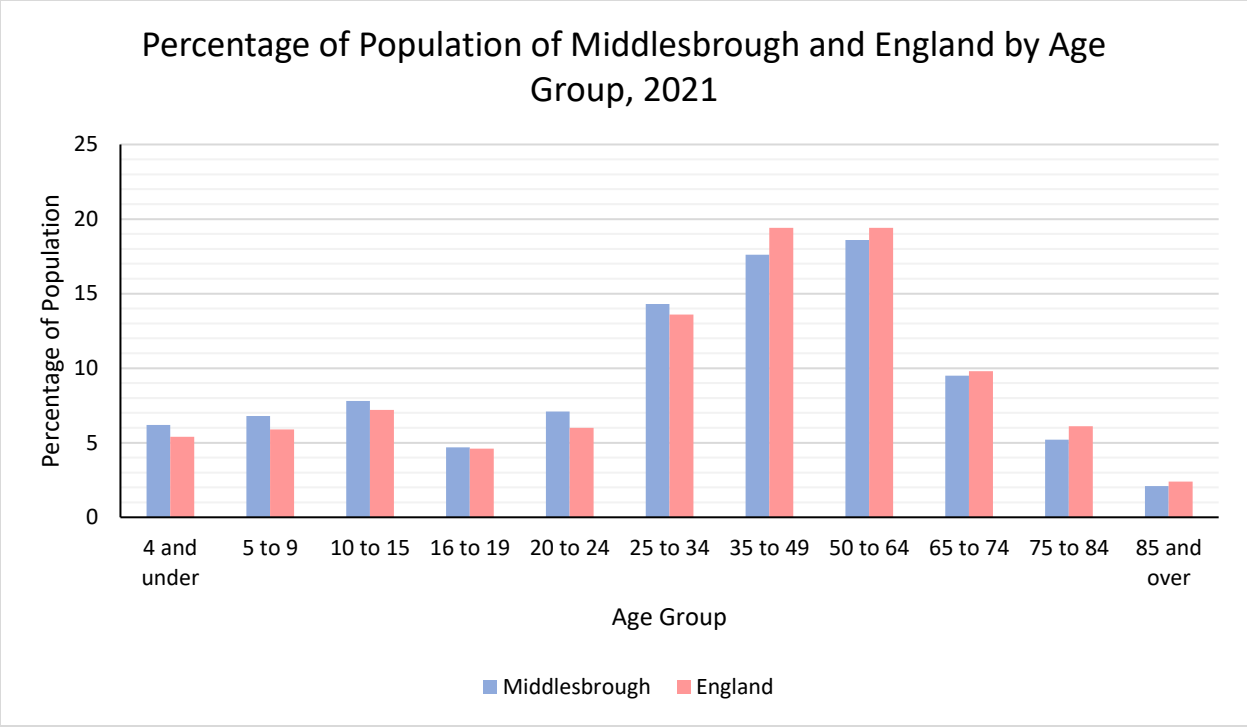


Figure 4.1: Percentage of Population of Middlesbrough and England by Age Group, 2021. Data from: (ONS, 2023b).

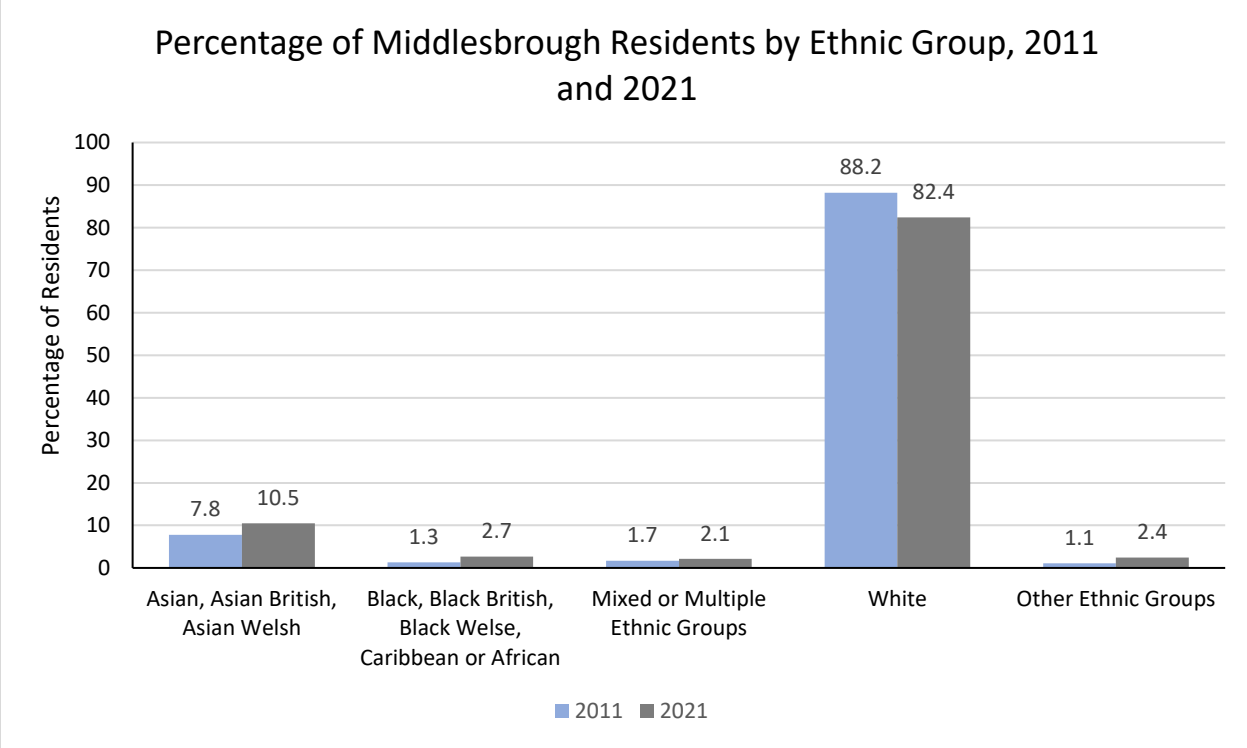


Figure 4.2: Percentage of Middlesbrough Residents by Ethnic Group, 2011 and 2021. Data from: (ONS, 2023b).

Middlesbrough is a majority-white community, but in the period between 2011 and 2021, the ethnic composition of the town changed. Figure 4.2 shows the percentage of Middlesbrough residents by ethnic group in 2011 and 2021.

During the same period, Middlesbrough saw the North East's largest rise in the proportion of people who did not identify with any British national identity (4.8% in 2011 to 7.9% in 2021) (ONS, 2023b). The decline in people claiming a British national identity may be partially attributable to changes in how the census collected this data from 2011 to 2021 (ONS, 2023b), but may also be linked to the changing ethnic makeup of the town. Middlesbrough and other communities in the North East host the largest proportion of asylum seekers in the UK. Throughout the 2010s, Middlesbrough was the only local authority in England to house more asylum seekers than the 1 asylum seeker per 200 residents ratio recommended by the central government (Middlesbrough housed asylum seekers at a ratio of 1 to 186 residents) (Reed, 2015). While Middlesbrough remains a majority white, British-identifying community, the number of asylum seekers in Middlesbrough has sparked concern from residents and local politicians (Reed, 2015).

4.1.1 Current Political Landscape

Middlesbrough is governed by a unitary authority borough of the same name (Middlesbrough Council, 2023), which is itself part of the larger devolved authority of Tees Valley. Tees Valley is a mayoral combined authority comprised of five council areas: Middlesbrough, Darlington, Stockton, Hartlepool, and Redcar and Cleveland (Tees Valley Combined Authority, 2023).

Conservative party member Ben Houchen is the Mayor of the Tees Valley Combined Authority, having taken office in 2017 and secured re-election in 2021 (Tees Valley Combined Authority, 2023). Houchen campaigned on the economic stimulation of Teesside, with the revitalisation of the Teesside International Airport central to his campaign. The airport was purchased by the Tees Valley Combined Authority for £40 million in 2019, with the promise from Houchen that it "would not cost taxpayers a penny" (Lloyd, 2018). Included in the

purchase of the airport was land slated for the creation of 350 homes; a plan which was cancelled in favour of further development of the airport (BBC, 2023). Since the purchase, Houchen has faced criticism for the lack of return on public investment constituted by the airport project. Teesside International has run at a loss since its purchase in 2019, a problem which was exacerbated by declining passenger numbers resulting from the COVID-19 pandemic. Between 2019 and 2022, the airport lost £30.3 million (Scott, 2021, Whitfield, 2022). In 2023, it was announced that Willis Aviation would fund a £25 million expansion of the airport, which when finished would create up to 300 new jobs in the area (BBC, 2023b). Houchen also faced criticism after it emerged that a majority stake in the company that operates the vacant Redcar Steelworks site was transferred to two local developers without public oversight; the developers received £45 million in dividends from the project despite apparently not having invested any of their own money in the project (Williams, 2023).

Middlesbrough itself has a tumultuous political history. Traditionally a labour stronghold, Middlesbrough voted overwhelmingly in favour of Brexit in the 2016 referendum (Middlesbrough Council, 2016) and elected its first Conservative MP, Simon Clarke, in 2017 (Johnson, 2017). Middlesbrough is one of 16 local authorities in England to have a directly elected mayor (Sandford, 2022). The mayor manages the day-to-day operations of the local authority, formulates policies, oversees the budget, and votes on resolutions of the Combined Mayoral Authority. In 2019, Independent Andy Preston, a property developer and former hedge fund manager, was elected mayor of Middlesbrough (BBC, 2023a). Preston was a political supporter of Ben Houchen and often found himself in conflict with the local council, which was comprised of a coalition of Independent and Conservative councillors. In an upset victory in 2023, Middlesbrough elected Labour Party member and former councillor Chris Cooke over the incumbent Andy Preston; in the same election, Labour councillors won a majority on the council (Mazza, 2023). Cooke has promised to make the council a “service-led organisation” that is connected to the community and to prioritise children’s social care (BBC, 2023a).

In early August 2024, Middlesbrough town centre was subjected to an episode of right-wing street violence and rioting. The violence in Middlesbrough was part of an outbreak of violence across the country at protests organised by far-right and anti-immigration groups

(Brown, 2024). The protests started in response to the murder of three young girls in Southport, England and subsequent false claims on social media that the crime was perpetrated by someone who had arrived in the UK illegally (Hendry and Turner, 2024). In Middlesbrough, rioters shouted racial slurs, clashed with police, smashed windows, lit fires and overturned vehicles. Significant damage was caused to the town's crown court, university and properties on Parliament Road (a severely deprived area that is home to a significant South Asian population). 43 people were arrested in Middlesbrough in connection to the August 4th riot (Hendry and Turner, 2024).

4.1.2 Industrial History

Small numbers of people have lived in the area in and around what is now Middlesbrough for over 1000 years. Numerous settlements in Teesside were established during the Viking occupation of Britain, some of which were later incorporated into Middlesbrough proper as the town grew in size (Gunn et al., 2014). Before the 1800s, Middlesbrough was a small agricultural community home to less than 50 residents (Hudson, 1986), but the 19th century and the Industrial Revolution brought about a period of rapid change for the town. The turning point came in 1829, when the colliery owner and then manager of the Stockton Darlington Railway, Joseph Pease, purchased a large estate in Middlesbrough. Pease planned a settlement that would be centred around exporting coal mined in the Durham coalfields via the River Tees (Taylor, 2004). Coal was to be transported via the Darlington Stockton Railway (completed in 1830) to Middlesbrough, loaded onto collier ships at the newly built Middlesbrough staithes (wooden platforms used for the loading of coal and other raw materials onto ships), and subsequently shipped out of the River Tees to the rest of the world (McCord and Rowe, 1977). Pease was right to think that Middlesbrough was well positioned for exporting coal, but he could not imagine the scale of the industry that would soon develop. While planning the development of Middlesbrough in 1826, Pease estimated that 10,000 tons of coal would be exported annually; in 1833 annual coal exports from Middlesbrough reached 336,000 tons (Taylor, 2002). The explosive growth of Middlesbrough's industrial sector necessitated a rapid growth in population, and workers flocked to Middlesbrough throughout

the mid-1800s looking for work in the area's burgeoning industry; the population of Middlesbrough grew from just 25 people in 1801 to 91,000 in 1901 (Bambra, 2016).

The greater Teesside area had abundant natural resources in the form of iron deposits in the Cleveland and Eston Hills, limestone in the Pennine Hills, and coal in the Durham coalfield that positioned Middlesbrough to become an industrial powerhouse in its own right (Hudson, 1986). The discovery of iron ore in the Eston Hills in 1850 spurned growth in the iron and steel industries. Iron ore was forged into pig iron, an intermediary iron product used in the forging of steel, that was exported from Middlesbrough or used to supply local steelworks (Taylor, 2004). By the mid-1870s, Middlesbrough was producing one-third of Britain's entire pig iron output and was given the nickname "Ironopolis" (Taylor, 2004). Steel and ironworks in other areas of England struggled to compete with the economic advantage provided to Middlesbrough's industries by economies of scale and the ease of access to raw materials (Hudson, 1986). While iron and steel became perhaps Middlesbrough's most iconic industries, they were not to be the only ones. While not as central to the economy as in other areas of the North East, workers from Middlesbrough were employed in shipbuilding at the Furness Shipyard in nearby Stockton (Beynon, 1994). The discovery of rock salt at the Middlesbrough Iron Works site in 1862 also facilitated the establishment of chemical industries, which would produce chemicals such as ammonia and sulphuric acid for use in explosives through the late 19th and early 20th centuries, and for fertilisers through the 1970s. The petrochemical industries, largely based in North Tees but employing tens of thousands of workers from surrounding areas including Middlesbrough, constituted one of the largest petrochemical complexes in the world by the mid-1960s (Warren and Pitt, 2018). The deep-water port in nearby Redcar and Cleveland allowed for easy access to international markets for these goods. Teesside's industrial base, of which Middlesbrough was an important part, was of global importance and was central to the accumulation of British capital throughout the 20th century (Hudson, 2005).

The latter half of the 20th century saw rapid deindustrialisation in Britain. In 1966, 11.7 million people, more than 30% of the British workforce, were employed in productive industries; in 2019 the number stood at just 2.7 million people, just 7.7% of the workforce (Beatty and Fothergill, 2020). While deindustrialisation was most apparent in the second half of

the 20th century, there were warning signs of impending collapse that became apparent earlier in Middlesbrough. By the 1910s, the Cleveland Hills iron deposits were becoming depleted and new steelworks in continental Europe, particularly in Germany, had gained a competitive advantage over those in Middlesbrough (Evenhuis, 2018). The interwar years saw domestic demand for iron and steel decrease and further ground in the international market was lost to foreign producers, which caused further damage to Middlesbrough's industry; shipbuilding along the River Tees also suffered during this period (Evenhuis, 2018). In 1945, the Teesside Industrial Development Board was formed to promote investment and development of new industrial estates in the area; this measure reinforced the area's economic reliance on heavy industry in the decades before deindustrialisation would take full effect (Hall, 1986).

Given its primarily industrial economy, Middlesbrough was particularly affected by deindustrialisation, with industrial and manufacturing corporations leaving the area to take advantage of lower-cost manufacturing in the global south. Despite the decline in competitive advantage to foreign markets, Middlesbrough was still central to British industrial production at the end of the 1950s (House, 1960). While employment in the steel industry declined in the 1960s, the steel crisis of the late 70s and early 80s rapidly accelerated job loss in the area. British steel production during this period was reliant on outdated and inefficient facilities and could not compete with steelworks in the global south, which used more advanced production methods and enjoyed lower labour costs (Rhodes and Wright, 1988). From 1976 to 1984, two-thirds of employment in the Teesside steel industry (about 35,000 jobs) was lost (Evenhuis, 2018). The local shipbuilding industry also largely collapsed in the 1980s with 18,000 jobs lost between 1982 and 1987 (Evenhuis, 2018). The petrochemical industries in the area fared only somewhat better, with job losses proceeding more gradually and spread throughout a longer period than in the steel and shipbuilding industries. Beginning in the 1980s, Imperial Chemical Industries (ICI) transitioned chemical production in Teesside away from petrochemicals towards more high-margin products like pharmaceuticals (Greco and Ellem, 2004); this transition resulted in a series of selloffs and plant closures throughout the late 20th and early 21st centuries. ICI closed in 2008; what remains of the chemical industry in Teesside is constituted by branches of large international corporations. Between 1971 and 2008, more than 100,000

jobs in productive industries were lost in Middlesbrough and the surrounding communities (Telford and Wistow, 2019). While deindustrialisation was most evident in the latter half of the 20th century, the process has continued in recent years. The Teesside Steelworks, a major industrial employer in Middlesbrough and the second largest steelworks in Europe, closed in 2015 resulting in the further loss of thousands of jobs (Warren and Pitt, 2018).

4.1.3 Thatcherism and Austerity

Neoliberal economic policy initiatives implemented by the Thatcher Government in the 1980s amplified the already severe impacts of deindustrialisation. Thatcher's approach to economic policy was based on the concept of moral economy; that a moral rejuvenation of Britain was a fundamental requirement to achieve an economic rejuvenation (Sutcliffe-Braithwaite, 2012). Thatcher's rhetoric promoted the idea that economic failure was a consequence of moral failings by collectives (e.g. trade unions) and individuals and that welfare facilitated feckless behaviour (Tomlinson, 2021); as such, spending on welfare benefits was reduced, leaving recently unemployed industrial workers vulnerable to poverty (Scott-Samuel et al., 2014, Albertson and Stepney, 2020). Industries such as shipbuilding and steel production were privatised with the intent of making them more cost-effective and industrial employment and trade union membership further declined in Middlesbrough. Thatcher's government also promoted mortgage markets and owner-occupied housing at the expense of government disinvestment from the housing market; a decision which severely reduced the availability of council housing (Nunn, 2014).

The effects of deindustrialisation and the economic policies of the Thatcher Government left Middlesbrough extraordinarily vulnerable at the start of the 21st century, and the area would be further devastated by austerity measures introduced in response to the 2008 global financial crisis. Austerity measures reduced local authority budgets by 30% between 2008 and 2015 and led to the shuttering of many public services (Bach, 2016). Simultaneously, welfare reform measures most severely impacted the poorest areas in the country (where a higher proportion of the population received support), many of which were former industrial communities like Middlesbrough (Beatty and Fothergill, 2018). Indeed, the worst-hit local

authority areas – mainly located in the North – lost around four times as much, per adult of working age, as the authorities least affected by the cuts – found exclusively in the South and East of England (e.g. Hart, Hampshire) (Beatty and Fothergill, 2018).

4.1.4 Existing Research in Teesside

4.1.5 Current Labour Market Conditions

Today, the largest proportion of employment in Middlesbrough is within the professional sector; 33.9% of all working people in Middlesbrough were employed in professional or associate professional occupations between October 2022 and September 2023 (ONS, 2024b). Professional occupations typically require a higher education qualification or significant on-the-job training, while associate professional occupations require the knowledge and experience necessary to support professionals, but do not require the same degree of formal education (ONS, 2021). While the professional sector is the largest in Middlesbrough, the proportion of workers employed in this sector is below average for both the North East (35.8%) and Great Britain as a whole (41.9%) (ONS, 2024b). The proportion of people employed as managers, directors, or senior officials in Middlesbrough is also well below average; just 7.4.% of working people were employed in these capacities as opposed to 10.5% for the country as a whole (ONS, 2024b). Middlesbrough also has a higher than average proportion of employees working in what are known as elementary occupations, relatively low-skill occupations that do not generally require further education or significant on-the-job training (ONS, 2024b). In 2022, the unemployment rate in Middlesbrough was 5.1%, higher than average for the North East (4.2%) and Britain as a whole (3.7%) (ONS, 2022). Those who were in full-time employment in Middlesbrough in 2023 earned significantly less gross weekly pay (£554.7) than is average in Britain (£682.6) (ONS, 2024b). Middlesbrough was ranked as the most income-deprived local authority in England (out of 316) in 2019 (IoD2019, 2019). It also has the highest proportion of severely deprived neighbourhoods of any community in England, and the highest proportion of children living in poverty (IoD2019, 2019).

4.1.6 Existing Research in Teesside

Given the above average rates of deprivation and the stark health inequalities present in Middlesbrough and the Teesside region more generally, it is perhaps unsurprising that the area has been the focus of a significant body of research examining the determinants of these inequalities and their effects on the people who live there. Significant research has been conducted by Tracey Shildrick and Robert MacDonald that has explored the intergenerational and structural aspects of poverty in Teesside (MacDonald and Shildrick, 2018, Macdonald et al., 2014, Shildrick and MacDonald, 2013). Their research has explored the lived experiences of individuals and communities grappling with long-term economic deprivation in Teesside and has emphasised the inadequacy of stereotypes around "cultures of worklessness" or "poverty dependency" and has instead emphasised the role that structural factors such as welfare policy and lack of stable work have had on entrenching poverty in the region (Macdonald et al., 2014, Shildrick, 2012, Shildrick and MacDonald, 2013). These ideas are further developed in Macdonald and Shildrick's book *Life in Low-Pay, No-Pay Britain* (2012) in which the authors examine the lives of people who cycle between low-paid, insecure jobs and unemployment in Teesside. The book emphasises that these cycles, and the deeply engrained poverty present in Teesside, are not due to a lack of work ethic but rather systemic barriers, such as the scarcity of stable jobs, the inadequacy of welfare support, and the stigma attached to poverty. Shildrick and Macdonald's work is built upon by Kayleigh Garthwait, whose work surrounding poverty and the use of foodbanks in Teesside has explored the stigma that surrounds poverty and its direct effects on health (Garthwaite, 2011, Garthwaite and Bambra, 2018, Garthwaite et al., 2015).

Other researchers have also examined health and social inequity in Teesside. Clare Bambra's book *Health Divides: Where You Live Can Kill You* (2017) explores how the geographic inequalities in health within Teesside and between Teesside and other English regions reflects broader social inequity. Health Geographer Danny Dorling has also written about the health inequalities that persist between Teesside, and the North East more generally, and other English regions (Dorling, 2023, Dorling et al., 2007, Dorling and Thomas, 2016). Critically, the

available evidence surrounding health inequalities in Teesside largely identifies the same underlying determinants—namely poverty, government policy, and social inequity more broadly. This existing evidence encourages future research, including this thesis, to examine the structural factors underpinning health inequalities, rather than individual health behaviours. While extensive research has been conducted in Teesside, none has yet examined the factors underpinning inequalities in DSA morbidity and mortality specifically. This thesis builds on the existing research in Teesside to fill this gap in the health inequalities literature.

4.1.7 My Time in Middlesbrough

In the lead-up to starting my fieldwork in Middlesbrough, I visited the community with one of my supervisors (Victoria McGowan) and toured parts of the community. My first impression of Middlesbrough was that it reminded me of the deindustrialised towns near where I grew up in the USA. There is a very particular atmosphere in deindustrialised communities that I picked up straight away in Middlesbrough; it's a sense that these are places that are past their prime. I was also immediately aware of how geographically isolated Middlesbrough was and how this isolation was made worse by poor public transit connections to larger metropolitan areas in the North East. Despite being only 40 miles away from Newcastle, the journey down to Middlesbrough took about an hour and a half (excluding train delays and cancellations, which were common) and required me to change trains halfway through the journey. At around £20 per round trip, I could see how the trip would be prohibitively expensive and time-consuming for anyone looking to regularly make the commute without a car. I very quickly got the sense that there just was not much going on in Middlesbrough. Permanently closed shops, vacant storefronts, and broken shop windows were all common sites around the town centre.

Middlesbrough is run down, but it has some assets. The city centre has areas that, while still feeling a bit rough around the edges, can be relatively busy. Captain Cook Square and the top of Linthorpe Road often had people about and on a busy afternoon it could be surprisingly difficult to get a seat in one of the coffee shops in the area. There are some nice cafés around the town centre. The Middlesbrough Institute of Modern Art is great, and the park out front is a

nice place to spend some time on a sunny day. Still, I did not have to go far to find visible signs of the town's decline. The Hill Street Shopping Centre, which is centrally located and could see a lot of foot traffic, was rarely busy and it seemed like every time I went back another shop had closed. The most successful business sector in town appeared to be the betting shops and casinos, of which there are seven within easy walking distance of the town centre. Even in the busier areas, it was not uncommon to see someone visibly intoxicated on the street or taking part in various forms of antisocial behaviour.

I had been advised by people I spoke with in the community that certain areas in the town, like those around Parliament and Gresham Roads, and Union Street could be dangerous. I ended up in each of these areas and others that I had been advised could be rough at various times for various reasons related to my fieldwork. When I was in these areas, I never felt particularly unsafe (admittedly I spent a limited amount of time in these places and was only there during daylight hours). Mostly, these "bad" areas just felt to me like they were deeply impoverished (which, incidentally, they were. The overwhelming majority of postcodes in these areas of the city are among the 10% most deprived in England). Many of the houses were in disrepair, the roads and pavements had not been well maintained, and there was no sign of any of the types of community enrichment (like flower boxes and trees), that are common in many other neighbourhoods. The level of deprivation could be striking, and it was visible beyond the physical neighbourhoods; I saw it in the residents themselves. It was not uncommon for me to meet people who looked much older than they were, and it seemed to me that there was an unusually high presence of mobility aids like walkers, canes, and wheelchairs in use in the town. I suspected these were a product of the health inequalities that are so common in deprived communities.

Middlesbrough is a fairly large borough, and while the town centre is certainly the major built-up area, it is not representative of the borough as a whole. The majority of the time I spent in the town was around the town centre; this is where most of the stakeholders I interviewed worked and where the vast majority of the community members I interviewed lived. Had I spent more time further afield in some of the outlying areas of the borough that are relatively more affluent, like Linthorpe or Nunthorpe, I may have formed a different impression.

On the whole, though, I liked Middlesbrough. It has its' problems, but so do most places. When I finished my fieldwork in Middlesbrough, I found that my impression of the place had not changed much from when I first started. Middlesbrough felt familiar, like the other deindustrialised communities I had spent time in around the world. It struck me as a place that once had a lot going for it, that was left behind as the economic tides changed, and that the rest of the country has largely forgotten about in the intervening years.

There was one building in particular in the town centre – the Centre North East building – that always jumped out at me when I was in that part of the town. A commercial building that stands at 19 storeys, Centre North East is the tallest in Middlesbrough. Despite the efforts of numerous developers who have sought to revitalise the building, it has been largely vacant since 2010 and is clearly in a state of disrepair. In casual conversation with residents in Middlesbrough, I was told that it was frequently broken into by homeless people seeking shelter or people looking for a place to use drugs. The Centre North East building sits directly across the street from the Middlesbrough Town Hall. That the building had been standing vacant over the town hall, the seat of Middlesbrough's local government, for more than 10 years always felt like a fitting metaphor for some of Middlesbrough's challenges to me.

4.2 South Tyneside

South Tyneside is one of the five boroughs in the metropolitan county of Tyne and Wear in North East England, as well as being part of the Tyneside conurbation, the sixth largest in England. South Tyneside covers the area south of the River Tyne, the principal waterway in Tyne and Wear which flows from Northumberland to the North Sea. South Tyneside is served by the Tyne & Wear Metro network, which connects the Tyneside towns of Newcastle upon Tyne, Gateshead, North Tyneside, South Tyneside, and Sunderland via light rail. While South Tyneside is one local authority, it is comprised of several smaller towns and villages (South Shields, Jarrow, Hebburn, Boldon, Whitburn, and Cleadon) that are distinct areas from one another. In 2021, South Tyneside had a population of 147,800, a .2% decline in population from 2011. South Tyneside was one of three local authorities in the North East to experience a

population decline between 2011 and 2021; the regional population as a whole increased by 1.9% throughout the same period. The median age in South Tyneside is 43, higher than the median age for both the North East (42) and for England (40) (ONS, 2023d). Figure 4.3 shows the percentage of South Tyneside residents by age group in 2021 compared to England as a whole.

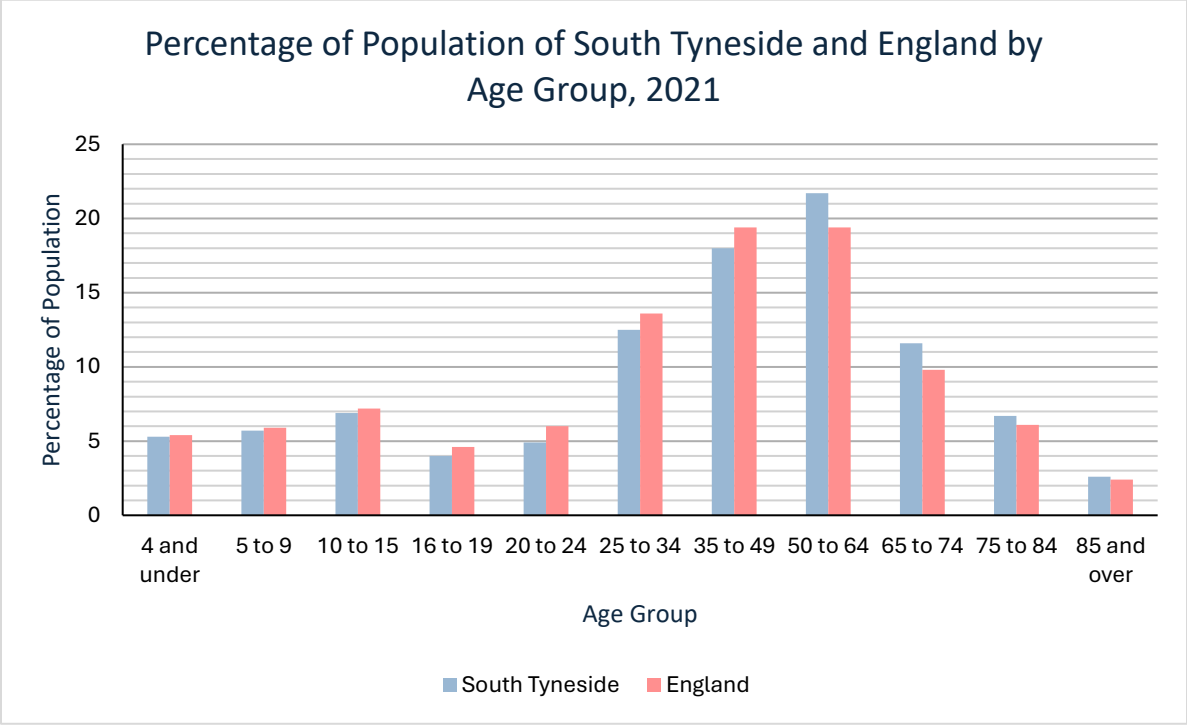


Figure 4.3: Percentage of Population of South Tyneside and England by Age Group, 2021. Data from: (ONS, 2023d)

South Tyneside is a majority-white local authority. Between 2011 and 2021, there were minor changes in the demographic makeup of the town, with a 1.1% decrease in the proportion of residents identifying as white and less than a 1% increase in the proportion of residents identifying as other ethnic groups (ONS, 2023d). The increase in non-white ethnic groups in South Tyneside between 2011 and 2021 was less significant than in England as a whole. In 2021, 0.5% of residents in South Tyneside identified with a non-UK national identity, compared to 0.2% in 2011; this increase was smaller than was seen across the North East (1.1%) and England as a whole (1.7%). As in Middlesbrough, this increase may be partially attributable to

changes in how this data was collected during the 2021 census (ONS, 2023d). Figure 4.4 shows the percentage of South Tyneside residents by ethnic group in 2011 and 2021.

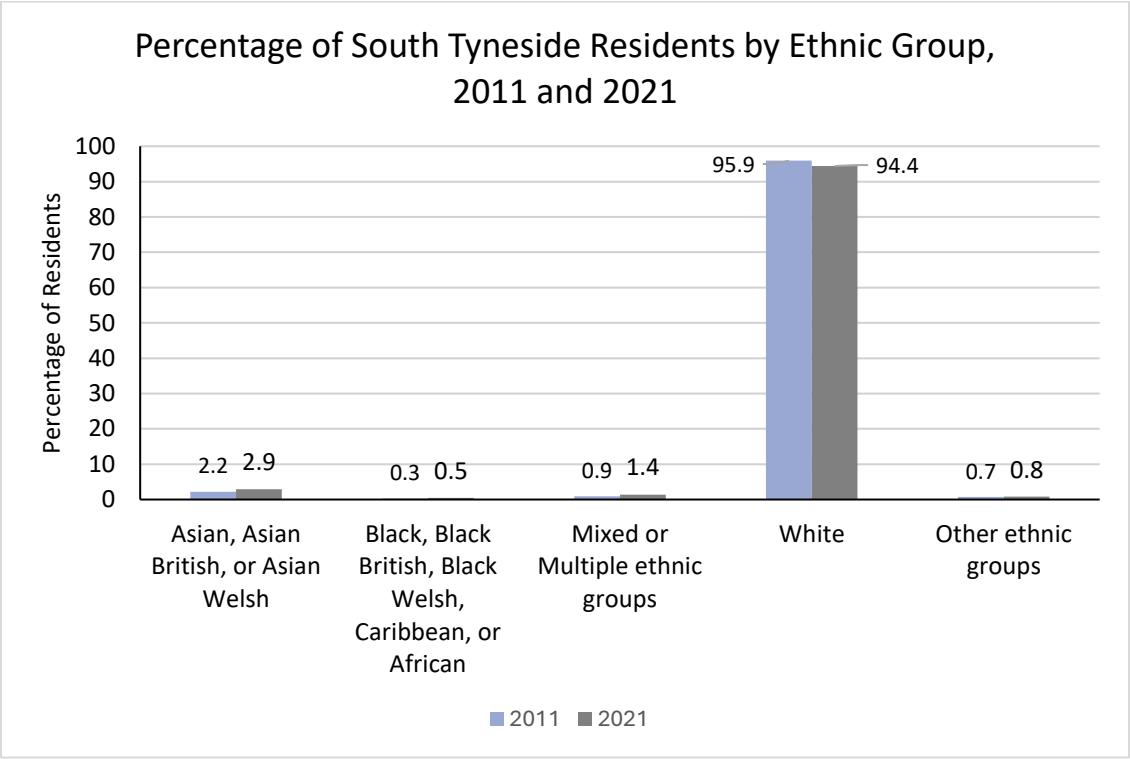


Figure 6: Percentage of South Tyneside Residents by Ethnic Group, 2011 and 2021. Data from: (ONS, 2023d).

4.2.1 Current Political Landscape

South Tyneside Council is a local authority covering the metropolitan borough of South Tyneside in the county of Tyne and Wear. South Tyneside was created in 1974 when the county of Tyne and Wear was formed. The local authority of South Tyneside covered four areas that before 1974 had been managed by separate local governments (Boldon Urban District, Hebburn Urban District, Jarrow Municipal Borough, and South Shields County Borough). Before the formation of the county Tyne and Wear, the towns that would eventually make up South Tyneside were part of County Durham. Since its first local election in 1974, South Tyneside has always had a labour-controlled council, except in 1978 when no party held control (The Elections Centre, 2013). In the EU referendum in 2016, South Tyneside voted to leave the EU by a wide margin (The Elections Centre, 2013). South Tyneside, like most English Local Authorities,

does not have a directly elected mayor, and the position of mayor is largely ceremonial. Day-to-day operation of the council and policy positions are managed by the elected councillors.

4.2.2 Industrial History

The history of South Tyneside is intrinsically linked to coal mining in County Durham and shipbuilding in South Tyneside communities. Extending from Bishop Auckland in the west to the border with Northumberland, the Durham Coalfield covered north, east, and central County Durham. While coal had been mined in the area for centuries, the Industrial Revolution increased the demand for coal, improved methods for reaching deeper and more productive coal seams and fuelled the rapid growth of the industry (Hudson, 1986). While not centres of coal mining themselves, the expansion of the coal industry in the interior of County Durham affected the growth of communities along the waterways and coast, such as South Shields, Jarrow, and Hebburn, as the increased production of coal in the interior necessitated improvements to its means of transportation (McCord and Rowe, 1977). Shipbuilding had been an industry present along the Tyne since the 1700s, but increased coastal development led to significant growth in the shipbuilding industry during the mid-19th century. While there were many relatively small shipyards throughout South Tyneside communities, Jarrow would become the most significant with the founding of the Palmers Shipbuilding Company in 1851. The founding of Palmers and Company and the job opportunities that followed grew the population of the town from 3,500 in 1851 to 35,000 in 1881 (Arnold, 2012).

Palmers and Company were initially founded to build colliers, bulk cargo ships designed to carry coal, to facilitate the transfer of coal from the North East to London (Arnold, 2012). Palmers and Company were not merely shipbuilders, they also integrated ironworks into the company's shipyard in Jarrow. The integration of ironworks and shipyards into one site was an innovative approach that would be replicated throughout Britain and much of Europe, as it allowed for rapid, low-cost construction of iron ships (Arnold, 2012). The start of the Crimean War in 1853 afforded Palmers and Company the opportunity to secure naval contracts, and in doing so produce some of the first all-iron warships for the Royal Navy at their Jarrow shipyard (Ville, 1993).

Throughout the 19th century, the economic landscape of communities in South Tyneside was dominated by the presence of a small number of shipbuilding companies. These companies employed the majority of workers, owned large portions of the land and housing, and offered the majority of amenities in their towns; in effect, South Tyneside communities were 'company towns', towns whose existence was wholly dependent on the presence and continued success of a very small number of private companies (Pollard and Robertson, 1979b). While labour relations in Tyneside shipyards were generally better than in other parts of England in the mid-1800s, this began to change in the last quarter of the century (Ville, 1993). Higher degrees of skilled labour were required as the ships being built in Tyneside shipyards increased in complexity, which gave rise to an enormous number of labour organisations (Ville, 1993). It is estimated that between 1892 and 1896 there were more than 100 shipbuilding unions in existence and an average of one major strike per month per month in Tyneside shipyards (Pollard and Robertson, 1979a). The high level of union membership in South Tyneside offered several benefits to workers, such as higher pay, unemployment and sickness insurance, and a formal apprenticeship system which allowed young men to enter the skilled workforce (Ville, 1993).

The start of the 20th century heralded a change for County Durham. Coal production peaked in the early 20th century leading to decreased coal exports (Beynon, 1994). Demand for coal and ships for the war effort in World War I sustained the area's industry in the opening years of the 20th century. In 1915 during the First World War, shipbuilding and coal infrastructure along the Tyne was of such importance to British war industry that it was targeted in the world's first strategic bombing campaign; a German Zeppelin bombed the Palmers and Company shipyard in Jarrow, causing the death of 17 people and the injury of 72 others (Kearney, 2015). Reduced demand for new ships in the 1920s and increased competition from shipyards in Western Europe and the United States dealt a strong blow to the ironworking and shipbuilding industries in South Tyneside (Hudson, 2005), with Palmer's laying off workers and closing their onsite ironworks in Jarrow in 1924 (Pollard and Robertson, 1979b). Palmers and Company, which had been at the centre of County Durham's shipbuilding industry, reported financial losses every year between 1922 and 1931, entered into administration in

1932, and closed their Jarrow shipyard in 1934 (Arnold, 2012). The closure of the Palmers and Company yard caused the loss of more than 7,000 jobs in Jarrow alone, more than 70% of the town's workforce (Arnold, 2012). South Shields also saw significant job losses during this period with the closure of a smaller shipyard on the coast, although Hebburn fared slightly better due to a relatively broader labour market (Arnold, 2012).

Unemployment remained acutely high in Jarrow for years after the closure of the Palmers and Company yard. The Jarrow Crusade (also referred to as the Jarrow March), was organised in October 1936 to highlight the extreme poverty faced by people in the town and to petition the government to intervene (Pickard, 1982). Two hundred former yard workers marched from Jarrow to London; a trip which took 26 days and ended with the delivery of a formal petition to parliament to aid in alleviating the poverty caused by unemployment (Palmowski, 2008). Although the march garnered significant public sympathy and is now considered one of the most well-known episodes in the history of protest in Britain (Palmowski, 2008), the government did not provide the assistance which the marchers had called for (Pickard, 1982). What remained of the shipbuilding industry along the Tyne in the 20th century would be further devastated during this period by the collapse in global supertanker demand and competition from lower-cost shipyards in Asia (Hudson, 1986).

4.2.3 Labour Disputes and Austerity

After the closure of the major shipyards, employment in South Tyneside was largely in minor shipyards and shipbreaking facilities (places where retired ships are broken down and their parts recycled or sold), or in the declining coal industry. Increased demand for coal during World War II bolstered the area's coal industry throughout the war, and the mines were nationalised in 1946. However, the post-war period saw the resumption of colliery closures and the closures continued apace throughout the 1960s (Martin, 2015). In the 1970s, coal miners, represented by the National Union of Mineworkers (NUM) briefly enjoyed increased collective bargaining power and a slow in the pace of coal pit closures as prices of the major competing fossil fuel, oil, rose due to political and economic instability in major oil-producing countries (Tomlinson, 2021).

The 1980s saw a major shift in relations between the central government and the NUM. In the early 1980s, the newly elected Thatcher government set out plans to increase coal pit closures and reduce the strength of the NUM (Phillips, 2014). Thatcher's decisions to reduce the strength of the NUM and cut funding to the National Coal Board (NCB) were a reflection of her government's broader moral ideology, which viewed labour unions and government subsidies as having no place in a moral capitalist society (Tomlinson, 2021). In response to the NCB's plan to close 20 major coal pits across Britain, miners in South Shields, Boldon, Hebburn, and dozens of other towns reliant on the coal industry around the country, participated in the 1984-85 Miners Strike, one of the largest industrial actions in British History (Harvey et al., 2014). The NUM, led by Arthur Scargill, sought to resist the Thatcher government's plans for the coal industry. The Thatcher government took an aggressive stance against the industrial action by refusing to negotiate with the NUM, deploying police to confront picketing minors, and making efforts to stockpile coal and use alternative energy sources to mitigate the impact of the strike on the country's energy supply (Phillips, 2014). The strike ultimately failed to halt the closures, leading to further job losses in South Tyneside and surrounding areas (Harvey et al., 2014).

It should be noted that while the pit closures of the 1980s are emblematic of Thatcher's approach to industry, they followed decades of decline in employment within the coal industry and coal pit output (Tomlinson, 2021). The significant shift under the Thatcher administration was not the loss of jobs and closure of coal pits, but the rejection of the idea that the government should be responsible for alleviating the resulting unemployment. Throughout the 1960s and 70s, the NCB, under pressure from the NUM, established a framework to transfer miners from closing pits to those still operating and to provide subsidies to encourage industrial employment in other industries in former coal mining areas (Tomlinson, 2021). The Thatcher government viewed these subsidies as wasteful spending and undue government influence over industry; as a result, these subsidies were cut, making the effects of deindustrialisation more harmful within these communities (Scott-Samuel et al., 2014). Economic policies that affected Middlesbrough during this period, such as a reduction in welfare spending and the promotion of owner-occupied housing, also affected communities in South Tyneside, deepening the poverty of unemployed former industrial workers (Scott-Samuel et al., 2014). Welfare reforms and town

council budget reductions as part of the austerity measures introduced in response to the 2008 global financial crisis would similarly impact South Tyneside (Beatty and Fothergill, 2018).

4.2.4 Current Labour Market Conditions

According to the most recent available data, in South Tyneside 36.1% of the population is employed in professional sectors; this is above average for the North East (35.8%), but below the national average (41.9%) (ONS, 2024c). That employment in professional occupations is above the regional average in South Tyneside may be a product of its proximity and connection via public transport to Newcastle upon Tyne, the economic centre of the North East where employment in professional occupations is also above average for the region. South Tyneside has below-average employment in managerial and senior official occupations (7.4%) relative to both the North East (8.0%) and Great Britain (10.5%). In South Tyneside, 12.5% of the population of working people are employed in elementary occupations, which is above both the regional (11.2%) and national averages (9.5%) (ONS, 2024c). The average gross weekly pay for full-time workers in South Tyneside in 2023 was £600.0, which was below average for both the North East (£613.7) and Great Britain as a whole (£682.6) (ONS, 2024c). A higher proportion of people in South Tyneside were unemployed (6.7%) than was average regionally (4.2%) and nationally (3.7%). Of those who were unemployed in South Tyneside, 40.9% reported that they were unemployed due to long-term illness or disability, significantly above average for both the North East (32.9%) and Great Britain (26.9%) (ONS, 2024c). According to the 2019 Index of Multiple Deprivation, of the 316 Local Authorities in England (excluding the Isles of Scilly), South Tyneside was ranked the 12th most income-deprived (IoD2019, 2019).

4.2.5 My Time in South Tyneside

When I selected South Tyneside as the second case study site for my research, I felt like I already knew a bit about the area. When I thought of South Tyneside, I thought of South Shields. I had been to South Shields (the largest town in the borough) once as I explored the areas surrounding Newcastle on my own soon after I moved to England, and I went again to

wait for a friend at the finish line of the Great North Run. Since South Shields is connected to Newcastle via the metro, it is an easy trip. If the metro is running on time, one could travel from the Newcastle city centre to South Shields in a little over half an hour. On those early trips I was visiting as something of a tourist, and I saw South Shields as a fairly standard seaside town. There was certainly a noticeable level of deprivation present, and it seemed like the majority of businesses were restaurants and pubs, with very little else.

It turns out that I had a lot to learn about South Tyneside. South Tyneside was a lot more than South Shields, and the towns and villages that made up the borough felt very distinct from one another. There was a world of difference between places like Jarrow, Hebburn and South Shields, and villages within the borough like Cleadon and Whitburn. I quickly came to learn that the residents of these different areas did not view their borough as one place and saw very little commonality between them; they are viewed as independent towns and knowledge of one did not confer even passing familiarity with another. I was surprised by just how little connection there was between these places in the eyes of their residents. Once, while speaking to a man from Jarrow, I mentioned that I was going to South Shields the next day for a meeting. He paused and seemed to think for a moment before telling me that he thought he had been to South Shields (approximately three miles away) once and that from what he remembered, he liked it well enough. The man in question had lived in Jarrow for longer than I had been alive, and he had been to South Shields only once that he could recall. I had been wrong to think of South Tyneside as one place.

Jarrow and Hebburn felt fairly similar to one another, but they were quite distinct from South Shields. While South Shields had the coast, a nice park, and fairly strong hospitality and retail sectors operating along the main street, Jarrow and Hebburn had none of these things. Both places felt old and in need of the sort of facelift that only significant investment can bring, and the sort of deprivation that I had become familiar with seeing in Middlesbrough was present. The first time I went to the main retail area in Hebburn, I briefly wondered if the area had been abandoned entirely, as not a single business was open, and I was the only one there. While most of the shops in that development were shuttered (perhaps permanently, as I never saw them open despite spending considerable time in the area) and it was rare to see anyone

shopping, there was some activity in the area. By far the busiest storefront was that of a local foodbank and community support organisation. It seemed to me that were it not for the presence of the foodbank, nobody would have any reason to go to the area at all. The main retail area in Jarrow, The Viking Centre, was only slightly busier than its counterpart in Hebburn and felt similarly rundown. While the deprivation present in these areas was obvious, there were also signs that the council had continued to invest in them insofar as possible. In Jarrow, Hebburn, and South Shields the council has built new buildings that house community centres, libraries, and leisure centres in the last ten years (Jarrow Focus, Hebburn Central, and The Word in each town respectively). While these buildings were certainly an asset to their respective communities, their impact on their broader areas seemed to me to be quite limited. To me, these buildings felt emblematic of the larger challenges faced by boroughs like South Tyneside; a dedicated council can build new community centres which may improve residents' day-to-day lives, but they cannot make the sort of investment needed to lift a place's residents out of poverty.

As in Middlesbrough, the signs of deprivation were present in the health of the area's residents. A common topic of conversation at the community drop-ins I frequented in Jarrow and Hebburn was ill-health, particularly chronic pain, and how to access healthcare quickly when one's GP was unavailable. By the time I started my fieldwork in South Tyneside, I had learned not to guess at people's ages, as they often looked much older than I would have expected for their actual age. Nonetheless, I was still surprised to learn that one of the members of a community drop-in I visited, who I would have thought was in his 50s, was less than 10 years older than me.

The difference between areas within the borough was, I came to think, a reflection of the level of deprivation present in these different areas. For example, Cleadon was home to multiple professional footballers and their multi-million-pound houses, while Jarrow and Hebburn are among the 10% most deprived areas in the country. Perhaps unsurprisingly, I spent very little time in Cleadon and Whitburn and considerably more in Jarrow and Hebburn, and to a lesser extent, South Shields. The disconnected nature of towns within South Tyneside also made it hard for me to form a clear impression and understanding of the places I visited. As

time went on with my fieldwork, I started to realise that I almost had three distinct field sites that just happened to be in the same borough. In retrospect, this was a deficit in my fieldwork in South Tyneside. Were I to do this portion of my study again, I would select just one town within South Tyneside and focus data collection on residents living there. Doing so would have provided more consistent data around shared identity and a clearer picture of how an individual area's history influences life there today. As it was, I collected data primarily in Jarrow and Hebburn with a small number of participants from South Shields as well.

4.3 Neoliberalism in Middlesbrough and South Tyneside

A common thread running throughout the histories of Middlesbrough and South Tyneside is the impact of neoliberal economic policy. Neoliberalism is a political and economic ideology that emphasizes free markets, privatization, deregulation, and a reduced role for the state in economic affairs and social wellbeing (Connell, 2010, Braedley and Luxton, 2010). Originating in the mid-20th century, it gained prominence in the late 20th century as a response to the perceived inefficiencies of Keynesian economics and the welfare state (Harvey, 2007). Neoliberalism prioritizes individual responsibility, competition, and market mechanisms as the primary means of organizing society (Braedley and Luxton, 2010, Steger and Roy, 2010). Prominent politicians of the late 20th century, such as Ronald Regan in the US and Margaret Thatcher in the UK, embraced a neoliberal worldview and made neoliberalism central to their policy platforms (King and Wood, 1999).

Neoliberalism has profoundly shaped British policy-making since the 1980s. Many of the pivotal moments in Middlesbrough and South Tyneside's recent histories, such as labour disputes, the privatisation of industries, the curtailing of collective bargaining power, and austerity, are a product of neoliberal economic policies. Margaret Thatcher's government in the 1980s was pivotal in beginning the implementation of neoliberal principles, emphasizing the privatization of state-owned enterprises, curtailing the power of trade unions, and fostering a culture of individualism (Hall et al., 1983, Scott-Samuel et al., 2014, Sutcliffe-Braithwaite, 2012, Tomlinson, 2021). These policies contributed to the significant economic downturn that

occurred in Middlesbrough, South Tyneside, and other northern communities throughout the late 20th century. While proponents of these policies argued they modernised the British economy (Albertson and Stepney, 2020), critical research in the years following has pointed to their role in creating regional economic disparities and long-term social dislocation (Schrecker and Bambra, 2015, Collins and McCartney, 2011, Lawson, 2020).

The 2008 financial crisis renewed the influence of neoliberalism in British policymaking through austerity measures, justified as necessary to reduce public deficits (Bambra, 2019). Austerity policies led to significant cuts in public spending on social services, welfare, and local government, disproportionately affecting communities that had already borne significant degradation from the neoliberal economic policies of the 1980s, like Middlesbrough and South Tyneside (Ginn, 2013, Gray and Barford, 2018, Grimshaw and Rubery, 2012, Pearce, 2013). These measures reinforced the neoliberal emphasis on individual responsibility while eroding collective forms of support and solidarity.

The concept of neoliberalism is central to understanding the economic and health landscapes in Middlesbrough and South Tyneside today. The significant changes that both towns have seen over the last 40 years are closely tied to neoliberal policy decisions. These policies have shaped both the economic opportunities available and the health outcomes of local populations, meaning that understanding neoliberalism is essential groundwork for those seeking to understand inequalities in health present in these towns today.

4.4 Health and Wellbeing in Middlesbrough and South Tyneside

Deprived communities in the North East are home to some of the most striking health inequalities in the country (Bambra, 2019). In Middlesbrough and South Tyneside, life expectancy is shorter, rates of smoking are higher, more people are living with a disability that severely impacts their day-to-day life, and people subjectively rate their health to be worse, than in other areas of England (PHE, 2020, ONS, 2023). The health of people in Middlesbrough and South Tyneside may suffer further due to the effects of deprivation amplification, whereby the negative effects of household-level deprivation are amplified by area-level deprivation

(Bambra, 2016, Macintyre, 2007). The most deprived areas of England, of which both Middlesbrough and South Tyneside are a part, were disproportionately affected by COVID-19 mortality and by the economic impacts of the pandemic (Bambra C et al., 2020). Middlesbrough and South Tyneside are also home to significantly higher than average rates of drug, suicide, and alcohol-related mortality, although the rates of these deaths vary significantly between communities. Table 4.1 presents three-year average age-standardised mortality rates from DSA per 100,000 population in both Middlesbrough and South Tyneside.

	Middlesbrough	**South Tyneside**	**North East**	**England**
Suicide	16.5	8.9	13.5	10.3
Drug Misuse Deaths*	14.1	10.9	9.7	5.2
Alcohol-Specific Mortality**	26.3	28.3	21.8	14.5

Table 4.1: Three-year average (2020-22) age-standardised mortality rates from DSA per 100,000 population. All data from ONS (ONS, 2022a, ONS, 2023a, ONS, 2023e).
**Drug misuse deaths are those in which drug abuse or dependence is an underlying cause or any of the drugs used are controlled under the Misuse of Drugs Act. It excludes deaths due to suicide and those where no further information on underlying causes was available.*
***Deaths from conditions wholly caused by alcohol. This is a more narrow definition of alcohol-related mortality, which includes deaths to which alcohol may have partially contributed.*

As shown in Table 4.1, Middlesbrough was above average for all DSA mortalities in 2020-2022. Middlesbrough had the second-highest rate of drug misuse deaths and suicide of all local authorities in the North East, and the third-highest rate of alcohol-specific mortality. Rates of DSA mortality in South Tyneside were more variable. South Tyneside had the highest rate of alcohol-specific mortality, above-average deaths from drug misuse, and the lowest suicide rate which was below the national average. While South Tyneside does have an older-than-average population for England, these rates are age-standardised, so differences in population age between areas are not driving differences in these mortality rates. It is unclear what factors are underpinning South Tyneside's widely variable rates of DSA mortality rates.

4.4 Chapter Summary

In this chapter, I have provided an overview of the settings in which this research was conducted and reflected on my time spent in the field collecting data. This overview of the research setting provides important context for the findings of this study. With this context in mind, the following three chapters will provide the findings generated from the data alongside a discussion connecting these themes to the broader empirical literature.

Chapter 5: "You'll tell me its cos of poverty, that's all a load of rubbish that. I mean, if you don't want to take drugs you don't have to." Individual-Level Determinants of DSA Morbidity and Mortality.

Individual-level determinants that influence health and well-being encompass a wide range of factors such as individual health behaviours, psychological characteristics and environmental exposures (Short and Mollborn, 2015). Interest in health behaviours as causes of ill health and mortality, and as targets of health behaviour change interventions, began in the early 20th century (Armstrong, 2009). More recently, the focus of public health researchers and practitioners has shifted away from behavioural determinants, which have been criticised for an overemphasis on individual choice and personal responsibility (Cockerham, 2005), towards the social determinants of health, the social forces that shape an individual's health environment (Short and Mollborn, 2015). The social determinants of health do not deny that individual traits, behaviours and exposures impact health but encourage broader consideration of the structural forces that limit choices and the social forces that shape values surrounding activities, identities, and decisions (Short and Mollborn, 2015).

Participants identified several Individual-level determinants that they believed were driving DSA morbidity and mortality in their towns. In this chapter, I will explore the choices, behaviours, and feelings that participants identified about the relevant theoretical and empirical literature.

5.1 The Use of Drugs and Alcohol as Coping Mechanisms

Drug and alcohol use were viewed by many participants as coping strategies that people would turn to when dealing with difficult circumstances. While participants often made clear that they viewed drugs and alcohol as negative or ineffective coping strategies, they believed that people often engaged in these behaviours because they saw no other alternative available to them. Participants described drugs and alcohol as a means of "blocking out" or "escaping" from negative emotions caused by unprocessed trauma, stress, and mental illness.

5.1.1 Adverse Childhood Experiences

Participants believed that childhood trauma was a factor that caused people to use drugs and alcohol later in life. It was reported by participants that drugs and alcohol served as a coping mechanism for traumatic experiences by providing an escape from, or a means of blocking out, negative thoughts and feelings that stemmed from trauma. Several participants shared that their own experiences with drug and/or alcohol use stemmed from a traumatic childhood experience, such as physical or sexual abuse, or as a result of prolonged exposure to a traumatic environment, such as a household in which both parents were addicted to alcohol. Several stakeholders, all of whom worked in a service provision capacity, believed that childhood trauma was ubiquitous amongst their service users. These participants stated that most, if not all, of their clients had some form of trauma history, particularly around physical and/or sexual abuse during childhood. The belief that traumatic experiences, particularly during childhood, were an important determinant of DSA morbidity and mortality is consistent with the literature; the association between adverse childhood experiences (ACE) and DSA morbidity and mortality in adulthood is well-established (Khoury et al., 2010, McFarlane, 1998, Wang et al., 2022, Zatti et al., 2017). Participants believed that instances of child abuse often involved drugs and/or alcohol use by the abusive adult, as drugs and alcohol lower inhibitions and make abusive acts more likely.

> "Yeah, well they haven't had the best, most stable like, childhoods really. Almost all of them really. That's probably the biggest predictor of people who use our services, is some sort of, a combination of adverse childhood experiences and events really. The more adverse events they've had the more likely they are that they're going to need our service. There is definitely a correlation there like." – South Tyneside Stakeholder

Participants believed that unresolved childhood trauma (that is, trauma that had not been treated or processed) caused emotional pain. Rather than seeking help, people who had experienced childhood trauma were believed by participants to have sought to "numb" or "block out" the pain of past trauma, or to have escaped from it by using drugs and alcohol. It

was also reported by participants that inadequate support was available for people who had suffered ACEs.

> "You see they'll tell you they often take the drugs to get rid of the pain they're suffering from, from, the past trauma. So rather than deal with it, because that's painful in itself and there's no support to deal with it, you block it. And you block it with the drugs, but then taking drugs comes with its own problems. – Middlesbrough Stakeholder

Participants, both stakeholders and community members, in Middlesbrough believed there were a large number of children living in their town who have been exposed to traumatic experiences; this was in contrast to South Tyneside, where ACEs were not believed to be unusually prevalent. Participants' accounts that ACEs were particularly common in Middlesbrough are consistent with the existing empirical data. While there is no direct evidence measuring the prevalence of ACEs in Middlesbrough, the number of looked after children by the local authority can serve as a suitable indirect metric, since looked after children have, by definition, experienced at least one ACE (as children are looked after due to abuse or neglect). In 2023, Middlesbrough had the second-highest rate of looked after children (150 per 10,000 children) in the North East and was well above average for the region (113 per 10,000 children); by contrast, South Tyneside was below average for the region (103 per 10,000 children). All North East local authorities had an above-average rate of looked after children when compared to England as a whole (71 per 10,000 children) (DfE, 2024).

> "I've never really spoken to someone that uses this service that didn't have that traumatic childhood where either their parents have been alcoholics or taking drugs or been in abject poverty or they've been sexually abused by parents or family members. And that stuff is so common. Really, really, common 'round here." – Middlesbrough Stakeholder

Participants attributed the prevalence of ACEs in Middlesbrough to the number of children who lived in deprived households and the prevalence of children who lived in homes in which one or more adults abused drugs and/or alcohol. Living with a parent who used drugs and/or alcohol was believed to be traumatic in and of itself, but also believed to increase the risk of child abuse or child sexual exploitation, furthering the risk of trauma. There is evidence

to support participants' beliefs that children living in deprived homes (Davara Lee et al., 2020), or in homes with adults who abuse drugs or alcohol (Moss et al., 2020, Manning et al., 2009), are at increased risk of ACEs. Participants' accounts provide insight into the association between structural determinants, such as deprivation, and individual-level risk factors. It is clear that to understand why ACEs are a common individual-level determinant of DSA morbidity and mortality, one needs to consider the structural factors that give rise to these experiences during childhood.

> "Wherever there's deprivation there is likely to be trauma, so an increased number of adverse childhood experiences. We've definitely got that here. It's just so common. If you start to look at these types of potential difficulties for people, I think that's why we've got a legacy." – Middlesbrough Stakeholder

5.1.2 Mental Illness

Participants believed that when someone was experiencing a period of mental ill health, they would sometimes use drugs to block out or escape from their symptoms. Participants suggested several plausible reasons why someone might use drugs or alcohol when they were dealing with a mental illness. Some participants felt that drugs and alcohol were more easily accessible to people than formal mental health services, such as counselling or medication from GPs. According to participants, since formal mental health services were inaccessible and people needed relief, people chose to use drugs and alcohol instead. This is an example of how structural forces such as health service capacity influence individual DSA behaviours. Further discussion of the factors underpinning poor health service capacity in participants' areas is included in Chapter 7.

> "[*People have to self-medicate*] because of the waiting lists. I mean, the crisis team are useless and sometimes the services just aren't there to support. Two-week wait to see a GP minimum. It's easier to just go to the pub or the off license, go see a drug dealer. You know, that's there now." – South Tyneside Community Member

Other participants believed that mental health treatments such as medications and therapy were stigmatised; these participants believed that people did not want to be seen as

"someone who depends on medication" to manage their mental health, so they chose to self-medicate with drugs and/or alcohol instead. Using drugs and/or alcohol as a means of self-medication was seen by some to be more socially acceptable in some circles than using formal mental health treatments, increasing the likelihood that people suffering from poor mental health would choose to use them instead. In these findings, we see evidence that social and cultural norms underpin what coping mechanisms are viewed as acceptable within participants' communities; these will be discussed further in Chapter 6.

> "People rely on alcohol and drugs to try and, since they don't want to be someone who depends on medication and whatnot, they try alcohol. So that's a big factor with them. That's their choice." – South Tyneside Community Member

Amongst stakeholders, it was reported that people used self-harming behaviour as a cry for help when one was struggling with their mental health; this belief was unique to stakeholders and was not shared by community members. According to these stakeholders, people would engage in self-harming behaviours and suicide attempts without the intent to die, because they knew these behaviours would attract the attention of service providers and get them the help they need. That people may take actions that are harmful to themselves, with a significant risk of severe consequences, but not attempt to end their lives, is a well-established idea (Millard, 2012). A wide body of literature that has sought to understand the risk factors for and determinants of self-harm and parasuicide (apparent attempted suicide undertaken without lethal intent) has demonstrated strong associations between parasuicide and female gender, socioeconomic deprivation, and young age (Raluca Ioana and Lungu, 2021, Ayton et al., 2003, Barnes et al., 2016, Gunnell et al., 2000). Based on the available literature, it seems that in this subtheme stakeholders have correctly identified that people in their areas have used parasuicide as a means of asking for help, but this explanation leaves important questions unanswered. To understand *why* some people in Middlesbrough and South Tyneside use parasuicide as a cry for help, we need to understand their broader social environment. As with other findings in this subtheme, participants' thoughts on the cultural and structural forces that influence individual behaviours can provide a more holistic view of these individual choices.

"Most people actually don't want to die. They just want, the people who tell us they want to die, that they're going to kill theyselves [*sic*], they want help and comfort rather than to die." – Middlesbrough Stakeholder

5.1.3 Poverty-Related Stress

Participants believed that living in poverty or deprived areas was stressful, and participants felt that this distress could become overwhelming at times. Middlesbrough and South Tyneside were both described as severely deprived communities (findings relating to the extent of poverty and the reasons for its prevalence in these areas are discussed in Chapter 7). Participants felt that when people were overwhelmed with the problems they had in their lives, such as bills they could not afford, unemployment, and low opportunities for economic advancement, they would sometimes turn to drugs and alcohol to help them cope. Participants' belief that poverty is associated with an increased risk of substance abuse is supported by empirical literature. Deprived living conditions, limited employment opportunities, low access to education, poor housing quality, and neighbourhood deprivation are known to increase the risk of substance use behaviours, although the exact mechanism through which this influence is applied is not clear (Karriker-Jaffe, 2011, Sellström et al., 2011, Patrick et al., 2012). Participants in this study suggest that a combination of these factors related to community-level deprivation causes people a severe level of stress and anxiety for which they turn to substances for relief. This finding suggests that to understand the factors that are ultimately driving substance use in Middlesbrough and South Tyneside, one must understand the factors that have caused the marked level of deprivation present in these areas.

"Poverty has a massive impact on your mental health in a negative direction. I think if you can't feed yourself, feed your family if you are not in employment, if you live in terrible housing, live in a horrible neighbourhood. It, you'll feel scared, have anxiety. It also might impact your ability to get support. If you can't get access to a doctor or don't have the same support services. Sooner or later, you'll do anything to cope." – Middlesbrough Community Member

5.2 Hopelessness

It was reported that living on a low income, in a deprived community, and dealing with the chronic stress associated with poverty created long-term feelings of hopelessness, worthlessness, and resignation. Participants described that people increasingly felt like there was no hope that things in their lives or their community would ever improve. When one is dealing with the challenges associated with poverty and struggling to find work, one feels worthless; after repeated setbacks and failure to improve their circumstances, one becomes resigned to the fact that things in their life will never improve. There is empirical evidence to support the belief that experiencing poverty or living in a deprived area increases feelings of hopelessness. Experiences living in poverty or deprived communities are associated with lower self-reported hope by individuals living in these circumstances (Bolland, 2003, Clark and Stubbeman, 2021, Jones et al., 2020). Participants felt that a lack of job opportunities worsened this feeling of hopelessness among members of the public, as they recognised that there were no available avenues through which they could realistically expect to improve their circumstances. One participant described the difficulty of finding full-time employment as a wall one could not get past.

> ‘‘Well just because the wall is so hard to get through, people just give up on trying to get over it. They just kind of accept life as it is. They won’t strive for a better life or anything, they’ll just settle for what they’ve got and just live out their life, which I think is bad because you should always have that opportunity and be able to better yourself. Because of the wall and the barrier, you just can’t. It’s frustrating to deal with. You just say, “Well I’ve tried my best and there is nothing else I can do.” And then you give up. Then you’re just sat up on whatever they can get.” – Middlesbrough Community Member

Both stakeholders and community members described a sense of hopelessness in others, but it was also evident in some community members’ accounting of their community and their own lives. Statements such as “What is there to live for here?” and “I don’t think things will ever get better here, they will get worse” were not uncommon in community member narratives. Hopelessness extended beyond some participants’ lifetimes, with them expressing the belief that there is no hope that things will improve even in the youngest

generations' lifetimes. Participants believed that even if there was interest in solving the problems of drug, suicide, alcohol mortality and poverty, these problems were so engrained that they had become intractable.

> ‘‘I feel very guilty that I have a nice house and these people, maybe through no fault of their own, have ended up in the situation they're in and they don't know how to get out of the situation. Or maybe there isn't help for them. There is something wrong. I don't think it will change. I cannae see it. I think it will decline further and more and more young people will be suffering. Sometimes I think, is there any hope for them?" – Middlesbrough Community Member

Stakeholders and community members shared that hopelessness was self-perpetuating and cyclical. According to participants, people were hopeless because of the level of deprivation they lived in, so they would begin to use drugs or alcohol, which made them more hopeless and less able to improve their circumstances. Participants felt that sometimes when the sense of hopelessness became inescapable, people would choose to die by suicide. When people use drugs or alcohol as a way of coping with hopelessness, which was believed to be common, they are susceptible to addiction. Participants believed that when someone was struggling with addiction frequently believed they lacked the capacity to change, so they accepted that they would always be addicted to drugs.

> "It's like, especially if you grew up in that environment it's easier to just say "well this is who I am." I do feel like, you know, it's kind of a mixture of escapism and boredom. What else is there to do? You know? – South Tyneside Community Member

Stakeholders that hopelessness made it very difficult for people to change their behaviours, particularly behaviours that were believed to be coping mechanisms, like drinking alcohol or using drugs. These stakeholders empathised with the sense of hopelessness that they saw in their clients, indicating that while it is unfortunate and something that should be addressed, hopelessness was an understandable response to the level of deprivation that people experienced.

> "You're feeling as though this is a system that has never cared about you, has never listened to you. Your family might feel like that as well, so you're not going to engage in it. It's about self-confidence, self-worth. You just don't think there is any hope in things improving. It's a self-fulfilling prophecy, but it's hard to tell them they're wrong. It's the whole horrible mess. It's the deprivation, it's a whole horrible mess." – South Tyneside Stakeholder

There is a notable similarity between the phenomena of distress and hopelessness as identified by participants in this study and Case and Deaton's concept of despair. While Case and Deaton's definition of despair captures, in part, the phenomenon identified by stakeholders in this study, the findings of this study indicate that the leading role that despair is given in the term 'deaths of despair', and its classification as a "cause" of these deaths, is misplaced. Hopelessness is an individual response arising due to structural level determinants, such as deprivation. While Case and Deaton (2020) acknowledge that social forces, including economic instability and deprivation, are responsible for increasing rates of despair among middle-aged non-Hispanic whites in the US, their decision to place despair in their label for DSA mortality and their reference to it as a cause of these deaths, is indicative of an overemphasis of the role that despair plays in leading to deaths by these causes. Distress and hopelessness, or despair, are not 'causing' DSA morbidity and mortality in Middlesbrough and South Tyneside, rather; they are the results of deprivation, which is itself simply one step on the pathway from structural violence to DSA morbidity and mortality.

5.3 Drug Use as a Choice that Causes Mental Health and Suicide

Some participants did not feel that drug use was a response to external forces, instead favouring the idea that drug use was simply a bad decision that people make. According to these participants, people used drugs because, put simply, people enjoyed the feelings that using drugs provided. Some participants believed that the high rates of drug use in their community existed because more people in South Tyneside in Middlesbrough enjoyed using

drugs than in other places, although they were not able to articulate why. While this belief was most common among community members, it was shared by some stakeholders as well.

> "Some of them will openly tell you that they do it to get the buzz. They offend because they get the buzz. That's one of them. It's not everyone is exactly the same, I can't tie them all up with a bow. But individuals have sat before me and said "I use because I want the buzz. I enjoy it. I don't want to change." – South Tyneside Stakeholder

These participants typically rejected the idea that drug use was a disease. Since people decided to initiate drug use, they were responsible for the problems that arose as a result; thus, as they saw it, addiction was a consequence of choices rather than a disease. The question of whether drug and alcohol addictions are diseases or choices warrants serious consideration. While the DSM-V classifies addiction as a disease (American Psychiatric Association, 2013), and many major medical and psychiatric bodies agree with this classification, arguments have been raised that call the disease classification into question (Heyman, 2009, Davies, 2018a, Kalant, 2014). Approaching addiction from a purely neurobiological perspective has failed to meaningfully advance treatments for addiction and neglects the fact that many people who recover from addiction do so without clinical intervention (Moscrop, 2011, Sinha et al., 2011, Harris et al., 2013, Heyman, 2009). Participants who shared this worldview rejected the idea that addiction is uncontrollable, explaining that if people who used drugs wanted to stop using them, they could simply choose to do so. These participants ultimately believed that drug use was a failing on behalf of the individual drug user and not a reflection of any broader social force. Academic debate over the best classification of addiction will continue, but if we cede the point that addiction is a choice it is still unclear why so many people in Middlesbrough and South Tyneside choose to initiate substance use in the first place. Answering this question requires engagement with the broader social and systemic determinants of drug and alcohol use.

> "You'll tell me its cause of poverty, that's all a load of rubbish that. I mean, if you don't want to take drugs you don't have to. I only had one cigarette when I was 14 and I never had another one since. It's up to you if you don't want to take drugs. You don't have to take them. You don't have to go drinking if you don't want to. Don't have to do anything.

It's a load of rubbish trying to blame that." – Middlesbrough Community Member

Many of the participants who shared the view that addiction is not a disease explained that because they lived in poverty or had experienced traumatic events during childhood, drug use could not be caused by these factors, since they had not chosen to use drugs as a result. An example of this thinking can be seen in one participant's account of his own life. This participant explained that he had grown up with parents who were alcoholics and had lived in severely deprived circumstances for most of his life. He had not had "the best life", but he had never chosen to use drugs. He reasoned that if other people in similar circumstances had chosen to use drugs, that was their fault and not a result of external forces. The question of why some people choose to initiate substance use while others in similar social and economic circumstances do not has been the subject of much academic interest. In 19888, economists Gary Becker and Kevin Murphy proposed the theory of rational addiction, which suggested that substance abuse behaviours can be understood through the framework of economic decision-making (Becker and Murphy, 1988). At the centre of rational addiction theory is the assumption that individuals rationally consider the long-term effects of substance abuse (e.g. negative health impacts and risk of arrest) as well as their short-term risks (e.g. financial cost and overdose) and rewards (e.g. escape from negative emotions, pleasurable feeling) (Rogeberg, 2020, Becker and Murphy, 1988). Simply put, rational choice theory proposes that substance abuse and addiction are rational choices that some individuals make when they deem that the present benefits of using a substance outweigh the long-term costs of doing so.

"I've been there so I just don't understand why they can't survive it like I did. I wouldn't say I'm a strong person. I've been through a canny few things. Some stuff… hit us harder than others. I lost 18 people in one year through cancer, illness, suicide. A lot of me [*sic*] friends killed themselves. People just dropped like flies. I didn't start taking smack though. There is no excuse for it, really. Not everybody chooses to start injecting themselves." – South Tyneside Community Member

The theory of rational addiction is not without its criticisms; it does not adequately explain the frequency of relapse after one has stopped using an addictive substance (Waal and Mørland, 1999, Vale, 2010) and fails to account for addictive substances' ability to impede long-

term rational assessment of risks and benefits (Vale, 2010, Rogeberg and Melberg, 2011). The work has also been criticised by psychologists practising in the field of addiction for an overemphasis on theory and an inability to predict real-world consumption patterns (Levine, 2000, West and Brown, 2013). Despite its shortcomings, rational choice theory can provide something of an answer to the question implicit in participants' belief that drug addiction was the product of individual choices—that being why some people choose to use substances and others do not, despite being in similar social circumstances. The answer, I think, is that the benefits of substance use are weighed differently by different people; for some an escape from poverty-related stress or negative emotions stemming from childhood trauma is worth the cost of future negative outcomes, for others it is not. It is tempting to moralise that decision, as many participants did, but I think that is a mistake. Stigmatising people who abuse substances or attributing blame for the negative outcomes of substance abuse only serves to increase related harms (Room, 2005, Ballentine, 2022, Link et al., 1997, Yang et al., 2017). A more helpful approach scrutinises the broader social environment that gives rise to things like ACEs and poverty which put people in a position where they have to rationally consider the risks and benefits of substance abuse in the first place.

Some participants suggested that an increase in the prevalence of mental health issues was attributable to increasing rates of drug use, particularly by young people. These participants believed that using drugs such as cocaine, cannabis, and hallucinogens increases the risk of mental health problems, particularly anxiety and depression. It was believed by some that frequent cocaine or marijuana use caused people to develop depression, and that suicides in their town were being driven by depression caused by drug use. There is some evidence to support participants' beliefs about the relationship between substance use and depression. Studies have found that heavy marijuana use and the use of cocaine are associated with an increased risk of depressive disorders, particularly when the use of these substances is initiated at a young age (Lev-Ran et al., 2014, Degenhardt et al., 2003, Langlois et al., 2021). There is also some evidence to suggest that frequent marijuana use increases the risk of suicidality (Han et al., 2021). The association between cocaine use and suicidal behaviour is more clear in the existing literature: cocaine use is associated with increased risk of suicidality (Moçambique et

al., 2022, Garlow, 2002, Zhornitsky et al., 2020), particularly when it co-occurs with alcohol use (Bailey et al., 2021). Participants reported that young men frequently attempt suicide shortly after ending a cocaine binge, a belief that is consistent with evidence surrounding episodes of suicide in the UK in which cocaine had been used before death (Rooney et al., 2023).

> "It all links back to cocaine addiction … I think that what's happening here, obviously the effect of cocaine is that it affects your dopamine levels. You get quite a big hit of dopamine and then obviously the reserve is gone for a few days. What's happening is these young people are going on benders, spending all their money, waking up and realizing what they've done and making the decision to end their life before their dopamine levels have been restored." – Middlesbrough Stakeholder

While marijuana is a depressant, this classification does not mean that marijuana is "depressing" in the colloquial use of the term or that it is necessarily associated with an increased prevalence of depression. While the evidence demonstrating an association between marijuana use and depressive disorders may seem to suggest that marijuana use "causes" depression, and thus support participants' belief that increased drug use underpins increasing rates of mental health disorders, there is evidence that suggests marijuana use is more common in those who already have a depressive disorder (Langlois et al., 2021) and that depressive disorders increase marijuana use and increase the risk of cannabis use disorder (Dierker et al., 2018, Dhodapkar, 2020, Smolkina et al., 2017). This alternative interpretation of the data would support the view of participants who saw drug use as a coping mechanism for poor mental health. While the evidence remains mixed on whether marijuana use is a product or a cause of mental illness, it remains unlikely that it is a primary driving factor behind increasing rates of mental health disorders. Rates of mental health issues among adults in England have increased dramatically in recent years (NHS Digital, 2016, Daly, 2022) but this increase in mental health disorders has occurred throughout a period in which drug use has been lower than historical averages (ONS, 2023b). It is therefore unlikely that drug use is a determining factor in the increase in the prevalence of mental health disorders.

Participants believed that increased attention needed to be given to preventing cocaine use, mainly through drug enforcement to make cocaine unobtainable, and to reduce the rate of

suicide in their towns. While stakeholders working in a mental health or drug treatment capacity should be aware that cocaine use is a risk factor for suicidality, it is important to note that most cases of suicide do not involve drug use immediately before death (Michael Esang and Saeed Ahmed, 2018). Reducing the rate at which cocaine is used will likely be insufficient to meaningfully reduce suicide-related deaths in Middlesbrough and South Tyneside and a holistic approach to suicide prevention that accounts for systemic, social, and individual level determinants is called for.

5.4 Low Work Ethic

It was believed by participants that many people in their areas no longer valued hard work. Participants attributed this change to poor parenting, reporting that parents had failed to instil the value of hard work in their children. According to these participants, people have learned that they can live off of benefits payments and "be paid to do nothing", so they chose to do that instead of working. According to participants, these people had become experts at maximising payments from the benefit system for example by convincing a doctor that they have a mental illness and thus should be entitled to PIP, or by having children to become eligible for tax credits.

> "They would look at me and think "what even are you?" I was raised, it wasn't even an option not to work. Everybody works and that's just how it is. You don't get anything for free in life. These people were just totally dependent on the system though. It was bizarre listening to them speak." – Middlesbrough Stakeholder.

There was a perception by some participants that the low work ethic on the part of individuals was a cause of the above-average unemployment rates and subsequent poverty in Middlesbrough and South Tyneside. The belief that unemployment and poverty are products of low work ethic is not a new one. The Elizabethan poor laws, introduced in the late 16th century codified the ideas of the 'deserving and the 'undeserving' poor; the former being those who were unable to work through no fault of their own (e.g. because of age or disability) and the

latter being those who were simply unwilling to work hard to provide for themselves and were a burden on their families and wider community (Barry and French, 2004). Since the deserving poor were impoverished through no fault of their own, they 'deserved' the sympathy and support of wider society; this is in contrast to the undeserving poor, who did not 'deserve' sympathy as their impoverishment was a result of a personal moral failing. For the undeserving poor, poverty was viewed as a product of laziness, irresponsible childbearing, substance abuse, and the inability to defer gratification (Tihelková, 2015). In this subtheme, participants have endorsed the view that many of those living in poverty in their community are the undeserving poor. Participants reported that many people in their towns make their financial situation worse by spending money on takeaways, drugs and alcohol, and luxury goods.

> "I would not say it's a lack of jobs. There are jobs out there, but us as a nation, I'm going to get on my soapbox here, we are renowned for being lazy which is why they bring people in from abroad to pick fruit and things like that because apparently, we're too good for that. There are lots of jobs out there. Most of these people are not wanting employment, or they'll give you every reason why they won't." – South Tyneside Community Member

The 20th century saw a shift in attitudes towards poverty. Ground-breaking social research conducted by Seebohm Rowntree and Charles Booth revealed the scale of poverty in Britain and acknowledged the role that structural forces and government inaction played in entrenching poverty (Linsley and Linsley, 1993). In the mid-20th century, the growth of labour movements, the rise of the welfare state, and the strong economic position of post-war Britain temporarily diminished the influence of the concept of the underserving poor on British society, however, this trend reversed in the 1980s (Tihelková, 2015). Widespread unemployment and the election of Margaret Thatcher rejuvenated the belief that poverty was the result of individual moral failing, with Thatcher harkening back to the Victorian approach to poverty and the distinction between the deserving and underserving poor (Thatcher, 1993). Thatcher revitalised the idea that many people living in poverty do so as a result of their inaction. This revitalisation of the Victorian philosophy of poverty has persisted in British political discourse ever since and is observable from Tony Blair's "welfare to workfare" rhetoric to David Cameron's justification of the 2010 austerity measures (Tihelková, 2015, Garthwaite, 2011).

Participants' accounts that unemployment and poverty were a result of laziness on the part of the unemployed and impoverished are underpinned by the same rhetoric that has long been used to characterise the causes of poverty in Britain. Participants blamed poverty on much the same behavioural causes that the Victorians did nearly 150 years previously, namely substance abuse (e.g. marijuana and cocaine), irresponsible childbearing, and the inability to defer gratification (the belief that deprived people waste their income on takeaway foods and luxury goods) (Katz, 2018). While participants themselves did not see a connection between deindustrialisation, Thatcherism, and changes in individuals' work ethic, there is a notable similarity between this subtheme and the behavioural view of deprivation that has been largely adopted in British political and cultural discourse over the last 40 years. These participants' views have been influenced by decades of government rhetoric and cultural discourse that endorses an antiquated moral worldview that blames deprivation on the deprived. It's not that the work ethic of individual people has changed, it's that large segments of British society view deprivation not as a systemic issue, but as a behavioural one. Throughout this subtheme, there is a clear presence of cultural phenomena such as class-based stigma, concerns about the morals of a perceived social underclass, and myths surrounding welfare fraud and intergenerational poverty. While these beliefs are not useful in understanding the prevalence of DSA behaviours, they provide an opportunity to explore these phenomena in more detail. Social and cultural beliefs and values will be discussed in detail in Chapter 6, but what is clear at this juncture is that participants' views of individual behaviours are shaped by social norms and cultural discourse.

In addition to having a low work ethic, it was believed that some people in Middlesbrough and South Tyneside were too proud to work in certain jobs. "Low status" jobs, such as work in a grocery shop, as a cleaner, or in warehousing, were seen as undesirable and people would rather continue to remain unemployed and claim benefits than work in one of these sectors. Some participants felt that people valued themselves too highly, citing the fact that people with low levels of educational attainment and work experience believed they deserved more than minimum wage, when, in their view, minimum wage was fair compensation for low-skill workers.

> "They want their perfect forever job and won't accept a job that what they see as beneath them for the time being. Like warehousing work, picker packer that sort of thing. They think they're better than that. They probably are better than that, but then whose to say that's better than an office job somewhere? A cleaner is no more lower down than somebody else, but a lot of people still have that." – South Tyneside Community Member

Participants in this subtheme were describing how they explained *others'* lack of employment, rather than describing their own experiences struggling to find work. It is worth highlighting that those participants who shared their *own* experiences with job searching while unemployed identified exclusively systemic level barriers to employment, such as lack of educational opportunities, insufficient wages, and low job availability (systemic barriers to employment are discussed further in Chapter 7). Nonetheless, there is some evidence to support the assertion that people, particularly men, may be averse to working in particular employment sectors. Qualitative research in Wales has shown that young men in deindustrialised communities refused to take available work that was considered embarrassing or feminine, such as those in retail, grocery, and food delivery (Jimenez and Walkerdine, 2011). Research conducted in the early 2000s identified the importance of manual labour to masculine working identity, suggesting that men continued to pursue work in traditional and familiar manual employment as these jobs declined in number in the late 20th and early 21st centuries (Nixon, 2006). Participants in this study may have identified a similar social phenomenon unfolding in their towns that has contributed to their area's unemployment rates; this indicates that to understand the level of poverty (and subsequent responses to it), one must consider the broader cultural forces at play in these towns; these will be discussed further in the following chapter.

5.5 Social Isolation and Loneliness

Social isolation was identified as a determinant of drug and alcohol-related morbidity and mortality. Participants emphasized the detrimental impact of social isolation on mental health, noting that individuals who lacked social connection experienced feelings of loneliness

and isolation. Loneliness and social isolation are two related, but distinct concepts. Loneliness is a negative feeling resulting from a *perceived* lack of a broad social network (Fakoya et al., 2020) Social isolation lacks an agreed-upon definition but has been conceptualised as an *objective* lack of connection to social or familial networks and one's broader community (Valtorta and Hanratty, 2012). Participants in this study made little distinction between the two concepts, but their descriptions of the phenomena they observed and their effects match most closely to loneliness. According to participants, when one is socially isolated or lonely, one's mental health often declines because one has time to ruminate on negative thoughts and emotions, which causes people to turn to drugs and/or alcohol to cope, or suicide to escape; there is evidence to support this belief. Loneliness and social isolation are both associated with a wide range of adverse health outcomes and premature mortality (Taylor et al., 2023). Available evidence suggests that loneliness is associated with increased risk of common mental health disorders like anxiety and depression (Heinrich and Gullone, 2006), and increased risk of suicidality independent of the presence of a mental health disorder (Stickley and Koyanagi, 2016). There is also evidence to suggest that loneliness increases the risk of harmful and/or dependent drinking and drug use (Wakabayashi et al., 2022, Polenick et al., 2019). Several participants shared personal accounts of how social isolation negatively impacted their mental health.

> "**Participant**: It's socialisation, or not having it. It's a big thing.
> **Participant:** That's the most important thing.
> **Participant:** Every day, no matter what, I just have a walk out to the shops just to get out and see people. If I don't, I'm just going to sit and watch the same crap on the telly.
> **Participant:** True, just to get out.
> **Participant:** it's just a spiral isn't it?
> **Participant:** You'll sit in the house and overthink things. It gets you down."
> **Participant:** Depression, aye. That's what the guy says to me, that you've been on your own too long. You do get depressed on your own."
>
> – South Tyneside Focus Group

COVID-19-related closures were cited as a factor that had heightened problems related to social isolation and had a negative impact on participants' mental health. Participants'

accounts that loneliness increased in response to COVID-19-related lockdowns is also consistent with the empirical evidence, which has shown a strong association between COVID-19 lockdowns and increased loneliness (Hwang et al., 2020, Groarke et al., 2020); however, the evidence indicates that loneliness levels fell to pre-pandemic levels with the lifting of lockdown measures (Kung et al., 2023). For young people in particular, participants reported that increases in the amount of time spent using technology such as phones, computers, and social media had increased feelings of isolation and inadequacy.

> "Social media plays a massive part for these younguins man. I'm not on Facebook, never been on social media, thank God. What I see from my little girl especially, she can be on TikTok for like five hours. She'll say like she feels like she's got no friends. She'll say "I hate Snapchat, because people post that they're out in the woods and they're playing having fun" whereas she's at home and feels like she's got no friends. That over and over and over again, to see that, it isn't good for the psyche. You start going down in the dumps. That can progress into depression and suicidal thoughts." – Middlesbrough Community Member

Social isolation was seen as a significant and growing problem in participants' towns but was not believed to be a problem unique to Middlesbrough or South Tyneside; rather, participants believed that increased social isolation in their communities was a reflection of a broader national trend. The belief that Middlesbrough and South Tyneside are not unique in terms of the prevalence of loneliness is somewhat surprising. In the UK, those with low education levels, low household income, and residing in the most deprived areas report significantly higher levels of loneliness and social isolation (Kung et al., 2023). Given that a large proportion of the population in Middlesbrough and South Tyneside meet these criteria, one would expect there to be disproportionately high levels of loneliness present. It is possible that participants misjudged the level of loneliness in their areas, perhaps due to the fact that participants were largely recruited from community organisations, so the sample was comprised of particularly well-connected individuals. Loneliness is a growing problem across the UK that has been covered in popular news media (Milner, 2024, Patel et al., 2019). Participants may have been exposed to news media coverage of growing loneliness in the UK and thus concluded that their communities were not unique. It may also have been the case that it was difficult for

participants to accurately estimate levels of loneliness between their towns and others more generally.

Community members emphasised the importance of social connection in preventing mental illness, believing that social connection was essential to one's well-being. Several community members shared stories of how finding opportunities for social connection within their communities offered tremendous benefits for their overall well-being.

> "Well, I'll use [*community centre*] as an example. I've talked to [*name*] and other people around. Anything like that, any initiative like that that brings people together, people who are isolated, suffering with mental health or whatever, that makes them welcome to come into a venue like that, to me it's fantastic. I'm not above saying it, I use it, and the biggest danger on me is that I just sit in the house in me [*sic*] own head. This place gets people out of the house and in someplace positive. Its helped loads." – Middlesbrough Community Member

Many different kinds of interventions have been developed to combat loneliness and social isolation (Fakoya et al., 2020). Support groups and informal opportunities for group socialisation have proved to be of value in reducing loneliness among adults (Kung et al., 2023, Fakoya et al., 2020, Heinrich and Gullone, 2006, Hwang et al., 2020). Unfortunately, as will become clear in Chapter 7, many such opportunities have been defunded and closed as a result of austerity measures. This indicates the importance of taking a holistic view of loneliness and social isolation. It is not sufficient to conclude that people in South Tyneside and Middlesbrough are lonely and that is why some people turn to DSA behaviours, one must consider the broader structural forces that give rise to social isolation and loneliness in the first place.

5.6 Chapter Summary

Participants identified several personal traits and emotions that lead people to use drugs and alcohol or to engage in self-injurious behaviours. Many of the elements in this theme are factors that affect individuals and cause them to engage in DSA-related behaviours as a coping

mechanism or as an escape. There is undeniably an element of choice and individual agency involved in the initiation of these behaviours. Participants believed that the choice to rely on DSA as a coping mechanism or an escape from negative circumstances is a choice that some individuals make, and others do not. While it is objectively true that people who engage in DSA behaviours do so of their own volition, to view DSA behaviours simply as the product of individual decisions is an oversimplification. The decision to use drugs and/or alcohol as a coping mechanism, or to use self-harm as an escape from one's circumstances, is not made in a vacuum. It is clear from many participant narratives in this theme that people are choosing to initiate DSA behaviours in response to external stimuli that exert negative influences on their lives, many of which exist entirely beyond one's control.

That some participants viewed problems with DSA behaviours and poverty in their community as a result of poor decision-making and a lack of work ethic from individuals and not something emblematic of a larger systemic failure is perhaps not surprising. There is a great deal of historical precedent for viewing these as a moral failing by individuals. This view, while antiquated, has not fallen entirely out of fashion in modern society. It is clear, however, from the existing evidence that to view poverty and DSA morbidity and mortality as a product of moral failure is inconsistent with empirical evidence linking these behaviours to higher-level determinants, and not a useful approach through which to solve the problems of DSA morbidity and mortality. A more holistic approach that considers the wider social determinants of health is warranted if we intend to meaningfully reduce DSA morbidity and mortality.

To look at these issues as a matter of individual behaviours and actions encourages us to identify solutions that individuals can undertake. For example, if loneliness is viewed solely as a problem caused by one's social isolation, we may encourage that person to seek opportunities to make positive social connections in their community. While this solution may appear sufficient, on closer consideration it is clear that it leaves large portions of the problem unsolved. Why has that person become socially isolated, to begin with? What opportunities exist in Middlesbrough and South Tyneside for positive social connection? What barriers have prevented residents in these areas from building strong social networks thus far? The person who is socially isolated and lonely, or who has been exposed to adverse childhood experiences

and uses drugs to cope, or who is living in poverty and has become hopeless that their situation will ever improve and chooses to die by suicide, is not simply making a choice. The people initiating these behaviours are doing so in response to a complex set of social and structural forces that have put them in a position where they are experiencing tremendous suffering. To truly understand the determinants of these behaviours, and how to prevent them, we need to look deeper than the individual and explore the higher-level determinants that have created their intolerable individual circumstances.

Chapter 6: "I think morals and values have to come into this." Cultural Determinants of DSA Morbidity and Mortality

Cultural determinants of health are a subset of the social determinants of health (Short and Mollborn, 2015). Cultural determinants are the belief systems, values, and social norms that are influenced by one's social environment and are known to have a significant impact on peoples' beliefs surrounding health, help-seeking, and health behaviours (Rice and Liamputtong, 2023). Participants believed that cultural determinants were important drivers of DSA morbidity and mortality in their towns. In this chapter, I will explore how cultural forces such as gender, stigma, and social class were seen to influence DSA morbidity and mortality by participants. I will also explore how the cultural determinants identified by participants influence some of the health behaviours discussed in Chapter 5, and how these cultural factors intersect with structural determinants of DSA morbidity and mortality, which will be discussed in greater detail in Chapter 7.

6.1 Masculinities and Traditional Gender Roles

Participants believed that deindustrialised areas like Middlesbrough and South Tyneside placed significant importance on gender roles and that these were partially responsible for men's rates of DSA morbidity and mortality in their areas. Participants reported that these areas had a "proud heritage of hard work and facing adversity" that men feel they need to live up to today. Participants connected the strong cultural importance of traditional gender roles to the areas' industrial legacies.

In Middlesbrough and South Tyneside, it was reported that men believed they should be the breadwinner for their families. Participants said that historically, men in these towns were able to provide for their families by working in industry but felt that this was no longer possible with the kinds of jobs available. Participants' belief that job opportunities had declined in their areas since the period of deindustrialisation is consistent with the available evidence (Hudson, 1989); deindustrialisation and its immediate economic impacts are discussed further in Chapter

7. Participants felt that men derived their sense of purpose from working and being productive, so when they were not able to do that, it was perceived that they felt like a failure. In turn, this failure to provide for their families was understood to be upsetting and harmful to their self-worth, so they turned to unhealthy coping mechanisms like drugs, alcohol, and self-harm.

> "I think the things that working-class men would have, a good job to provide for their families, they just don't have that anymore. I think this sounds, I don't know like I'm a dinosaur or something. But I think men, men want to work. Everyone wants to work, to be productive. But if the women around you are going off and getting jobs or going to school and you're left behind and can't compete, it has a massive effect." – Middlesbrough Community Member

Participants believed that areas like Middlesbrough and South Tyneside placed significant importance on gender roles and that these are partially responsible for men's rates of DSA morbidity and mortality. Participants believed that masculine gender norms in their areas were closely tied to the culture that surrounded heavy industry. The socialisation of masculine gender norms, the process by which boys learn the socially expected behaviours and characteristics of men, begins at a young age (Peate, 2020). Even before a boy reaches working age, "anticipatory socialisation", in which expectations and understanding about work are formed, can begin by observing the working life of men in the boy's immediate family and surrounding community (Strangleman, 2024). The transition from school to work typically marked a period of transition into manhood for working-class men in Britain (McDowell, 2001). Participants believed that the historical legacy of men working in industry had created the sense that men should be the breadwinners in their families. This belief is consistent with the empirical evidence, which has found that in industrial communities working in industry was seen to provide a degree of social capital and financial independence for men that strengthened the masculine ideal of being the "breadwinner" for one's family (Nayak, 2006). As deindustrialisation took hold in the North East, the options for transition into the working world for young men rapidly changed, with severe limitations on economic opportunity and a rise in unstable working environments, such as those on temporary contracts or a part-time basis (Nayak, 2006). Participants in this study suggested

that while the available work opportunities had changed, the cultural expectations around work for men remained largely the same.

> "To answer the question though, I think a lot of this goes back to heavy industry, to mines, to traditional roles. To how men were. Old habits die hard, and people have a view don't they about how they're supposed to be as a guy in the North East." – South Tyneside Stakeholder

In the economic environment that has arisen after deindustrialisation, low-skill service jobs, such as cleaning, bar work and retail services, constitute the majority of available jobs and such jobs are often perceived to be of low social class (McDowell, 2011). While industrial work was also traditionally considered low-skill employment (as it does not typically require higher education or professional certification), ethnographic research has shown that work in these two sectors is viewed very differently by men (Nixon, 2006). Service work in which employees interact with customers involves 'emotional labour', the management of feelings and relationships when dealing with customers; evidence from working-class men in the North of England suggests that men view the traits needed to excel in these fields as diametrically opposed to masculine ideals, making work in these sectors unacceptable to them (Nixon, 2009). The finding from this study that industrial work and class were central to masculine identity in Middlesbrough and South Tyneside helps to explain why, as discussed in Chapter 5, some men may choose not to work in certain sectors. It is not, as some participants suggested, that people have become lazy and no longer value hard work, it is that there is a general lack of available work opportunities and what opportunities do exist are not compatible with masculine working-class identity.

This finding should be approached with a degree of caution. While there is some evidence to support the belief that some men choose not to work in certain sectors that they view as incompatible with masculine identity, past qualitative research with young men in Teesside has produced different findings. MacDonald and Shildrick (2018) found that young men in Teesside generally did not struggle to identify modern jobs that were compatible with traditional masculine values and others were not opposed to work in more feminised forms of employment (e.g. the service sector). The discrepancy between the

findings of this study and those of MacDonald and Shildrick (2018) may be attributable to the age of participants in each study. As discussed in Chapter 3 (table 3.3), the sample in this study was largely comprised of middle-aged and older adults. It may be the case that younger men have adopted less strict gendered expectations surrounding work or have adapted their expectations to the available job market. Future qualitative research with men from a wider age range could provide insight into how men of different ages view work in feminised sectors.

It is also evident that there is a strong class-based influence on masculine gender roles in participants' descriptions of men's working lives. This is consistent with sociological theories of intersectionality and multiple masculinities, which suggest that social categories such as social class and gender interact to produce systems of (dis)advantage and power (Crenshaw, 1989) and that masculinity is understood differently by different social groups (Connell and Messerschmidt, 2005). Descriptions of traditionally masculine traits vary significantly across social classes, with upper-class masculinities characterised by qualities such as 'confident', 'powerful', and 'ambitious' and working-class masculinities characterised by traits such as 'tough', 'hard-working' and 'dedicated' (White and Diekman, 2023). It is notable that in this study participants frequently described men in terms that fit the latter category.

> "Starting out with being a kid expecting men to be strong, to fight and be tough and try these things and be risk takers. There is that element, the bravado and stereotyping. Then there is the element where they, men, are supposed to work hard, to provide for families and if they don't, they're failing." – South Tyneside Stakeholder.

The traits commonly associated with working-class masculinity that were considered an asset by industrial employers (Willis, 2017), are now often prohibitive to employment in the service sector (McDowell, 2020). The masculine working-class identity that participants believed was present in Middlesbrough and South Tyneside may be detrimental to men's ability to enter the post-industrial labour market, and this may help to explain the high unemployment rate and economic instability of men in these areas (and thus, the above average rates of DSA morbidity and mortality), but it is not the whole story. Working-class

men have shown a willingness to reorient their identities through new forms of employment, but often lack the resources necessary to do so, such as further education and job opportunities (Walker, 2022, McDowell, 2020, Haywood and Mac an Ghaill, 2013); this highlights how cultural determinants such as class-based gender roles and structural determinants such as access to education and job opportunities intersect to produce DSA morbidity and mortality.

The belief that failure to fulfil gendered expectations for work results in distress – which, in turn, leads to negative coping mechanisms – is supported by broader theoretical literature. What participants have described in this subtheme is, in effect, a sort of 'moral injury'. Moral injury is a term derived from the literature on psychological trauma that results from conflict between deeply held values of 'what is right' and the actions an individual has undertaken (Shay, 2014). While typically used to describe the trauma resulting from actions undertaken during violent conflict, moral injury may also describe what happens when working-class men fail to fulfil their expectations for how men in their communities should behave. This is not to draw an equivalency between failure to fulfil gendered expectations and the trauma resulting from participation in armed conflict, but there is precedent for viewing the experience of deindustrialisation as a form of trauma for entire communities (Lawson, 2020), so it is reasonable to believe that the individual experience of living in a deindustrialised community can constitute a traumatic experience for the demographic most affected by the economic shift deindustrialisation entails. If we view the failure of securing gender-affirming work to be a source of moral injury for working-class men, then participants' belief that unhealthy coping strategies such as substance abuse follow as a result is consistent with the literature, which links traumatic experiences and moral injury to DSA outcomes (Shay, 2014, Belfrage et al., 2022).

> "So, if you think some of these men, they don't have jobs, they can't get a job because they're addicted to whatever, they're not fulfilling their purpose to provide. It's a recipe for suicide. They're lacking that purpose." – Middlesbrough Stakeholder

Normative masculine gender roles were identified as a barrier to accessing mental health and support services. It was believed that men, particularly older men, would not talk about

their problems with mental health or their feelings more generally, because to do so was seen as weak. Participants reported that since men are supposed to be tough, so they would choose to conceal their emotions and not seek help when they were suffering. Participants' belief that normative masculine gender roles are a barrier to men seeking mental health services is consistent with the literature (Seidler et al., 2016). The hesitancy of men to attend mental health services or seek support with negative emotions from their social networks has been attributed to traditional masculinity's value of traits such as stoicism, toughness, and independence (O'Neil, 2008). Participants believed that peer support opportunities for men were also lacking. Participants reported that men were afraid to open up to their friends, and friends feared being emotionally vulnerable by providing support, which created peer networks in which nobody was able to share emotions without fear of judgment.

> "Men don't like to talk about their feelings because that's a sign of weakness straight away. They have to be the macho man. They have to be seen to be holding it all together and they don't. They think "Well if I talk to someone I'm less of a man." I think because they don't feel like they can open up and talk to people." – Middlesbrough Stakeholder

Some participants believed that because men were afraid to seek help or share their emotions, they were more likely to engage in negative coping strategies, such as drinking or drug use, to help them cope with problems. Participants believed that men preferred external methods of coping with negative emotions – those that allow one to escape from the self – such as drinking and drug use, as opposed to women who they believed favoured internal coping mechanisms – those that seek to deal with one's internal problems. There is evidence to support the belief that men are more likely than women to engage in substance use when experiencing a mental health disorder such as anxiety or depression (Cavanagh et al., 2017). Participants believed that women are generally much more able to be emotionally vulnerable and talk about their feelings, which explains why they are less likely to suffer from DSA morbidity and mortality.

> "I would think it's something to do, especially going down the mental health side of things, as a man, its bloody hard to speak up. As a woman, it's the norm. Which is good. I think we're getting to a state in this country where people are encouraging men to speak more, which is good. I would say, what's hard for men to do is normal for a woman." –

Middlesbrough Community Member

Stakeholders felt that masculinity can also make it more dangerous for men to be mentally ill or in crisis. Participants felt that men tend to be more violent and aggressive than women, so when they want to hurt themselves, they choose more violent means. This belief from stakeholders is consistent with the available evidence, which shows that when attempting suicide men are more likely to utilise violent means with a high risk of lethality than women are (Callanan and Davis, 2012); this is a reflection of a larger phenomenon known as the gender paradox in suicide (Canetto and Sakinofsky, 1998). There was agreement amongst stakeholders in this study that men's preference for more violent means of self-harm and suicide was responsible for the above-average male suicide rate; there is some evidence to support this belief. Investigation into the gender paradox in suicide has yielded mixed results regarding the underlying causes. Some research has found that the gender paradox in suicide is largely attributable to the methods used by men vs. women (Tsirigotis et al., 2011) while other research has provided evidence that women attempting suicide express less lethal intent than their male counterparts, indicating that suicide may serve different functions for men and women (e.g. intent to escape a situation via. death for men, vs. a cry for help from women) (Freeman et al., 2017).

> "With the male population, men don't like speaking about their feelings and won't reach out. Statistically, they're less likely to engage with services and more likely to use more dangerous methods [*of suicide*] and not communicate. Generally, you're more likely to doing [*sic*] the violent acts that will lead to death more than females would." – South Tyneside Stakeholder

Participants' belief in this subtheme is, in short, that normative masculine gender roles prevent men from seeking help for their mental health, and that men use substances or die by suicide as a result. While this belief is consistent with the empirical literature, it neglects important evidence that suggests a more nuanced view of men's mental health is necessary. When men do overcome stigma and choose to engage with services, they are often not well served by providers. Clinicians report feeling inadequately prepared to engage with and provide care to men (Harris et al., 2015). Men often disengage from treatment

early (Swift and Greenberg, 2012) and when they do disengage, they are unlikely to reengage via alternative services (Möller-Leimkühler, 2002). A study of men who died by suicide in 2015 in the US, UK, Australia, and Canada found that many of the men who died by suicide had engaged with a service provider in the week prior to their death (Chock et al., 2015). The problem is not just that men do not engage with services, it is also that when they do choose to engage with services, service providers fail to fully engage *them*.

Recent advances in the literature have sought to move away from pathological characterisations of masculinity and towards a view that acknowledges the complexities of men's mental health needs (Seidler et al., 2018). Researchers have attempted to learn what clinical approaches are engaging for men and how these approaches can be integrated into a wider range of mental health services. Collaborative client-clinician relationships, as opposed to a standard clinician-led model of mental health care delivery, have been found to be engaging for men (Kivari et al., 2018) and these models are compatible with many evidence-based forms of psychological treatment, such as cognitive behavioural therapy (River, 2018). Outside of traditional clinical settings, informal peer-support groups such as "men's sheds" have shown effectiveness in improving men's mental health and have high acceptability with men (Foettinger et al., 2022). The concept of multiple masculinities proposes that masculinity is not a monolith and that a diverse range of masculine identities develops at the intersection of social determinants of health such as social class, race, and sexuality (Evans et al., 2011), suggesting that to effectively serve men clinicians and public health practitioners must understand the complex patterns of masculine identity (Seidler et al., 2018). While the evidence surrounding how best to meet men's mental health needs will continue to develop, it is clear that a more nuanced view of the barriers to effective mental health treatment for men than the one provided by participants in this study is called for.

Notably absent from this subtheme is how people other than men experience gender roles in relation to DSA morbidity and mortality. The absence of non-masculine gender roles in the findings of this study can be explained by the way the topic of gender roles was raised during interviews. Participants were asked if they felt that there were groups of people within their town who experience these problems more than others, or who are more likely

to die by one of these causes. Participants felt men are more likely to die by these causes than women are, so the natural follow-up question was to ask them to explain why. This often turned the interview to the topic of normative gender roles. Participants were not asked about how feminine gender roles or atypical masculine gender roles influenced DSA behaviours. The belief that DSA-related mortality is more common in men is consistent with the available evidence, which shows men die at a significantly higher rate from these causes than women do (Walsh et al., 2021).

A small number of participants shared opinions about how normative feminine gender roles influence DSA behaviours nonetheless; their viewpoints varied considerably. Some participants felt that traditional feminine gender roles stressed the importance of child raising and providing care to others; these participants explained that acting in accordance with these values was prohibitive to excessive drug and alcohol use, making drug and alcohol problems less likely in women or making it easier for them to cease drug and alcohol use when it started to affect their children. There is evidence to support the belief that for some women, motherhood can be a motivating factor in engaging in substance abuse treatment (Adams et al., 2021). Other participants felt that because normative feminine gender roles encouraged women to be at home taking care of children, they were more stigmatised and harshly judged by society at large when they had a problem with drugs or alcohol and were thus less likely to seek help with these problems. Previous qualitative research supports participants' belief that women, particularly women who are mothers, face significant stigmatisation for substance use behaviours and that this can serve as a barrier to accessing services (Lee and Boeri, 2017).

> "Personally, I know when I meet a woman who has been threatened with removing her children, they can behave real quick and they can stop [*drinking or using drugs*] real quick. They can be addicts and alcoholics, but as soon as there's any threat around them seeing their children, they stop." – Middlesbrough Stakeholder~

There is insufficient data from this study to identify how normative feminine gender roles influence DSA behaviours and how participants explained the significantly lower rates of mortality from these causes. Future research should explore the interactions between

DSA behaviours and gender roles among a broader range of gender identities.

6.2 Communal Identity

Participants felt that in addition to deprivation, deindustrialisation caused a loss of identity in Middlesbrough that the wider area still had not recovered from. The centrality of industry to Middlesbrough's identity was evident when participants were asked to describe the area; participants frequently described Middlesbrough with words such as "industrial" and "traditional". This is in contrast to South Tyneside, where when asked to tell me about their area, participants frequently referenced proximity to the coast, Newcastle, and Sunderland. Even the colloquial name for people from Middlesbrough and the surrounding communities of Teesside, "Smoggies", a reference to the smog produced by heavy industry, harkens back to the area's industrial legacy. Participants in Middlesbrough reported that people still viewed their area as an industrial community because nothing has replaced industry as the central economic activity. The process of deindustrialisation was seen by participants in Middlesbrough to have caused resentment for the central government and other parts of the country that have fared better than the North since the 1980s. Resentment is a common response to deindustrialisation that has been observed in communities severely impacted by deindustrialisation from North America (Linkon, 2018), to Northern England (Webster, 2003). The resentment present in Middlesbrough today feeds into the fatalistic worldview that participants characterised as hopelessness (discussed in Chapter 5). People in the community have seen that conditions in their area have deteriorated from the high experienced in the latter half of the 20th century, that the government has done little to slow the decline and have no reason to believe that things will change going forward. The finding that deindustrialisation has given rise to a fatalistic worldview in Middlesbrough is consistent with research in other deindustrialised communities (Scheiring and King, 2023).

> "Literally everyone will have a tie to those industries and we're watching them die while others succeed and the ones that succeed are not here. It's hard to watch everyone around you get poor. All of this just creates a more militant stance." – Middlesbrough

Stakeholder

Some participants in Middlesbrough believed that their area had been deliberately kept poor by the central government. According to these participants, the government wanted to have impoverished places so that service providers could generate a profit and the rest of the country had a place to look down upon. The feeling that the government had deliberately kept Middlesbrough poor was representative of the sense of resentment for the central government that participants in Middlesbrough felt was common in their area.

> "I think the government that we have in power wants people that they deem as feckless in society. They don't want people to be educated. They don't want to be challenging the status quo. They don't want to be challenging them and that disparity is getting greater and greater based on the last number of years of government and got worse." – Middlesbrough Stakeholder

Participants believed that the resentment for the central government had caused a growth in racism and support for populist political movements. These participants explained that it was easier to blame outsiders for the problems in Middlesbrough, rather than to acknowledge that the government was responsible. A rise in support for populist candidates and movements, such as the election of Donald Trump in the United States, has been observed in communities that were hard hit by deindustrialisation (Baccini and Weymouth, 2021) and Middlesbrough is not an exception. In the 2016 Brexit referendum, Middlesbrough along with other Teesside communities voted overwhelmingly to leave the European Union (Middlesbrough Council, 2016). The connection between deindustrialisation and support for the "Leave" campaign was not missed by John Tennent, leader of the United Kingdom Independence Party (UKIP) in Teesside. Tennent said "There's a lot of people who are disenfranchised. They feel disaffected and they look at the European institutions where people are well paid, with big expensive lives, all being paid for by us ordinary hardworking people" ('Disenfranchised' Teesside supports Brexit, 2016). A rise in ethnocentrism and racism as a result of deindustrialisation is also consistent with the existing literature, as this phenomenon has been noted elsewhere in deindustrialised areas

of England (Webster, 2003). Some participants believed the government had fed into this rhetoric to ensure the people did not blame the government for the problems in their community.

> "Then you get people who just want to justify what is going on. They'll blame [*refugees and asylum seekers*]. Say it's their fault. So of course, they feel excluded. But at the end of the day, they're a massive part of our community now. It's easy, isn't it? No one has to take responsibility for themselves and what's going on, just blame somebody else." – Middlesbrough Community Member

While participants believed the industry was still central to Middlesbrough's identity, they acknowledged that work in the industrial sector had largely left the area. Participants described the disconnect between Middlesbrough's communal identity (the collective identity that indicates the distinguishing features of the community) and the economic reality in stark terms. Middlesbrough was described as "a shell of a place" and "the land of the living dead". Some participants felt that establishing a new source of communal identity for the town was an important step in establishing a prosperous future. What participants described amounts to a form of shared trauma.

> "There needs to be progress made on "what does Middlesbrough become?" Otherwise, we'll always be stuck on "what was Middlesbrough?"" – Middlesbrough Stakeholder

Trauma is often conceived as something that happens to individuals after experiencing a distressing event; however, participants' accounts provide evidence that another form of trauma may be present in Middlesbrough. Collective trauma refers to the psychological distress that a group, such as a community or culture, experiences in response to a shared trauma (Hirschberger, 2018). While collective trauma is often observed in communities that have experienced violent conflict or been victimised by racial or ethnic violence (Li et al., 2022), deindustrialisation has been conceived of as a form of structural violence that results in collective trauma (Lawson, 2020, Clark, 2023). Unlike individual memories of traumatic experiences, collective trauma is remembered by the community as a whole and may be remembered by individuals who did not directly experience the traumatic event (Hirschberger,

2018); this process is known as transgenerational transmission of trauma (Volkan, 2001). There was evidence of the process of transgenerational taking place in Middlesbrough within some participant accounts of deindustrialisation.

> "From my own family, I come from coal miners, so I know [*deindustrialisation*] had a massive impact. I was quite young then, but my dad still talks about it. It gets passed down. In the 90s it started to recover a bit, but the 80s you had that feeling of there being nothing to replace what was taken away." – Middlesbrough Community Member

The concepts of transgenerational and collective trauma can help explain how deindustrialisation, a process which peaked in Middlesbrough in the 1980s, continues to have a profound impact on the identity of the area today. The identity of a community is socially constructed and transferred across generations (Emery, 2019). The collective trauma of deindustrialisation disrupts the intergenerational transfer of identity as older generations struggle to articulate communal identity amid changing social and economic circumstances (Bright, 2012). Younger generations in deindustrialised areas, like Middlesbrough, are left with identities and social expectations (ie. that an adult man without further education will be able to secure full-time, long-term employment and provide for a family) constructed around historical industries that cannot be achieved in current post-industrial labour market conditions. The division between what is expected of people as members of a community and what is realistically attainable has been identified by sociologists as a source of shame and a sense of collective loss (Walkerdine and Jimenez, 2012, Walkerdine, 2010). In Middlesbrough, this fractured sense of identity helps to explain why there is a connection between deindustrialisation and the feeling that participants described as hopelessness (see Chapter 5). Older generations in Middlesbrough experienced deindustrialisation and the entailing losses first-hand, while younger generations have been raised with a set of cultural expectations that they could not meet. The gap between what is culturally expected of people in Middlesbrough and what is realistically achievable may partially explain why Middlesbrough has worse DSA-related outcomes than other areas of the North East.

> "My partner was saying, he explained it like the men would go working down the pit. They'd come back, go to the pub, slap their wife about a bit, and get up and go to work. I think we still have that kind of attitude in a lot of men. I think it's been passed down

through the generations, that expectation. The culture is very much still there. So, if you think some of these men, they don't have jobs, they can't get a job. They're not able to, not fulfilling their purpose to provide. It's a recipe for suicide. They're lacking that purpose." – Middlesbrough Stakeholder

This theme was notably absent in South Tyneside, where stakeholders and community members generally described their area in relation to its surroundings. While participants acknowledged South Tyneside's industrial history and the presence of deprivation, participants felt that the history of the community is not what people thought of when they thought of South Tyneside.

"It has some wonderful assets. It's got a wonderful coastline, which you may or may not be aware of. From the border of Sunderland down to South Shields it's a bit of, a kind of local asset. It's got a variety of different communities in a way really. I think South Shields is often what people think about when they think about South Tyneside, or they think about the coast, or they'll think of the diversity of community when they think of South Shields." – South Tyneside Stakeholder

When participants in South Tyneside were asked why the government had failed to alleviate the problems in their community, the explanations provided were significantly more forgiving to the central government than those provided in Middlesbrough. The nature of industry in Middlesbrough and South Tyneside may partially explain why deindustrialisation was so present in Middlesbrough's collective identity and less so in South Tyneside. One of Middlesbrough's chief industries was steel production and former steel-producing areas have been observed to have a stronger connection between their industry and their collective identity than other industrial areas (Zukin, 1993, Rhodes, 2013), it is possible that the failure to achieve cultural expectations is felt more viscerally by people in Middlesbrough than in South Tyneside. Additionally, South Tyneside deindustrialised sooner than Middlesbrough, with the shipyards (the principal industrial employers in South Tyneside) facing staff reductions and yard closures beginning in the 1920s compared to closures in the 1980s in Middlesbrough (Hudson, 1986). The additional 60 years that South Tyneside had between the peak of deindustrialisation and the present, and the economic development of nearby Newcastle and Sunderland, may have allowed for more of a reorientation of the town's communal identity than has happened in Middlesbrough. Participants in South Tyneside typically responded that they did not know or

believed that it was simply a product of the fact that the Government had a limited amount of money and could not afford to solve every problem that needed to be addressed within the country.

> "I'm not sure if this is how it works, I'm not about the government, obviously I think they give money to like NATOs and stuff like that, but with the wars going on they give more to, they prioritise the wars in Europe or wherever and its obviously meant they have to raise estates higher, cause like, they haven't got enough money." – South Tyneside Community Member

6.3 Normalisation of Drug Use

There was a perception by participants that the use of drugs had become normalised within society over the last 30 or 40 years. According to participants, few people today feel as though cannabis is a harmful drug, instead viewing it as a socially acceptable substance to use. Participants believed it was considered acceptable to smoke cannabis or use cocaine rather than confronting one's problems, so one's problems would become worse because the person would not address them. People were believed to equate cannabis use to casual alcohol consumption, which furthered the normalisation of drug use.

> "People just don't think twice about smoking [*cannabis*] away in front of you, so you're at risk of taking in what they're smoking. You know, second hand. There are, a lot of them are kids ... They will just walk right down the main street, smoking, without a care. It's a definite change in what people think is okay." – South Tyneside Community Member

Some participants felt that other drugs, such as heroin and cocaine, had become normalised as well. What participants in this study were describing when they referenced the normalisation of drug use is a well-established topic of discussion within the sociological literature. Normalisation theory, advanced by Measham et al. (1994) explained how drugs become normalised within sub-cultures and broader society (Pennay and Measham, 2016). Measham et al. cited increasing accessibility of drugs, increasing rates of drug experimentation during youth, high levels of drug knowledge, and the cultural

accommodation of certain drugs by non-drug users (e.g. in popular culture) as evidence that drug use had become socially acceptable and culturally embedded in society (Measham et al., 1994, Parker et al., 1995, Parker, 1998). Before the introduction of normalisation theory, drug studies literature associated drug use with social deviance (Hirschi, 2002), subcultural identity (Golub et al., 2005), or psychological and physiological predispositions (Kellam et al., 1989). Since the normalisation theory was advanced, researchers have further explored the process of drug normalisation; some of this research supports normalisation theory (Simpson et al., 2007, Pearson, 2001), while some have found that other theoretical approaches better explain increasing rates of drug use (Gourley, 2004, Shildrick, 2002). Participants pointed to the 1990s as the period in which society started to romanticise heroin use, with fashion trends such as 'heroin chic' contributing to the normalisation of the drug, and believed that a similar process had happened with cocaine more recently.

> "One of the really, really sad parts of society at the moment is this normalisation of cocaine. That purchasing of cocaine in the more affluent areas, the more functioning addicts, who aren't really taking account of the fact that they're doing that and they're doing it every weekend. They're not viewing it as a problem, but all the while they're funding these major organised crime groups. It's a problem I don't see going away, I see it getting worse because it seems to be the case that we've normalised cocaine use." – Middlesbrough Stakeholder

Participants felt that the normalisation of drug use had coincided with a dramatic expansion in the availability of drugs. In both Middlesbrough and South Tyneside, participants felt that drugs were ubiquitous and easy to acquire. Drugs such as heroin were described by participants as affordable and easy to find. Normalisation theory can help to explain why the normalisation of drugs identified by participants coincided with the perceived expansion of their availability. Evidence from the UK suggests that social drug supply acts have become accepted as behaviour akin to gift-giving or as a normal friendship activity within social networks and are no longer conceived as 'drug dealing' (even when large amounts of money or drugs are exchanged) (Coomber et al., 2016); this may help to explain the ease with which drugs can be accessed in these towns. Another contributing factor may be that limited economic opportunity in legal sectors of the economy encourages

people to enter illicit economies such as drug supplying to generate income; this will be discussed further in Chapter 7.

> "I mean [*heroin is*] not hard to find 'round here. You give me £20, and I could leave here right now and be sorted with heroin in about 5 minutes. It's not hard to find. I'm not usually this smart looking, I cleaned up a bit. I was on the phone the other day. I can't remember who I was calling, but I hung up the phone and this dude comes up to us and says, "You looking for some brown?" – South Tyneside Community Member

Participants reported that there were drug dealers on "every corner" in certain low-income areas. The increasing visibility of drug use and drug dealing was believed by participants to have made it easier for people to initiate and continue drug use. Participants also highlighted that in addition to being widely available, drugs were increasingly potent, which they believed increased the likelihood of dependence and overdose. Participants' belief that increasing rates of overdose deaths were attributable to more people using increasingly potent drugs is not consistent with the available evidence. While rates of drug-related deaths in England have increased dramatically in recent years (Augarde et al., 2022), there is little evidence that people are using drugs at higher rates than has been the case historically. While marijuana remains the most popular illicit drug used in England, rates of marijuana use among young people have steadily decreased over the last 20 years (NHS Digital, 2022). While there has been a slight increase in the rate at which people use drugs in England since 2012, the rate is still below the historical average since data collection began in 1995 and is lower than it was in any year before 2012 (NHS Digital, 2022). Empirical evidence has shown that increasing rates of drug-related deaths are driven by an ageing cohort of drug users for whom drug use is becoming more dangerous and an increase in the rate of polysubstance use (the use of multiple different drugs at one time, which creates the risk of dangerous drug interactions), not by an increase in the number of people who use drugs (Kimber et al., 2019).

> "It's not just heroin. We have a thing called crack cocaine. Apparently its cheaper than buying a pint and apparently, from what I've gathered, it's a tremendous high, better than anything else, and you can get this crack cocaine quicker than you can get a pizza delivered. It's easy to buy, easier than going to a shop and buying a bottle of lemonade. I

think everyone is a dealer. You buy it and you sell it, it's a free-for-all for making money."
– Middlesbrough Community Member

Given the lack of evidence for an increase in the number of people who use drugs, it is unclear how the normalisation of drugs could be driving increasing rates of drug-related deaths. Participants' belief that many more people are using drugs in their areas than in previous decades may be a product of increased visibility of drug users. As police budgets have been reduced, resources have increasingly been allocated towards higher priority crimes and away from antisocial behaviour, which may have made public intoxication more common. The use of crack cocaine, ketamine, and new psychoactive substances (such as synthetic cannabis, street name "spice") increased between 2015 and 2020 (ONS, 2022). Use of these substances, particularly synthetic cannabis, is associated with psychiatric symptoms such as agitation, paranoia, and psychosis (Tait et al., 2016), so it is possible that increasing rates of use of these drugs have led to an increase in highly visible antisocial behaviour from people who use drugs. It is also possible that while rates of drug use are still below historical averages, the visibility and disruptive nature of drug use have increased due to the influence of structural forces. As a result of austerity, police budgets have been cut (NAO, 2018), youth services have been closed (Davies, 2019), drug treatment services have faced budget reductions and closures (Roscoe et al., 2021), and access to mental health services has declined (Cummins, 2018). While rates of drug use may not have increased, a combination of these structural forces may be forcing drug use into the public eye. If this is the case, participants have correctly identified a problem (that drug use is an increasingly visible and disturbing problem in their community) but misidentified the cause. A deeper discussion of austerity and its impacts on Middlesbrough and South Tyneside is provided in Chapter 7.

6.4 Peer Influence

Community members highlighted the significant influence that they believed peer groups had on individuals' drug use behaviours, reporting that people were often influenced by

friends who engage in substance use to do the same. These concerns were largely centred around young people, with participants expressing concern about peer pressure leading otherwise 'good kids' to engage in negative behaviours. Concerns about peer influence and social pressure to behave in ways that are consistent within-group social norms as a determinant of substance abuse are well established in the literature and participants' belief that peer pressure may be contributing to adolescent substance use and anti-social behaviours is consistent with the available evidence. Peer pressure has been identified as a risk factor for adolescent substance abuse (Robertson et al., 2003, Crockett et al., 2006), self-harm (Nock and Prinstein, 2005), and academic underperformance and criminality (Santor et al., 2000). As discussed in Chapter 5, there is also evidence to support the belief that children who have an unhealthy home environment are more likely to begin using substances.

> "It's not the majority of kids, its only certain ones. It's normally the bad apple. It's the bad apple. Out of 20 kids there might only be three bad'uns, the other lot are just followers on. You always get a kingpin; you always get an alpha. That's the one that brings the other ones in." – Middlesbrough Community Member

Participants cited troubled upbringings and a lack of positive role models in deprived communities as factors that contributed to the dynamic of peer influence as a determinant of drug use. Participants felt that some children began using drugs and engaging in criminal activity because they had grown up in troubled homes. Participants felt that many children lacked positive role models, so they would look to their peers for direction on how they should behave. According to participants, this created an environment in which more and more children influenced their peers into engaging in drug use behaviours, leading to increased rates of drug use. While the role of peer influence in encouraging drug use that participants in this study identified is consistent with the available evidence, it is less clear that this is a new or increasingly problematic phenomenon. Concerns about peer influence as a determinant of adolescent substance use date back to the late 1970s (Akers et al., 1979). As previously discussed in the *Normalisation of Drug Use* subtheme, there is a lack of evidence to support the belief that more people are using drugs now than has historically been the case. Given that peer influence is not a new phenomenon and the lack of evidence that more people are using drugs

than before, it seems that in this subtheme participants have identified a risk factor for substance abuse but not an explanation for why drug-related deaths are above average in their areas.

> "It's a thing where they're being taught by their peers and everything, all that stuff. People have morals to a degree, what you do. There was this notorious lad on the estate where I live, he was bad. These lads were mocking me for litter picking one day and this lad turned round and said, "because he wants to make the area better and help the environment." So, they know, they're intelligent people, but they get sucked into this bad behaviour because of where they grew up and it all spirals on from there." – Middlesbrough Community Member

Stakeholders' concerns about peer influence as a determinant of drug use were generally more focused on the effect that peer groups had on individuals in recovery from a substance abuse disorder. It was reported that people early in the process of recovery faced significant challenges; their existing peer groups often consisted of people who use drugs, they lacked stable employment, and their immediate environment often involved easy access to drugs, all of which was seen by participants to have made it very difficult for people who wished to discontinue drug use to do so in a sustainable way. It was reported that people who are seeking sobriety are often put in the position of either isolating themselves by cutting off contact with their peers or continuing to use drugs to fit in with the expected behaviour in their social circles. Maintaining social connections to family members and friends who use drugs and unemployment are known risk factors for relapse among people in recovery from a substance use disorder (Mohammadpoorasl et al., 2012, Hser et al., 1999). Recovery has been described as a process of social transition in which the addicted person needs to form new identities and perspectives in which their identity as an addict is excluded (Best et al., 2016). The factors that stakeholders described as obstacles to recovery can be viewed as barriers to successful social transition for people in recovery. According to stakeholders in this study, even if people were able to fundamentally change their existing social networks, they would still be surrounded by drug use in their homes and communities, increasing the likelihood of relapse.

> "We say "oh well this person isn't motivated because they haven't attended their appointments, they're still using drugs." Well, no, look at what we're asking them to do. We're asking them to fundamentally put a stop to their coping mechanisms, rewire all

> their social connections, which are built around drug use … it's an uphill battle really before they can even start a reduction plan – South Tyneside Stakeholder

To understand why the barriers to recovery identified by stakeholders are so common in Middlesbrough and South Tyneside, we need to consider the broader social context in which people in these areas live. Many of the barriers identified by participants, such as housing, lack of stable employment, and easy access to drugs, are attributable to structural factors which will be discussed in Chapter 7. Here, we see evidence of the interplay between structural determinants and cultural norms; cultural norms influence substance use behaviours because structural determinants have created a social environment in which these influences are inescapable.

6.5 Parenting Standards and Inter-Generational Poverty

Participants believed that social norms around what constituted acceptable parenting practices and standards had shifted. It was believed by participants that parents no longer discouraged their children from using drugs, sometimes going so far as to encourage this behaviour by using drugs in front of their children. According to participants, this shift in parenting had caused more children to start using drugs and at a younger age, because their parents did not discourage them from doing so. There was agreement among some participants that the behaviour of children was a direct reflection of how parents behaved, as children emulated their parents and only engaged in behaviours their parents thought were okay, or that their parents themselves engaged in.

> "There are a lot of children smoking cannabis in this town. It's probably because it's accepted at home. Their parents are smoking at home, and they give it to their kids. It's so widely accepted that people have almost forgotten it's a controlled drug, and rightly so as well because it does affect the brain." – Middlesbrough Stakeholder

Some of the changes in individual behaviour, namely low work ethic (see Chapter 5), were attributed by participants to poor parenting. It was believed that parents no longer taught

their kids the importance of hard work, so children have grown up to be lazy and entitled. According to participants, young people saw that their parents had not worked and were happy to live off benefits indefinitely, and they have learned that this behaviour was an acceptable way of living one's life. Participants felt that children were impressionable and that they were brought up in a culture of "laziness" in which claiming benefits and not working was considered to be the norm. Since children were seen to have been raised by parents who were content to rely on benefits, they had not developed positive aspirations and have grown up to do the same thing, never having been shown the value of hard work. The concern that there is an intergenerational culture of deprivation in which children learn from their parents not to work and to live off of benefits is pervasive in British political discourse; this sentiment has been expressed by both Labour and Conservative governments and echoed in popular media (Shildrick, 2012).

> "If you've got deprivation and a family where no one works, they're all on benefits, there is no incentive to get up and look for a job. It's how they're being raised." – South Tyneside Community Focus Group

Participants' belief that worklessness was cultural in nature and transmitted across generations has a long history; elements of this idea are visible in the 17th-century concept of the "undeserving poor", discussed in Chapter 5. More recently, at the start of the 20th century, Eugenicists searched for the biological basis of poverty and social degeneracy (Turda, 2022). As eugenics fell out of favour, the discourse shifted to "cultures of poverty" and "cycles of deprivation" (Welshman, 2007). The coalition government of the 2010s made addressing the problems of worklessness and benefits as a "lifestyle choice" central to their welfare reform efforts in 2010 (Wintour, 2010). Given the prominence of the idea that poverty and worklessness are culturally transmitted in popular discourse and the centrality of this idea to British welfare policy in the 21st century, it is perhaps unsurprising that some participants in Middlesbrough and South Tyneside held this view as well.

It was believed by some participants that low work ethic had become multi-generational and engrained in families. These participants reported that there were generations of people in

Middlesbrough and South Tyneside who had never worked and had lived solely off of income from benefits, whose children had been raised to do the same. One participant described this as "a culture of deprivation." While the idea that worklessness is culturally transmitted is common and well-precedented, it is entirely without the support of empirical evidence. Researchers have consistently failed to provide evidence of a culture of worklessness in deprived communities in which multiple generations of people do not work and claim benefits (Fletcher et al., 2008, Shildrick, 2012, MacDonald and Marsh, 2005, Macdonald et al., 2014). There is no denying that unemployment and benefits claims are higher in deprived, deindustrialised communities like South Tyneside and Middlesbrough (Beatty and Fothergill, 2020), however; this is attributable to broader structural forces, such as a lack of job opportunities (Macmillan, 2014) and cumulative disadvantage stemming from exposure to poverty beginning in early childhood (MacDonald and Marsh, 2005, Macdonald et al., 2014). When investigating factors underpinning worklessness, Macdonald et al. (2014) found that factors such as poor education, poor housing, family instability, issues relating to mental health and substance abuse, a lack of available jobs, and poor physical health were responsible for creating and maintaining worklessness in Teesside communities. Macdonald et al. (2014) acknowledged the role that individual behaviours and social norms, such as criminal behaviours and drug use, had played in preventing people from entering the job market, however; they argue that a complex view of worklessness, in which both individual and structural level factors are considered, is warranted.

> "What I noticed was that these families had been living that way for four generations. They know everything there is to know about the benefits system. Why would they work? It doesn't even cross their minds. They're so educated about the benefits they can claim. It was a really interesting cycle to listen to them and the way they talked, what their life was about. It was drama after drama and it's because they're uneducated. A culture of deprivation. Totally shameless" - Middlesbrough Stakeholder

Many of the factors identified by researchers as driving long-term worklessness were identified by participants in this study. Some of those factors, such as criminal behaviour and substance abuse, are individual-level factors that were believed by participants to be

initiated in response to social conditions (as discussed in Chapter 5). Other factors, such as poor housing, lack of quality education, low availability of jobs, and long-term exposure to poverty can be tied to structural factors that will be discussed in greater detail in Chapter 7. What is clear is that attributing the prevalence of poverty and benefits claims in Middlesbrough and South Tyneside to a culture of deprivation is both inconsistent with the existing literature and an oversimplification of the causes of deprivation. It seems that in this subtheme, as in the subtheme relating to the normalisation of drug use, participants may have correctly identified a problem (that unemployment and benefits reliance is pervasive in their area) but have incorrectly attributed the cause. To understand why multiple generations of people have lived in poverty in Middlesbrough and South Tyneside, one must look to the structural level factors that have entrenched people in poverty and that created the social conditions in which people have decided to initiate behaviours such as criminality and substance abuse.

Participants reported that as a result of poor parenting, the morals and values of young people had shifted and were no longer aligned with the traditional morals and values of British society. It was believed by participants that people no longer respected their elders, valued education or fiscal responsibility, respected authority, valued law and order, or engaged in polite society (such as greeting or acknowledging strangers in public). In general, it was believed by participants that people have no moral compass anymore. Concerns about a perceived decline in the morals and values of society have an exceptionally long history. More than 2000 years ago in Ancient Greece, philosophers Plato and Socrates lamented the erosion of moral values and stressed the need for leadership to uphold morality within society (Fitzpatrick, 2018). In British society, similar consternation has been expressed for hundreds of years. In the 18th century, William Hogarth, an artist and social critic, depicted the moral decay he perceived in urban society through his works “Gin Lane” and “Beer Street” (Nicholls, 2003). In the 19th century, William Booth founded the Salvation Army to promote Christian morality and social reform to address what he saw as the erosion of Christian values amongst the poor (Hattersley, 2017). In the 20th century, Margaret Thatcher spoke of the need for a moral rejuvenation of Britain, believing that the welfare

state had fostered fecklessness and immoral behaviour amongst the working class (Tomlinson, 2021). Participants in this study echoed these concerns, believing that too much blame for societies' problems was placed on the Government when the focus should be on the morals and values of society as a whole.

> "I just think society is becoming fucked up. Some people say people have become godless or they've moved away from spirituality. It might be a bit of that. Whatever it is, they've lost all moral compass, it's like… its bad now. Wherever I walk, in the park or this and that, there is always characters off their heads [*on drugs*]." – Middlesbrough Community Member

Participants' concerns that the morals and values of British society have degraded follow the well-established precedent of laying the blame for this perceived change at the feet of poor people living in deprived urban conditions. These concerns can largely be dismissed, as they are not specific enough to seriously consider (participants who expressed these views were unable to specify when the change began, what factors had caused it, or how broad changes to society as a whole had manifested in health inequalities in Middlesbrough and South Tyneside). While the belief that the morals and values of British society are eroding is not a helpful explanation for rates of DSA morbidity and mortality, it is indicative of the presence of class-based stigma in participant narratives, which is itself worthy of further scrutiny.

6.6 Social Class: Stigmatised Places and People

It was believed by participants that their towns were stigmatised by wider society. Participants reported that when people thought about Middlesbrough and South Tyneside, they thought of poverty, drugs, and crime. It was felt by participants that the perception of their towns was made worse by the highly visible nature of drug use and homelessness, which people visiting the area quickly noticed.

> "When I moved here people are like "oh, why are you moving to South Tyneside? It's full of druggies." It doesn't, it's not a great representation. It just sends the message it's just

> full of druggies, and it's not. It's just one problem, every town's got them. But you come out the metro station and there is always people with issues hanging around. It's been mentioned to me a few times to me that it's the first thing you see." – South Tyneside Community Member

According to these participants, low-income communities in general were looked down upon, and in that regard, Middlesbrough and South Tyneside were no different. The phenomenon participants described in this subtheme, that their areas are stigmatised, is well established in the literature. Ethnographic studies have consistently shown that low-income cities, towns, and neighbourhoods are subject to highly negative and disparaging media portrayals (Wacquant, 2007, Bambra, 2016, Garthwaite and Bambra, 2018, Goldstein, 2004); this phenomenon is known as territorial stigma (Wacquant, 2007). Participants in this study were aware that representations of their areas in political discourse and news media had further entrenched the sense of stigmatisation, citing the show "Benefits Street" as just one example. One recent example of territorial stigma being perpetuated through political discourse is James Cleverly, the Secretary of State for the Home Department, calling Stockton-on-Tees (a deprived town that borders Middlesbrough) a "shit-hole" in late 2023 (Andrew, 2023).

> "When you mention you're from Middlesbrough you get "oh smoggies." That's a nickname for people from Middlesbrough back when it was very industrial with all the smoke. It's seen as a really deprived place. It's been on some quite nasty TV shows where people were portrayed really negatively. It's called Benefits Street, and it was in Middlesbrough. Stockton as well. So, we get a lot of negative portrayal. A few years ago one of the newspapers had Middlesbrough as the worst place in the UK to live." – Middlesbrough Community Member

Territorial stigma is itself a component of broader, class-based stigma, wide-reaching cultural attitudes and norms through which people of low social class are marginalised within society (Wutich et al., 2014). Participants told me that people from low-income communities were lumped together, and people applied their judgements about the town to the individuals who lived there; there is empirical evidence to support this belief. Low-income areas are often portrayed as dangerous and are associated with criminality; portrayals that are often applied to the people living in these areas (Crossley, 2017).

Territorial stigma is a social determinant of health that influences both the health of people living in the area and the structural conditions in an area, such as residents' access to employment, housing, and medical care (Keene and Padilla, 2014). Territorial stigma may also be further entrenched by structural determinants, such as geographically concentrated reductions in state spending on welfare programmes, local services, and infrastructure (Garthwaite and Bambra, 2018). The accounts of participants in this subtheme indicate that Middlesbrough and South Tyneside are subject to territorial stigma.

The effects that living in a stigmatised area have on residents is an area of growing research interest (Garthwaite and Bambra, 2018). Participants in this study indicated that growing up in a stigmatised community instilled a sense of shame in residents that affected them for the rest of their lives. According to participants, people internalised the stereotypes about their community and people living in poverty and believed them to be true about themselves. Participants believed that this negatively affected one's outlook and general well-being; this belief is consistent with ethnographic research on the effects of territorial stigma elsewhere in the world (Kelaher et al., 2010). Participants believed that feelings of alienation from broader society created resentment for people in other parts of the country. Participants reported that people, particularly those in the South, had no understanding of what life in these areas was really like. The sense of shame described by some participants was visible in other participants' accounts of their experience living in the community. Participants expressed embarrassment, shame, and anger about the fact that they live in a town that is so looked down upon.

> "I'm sorry. I am, I'm sorry I'm from Middlesbrough. I'm ashamed to say I'm from Middlesbrough. That's why I went to [*a different country*]. If it wasn't for [*personal circumstances]* I would never have come back here." – Middlesbrough Community Member

The shame associated with living in a stigmatised place that was described by some participants, and present in the narratives of others, has also been observed in other stigmatised contexts (Airey, 2003). While participants in this study did not say that territorial stigma had direct impacts on people's mental health in their areas, the similarity of their

accounts of what it is like to live in their community to previous research in other stigmatised places suggests that we can draw inferences about the effects that territorial stigma has on the mental health of people in Middlesbrough and South Tyneside. Territorial stigma has been seen to affect a wide range of mental health-related outcomes, from stress levels (Wutich et al., 2014), to anxiety and depression (Taylor and Turner, 2002). It is notable that, as discussed in Chapter 5, stress, anxiety, and depression were all identified by participants in this study as individual-level determinants that people respond to by using drugs and alcohol to cope, or self-harm and suicide to escape. This finding provides further evidence that many of the behaviours discussed in Chapter 5, which participants viewed as individual-level factors, are actually responses to broader cultural forces such as territorial stigma.

Participants explained that stigma changed how people viewed themselves and their lives. Participants believed that experiences that were routine or unexceptional for many in British society, such as career advancement and pursuing further education after school, were seen as out of reach for low-socioeconomic class people. This divide between the "haves" and the "have nots" was described by some participants and could be observed in other participants' accounts of their own lives. One participant described how when he was growing up as a child on an estate in Middlesbrough, he knew that children in his area would not be going to university because that was something for people of a higher social class. When another participant was describing the job market in her town, she consistently described a two-tiered society in which there were jobs available for "them", but not for "us". This two-tiered nature of society was so fundamental to her experience and worldview that she struggled to articulate it to me, but it was clearly based along class lines.

> "**Participant**: …so, there is a lot going on in South Tyneside, but people like us, we get affected by it most because we can't get a job in them sectors. Even if we've got experience.
> **Interviewer:** You've said that a few times now, "people like us". What do you mean by that?
> **Participant:** Like me. Like, I'm in a major financial crisis. I'm living on the dole.
> **Interviewer**: But who is "us"? Or maybe, who is "them"?
> **Participant:** I… I don't know, really, like how else to say it."

- South Tyneside Community Member

What participants were sharing is a worldview that had been shaped by repeated class-based stigmatising and discriminatory experiences. That low social class children and families experience stigma starting in early childhood and continuing throughout their lives, and that this, in turn, has an effect on how they engage, or choose not to engage, with educational institutions is well established in the literature (Wilson and McGuire, 2021, Reutter et al., 2009, Mazzoli Smith and Todd, 2019). On an institutional level, stigma may be perpetuated by policymakers and institutions, with policymakers attributing the underachievement of low social-class students to the values of low social-class families (Yandell, 2013). On an individual level, stigma may be internalised and influence how one interacts with the world; for example, people from low social class backgrounds may internalise the stereotype that they are lazy and foolish (sentiments shared by some participants in this study, see the previous subsection) and thus less worthy of education than others (Corrigan et al., 2016). After repeated experiences encountering stigma throughout their time in education, people conclude that further education is not a realistic option for them. The effects of this are twofold, people internalise the stigma they experience, leading to feelings of shame and low self-work (Corrigan et al., 2016) and they are effectively locked out of employment sectors for which higher education is a requirement of entry (McQuaid and Lindsay, 2002). As one participant pointed out, even when people from low socio-economic backgrounds are qualified for work, they still have lower chances of accessing employment than their higher-class counterparts (Friedman and Laurison, 2020). When employed, being of low socioeconomic status can be stigmatised within the workplace (Loughnan et al., 2014). All of these factors combine to reinforce class stereotypes and create the two-tiered society which participants in this study described.

There is evidence to suggest that people will avoid situations in which they perceive it likely that they will feel excluded or looked down upon. Experiences with discrimination and stigma, or anticipation of these experiences, can raise cortisol levels and blood pressure, stress responses that in addition to creating health risks, promote avoidant behaviour of the discriminating place or person (James et al., 1984, Krieger, 1990). The avoidance of

stigmatising experiences may be a factor contributing to the difficulty people described in finding employment; they need opportunities in workplaces in which they will feel welcome and valued and not in which they will feel stigmatised. When viewed in light of the need working-class men feel to work in sectors which are compatible with their normative masculine gender identity (as discussed earlier in the subtheme *Masculinities and Traditional Gender Roles*), we can see that cultural determinants severely limit opportunities for employment within Middlesbrough and South Tyneside. It is important to note here that cultural factors are not the only factors contributing to unemployment and subsequent deprivation in these places; there is a tangible lack of opportunities comparable to other areas that is a result of structural factors, these will be discussed in Chapter 7. What is clear here is that cultural and structural factors overlap to produce the social conditions present in participants' communities.

Avoidance of stigmatising experiences may also explain why some participants felt people in their towns chose not to engage with mental health and addiction treatment services as people in other communities did and why some people preferred to use substances to cope with their mental health problems (as discussed in Chapter 5). Service providers are, as a product of the advanced degrees they are required to hold and the income conferred by their jobs, of a higher social class than the low-class people they are meant to provide services for. There is evidence to suggest that low socioeconomic class people will avoid engagement with services because these interactions make them feel looked down upon and stigmatised (McKenzie, 2015). When viewed in this light, the belief by participants that people avoided engaging with formal support services even when they needed support can be interpreted differently. The problem is not that people are ignorant to the value of formal support services, or that these services are entirely absent (although, as we will see in Chapter 7, they are often of insufficient capacity); it is that the behaviours of low-class people, like so many in Middlesbrough and South Tyneside, are influenced by social stigma.

6.7 Chapter Summary

In this chapter, I have discussed how participants understood the influence that social and cultural factors have on DSA morbidity and mortality in their communities. Many of the beliefs expressed in this theme stem from deeply ingrained cultural narratives surrounding poverty and deprivation. These narratives, which have been woven into the fabric of society over generations, often paint a picture of moral decline and worklessness within certain demographics. As I have discussed, these concerns about the moral decline of society and worklessness are well-established in the public and political discourse surrounding these issues. While these concerns are often unspecific and have little support from the empirical or theoretical literature, they are themselves useful examples of how class-based stigma shapes the worldviews of people throughout society. Other factors identified by participants, such as normative masculine gender roles that prevent help-seeking behaviour and encourage men in these communities to suffer in silence, can provide useful insights into the cultural forces that allow the problems of DSA morbidity and mortality to proliferate in Middlesbrough and South Tyneside. Participants' narratives surrounding these determinants are indicative of how social norms and customs are transmitted from one generation to the next and how these norms and customs exert influence on the individual health behaviours of people living within these cultures. It is evident from participants' narratives that in order to understand people's behaviours, we must first understand the cultural norms and expectations that they are socialised with.

While some of the cultural determinants discussed in this chapter likely influence driving DSA morbidity and mortality in these towns, they are not sufficient in and of themselves to explain the entirety of the problem. For example, while factors such as class-based stigma and normative masculine gender roles likely influence people's ability to find and hold employment, they do not explain why employment opportunities declined so dramatically in the 20th century and why social welfare safety nets were unable to prevent large swathes of these communities falling into poverty. To understand why these cultural determinants have arisen and have such sway over life in Middlesbrough and South

Tyneside, we need to also understand the broader structural forces that have shaped the political and economic realities of living in these towns.

Chapter 7: "They're not mentally ill, their lives are just shit": Structural Determinants of DSA Morbidity and Mortality

7.1 Introduction

Structural determinants refer to the political and economic systems that govern day-to-day life and give rise to the conditions in which people turn to DSA-related behaviours. There is a notable similarity between the theme of structural determinants, which was generated from participants' narratives, and the concept of the social determinants of health that is commonly used in public health discourse. The social determinants of health refer to the socio-economic conditions that influence health outcomes (Bartley, 2016). Participants identified several structural determinants, such as poverty, austerity, a lack of investment in their areas, poor governance, and ineffective services, that they felt contributed either directly or indirectly to DSA morbidity and mortality. In this chapter, I explore how participants saw these structural determinants influencing DSA morbidity and mortality in their communities.

7.2 Poverty

In Middlesbrough and South Tyneside, participants believed that the level of poverty in their areas was severe. Participants described high levels of material deprivation, in which people struggle to meet their most basic needs like food, housing, and energy costs. Many community members told me that they were struggling with poverty—they often shared that throughout the last winter (that being the winter of 2022-23) they were unable to heat their homes, or had done so only briefly because they lacked sufficient money to do so.

> "I think [*poverty is*] a massive issue for everyone in South Tyneside. Everyone is in a financial crisis. Obviously trying to find food for the family and things like that. Nobody can bloody afford it, so if you don't do two jobs you can't hold everything."– South Tyneside Community Member

Participants believed the level of poverty in their areas dates back to the process of deindustrialisation and the economic policies of the 1980s. Middlesbrough and South Tyneside before deindustrialisation were described by participants with words and phrases such as "really prosperous" and places where "everyone had a job, everyone was looked after." While participants may have been recalling the past through 'rose-tinted glasses', their belief that the 1980s saw a major decline in employment and economic activity in their areas is consistent with the available evidence (Beatty and Fothergill, 2020). Participants felt that after deindustrialisation, other areas of the country had continued to progress economically while their areas had remained stagnant. Participants described their communities as left behind during the 1980s and believed they were still left behind today.

> "It's all the areas that had their industry ripped out by Margaret bloody Thatcher. … It's the same everywhere. The South Yorkshire coalfield areas, Durham Valley, Middlesbrough, Billingham, South Tyneside, they had their heart ripped out then, they were left behind then, and they're still left behind now." – South Tyneside Stakeholder

While deindustrialisation was not a uniquely British phenomenon and has been observed to have had a negative effect on communities around the world, government policy initiatives implemented by the Thatcher government in the 1980s amplified the already severe impacts of deindustrialisation. Government spending on welfare benefits was reduced, leaving recently unemployed industrial workers in Middlesbrough and South Tyneside vulnerable to poverty. (Scott-Samuel et al., 2014, Albertson and Stepney, 2020). Participants in this study remembered the effect that the factory and mine closures and welfare reforms had on their areas and identified this period as a turning point at which living conditions began to decline.

> "Industry declined and maybe them typical jobs, manual fairly well-paid type of jobs reduced in numbers. There was just nothing left for people. There still isn't, not like there was." – Middlesbrough Stakeholder.

Participants believed that their areas had struggled with a higher-than-average level of poverty for years as a result of jobs lost to deindustrialisation, but they pointed to specific inflexion points in more recent history which made the level of poverty worse; these included the 2008 global financial crisis and the cost-of-living crisis which began in early 2022. The North

East was one of the English regions to suffer the greatest economic downturn as a result of the financial crisis and also one of the slowest to recover in the years following (Sensier and Devine, 2020). While standards of living stagnated across all English regions in the years following the financial crisis, the North East saw the most significant rise of all regions in the number of households below the minimum income standard (Liddle et al., 2023). Participants in this study reported that the increase in regional poverty observed by researchers was highly visible within their communities during that time.

> "It was a little bit after the US when [*the financial crisis*] really hit here. Probably six months or so. So maybe 2010, 2011. It… I don't remember exactly when. But yeah, I'd be going to toddler groups and things with my son, and you would see drug deals happening in front of you. A lot of people was out of work. [*The area*] definitely started to go downhill then. I don't recall it being that bad when my daughter, who is [*late teenage*] now, when she was a baby." – Middlesbrough Community Member

The economic downturn that resulted from the recession in 2008 was followed by the introduction of austerity measures in 2010 in response to a growing national budget deficit (Kerasidou and Kingori, 2019). Austerity measures reduced local authority budgets by 30% between 2008 and 2015 and led to the shuttering of many public services (Bach, 2016). The worst-hit local authority areas – mainly located in the North - lost around four times as much, per adult of working age, as the authorities least affected by the cuts – found exclusively in the South and East of England (Beatty and Fothergill, 2018). Participants in this study were acutely aware of the harmful effects that the 2010 austerity measures had on people living in Middlesbrough and South Tyneside, reporting that the closure of public services and budget reductions had made life harder for residents.

> "I can tell you now, before 2010, things weren't like this. It's getting worse. There were more youth provisions. There was just generally more support for people. They pulled that funding away and we're not recovering. It's just gradually getting worse and worse." – Middlesbrough Stakeholder

As a result of the slow economic recovery from the 2008 recession, a decade of austerity, and the above-average level of poverty present, Middlesbrough and South Tyneside were highly vulnerable at the start of the 2022 cost-of-living crisis, the unprecedented rise in the prices of essential goods and services like food, housing, and energy that resulted from a complex set of geopolitical and economic circumstances (Broadbent et al., 2023). Participants reported that since the cost-of-living crisis began the level of poverty in their areas had climbed dramatically, sharing that most people were struggling to make ends meet and more people were relying on benefits or charity service provision. From early in the cost-of-living crisis, it was clear to researchers that rising costs would most affect those already living on low incomes in deprived areas and would further entrench geographic health and wealth inequalities (Limb, 2022). What participants described here is how that effect played out in vulnerable communities, describing that people fell into a level of poverty that was more severe than they had ever experienced before.

> "[*Poverty has*] got worse now, at the moment, it's worse than I can ever remember in my lifetime with the cost-of-living crisis. Now you've got basics like fuel, energy, food which are basics, out of reach for most people." – Middlesbrough Community Member

Participants reported that living in poverty negatively impacted one's mental health. Financial difficulty, according to participants, impacted mental health by causing extreme worry about how one would be able to pay the bills and meet their basic needs, such as food and housing. This belief is consistent with empirical evidence, which has demonstrated that people living in poverty are more likely to report poor mental health and wellbeing (Marmot, 2005, Subramanian and Kawachi, 2006). Participants believed that when the stress caused by severe financial hardship became too much to handle, some people sought to escape by taking their own lives; in this way, participants saw poverty and financial difficulty as a cause of suicide.

> "I know there are a few people who have, you know. I know there were people who have got so stressed, you know, with everything going on, sky-high prices and they've… pretty much, committed suicide." – South Tyneside Community Member

Of note in the above quotation is the phrase “got so stressed”. This phrase highlights a distinction that participants made between what they referred to as mental illness and things like stress, worry, hopelessness, and anxiety. Participants believed that the latter were not necessarily indicative of mental illness but were an emotional response to external circumstances (e.g. poverty and acute financial hardship); in doing so, participants were implicitly endorsing the biomedical model of mental illness, which sees biological processes as the underlying cause of mental health disorders (Huda, 2021). This biomedical view of mental illness was present in both stakeholder and community member narratives.

> “These are probably not people who are acutely, what we would call acutely mentally ill. They're not suffering from like an acute psychotic episode, they're not deeply depressed, or those kinds of things. They're just people who are extremely distressed … often we’re seeing people and they’re not mentally ill, their lives are just shit.” – Middlesbrough Stakeholder

When viewed from a purely biomedical perspective, in the absence of these biological processes, one is not mentally ill. To the extent that social factors are involved in causing mental illness, the biomedical model suggests that they do so through biological means (Guze, 1992). The biomedical model of mental illness has been widely criticised (Bentall, 2010, Deacon, 2013), and largely supplanted by the biopsychosocial model in contemporary psychiatric literature (Hogan, 2019). The biopsychosocial model argues that mental illness is caused by a combination of biological, psychological, and social factors that interact to produce the disruptive behaviours and emotions that define mental illness (Engel, 1981, Huda, 2021).

While the disagreement between what participants believed constituted mental illness and what contemporary psychiatric theory suggests may appear largely semantic, it provides insight into a problematic societal attitude in which the distress caused by social forces is somehow different or less important than a diagnosable mental illness. Note the word “*just*” at the end of the previous quote from a stakeholder, implying that having a “shit” life is less clinically significant than having an acute mental illness. This has important implications for both help-seeking behaviours and public policy. Public health practitioners need to ensure that

mental health education campaigns inform both the public and stakeholders alike that things like stress and worry that have become disruptive to daily life are not routine experiences and should be discussed with a healthcare provider (ie that these feelings are not "just" anything and are themselves worthy of treatment). Policymakers seeking to address rising rates of mental illness need to recognise the importance of social factors, such as poverty and financial hardship, in causing mental illness and implement policies to prevent them, rather than just expanding access to psychiatric services to treat them once they have already arisen.

In addition to causing suicide, participants believed that living in poverty leads people to begin using drugs and alcohol. Drug and alcohol use were seen to result from two effects of living in poverty. First, as with suicide, drugs and alcohol were seen as an escape from the day-to-day pressures of living in poverty. Participants described how drugs and alcohol were an effective, albeit harmful, escape from one's problems, and that they were often less expensive or more convenient than other methods of dealing with stress, such as seeking mental health support.

> "Drugs and alcohol are convenient. You can go to your local corner shop and pick up a crate of beer say for £12. Or drugs you can get like for £10 or £15. It's just more… easy to get rather than fighting through it. It's just a cheaper option basically. I think that's why more younger people and stuff do it. Because the economy, their only means of escape or getting help with the money they've got is that stuff." – Middlesbrough Community Member

Participants reported that drugs and alcohol were cheap, with it only costing a few pounds to become intoxicated, so people who are bored would use drugs and alcohol recreationally, which when done frequently became harmful. Participants believed there was very little to do in their areas besides drinking or using drugs, so these activities had become central to their areas' social environment.

> "This is a drinking town, this is. I don't know if you've noticed, but it's like shop, pub, shop, pub, shop, pub" all down the street. Except the shops are all closing down now. So, what else are you meant to do for fun?" – South Tyneside Community Member

Participants in Middlesbrough were particularly concerned about the number of children living in poverty in their area, expressing the belief that Middlesbrough had unusually high levels of child poverty; this is in contrast to South Tyneside, where this belief was not shared by participants. That this belief was frequently expressed in Middlesbrough is not surprising when one considers the empirical evidence, which shows that Middlesbrough is the local authority with the highest proportion of children living in poverty of all local authorities in England (IoD2019, 2019). Participants felt that young people living in poverty were particularly vulnerable and that most children at risk of harm or being taken into care were in those situations because of factors related to poverty.

> "You've got more children experiencing trauma and then they carry that into later life and that influences drug-related deaths and that. Children taken into care. So, there is greater issues at that level that get carried into life. It's another link to deprivation really, that's where it all starts" – Middlesbrough Stakeholder

Concern from participants around the number of children living in poverty in Middlesbrough is indicative of the importance of considering how structural determinants affect individual experiences and behaviours. In Chapter 5, I discussed how participants in Middlesbrough believed childhood trauma was unusually common in their area and that they believed people often turn to DSA behaviours to cope with unresolved childhood trauma (see Chapter 5, section 5.1). In this subtheme, participants explained that they saw the level of poverty in their communities as arising from structural factors. Children living in poverty are at heightened risk of experiencing adverse childhood experiences (Davara Lee et al., 2020). Childhood trauma, which participants identified as an individual determinant that leads to negative DSA outcomes, is often a product of structural factors. This is a clear example of how individual determinants are influenced by higher-level determinants. To understand the factors underpinning DSA morbidity and mortality, individual determinants like traumatic childhood experiences need to be viewed in the structural context that gives rise to those individual factors.

> "Wherever there's deprivation there is likely to be trauma, so an increased number of adverse childhood experiences. We've definitely got that here. It's just so common. If you start to look at these types of potential difficulties for people, I think that's why we've got

a legacy." – Middlesbrough Stakeholder

7.3 Housing and Homelessness

Participants believed that one challenge related to the poverty facing their areas was a rise in homelessness. They instead attributed the rise in homelessness to limited housing access and rising housing costs. Participants also believed that homelessness and rough sleeping increase the risk of drug and alcohol use, as people sleeping rough used substances to provide comfort and make their situation more bearable. What participants described as "homelessness" referred to people sleeping on the street or 'rough sleeping' as it is referred to in official datasets.

> "You're seeing more homeless people. Sort of in [*South*] Shields town centre which you never used to. You would see them in Newcastle, but it didn't spread down here. Even in town, I never used to notice them a couple years ago. I'd seen one or two, but the last couple of years it just seems… it just wasn't seen around town before. It's got worse aye. Didn't see it years ago." – South Tyneside Community Member

Data regarding the number of people sleeping rough by local authority are of poor quality due to significant variation in data collection methods and the practical difficulties of counting a transient population (it is left to each local authority to determine how they will count rough sleepers, and they are only required to do so on one night per year) (Dempsey and Barton, 2019). The available data indicate that Middlesbrough and South Tyneside have rates of rough sleeping above average for the region (Dempsey and Barton, 2019) and the number of people rough sleeping in England has risen significantly since 2010 (Department for Levelling Up, Housing & Communities, 2023).

Participants believed that homelessness had increased due to mortgages becoming unaffordable, which had made homeownership difficult to attain and caused the cost of privately rented accommodation to increase. Council housing and housing benefits were seen by participants to be difficult to access. The process of securing social housing was described as difficult and full of setbacks. Applying for council housing was complex, and participants were not always clear on how to navigate the process. The difficulty in accessing social housing that

participants described is a product of structural forces. Many council estates have been privatised, a phenomenon that stems from the Housing Act of 1980, also known as "right to buy", and as a result most affordable accommodation comes from private landlords (Disney and Luo, 2017). The Thatcher Government implemented the Housing Act of 1980 to promote mortgage markets and owner-occupied housing at the expense of government disinvestment from the housing market; a decision which facilitated the transfer of publicly-owned accommodation to private individuals (van Ham et al., 2013). Criticism of Right to Buy legislation is not new and the negative impacts on communities and social housing stock are well documented (Cooper et al., 2020, Beswick and Penny, 2018); in this subtheme, participants have provided further evidence that this legislation continues to cause harm in their communities more than 40 years after it came into effect.

> "I live over in [*area of Middlesbrough*] which many years ago was a council estate, which has now turned into a private landlords haven. All that was sold off years ago. It's not, it's not a town centre problem, it's a growing problem because it's so difficult to manage with the rise in private landlords, no checks being done." – Middlesbrough Stakeholder

Participants believed that for people who cannot afford to own a home, private rented accommodation was the only option, and they consistently described this as low quality and dangerous. Participants believed that private landlords would not house people with a wide range of criminal convictions that were seen as common among people who have experienced homelessness or been evicted, such as arson (as, according to participants, people sleeping rough start fires for warmth). Participants also stated that drug use and drug-related crime were common in private accommodations and that people living alone in shared accommodation, even those licensed by the council, were vulnerable to sexual abuse and exploitation and would be exposed to drug dealing and crime.

> "The private rented sector especially but even some of the hostels and registered providers, some of the landlords… Aye, sort of, people who are in those accommodation options are surrounded by active drug use, drug dealing, bothering them, tempting them, manipulating them, crime, antisocial behaviour, all of these things … they're dangerous places. Not the sort of place you'd want to live." – Middlesbrough Stakeholder

In Chapter 6, section 6.4, I described how participants, particularly stakeholders, believed that peer influence was a cultural determinant of DSA mortality because one's peers often influenced them to continue using drugs and alcohol. This subtheme provides insight into how structural determinants and cultural determinants intersect to produce DSA mortality; one's peers in a shared accommodation pressure them to continue using drugs, but that one lacks access to social housing and must live in a low-quality shared accommodation is a product of policy decisions by the central government.

7.4 Unemployment, Underemployment, and Lack of Job Opportunities

Participants believed that there were very limited job opportunities in their area, particularly opportunities which paid enough to live on. It was believed by participants that historically there had been lots of work available in Middlesbrough and South Tyneside, but that available employment opportunities had never recovered to pre-deindustrialisation levels and what employment opportunities were available provided insufficient working hours and income. Participants reported that accordingly, unemployment remained common in their areas. The scale of loss in employment in industrial communities as a result of deindustrialisation was severe; between 1971 and 2008, more than 100,000 jobs in the productive industries were lost in Teesside (Telford and Wistow, 2019). In South Tyneside, job losses began earlier and spanned a longer period, but were similarly devastating to the area's economic landscape (Hudson, 1986). Participants believed that in the years following deindustrialisation, the government had failed to invest in the economic development of their areas, so the labour markets remained depressed. The job losses caused by deindustrialisation were highly visible to participants who lived in the area during that time.

> "Oh, there was [*jobs available*] in 70s. The shipyards, ICI, but that's all gone. Same with mining out of Middlesbrough. It's all gone, so the communities are dying. There are some areas a lot worse than Middlesbrough but I cannae see the next five to ten years getting better, I just cannae envisualise [*sic*] it. It was hard and we never really recovered from that. The industry died. … The towns went right down. Even now, from then." – Middlesbrough Community Member

Participants believed that the onset of the COVID-19 pandemic caused another round of job losses in their areas, as hospitality businesses closed and never reopened after the pandemic abated. Retail, which was seen to have been relatively stable, was reported by participants to have declined in recent years as well. The decline in bricks-and-mortar retail shopping in favour of online shopping has been well documented and has been underway since the mid-2000s (Jones and Livingstone, 2018); this trend was exacerbated by the pandemic and resulted in bankruptcy for a number of major UK department stores (White et al., 2023). The economic effects of the COVID-19 pandemic most significantly affected the most deprived areas of England, including Northern authorities like Middlesbrough and South Tyneside (Bambra et al., 2020a). Participants reported that as a result of deindustrialisation and the pandemic, there was simply not enough work to go around, with many people in the community not holding a job, because no jobs were available for them.

> "Obviously when COVID hit that was a major setback for all of us really. Some of us couldn't go to work, couldn't go out. Obviously now the prices have gone sky high, and nobody can afford anything. So ever since the COVID hit, jobs have got less and less. If they are looking for workers, they're looking for specific people with specific skills. I've got all sorts of skills on my CV, but apparently mine wasn't good enough." – South Tyneside Community Member

The quote above is illustrative of two different barriers to employment in Middlesbrough and South Tyneside: the first, as discussed, is the loss of jobs due to the economic impact of COVID-19; the second is a gap between the skills that applicants possess, and the skills employers find desirable. Participants believed that some people in their areas lacked the most basic skills, such as literacy and numeracy, which made it very difficult to apply for jobs, much less be hired. Others believed that the skills gap was more focused on formal education, with work experience not being seen as an adequate substitute for formal education. What participants have described here is known to researchers and policymakers as the 'adult skills gap', a mismatch between the skills possessed by adults of working age and those desired by employers. Adults in the most deprived areas in England are the least likely to access work skills training, despite being the group whom it would benefit most (Luchinskaya and Dickinson, 2019). As a result of austerity, since 2010 government funding for skills training

has decreased and employer funding has remained stagnant, further disadvantaging individuals who cannot fund their own training (Luchinskaya and Dickinson, 2019). The adult skills gap creates an environment in which working-age adults are shut out of the job market, or confined to lower-skill occupations that confer lower pay.

> "That kind of gap between adult skills and the kinds of jobs that are available. So, you know, so that adult skills gap is a thing that's really been noticed. … So, like, how do we make sure there is a connection between communities, the skills that are needed, and the jobs that are available? It's not like there aren't jobs, there just isn't a connection between the people and the jobs in quite the same way." – South Tyneside Stakeholder

Participants described the jobs that were generally accessible in their areas as low-paying, low-skill positions, such as cleaning, retail, and warehouse work. It could be hard to start working in low-wage work, participants explained, because doing so would disqualify one from claiming benefits but also would not provide enough money to live on, which kept people trapped in unemployment. The phenomenon that participants have described here is known as 'benefits cliff edge', the loss of access to benefits when one's income crosses the benefits threshold. Benefits cliffs are well known by economists to provide significant disincentives to work (Richardson and Blizard, 2022). Participants reported that the vast majority of the jobs available in their areas were on a zero-hour basis, making the work unstable, which further incentivised people to remain on benefits.

> "Those who are in work its service-based jobs. So, working in shops, taxi drivers, zero-hour contracts, delivery jobs, nothing with good prospects. And security guards as well, but nothing with any advancement to it. And you never know how much work you'll get the next week or the one after." – Middlesbrough Community Member

In Chapter 5, I discussed how participants felt that many people in their community chose not to work and how they attributed this to poor work ethic on the part of individuals. What participants have described in this subtheme encourages us to view that phenomenon in a new light; participants may be correct that some people in their community choose not to work, but they may be making that choice because of structural barriers that disincentivise them from doing so. This is another example of how structural barriers, such as the disincentives inherent

to the benefits system as it is currently designed, are themselves determinants of the choices made by individuals.

Participants felt that a lack of employment or difficulty securing a job impacted people's mental health and self-worth. According to these participants, work provided a sense of self-worth and purpose. When one did not have employment, it was reported by participants, that they faced the financial pressure of unemployment, coupled with a sense that they were not worth hiring, which compounded the mental health effects of unemployment itself. As a result, participants indicated that people would use drugs and alcohol to cope with the negative mental health effects of unemployment. This belief that unemployment negatively impacts mental health is consistent with the available evidence, which shows that unemployment is associated with a higher risk of common mental health disorders, low self-esteem, and suicidality (Flatau et al., 2000, Wilson and Finch, 2021, Boardman and Rinaldi, 2021).

> "If you've got no job, no money coming in, and the bills pile up, you sit there thinking "oh god, what am I going to do?" If you don't get them paid that increases, you get a red letter [a notice of late or missed payment]. It's either find someone who can give us some drink or a drug. Gives you relief. Takes the pressures off." -Middlesbrough Community Member

Based on participants' accounts of the importance of work to normative masculine identity (discussed in Chapter 6), it is likely that unemployment has a particularly large impact on men's mental health as compared to women; there is evidence to support this assertion (Artazcoz et al., 2004). This is another example of how structural determinants intersect with cultural determinants to produce DSA morbidity and mortality; industrial work formed a culture in which employment was central to masculine identity, when industrial work declined and the jobs were not replaced, the structural determinant of unemployment began to exert a negative influence on men's mental health because of the cultural beliefs around the importance of work. This finding demonstrates the complex and often cyclical nature of the determinants of DSA morbidity and mortality.

Some participants reported that a lack of job prospects led people, particularly young men, to enter into occupations in illegal sectors such as drug dealing. It was believed by

participants that drug dealing was viewed as a high-status job in which one could be self-employed, earn substantial income, and afford luxury goods such as jewellery and sports cars. There is evidence to support these beliefs; ethnographic research has found that drug dealing is viewed as an acceptable, high-class form of self-employment for young men in working-class communities (Collison, 2017).

> "They want to be the drug dealer. The one with the gold chains on and the girls and the car and that sort of stuff. It looks attractive. I guess because in them sort of areas the unemployment rate is huge. No one is working. The people who are successful are criminals, selling drugs, selling cigarettes, counterfeit clothes, money lenders. They're all criminals, so it seems like the easiest way to do it." – Middlesbrough Community Member

Quantitative research has also found that factors such as poverty, family structure, and neighbourhood characteristics constrain life choices in urban environments and normalise entrance into the drug market as a source of income (Dunlap et al., 2010). Entrance into the drug trade has been observed to normalise both the distribution and use of illegal drugs within social groups (MacDonald and Marsh, 2002). This may help to explain why, as discussed in Chapter 5, participants felt that drug use had become more common in their areas and drugs were more accessible now than in the past. As opportunities for employment in Middlesbrough and South Tyneside have declined, people may have begun to enter illegal markets to generate income and achieve high-class lifestyles. This finding highlights the importance of taking a holistic view when considering the issues of drug dealing and drug use; these problems are neither entirely structural nor cultural, they are a product of complex and overlapping determinants.

7.5 Government Neglect

Participants reported that the central government had failed to meaningfully invest in their areas in the intervening years since deindustrialisation; this failure was attributed to the belief that central government was out of touch with the needs of towns like Middlesbrough and South Tyneside. Some participants believed the lack of understanding about their towns

was a reflection of the North-South divide; this refers to the longstanding geographic health and wealth inequalities between the North and South of England (Bambra, 2016). The root causes of the North-South divide are generally acknowledged to be political and economic (Bambra et al., 2014). London is both the political and economic centre of England and this has historically influenced economic development policy (Bambra et al., 2014). Despite efforts by the central government between 2000 and 2010 to reduce regional social and health inequalities (Whitehead, 2007), the economic and health gaps between the North and South have grown in England since 2010 (Taylor-Robinson et al., 2019) and were further exacerbated by the COVID-19 pandemic (Bambra et al., 2020b). It was believed by participants in this study that the failure to address inequalities was because the government did not understand that communities in the North had different needs from those in the South, so they passed policies that benefited those in the South at the expense of those in the North.

> "I just feel because the Government is in London, they think, I think, the Government thinks the North East is all just Manchester somewhere. They don't seem to understand. Even when they come up here, it's just for a photo opportunity. No one really knows what everyday life is like. They don't come to community projects or actually see the people. It's just such a waste." – Middlesbrough Community Member

Other participants attributed the out-of-touch nature of the Government to class-based stigma. These participants believed that the Government represented the interests of the wealthy and business owners and did not care about the needs of impoverished people around the country. Most participants did not specify whether they meant the Government in general, or the Conservative Government who were in power at the time of data collection. That governments tend to be more responsive to the policy desires of high-income citizens than low-income citizens is a common grievance that is borne out in the empirical literature (Persson and Sundell, 2024). Sociologists who have studied the relationship between class-based stigma and neoliberal economic policies have found a bilateral relationship; class-based stigma is both a cause of and a response to, economic policy decisions (Wacquant, 2010, Tyler, 2013). Participants in this study were aware of this duality. In Chapter 6, I discussed how participants believed class-based territorial stigma is a response from the news media and the public more

broadly to government actions and statements. In this chapter, participants have made clear that they also saw class-based stigma as a cause of policy decisions themselves. This finding highlights the complex nature of stigma and the interconnection between cultural and structural determinants of health.

> "At the same time, the government wants us worried about small boats, not worried about Michelle Mone's [a member of the House of Lords] yacht. This is a government that likes big boats, doesn't like small boats. If we focus on the small boats, then we don't notice them and their mates buying yachts. That's really where the failure comes. They want us distracted from the fact that they couldn't give a shit about the poor if they tried." – South Tyneside Stakeholder

Other participants attributed the failure of the Government to alleviate poverty in their areas to the fact that the government had put too much priority on international spending, pointing to the amount of money that has been given to Ukraine since the Russian invasion in early 2022, believing that this money would have been better spent at home. At times this thinking became conspiratorial, with participants sharing beliefs such as the war in Ukraine was a hoax perpetuated by governments to justify war-related spending, the US-led coalition invasion of Afghanistan in 2001 was conducted to secure heroin to sell in British and American communities, and the COVID-19 pandemic was a hoax to funnel public money into private hands. Endorsement of conspiratorial beliefs is associated with low socioeconomic status, economic precarity, and low education (Green and Douglas, 2018, Garrett and Weeks, 2017). Sociologists studying the function of conspiracy theories on people in low-socioeconomic groups have found that conspiratorial beliefs act as narratives that revolve around seeking revenge against elite groups (Adam-Troian et al., 2023). People of low income perceive that their situation is caused by powerful institutions and people (such as those in government), lose trust that these institutions act in their best interest, and become open to conspiratorial thinking (Adam-Troian et al., 2023). When viewed in this light, it becomes clear that the conspiratorial beliefs endorsed by participants in this study are themselves a product of the distrust for government that has been caused by the Government's failure to address growing wealth inequality in their areas.

> "After like 2000 or 2001, like I say America and UK moved in Afghanistan, started stealing all the poppy fields. I read somewhere the other day that after the US finally left, poppy production dropped 99% or something. That's a bit strange, isn't it? It's almost as if someone was having them grow it. They'll do anything helping the corporations and their little billionaire buddies." – South Tyneside Community Member

Some participants felt that the central government had tried to alleviate poverty in their areas through investment and development efforts, but that these efforts had been a failure. These participants saw that lots of money had been spent to improve things, but very little had changed in their lives. Some development efforts, such as those to build new housing in Middlesbrough, were seen to have been actively harmful because older housing was demolished and then funding was cut before it could be replaced. Participants' belief that government efforts to reduce economic inequality have largely failed has the support of empirical evidence; by the government's own assessment, efforts to close spatial, economic and health inequalities by successive administrations have been a failure (HM Government, 2022). The failure of past governments to close inequalities was attributed to policies that were too short-term in focus, narrow in scope, too centralised, and dismissive of local needs (HM Government, 2022). Participants in this study echoed those critiques of past development efforts. Despite ostensibly intending to learn from past mistakes before its implementation, the Levelling Up agenda risks repeating many of these past policy errors (Diamond et al., 2023).

> "Funding is still quite, probably as a result of austerity, it's even more siloed than it was before. It's quite difficult to look at the whole person, or the whole family, across a range of services and support. Less people employed to consider policy from a broader perspective. It's short-term too. We might get a grant for 12 months, or 18. We have to be hyper-focused, more focused on operational efficiency which is the opposite of building connections with other services." – Middlesbrough Stakeholder

7.6 Barriers to Accessing Services

Participants in Middlesbrough and South Tyneside identified several barriers that they felt made it difficult or impossible for people to find support from services when they were dealing with a mental health or substance abuse problem. One significant barrier was a lack of

knowledge in their communities about what services were available. Information about support services was often advertised online, and some participants did not use computers, so felt they had no way of learning what supports were available. What participants described is known to public health researchers as digital exclusion, broadly defined as the inability to use or access internet-based services (Robotham et al., 2016). Digital exclusion disproportionately affects people on low incomes and those living in deprived communities (Watts, 2020, Sanders and Scanlon, 2021). It is a known barrier to accessing a range of services, from mental health (Greer et al., 2019), to healthcare (Holmes and Burgess, 2022), to education (Khalid and Pedersen, 2016). Participants believed that the transition to telehealth and e-consult services made by mental and physical healthcare providers at the start of the pandemic had further reduced access to services; a belief consistent with the available evidence (Thakrar et al., 2021). This is another example of how structural factors influence help-seeking behaviour – people who want to access services for support with their mental health are unable to do so because they are excluded by methods of service delivery.

> "Everything is online now. If you haven't got a computer, how are you supposed to do anything online? It's hard, especially for, I'm alright using a computer, but it's understanding a computer. If you don't understand the computer, how are you supposed to learn how to use one? If you haven't got online, then you're screwed. That makes it so much harder for people." – Middlesbrough Community Member

Participants believed that bad experiences with a service, or services having a bad reputation, made people hesitant to engage with the service at all. According to these participants, if someone had a bad experience with a service, or knew someone who had a bad experience, they were less likely to reach out to that service when they needed support. Multiple participants told me that they would never call crisis support lines, such as Samaritans or their local crisis team again, even if they were in crisis, because of negative experiences with these services in the past. These participants believed this sentiment was not uncommon in their community.

> "When someone tells you they're suicidal you just have to say that "ring the crisis team" but you know it won't matter. It's frustrating. People don't want to ring them, and I

totally understand, I wouldn't either. If you've had a bad experience with them, that's what leaves an impression. Especially when you're in crisis." – South Tyneside Stakeholder

Waiting lists were identified as a significant barrier to accessing services in both Middlesbrough and South Tyneside. GPs, dentists, and mental health service providers were identified as services with waiting lists so long as to be unusable to most people. The number of people on waiting lists for healthcare procedures or specialist visits in England has been the subject of significant public discussion for some time (O'Dowd, 2017). While waiting lists for NHS services are too long throughout the country, spatial inequalities in wait times exist, with more deprived areas experiencing longer wait times than their less deprived counterparts (Cookson et al., 2016). Longer waiting times for mental health treatment are associated with worse patient outcomes (Reichert and Jacobs, 2018); and participants in this study provided examples of when these wait times affected their mental health.

"Even your GP. Your GP is hard enough to find now. If you call your GP, they just want to speak to you on the phone. Good luck if you want to actually meet them, you'll wait years. I had about two mental breakdowns before I had an appointment." – Middlesbrough Community Member

Increased waiting times have been a feature of many health systems around the world in recent years, and the causes have been investigated. Researchers have found that Increased pressure on health systems caused by ageing populations and increasing complexity of healthcare needs are likely one factor (McIntyre and Chow, 2020), and the increased strain on health systems caused by the COVID-19 pandemic has certainly exacerbated the problem (Morris and Reed, 2022). In the context of mental health in the UK, it is clear that reductions in funding dedicated to mental health treatment and care as a result of austerity have reduced access to mental healthcare, resulting in worse mental health outcomes (Docherty and Thornicroft, 2015, Cummins, 2018). This barrier to service that participants identified is a direct result of policy decisions and highlights the importance of considering the role that structural factors have in determining help-seeking behaviours.

7.7 Ineffective Services

7.7.1 Mental Health Services

It was believed by participants that when one was able to access mental health services, they were often ineffective at improving mental health. One major challenge to effective mental health service delivery identified by both stakeholders and community members was that many mental health services would not provide support to people experiencing co-occurring substance use and mental health disorders if the person was still using substances. Participants felt that addiction often stemmed from poor mental health, which left people in a cycle where they could not combat their addiction because of their mental health but could not get support for their mental health because of their addiction. Co-occurring mental health and substance use disorders, sometimes called "dual-diagnosis", are a known challenge to mental healthcare providers. Most people entering drug (70% of patients) and alcohol (86% of patients) treatment in the UK are also experiencing a mental health disorder (Metcalfe, 2024). Participants in this study felt that mental health and substance use treatment providers needed to take a more integrated approach to service in which both mental health and substance use disorders were treated in tandem.

> "It's counterproductive because I know to get counselling you have to be free of drugs and drink, but at the same time, that could be the issue that's causing the drugs and drink. It feels like, to me, surely, it's not ideal to go to sessions drunk, but if you could solve that problem maybe they wouldn't be drinking anyway. Surely instead of just trying to put a bandage over it you should be going to try and fix it." – Middlesbrough Community Member

On this point, the English government appears to agree with participants in this study, acknowledging in their official drug strategy that more integrated services are required to support people with co-occurring mental health and substance use disorders (HM Government, 2023). There is evidence to support the belief that an integrated approach to service would benefit the mental health of people with co-occurring disorders. The Department of Health and Social Care reported a 25% fall in suicide rates in NHS mental health trusts with specific policies

on the treatment of co-occurring mental health and substance use disorders (Department of Health & Social Care, 2023).

Mental health support charities, such as CALM or The Samaritans, were also seen by participants to be unhelpful to people in need of support. It was believed that these charities rarely provided meaningful support and had little impact. The existing evidence on the effectiveness of crisis lines such as The Samaritans is weak, with very little evidence that they improve long-term outcomes and limited evidence that they improve immediate caller distress (Sasha Zabelski et al., 2023, Hoffberg et al., 2020). In South Tyneside, there was significant concern about the effectiveness and quality of service delivered by the local crisis team. Participants felt that the crisis team was largely ineffective at helping people who were in crisis and that it had a negative reputation in the community. It was believed that the crisis team either did very little for callers, such as telling them to contact their GP, or took extreme action like having people sectioned. Stakeholders in South Tyneside believed that people misunderstood the purpose of the crisis lines, describing that while they were intended as a referral service, people in the community expected them to offer immediate mental health support.

> "So basically, you speak to a different person each time [*you call*], so you don't get to know somebody. I rang up and they said in the end after about 10 or 15 minutes, they asked if I was suicidal. I told them not yet, they said they had people who are suicidal, so they hung up on me. So, basically, I don't ring them anymore." – South Tyneside Community Member

> "There is probably a misconception, generally speaking, from the general public about what crisis services do. I think the word "crisis", that perception is different to everybody. It is very difficult that what some would class as a mental health crisis is very different to what other people would. There is lots of other things what [*sic*] could be helpful, what [sic] could be done in the community. People don't need to be in hospital, they need a referral." – South Tyneside Stakeholder

The disconnect between the services offered by local and national crisis lines (a rapid response to people at immediate risk of taking their own life), and what community members wanted these lines to provide (ongoing mental health support and care), may be emblematic of

a larger issue with mental healthcare access previously identified by participants: that traditional mental health services are inaccessible because of long waiting times. Since these services are inaccessible, people may be turning to crisis lines as they are the only mental health service that they have access to, but they are unsatisfied because these lines are not equipped to provide ongoing support or psychiatric services. Community members' negative perceptions of crisis lines and the paucity of evidence supporting their effectiveness suggests that policymakers should pursue other means of improving quick access to mental healthcare, such as reinvestment in community mental health services which provide both crisis response and ongoing mental health support services.

7.7.2 Substance Abuse Treatment Services

Some participants, both community members and stakeholders who did not work in public health or drug treatment sectors, reported that existing drug treatment services were not effectively able to help people achieve sobriety. These participants believed that the frequency of relapse among people who had received treatment from drug treatment services was an indication that these services did not work. Participants expressed particular concern about medication-assisted treatment for addiction (the use of medications such as Methadone and Buprenorphine to reduce cravings and withdrawal symptoms). Participants believed that medication-assisted treatment simply did not work, because many people continued to use drugs in addition to their prescribed medications. It was reported by participants that many people spent decades receiving medication-assisted treatment, which was seen as further evidence that the treatments do not work. While it is a myth that most people taking part in medication-assisted treatment do so for decades (less than 10% of patients use methadone for more than 10 years) (Fullerton et al., 2014), research into the neurobiological mechanisms underlying addiction has, thus far, failed to meaningfully advance the effectiveness of addiction treatments (Sinha et al., 2011). The drugs most commonly used in psychiatric treatments for addiction date back to the 1970s, with relatively few advances in the decades since (Heilig et al., 2016). Rates of relapse after a period of abstinence remain a pervasive problem in substance abuse treatment despite the use of medication-assisted treatments (O'Brien and

Gardner, 2005). Some participants believed that the ineffectiveness of medication-assisted treatments for addiction was an indication that these treatments should be discontinued.

> "For me, methadone hasn't made my community safer, it hasn't. I know of people who have been on methadone for 25 years. It doesn't work. I know the people who are on that, most of them live in my community. Most of them are using on top." – Middlesbrough Stakeholder

One reason for the failure of neurobiology to develop effective strategies to treat addiction may be that research has neglected the social forces, such as social exclusion and the marginalisation of people living with addiction (Heilig et al., 2016). While advances in treatments for addiction have been slow, existing medication-assisted treatments are still among the most effective interventions for treating substance abuse disorders, particularly those involving opiates (Ma et al., 2019, Catherine Anne Fullerton et al., 2014). This suggests that while participants have correctly identified deficiencies within the drug treatment system, their suggestion that medication-assisted treatment be discontinued lacks empirical support. When viewed together, the available evidence suggests that future research and drug treatment strategies should move towards a more holistic view which considers both the social environment and neurobiological factors that underpin addiction.

7.7.3 Foodbanks and Charities

Some participants reported that services that provide basic needs, such as food and clothing, at no cost inadvertently facilitated addiction. According to these participants, the people running these services were trying to help, but in providing service users with all of their basic needs at no cost, they were freeing up funds that could then be used on drugs and alcohol. These participants believed that this practice was widespread and that charity provision was doing more harm than good in their areas. While there is a lack of empirical evidence to support the belief that service users frequently exchange goods received via charity for drugs and alcohol, anecdotal evidence from the media indicates that this practice does occasionally occur. Stories of foodbank users exchanging food and school meal credits for drugs and alcohol are not uncommon, with such stories featured in outlets such as the Daily Mail

(Gallagher, 2015) and The Times (Simpson, 2015). Conservative politicians have also criticised free food provision, claiming that it facilitates funding addiction and that it creates a 'culture of reliance' on charity services (Clarkson, 2020).

> **Participant:** "I do think, there have been councillors who have gone up to [*charity service*] and they've said they're buying drugs under the table and ones laid out in a drug overdose and things like that. Basically, they're getting [*food*] and selling it on for heroin. So, is it a waste of money?"
> **Interviewer:** "Is it a waste of money? Do you think so?"
> **Participant:** Well, if those on the programme going out on and getting heroin in kind… then, to me, it isn't working, and we stop it. We're almost giving away heroin at that point, don't you think?"
> – Middlesbrough Stakeholder

It makes intuitive sense that a small number of people would exploit charity services to fund an addiction, and anecdotal reports both in this study and in the news media suggest it happens at least occasionally. In the absence of empirical evidence, it is difficult to assess how frequently this practice occurs, but there is certainly not enough evidence to conclude, as some participants had, that these services do more harm than good. It is worth noting that other participants, many of whom reported having used foodbanks themselves, described these services as "essential" and "a lifeline". The frequency with which this practice was believed by some participants to occur is further evidence of the presence of class-based stigma in participant narratives (previously discussed in Chapter 6). Foodbanks and the people who rely on them have been observed to be subject to class-based stigma in the UK (Garthwaite, 2016), and this stigma is perpetuated by rhetoric depicting people who use foodbanks as 'shirkers and scroungers' (Garthwaite, 2011). That some participants believed charity services did more harm than good is indicative of the influence that cultural determinants like class-based stigma have on the perception of services; that these participants believed charity services should be curtailed or ended altogether demonstrates how cultural norms and attitudes can influence policy decisions and social structures. These findings provide further evidence for the complex and often intersecting influence of cultural and structural determinants of health.

While there is little evidence that foodbanks frequently facilitate addiction, that foodbanks can be harmful to society is an idea that has been discussed in the broader literature. It has been argued that they provide the illusion of effectively responding to hunger and poverty, while further eroding the social structures, such as income supports, that are intended to protect the most vulnerable members of society (Riches, 2002, Garthwaite et al., 2015). The normalisation of foodbanks as a response to growing poverty in the UK allows policymakers to avoid addressing the structural forces, such as austerity, driving the growth in poverty (Schrecker and Bambra, 2015). Some participants in this study shared these concerns, reporting that food banks are emblematic of the government's failure to alleviate poverty and support people on low incomes. This highlights how well-intentioned efforts to address the consequences of harmful policy decisions can inadvertently perpetuate the harms that they seek to prevent.

> "In my opinion, we shouldn't have a foodbank, we shouldn't ever have a foodbank. But we rely on them a lot. We, you know, in this country, nobody should be homeless. Nobody should be without food. But we're in the position where we have to have those things. We've got the wealth in this country to provide for everyone very comfortable [*sic*], but we choose not to, or some people choose not to. We're just papering over." – South Tyneside Community Member

7.8 Austerity-Related Funding Cuts and Closures

Participants believed that there was a lack of youth clubs and opportunities for recreation for children and young people. According to participants, these services had been present at one time but had largely been forced to close in recent years. It was reported that there was simply very little for children to do outside of school hours because there were no youth centres or after-school activities. The closure of youth clubs and services is a direct consequence of austerity. Austerity brought major reductions in funding from the central government for council services, including youth clubs, libraries, museums, and parks (Davies, 2019). In fiscal year 2011-2012, the start of the austerity era, council spending on services for young people fell from £1184 million to £877 million (Davies, 2019). The reductions in funding

were not applied evenly throughout the country, with the most deprived local authorities bearing a greater brunt in funding cuts for youth services than their least deprived counterparts (Davies, 2019), a geographical pattern that was mirrored in other austerity-related funding cuts (Bambra, 2019). Participants in this study were aware that the decline in youth services available in their areas was directly attributable to austerity.

> "2010 they were taken away from us. We used to have a big budget for youth provision. So, we would have a lot of, basically local authorities basically funded youth provisions. Youth clubs, council workers. The council employed people with things like degrees and that, so they were professionals, you know? They had an awareness of issues and would be good members of staff to have working with young people. But they took away that funding. The Tories took that away." – Middlesbrough Community Member

Participants believed that since there were very few organised activities for young people, and few structured places for them to spend their free time, they would spend their time on the streets; participants felt this left children vulnerable to exploitation, harmed their mental health, and led to a rise in substance abuse among young people. Research in England has found that participation in youth groups provides members with a sense of belonging and social support and improves subjective well-being (Holding et al., 2022, Laurence, 2021), factors known to reduce the risk of substance abuse and criminal activity among young people (Tomova et al., 2021). Austerity-related funding cuts to youth services also impacted youth drug and alcohol services, reducing access to education, treatment, and counselling for young people who use substances (Zosia, 2021). By reducing access to youth clubs and youth substance abuse services, austerity both increased the risk of substance abuse among young people and reduced the support available to help treat young people with substance abuse disorders.

> "When I was younger, there used to be like youth clubs and stuff and community centres. A lot of those are shut down now and there's not as many facilities for that. I think now that there's not that, there's not those facilities, people are just going to go drinking in the field instead, they take drugs and it's just for something to do really, 'cause they've been told there is no place for them anymore." – South Tyneside Community Member

According to participants, services across the board had seen a reduction in funding, which left services in all sectors struggling to meet demand or needing to scale back their

service offer. Participants attributed the reduction in funding for services to austerity, reporting that before the austerity measures the service capacity of their areas had been much greater. Services that participants believed had been cut as a result of austerity included educational opportunities for adults, and council services such as refuse collection, street cleaning, and library and community centre opening hours. Participants were correct to attribute the decline in council services to austerity-related funding cuts, which have pushed local governments to a financial breaking point. Between 2010 and 2020, councils lost more than 50% of their government grants in real terms (NAO, 2021). Since 2021, six councils have issued a section 114 notice, effectively declaring bankruptcy, and another 14, including Middlesbrough, have indicated that they are at risk of effective bankruptcy in the next year (Local Government Information Unit, 2024). Participants reported that a lack of council funding had made their areas worse places to live, negatively affected residents' well-being, and increased social isolation. It should be noted that in Chapter 5, social isolation and loneliness were identified as an individual-level determinant that increases the risk of drug and alcohol use; this provides further evidence of how structural factors such as austerity underpin many DSA-related behaviours.

> "It's all money driven, and you can only do what you can do, you know what I mean? It's quite sad. Everything is shut for extra days. You've got the town hall. Amazingly that's only open three days a week. Central Library is shut today, the Grove Hill Library is shut. I was quite stunned at that. The man who founded that library back in the 1800s or whatever, he'd be turning in his grave at this big place of learning shutting half the week. It's this whole financial thing, but that causes people to become more isolated. I haven't got that to go to anymore, so people stay in their house." – Middlesbrough Community Member

Participants believed that the number of drug and alcohol-related services had also been reduced in recent years, leaving a service gap that made it difficult to get help with addiction-related issues. It was reported that the treatment capacity of existing substance abuse treatment services had declined. Rehabilitation services were also seen as limited, with very few opportunities for people to do in-patient rehab. These declines in substance abuse service capacity are a direct result of changes to the health service funding policy and austerity.

The Health and Social Care Act of 2012 transferred public health responsibilities, including funding for substance abuse treatment, from the NHS to local authorities (Roscoe et al., 2021). This coincided with the start of austerity which, as previously discussed, saw significant declines in local authority budgets. Since 2014/15, there have been significant reductions in spending on substance abuse treatment services (Roscoe et al., 2021). Declining spending on these services has coincided with declines in the number of people accessing services annually and increases in the number of drug and alcohol-related deaths (Drummond, 2017, Roberts et al., 2020). Participants in this study were acutely aware that the declining capacity of substance abuse treatment services and the corresponding rise in drug-related deaths were a product of austerity.

> "You'd be hard pushed to argue the correlation between the substance misuse budget more than halving since we moved from, with the 2013 reforms and public health moved from the NHS to local authorities, over the next sort of 5, 6, 7 years became less than half of what it was. You cannot deny that correlation between disinvestment and the loss of specialist capacity and the drug-related deaths getting to the highest levels on record and Teesside now being one of the drug death capitals of Europe. I just do not think that can be denied or overstated really." – Middlesbrough Stakeholder

Concerns about the declining availability of drug and alcohol treatment services were generally expressed by stakeholders, with community members rarely sharing these beliefs. That community members did not identify a decline in funding for drug and alcohol services may speak to a lack of awareness about these services among the general public. Since most people do not need to engage with substance abuse services, they are much more likely to notice a decline in things like the operating hours of their local library than they are in the treatment capacity of their local substance abuse treatment organisation. While community members did not identify declines in funding for these services as a factor driving an increase in drug-related deaths, it may be the case that they have noticed the effects but misattributed the cause. In Chapter 6, I discussed how participants believed drug use had become normalised in their areas; as evidence, participants cited an increase in the visibility of drug use and drug users on the streets of their communities. An alternative explanation for what participants noticed is that this is actually a consequence of a poorly funded substance abuse treatment

system that lacks the capacity to effectively serve the number of people who use drugs within the area. This would indicate that what participants believed was a cultural norm surrounding the acceptability of drug use, may actually be a product of structural changes that have made substance abuse treatments harder to access.

7.9 Poor Local Governance

In general, Middlesbrough participants had a negative perception of their local council; this was not found in South Tyneside. The council was described as incompetent, out of touch, and neglectful. It was commonly believed by participants from Middlesbrough that the council had repeatedly wasted money on projects and investments that had not benefited the town, such as Level X (a leisure centre in Captain Cook Square), the purchase of the Crown Pub, and the installation of cycle lanes on Linthorpe Road. When viewed in the context of Middlesbrough's recent political history, participants' lack of faith in the financial management of their council begins to make sense. Between October 2019 and November 2020, Middlesbrough Council unlawfully hired an external advisor to work directly with then-mayor Andy Preston; the exact nature of this advisor's role was unclear, but the council paid £32,000 for their services (BBC, 2024). Mayor Preston also oversaw the failed development of the Boho X tower, a project which cost the council more than $600,000 in planning and permitting costs before the project was significantly scaled back (BBC, 2020). Shortly before leaving office in 2023, Mayor Preston oversaw the purchase of The Crown Pub, a historic building which had been vacant since 2015; the purchase was completed without a structural survey of the building and the final purchase price, £750,000, was 60% more than the estimated market value of the building (Morris and Corrigan, 2024). Participants in Middlesbrough were aware of these costs and believed they constituted wasted money that should have been spent elsewhere.

> "Then we got the Level X and that pub. The council took that over and that was Middlesbrough mayor and all that. Now he wants to take a second pub up. Those daft

cycle lanes too. Why? Wasted all that money but nobody's even touched it yet. Waste of money. They just like buildings." – Middlesbrough Community Member

Many participants believed that the financial hardship experienced by the council was caused by financial mismanagement on the part of councillors. At the time that Middlesbrough community member interviews were conducted in July 2023, there was a persistent rumour that the town was on the verge of bankruptcy which was shared by many participants. This rumour turned out to be true, with the local authority narrowly avoiding effective bankruptcy at the start of 2024 by raising council tax, beginning to charge for green waste collection, reducing funding for museums, parks, and libraries, and accepting exceptional financial support from central government (Corrigan, 2024). It was believed that the council's failure to meaningfully improve things in the area was a product of the fact that they did not have a good understanding of, or much concern for, the communities they served. Participants believed that mismanagement by the council had made the level of poverty in their areas worse than it otherwise would have been. While it is understandable that some would perceive the economic development efforts undertaken by Mayor Preston to constitute unnecessary and unreasonable spending for a council already facing financial hardship, it is not entirely fair to place blame for the council's lack of funds squarely on council spending priorities. As previously discussed in the subtheme *Austerity Related Funding Cuts and Closures*, councils have seen a severe reduction in funding from the central government since the start of austerity (NAO, 2021). The financial hardship experienced by Middlesbrough Council is a problem caused by central government funding policies that are exacerbated by poor spending decisions at the council level. That participants in Middlesbrough saw their council's financial position as resulting purely from unnecessary spending is an example of how structural determinants can be overlooked in broader society. Participants in Middlesbrough saw that their council had wasted money, that council tax was rising while services were being reduced and concluded that the council was to blame; in doing so, they neglected the fact that their council was already severely underfunded as a result of more than a decade of austerity enacted by the central government.

In South Tyneside, participants generally took a favourable or neutral view of the council. While participants here sometimes expressed the belief that the council should have done more to help their areas, they often acknowledged that the council had limited funding available to them and that many of the problems in their areas were beyond the scope of what could be done by local government.

> "The council's responsibility with its funding, wherever it comes from, is social care. Social care is, I'm not going to say a drain because I'm going to be older than I am, but because people are living longer, Tim, there is a greater need for social care. The money that comes from government is not enough. What the council has to do is cut its cloth according to its means just like everyone else has to do. But the social care budget is going up year on year and the budget from government is going down and down. So, everything else is curtailed. It's not their fault like, they aren't getting enough in." – South Tyneside Community Member

It is difficult to pinpoint exactly what underlies the difference between how the South Tyneside and Middlesbrough councils were perceived by participants, but South Tyneside's history of a generally more politically stable and unified council may be at least partially responsible. While a former member of South Tyneside Council recently faced an investigation for nearly £19,000 of inappropriate spending of council funds on personal purchases (Tickell, 2024), the council as a whole has largely avoided high-profile scrutiny of public spending. South Tyneside Council has also avoided the level of political infighting seen in Middlesbrough, which is likely due to its more politically homogenous body of councillors; South Tyneside Council is overwhelmingly comprised of Labour councillors and has been since its inception (The Elections Centre, 2013). That participants in South Tyneside more clearly identified the role of austerity in driving their council's lack of funding indicates that the public is more readily able to identify structural causes of deprivation in the absence of more immediate aggravating factors. It is also likely true that to an extent South Tyneside is in fact financially better off precisely because it has avoided the sort of wasteful spending seen in Middlesbrough.

7.10 Benefits System

The benefits system was seen by some participants as rife with exploitation and fraud. According to these participants, people have learned how to cheat the system to maximise their benefits payout. Participants cited an increase in the number of people claiming to have a disability caused by mental illness as evidence of people exploiting the system, reporting that most people who claimed to have a mental health-related disability did not actually qualify for Personal Independence Payments (PIP), a category of benefits for people who have a disability that prevents them from working. While benefit fraud does occur, official estimates from the Department for Work & Pensions (DWP) indicate that it is fairly rare. Overpayment due to fraudulent PIP claims accounted for just 0.2% of total benefits expenditure, the lowest recorded level since PIP was introduced (DWP, 2023). Participants' incorrect perception of the frequency with which benefits fraud occurs may be attributable to news media coverage. Stories discussing benefit fraud are pervasive in British news media, are particularly commonplace in local and regional press, and are likely to have increased public concern about fraud in the benefit system (Gavin, 2021). Misperceptions of the frequency of benefit fraud have been important components in justifying welfare cuts (Barton and Davis, 2018, Lamnek and Ottermann, 2007) and there is evidence in this study that this effect continues. While participants acknowledged the importance of having a social safety net in place, many participants felt that the amount of money that could be received on benefit was too high and the standards to qualify were too low; as such, they favoured reductions in benefit payments and the tightening of eligibility requirements.

> "Everyone just says they have mental health and suddenly its "poor you, have you got PIP yet?" So, all we do is give these people money and then that money is going to drug dealers. If we don't start doing something about all this… lord knows. Its insanity, Tim." – Middlesbrough Stakeholder

Misperceptions among participants about the frequency of benefit fraud due to disproportionate media coverage may also underpin participants' beliefs about 'intergenerational poverty', as discussed in Chapter 6. Like the myth of intergenerational poverty, concerns about benefit fraud echo Dickensian language about 'shirkers' and 'scroungers', people of low moral character who seek to take advantage of broader society.

These narratives serve a broader function within the neoliberal economic system in that they generate anger at a perceived underclass (Happer and Philo, 2013), undermine trust in the welfare system (Lundström, 2013), and distract from the structural nature of poverty by attributing it to the behaviour of the impoverished (Hughes, 2015). In turn, these beliefs are echoed by members of government and used as justification to further degrade the welfare state.

> "A lot of these people are going to their doctors and getting fit notes, which basically stops them from having to do anything. They give that to the job centre and their work coach will go "okay, you don't need to apply for any positions for a month." Then they get another fit note, and it continues. The work coaches and doctors are signing it off and then you look on their Facebook page and there isn't any evidence that they're not fine. It's not fair. A lot of non-genuine people are using that to stay on benefits, apply for additional benefits even. The government needs to clamp down." – South Tyneside Community Member

In the quote above, a community member shared concerns about the exploitation of disability-related payments on the grounds of mental health. The language the participant used is strikingly similar to the language that would be used by Prime Minister Rishi Sunak in his April 19th, 2024, announcement of reforms to the benefits system. In announcing the tightening of requirements to qualify for disability payments for mental health conditions and curtailing the ability of doctors to issue fit notes, Sunak condemned rising numbers of mental health-related disability claims as "sicknote culture" that is "not fair on the taxpayer" and described welfare reform as "a moral mission" (Devlin and Gregory, 2024). Cultural attitudes towards benefits and the people who receive them are shaped by government rhetoric and disproportionate news media coverage which are then used to justify further reductions in vital social supports; these reductions then cause further suffering and ill health and deepen regional health and wealth inequalities (Barr et al., 2016, Schrecker and Bambra, 2015). In this way, cultural norms shape the structural determinants of DSA morbidity and mortality.

Other participants expressed different concerns with the benefits system. These participants felt that benefits were an important social support, but that the system was often difficult to engage with and that the benefits one could receive were often insufficient to help

them escape poverty. This belief from participants highlights another effect of austerity and the welfare reform measures implemented in the UK over the last 15 years. The benefits system has been the subject of numerous reform attempts as successive governments have sought to reduce benefit spending, combat perceived benefit fraud, simplify the benefits system, and encourage people to return to work (Beatty and Fothergill, 2018). It was reported by participants that applying for benefits was complicated and confusing. When people were able to access benefits, participants reported that the system could be degrading and stigmatising and often applied sanctions arbitrarily; it was believed that these effects negatively impacted the mental health of people claiming benefits.

> "I hear of people being sanctioned for absolutely bizarre reasons. For having an appointment in hospital that they couldn't change for example. It was either the hospital appointment or the benefits appointment, they chose hospital and got sanctioned. Where is the justice in that? The benefits system is… Sanctions are meant to frustrate people, so they start looking to go back to work, but it's having the opposite effect. It's locking people into poverty. They spend all their time just avoiding sanctions so they can't think of ever doing anything else. They have to do all sorts of ridiculous things which is terrible for their self-esteem. How does that make any sense at all? Then you're sat at home with a load of problems, hating yourself and thinking you're of no use to anyone." – Middlesbrough Community Member

Participants' beliefs about benefits and their impact on mental health are consistent with the available evidence. Numerous welfare reform measures in the UK, from the introduction of the Working Capabilities Assessment (Barr et al., 2016), to the introduction of Universal Credit (Wickham et al., 2020), have been linked to rises in suicides, self-reported mental health problems, and increased prescriptions of anti-depressants. Welfare reform measures most severely impacted the poorest areas in the country, particularly deindustrialised communities, where a higher proportion of the population received support (Bambra, 2019). What participants have described here is a well-known phenomenon and is indicative of the influence that structural determinants like welfare policy have on mental health and well-being.

7.11 Drug Policy and Policing Fail to Prevent Drug Use

There was agreement among participants that the police were underfunded. Participants believed that police budgets had been reduced, which meant that police numbers had been cut and police were responsible for covering the same area with fewer resources. Participants were correct to believe that police budgets and staffing levels have been reduced. Between 2010 and 2019, police budgets in England and Wales fell by 19% in real terms, which coincided with a 15% reduction in the number of officers (NAO, 2018). The reduction in the number of active police officers as a result of austerity caused a fall in public confidence in policing and decreased visibility of front-line policing (Barton, 2013, Caveney et al., 2020). That a reduction in the number of police has caused a loss of confidence in policing by the general public is evident in participant narratives in this study. Participants in Middlesbrough and South Tyneside believed that the police force had a bad reputation in the towns and that people would not call them to report crimes because they had learned that nothing would be done if they made a report.

> "There was a thing on tele this morning about why people don't report crime, people won't report crime in Middlesbrough because what's the point? Nothing is going to happen. Unless it's a really serious crime, but burglaries and fights and drugs, it's just everywhere. "Contact the police." Why? They won't do anything. They won't even show up." – Middlesbrough Community Member

According to participants, declines in police funding meant that the remaining police officers had to prioritise enforcement of violent crime while neglecting antisocial behaviour and property crime, leading to a rise in shoplifting, aggressive behaviour, and public drug use. The reduction in the number of police available to respond to antisocial behaviour may be a contributing factor in what participants saw as increased visibility of drug use in their areas (discussed in Chapter 6). While participants felt the increase in the number of people using drugs in their areas was due to cultural changes around the normalisation of drug use, this may be a product of increasing visibility of people who use drugs as police have less manpower and

resources to prevent public drug use. There is evidence to support this belief; police budget cuts have been linked to declining rates of crime reduction and shifting police priorities away from low-level crimes such as antisocial behaviour (Caveney et al., 2020). It may also be the case that declining police enforcement of public drug use has fostered a cultural change through which public drug use has become more socially acceptable (as there is no longer significant concern that one will be punished for doing so). Further research should investigate how changes in policing-related policies influence cultural beliefs surrounding drug use, as this may be another area in which structural factors influence cultural norms.

Participants generally agreed that government drug policy had failed to meaningfully combat the use and supply of illegal drugs, although their explanations for why this failure has occurred varied. Some participants believed that drug policy and policing were too "soft". These participants felt that the government and society as a whole had encouraged drug use by medicalising addiction, instead of punishing it like other forms of social deviance; in turn, these participants believed that to reduce the rate of drug use in society, the government must enforce severe penalties for drug use and drug dealing and maintain the prohibition of drugs. While this argument makes a degree of intuitive sense, it is largely without the support of empirical evidence. Illicit substances remain available and affordable to consumers despite decades of expensive prohibition (Buchanan, 2015, Dalgarno et al., 2021). Multi-national criminal organisations have formed to meet the demand for illicit substances and in doing so have given rise to violence and corruption both globally and within the UK (McCoy, 2003). Some participants in this study were aware that drug prohibition had given rise to organised criminal groups in their areas.

> "Whenever drugs are being sold there is an entire industry around that. It's the same as, I don't know, if we needed paper. We'd set up a logging station and rip down loads of trees and blight that land. That whole industry that creates around that one item, it's the exact same with drugs, but we don't think of it that way. That's where these OCGs [Organised Criminal Groups] come from. It all ties back to the market for drugs." – Middlesbrough Stakeholder

A quarter of UK teenagers report having used an illegal substance at least once in their lives despite facing criminal penalties for doing so (Godlee and Hurley, 2016). Prohibition and stigma make drug use less safe and dissuade people who use drugs from accessing health services (Csete et al., 2016). Drug prohibition has resoundingly failed in its mission of preventing drug use and reducing the rate of drug-related deaths.

Other participants were aware that prohibition has failed to prevent drug use and had increased the risk of drug-related deaths and associated health effects, such as HIV and Hepatitis C. These participants reported that current drug laws were ineffective because they were too harsh and focused on prohibition. While specific drug policy recommendations varied (from full legalisation of all drugs to the decriminalisation of only certain drugs like marijuana), there was agreement among these participants that drug use could not be prevented by prohibition alone.

> "[*The government*] lost the war on drugs. They were never going to win that war. Drugs are fun. It's a basic fact, drugs are fun. They won't stop people from doing them. They just treated every drug as the same. I don't classify drugs all the same. There is a scale. I wouldn't say anyone should be allowed to just buy heroin, but some of them should be legal." – South Tyneside Community Member

These participants felt that money has been wasted on drug enforcement and that harm minimisation would be more effective at reducing drug-related harms. Indeed, empirical evidence supports this view. Drug laws have been liberalised in different settings around the world, from Portugal to the Czech Republic, to some US states; all have seen significant savings in money, major public health benefits, and no significant increases in drug use (Csete et al., 2016). In the UK, approaches that have been seen to reduce the risk of drug-related death, such as drug testing and overdose prevention efforts (such as the distribution of the opioid antagonist naloxone) remain controversial and lack the support of the central government (Measham and Turnbull, 2021, Sumnall et al., 2023). Participants were aware that harm minimisation strategies they thought would be effective were currently not supported by the Government.

> "They will not allow certain harm reduction activities to take place. Needle exchange for example, that will take place in a back alley because it can't inside a council building because of the way the law is written." – Middlesbrough Stakeholder

The failure on the part of the central government to adopt harm minimisation measures is exemplary of how structural forces influence high-risk individual behaviours. Individuals choose to use drugs for a complex range of reasons and governments have a choice in how they respond to these behaviours. Responses that focus on punitive action only serve to increase the risk of harm from the choices that individuals make. Participants in this study, and the empirical evidence, suggest that central government should transition towards a model focused on harm reduction; while this would not be sufficient to prevent drug use, it would meaningfully reduce the burden of associated harms.

7.12 Chapter Summary

In this chapter, I have discussed the structural determinants that participants felt had increased the risk of DSA-related morbidity and mortality in their community. Some of these structural determinants, such as drug policies and austerity measures that reduced access to substance abuse and mental health services, were seen to have a direct influence on the rate of DSA mortality. Other structural determinants, such as poverty and unemployment, acted more indirectly by creating the social environment in which people were believed to turn to DSA behaviours to cope or escape from suffering. In both cases, there is clear empirical evidence to support participants' beliefs that understanding these structural determinants is a critical step in understanding how DSA mortality and morbidity have become such a significant problem in Middlesbrough and South Tyneside.

The findings discussed in this chapter also highlight the complex and often intersecting nature of structural, cultural, and individual-level determinants. Close inspection of participants' narratives has highlighted how cultural norms and attitudes influence government policy decisions and reinforce structural determinants of DSA morbidity. I have demonstrated

how many of the individual determinants of DSA morbidity and mortality identified by participants and discussed in Chapter 5 are themselves a response to conditions created by decades of government policy change. Participants' narratives have provided insight into how structural determinants such as housing policy have influenced the social forces that encourage participation in DSA-related behaviours. It is clear from these findings that the factors driving DSA morbidity and mortality are multifaceted. DSA morbidity and mortality are not caused by the actions of individuals, the result of cultural norms, or a product of policy decisions, they are all of these things in combination with one another.

When the overarching determinants of the problems of DSA morbidity and mortality identified by participants are viewed together, it becomes clear that these issues are more complex than may initially be assumed. A theoretical framing of the determinants of DSA morbidity and mortality as a product of structural violence will provide a clearer understanding of how individual, cultural, and structural determinants constitute a complex web of influences and will underscore the need for approaching DSA morbidity and mortality as issues rooted in social injustice.

Chapter 8: The Cycle of Structural Violence

The previous three chapters have demonstrated that DSA morbidity and mortality in Middlesbrough and South Tyneside are produced by individual, cultural, and structural determinants. These determinants do not exist in isolation from one another; rather, they overlap and intersect to produce suffering and death from these causes. These findings answer the first research question that guided this thesis regarding how participants explained the above average prevalence of deaths from these causes in their towns. The second question, surrounding participant explanations for the inequalities present in their areas remains only partially answered. The participants in this study felt that many of these structural factors disproportionately affected Northern communities such as Middlesbrough and South Tyneside, a perspective supported by the empirical evidence presented throughout this thesis; however, a more comprehensive answer to this question can be gained through viewing the findings of this study through a theoretical lens.

This chapter places the findings of this study within the context of, what I describe as, a cycle of structural violence. It begins with a discussion of structural violence and its intersections with the concepts of slow and symbolic violence. Viewing these findings through the lens of structural violence reveals how economic policies have created the social conditions in which DSA morbidity and mortality occur and that the status quo is maintained, and reinforced, through an interaction with both slow and symbolic violence. After a theoretical discussion of the findings, I appraise the strengths and weaknesses of this study and its implications for future research.

8.1 Structural Violence

As discussed in Chapter 2, the concept of structural violence describes a form of violence that is present when social structures or institutions cause harm to individuals or groups of people (Banerjee et al., 2012, Galtung, 1969). While the term ‘violence’ recalls images of physical conflict or warfare, within the concept of structural violence it has been defined as

"avoidable impairment of fundamental human needs or…the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible." (Galtung, 1969)(UK Government). With that definition in mind, it becomes clear that participants in this study have provided direct evidence that structural violence has been inflicted upon the people in their areas. Here I present four overarching examples of how structural violence is enacted within Middlesbrough and South Tyneside: by deindustrialisation, by poverty, by austerity, and by compounding violence.

8.1.1 Violence by Deindustrialisation

One of the clearest examples of structural violence present in participants' narratives was their recounting of the effects that deindustrialisation and the economic policies of the 1980s had on their communities. As discussed in Chapter 6, participants believed that deindustrialisation coincided with a rise in poverty and unemployment in their areas. This belief was consistent with the empirical evidence, which shows that deindustrialisation and the economic policies of the Thatcher administration in the 1980s caused a drastic rise in unemployment and poverty in affected areas (Albertson and Stepney, 2020, Scott-Samuel et al., 2014, Beatty and Fothergill, 2020). A number of the individual-level determinants that were identified by participants were either a direct result of poverty, or a second-order effect thereof. As discussed in Chapter 5, participants felt that poverty was an individual-level determinant of DSA morbidity and mortality; a belief which was consistent with available evidence on the association of low income with DSA mortality (Patrick et al., 2012, Karriker-Jaffe, 2011, Näher et al., 2019, Beseran et al., 2022). Participants' narratives provided insight into why this association exists. According to participants, when one was dealing with the stress of living in poverty, one sometimes turned to drugs, alcohol, or self-injurious behaviour to cope or as a means of escape, which increased the risk of DSA mortality; this is an example of a first-order effect of poverty on DSA morbidity and mortality. Second-order effects of poverty included increased risk of adverse childhood experiences, an individual-level determinant identified by participants that is associated with living in a low-income family, and the feeling of hopelessness that participants described as arising from long-term exposure to poverty (both

discussed in Chapter 5).

8.1.2 Poverty as Violence

When participants' thoughts on individual and structural determinants are viewed together, it is clear participants felt that deindustrialisation and economic policies in the 1980s had given rise to a previously unseen level of poverty in their areas, that this poverty had caused profound suffering, and that people had responded to this suffering by engaging in DSA behaviours. The economic policies of the 1980s were based in a neoliberal worldview—a political and economic ideology which advocates for free markets, deregulation, privatisation, and a reduction in government intervention in the economy (Steger and Roy, 2010). Participants' narratives surrounding deindustrialisation and the neoliberal economic policies of the Thatcher Government show how these phenomena have caused significant impairment of human life in Middlesbrough and South Tyneside; this is a clear example of structural violence. That the process of deindustrialisation and the neoliberal economic policies of the 1980s were deeply harmful to some British communities is not a novel finding. There is a wealth of evidence that exists linking deindustrialisation and neoliberalism to the entrenchment of geographic health and wealth inequalities, which further exacerbate social inequity in British society (Bambra et al., 2014, Erdem and Glyn, 2001, Telford, 2022, Dorling et al., 2007, Garnham, 2015). Participants in this study provided evidence that inequalities in DSA morbidity and mortality in their areas today share a root cause with broader health inequalities in Britain; these problems are not unique, they are a reflection of deeply entrenched inequity that has been caused by the structural violence of deindustrialisation and neoliberal economic policy.

8.1.3 Violence by Austerity

Another clear example of structural violence present in participant narratives was austerity. In Chapter 7, I discussed how austerity was described by participants as having reduced budgets for support services, such as substance abuse treatment services and mental health services, for people struggling with DSA behaviours. Here I highlighted the harms identified by participants and how the reduction in services had translated to reduced service

capacity and increased rates of DSA morbidity and mortality, which aligns with the broader empirical literature (Cummins, 2018, Roscoe et al., 2021, Roberts et al., 2020). Austerity also weakened local authorities' ability to fund both social services and basic council functions, which made the overall quality of life in participants' areas worse by increasing social isolation, reducing access to safe recreational activities for children, and limiting the accessibility of community resources like museums, libraries, and community centres.

Participants' narratives presented here combined with the available empirical evidence provide sufficient basis to conclude that austerity can be understood as structural violence. It is important to note that while the national budget deficit in the UK did increase as a result of the 2008 financial crisis (Kerasidou and Kingori, 2019), austerity was not an inevitable consequence. Austerity was a continuation of the neoliberal economic approach that has been embraced by successive governments since the 1980s (Arrieta, 2022). Rather than acknowledge that the national budget deficit was a product of market failures, the government chose to maintain that it was the result of irresponsible spending decisions that needed to be addressed through public spending cuts and not through increased taxation (Grimshaw and Rubery, 2012, Taylor-Gooby and Stoker, 2011, Arrieta, 2022). It is important to recognise that implementing austerity was a choice and the harms it has caused were not unavoidable. The decision to implement austerity measures most severely impacted already disadvantaged communities and populations and exacerbated existing social inequality (Schrecker and Bambra, 2015, Taylor-Gooby and Stoker, 2011), an outcome that was predicted soon after the onset of austerity (Reeves et al., 2013, Limb, 2012, Marmot et al., 2013). Participants' belief that austerity increased DSA morbidity and mortality in their areas aligns with the existing evidence. The rise in DSA morbidity and mortality was avoidable and is a symptom of the broader harm inflicted on vulnerable populations by the structural violence of neoliberal economics and austerity.

8.1.4 Compounding Violence

It is clear from participants' accounts and the empirical evidence that neither deindustrialisation, the neoliberal economic policies of the Thatcher administration, nor austerity is solely to blame for the above-average prevalence of DSA morbidity and mortality in

Middlesbrough and South Tyneside; rather, all of these factors had a compounding harmful effect that has created the environment in which deaths from these causes arise. The common thread throughout the structural determinants that participants identified was neoliberalism, which broke down communities and removed social safety nets. The restriction of collective bargaining power, the scaling back of the welfare state, disinvestment from local services, and the expansion of privatisation are hallmarks of the neoliberal worldview that has dominated British domestic policy since the 1980s (Collins and McCartney, 2011, Sutcliffe-Braithwaite, 2012) and all were identified by participants in this study as factors driving DSA morbidity and mortality in their areas. While participants provided unique insight into how these structurally violent neoliberal policies have shaped the social landscape in their areas and led to inequalities in DSA morbidity and mortality, the findings of this study add to the existing, broader, evidence linking neoliberalism to tangible harm (Schrecker and Bambra, 2015, Bambra, 2019, Taylor-Robinson et al., 2019, Beatty and Fothergill, 2018, Beatty et al., 2013). In effect, participants in this study have helped to write a new chapter of an old story; neoliberal economic policies are structurally violent and lead to tangible suffering and death in vulnerable communities and populations.

What participants' narratives demonstrate is that structural violence in the form of neoliberal economic policies has created the social environment in which DSA morbidity and mortality occur. In some instances, this harm has occurred directly, as when austerity reduced access to substance abuse treatment services); in others, the harm was produced more tangentially, as when the lack of economic development after deindustrialisation restricted employment opportunities and created an overwhelming level of poverty within affected areas. While the mechanisms varied, participants provided a clear picture that structural violence is at the root of the inequalities in DSA morbidity and mortality present in their areas today.

8.2 Slow Violence

The common thread running throughout Middlesbrough and South Tyneside is the lack of a clear, spectacular precipitating event and the incremental degradation of communities

over time; a thread which is also present in the findings of this study and is most visible when considering the relationship between structural determinants and individual determinants. Observations of the prolonged nature through which the structural violence of deindustrialisation is inflicted are not new. Sherry-Lee Linkon (2018), advanced the concept of the 'half-life of deindustrialisation' as a framework through which to understand how deindustrialisation continued to cause significant harm in affected communities years after the industry had closed. Linkon's (2018) concept has also been applied by researchers examining the effects of deindustrialisation in Scottish communities (Clark, 2023). The concept of the 'half-life of deindustrialisation' is strikingly similar to another concept, that of slow violence. Slow violence explains how violence can occur gradually and out of site.

Throughout Chapter 7, I discussed the presence of poverty, unemployment, lack of access to education, poor housing, and a decline in council-run services. As discussed in that chapter, these factors are the product of various neoliberal economic policies spanning the last 40 years and participants believed that all of these factors had slowly created the social environment which caused the above-average prevalence of DSA morbidity and mortality in their areas. In Chapter 6, I discussed how participants felt that the communal identity of Middlesbrough had been lost during the process of deindustrialisation and how this loss of identity constituted a prolonged form of collective trauma for residents in the area that ultimately resulted in what participants described as a sense of hopelessness. In Chapter 5, I discussed how participants believed the sense of hopelessness that resulted from that long-term exposure to deprivation and the collective trauma of deindustrialisation led some individuals to engage in DSA behaviours to cope with or escape from, this sense of hopelessness. There is a clear connection between the structural determinants that shape the lived environment in Middlesbrough and South Tyneside discussed in Chapter 7, which are a result of economic policies, the cultural determinants discussed in Chapter 6, and the individual determinants discussed in Chapter 5; in this way, the findings of this study indicate that structural violence shapes both culture and individual determinants over an extended period of time and leads to DSA morbidity and mortality—this is slow violence in action.

This study has shown that participants witnessed a slow degradation of myriad aspects of their communities, perpetuated by a series of structurally violent neoliberal economic policies, that have culminated in a severely depressed social environment in Middlesbrough and South Tyneside. Participants believed this environment has caused, in their words, 'distress', 'hopelessness', and mental illness, driving people to engage in DSA behaviours. Whether it be to cope, to escape, or simply because one felt there was nothing else for them to do, participants' beliefs about the reasons people chose to initiate DSA behaviours all tied back to the depressed social environment that has been created by decades of sustained neoliberal pressure. I propose that this can be understood as a form of slow structural violence. The root causes are ultimately structural in nature, but they have not occurred all at once; rather, the effects of structural violence have accumulated slowly over the preceding decades, with each inflexion point identified by participants (i.e. deindustrialisation and Thatcherism, austerity, and responses to COVID-19) making conditions incrementally worse.

One of the defining characteristics of slow violence is its ability to go overlooked, with its consequences being dismissed as 'natural' (Pain, 2019, Nixon, 2011). It is this intrinsic characteristic of slow violence that makes it relevant to the findings of this study. There is not one specific precipitating event for people to point to as the decision which caused conditions in their communities to deteriorate. Participant narratives describe a multidimensional, long-term degradation of all aspects of daily life that has deepened existing health and wealth inequalities and led to suffering and death in Middlesbrough and South Tyneside. This is slow violence, and its relevance to the findings of this study is the obscurity it provides to the decisions that have given rise to inequalities in DSA morbidity and mortality. Slow violence is hard to identify because it lacks a clear beginning, and its effects are felt over an extended period of time. In the absence of a clear precipitating event, people look for explanations for the degradation of their communities, and another form of violence offers an explanation.

8.3 Symbolic Violence

As discussed in Chapter 2 section 2.4.2, the concept of symbolic violence explains how

harmful social orders are legitimised and maintained. Symbolic violence is a framework that can help explain how the effects of structural violence can go overlooked or be explained away by moralising and individualising the resulting harms, which leads to the perception that the existing social order is just and legitimate. It is this, the outcome of symbolic violence (i.e. that social groups accept the existing social order as just and legitimate), that is relevant to the framing of DSA morbidity and mortality as the product of structural violence. Here I discuss symbolic violence operating through moral violence and cultural violence.

8.3.1 Moral Violence

Sociological research has revealed how symbolic violence in the form of media representation and public discourse cements the perception of substance abuse and mental illness as the result of moral failure and perpetuates the stigmatisation of these conditions (Stuart, 2006, El Hayek et al., 2024). The effect of moralising and stigmatising mental health and substance abuse is that, as these beliefs become widespread, morbidity and mortality from these conditions begin to be seen as the inevitable outcome of poor decisions. This normalisation of death and suffering is a central component of the cycle of structural violence. The death and suffering caused by structural violence are perceived as 'natural' because symbolic violence provides a compelling societal narrative that explains it as such.

It cannot be ignored that some elements of participants' narratives, particularly those surrounding the degradation of societal morals and values do not appear to fit neatly within the theoretical framing of structural violence. These beliefs are not themselves structural violence (as they are culturally constructed narratives and not derived from a particular social structure), but they are symbolic violence, and they serve an important function within the cycle of slow structural violence that is observable in the findings of this study. In Chapter 6, I discussed how participants felt that drug use had become normalised which had led to increased drug use and a higher rate of drug-related mortality and poor parenting had led to generations of people living in poverty and abusing substances. In that discussion, I demonstrated that these beliefs are longstanding cultural narratives that lack the support of empirical evidence and fail to explain the inequalities in DSA morbidity and mortality present in Middlesbrough and South

Tyneside. The connection between these beliefs and the slow structural violence that I argue is driving DSA morbidity and mortality can be understood through a close examination of the intrinsic traits of slow structural violence.

It is in this appearance of naturalness that symbolic violence surrounding societal values becomes particularly relevant to structural violence. While there were several distinct beliefs present in participant narratives regarding societal norms and values (the normalisation of drug use and parents encouraging drug use and facilitating intergenerational poverty, all discussed in Chapter 6) there was a common thread running through these subthemes, the moralisation of DSA morbidity and mortality. In the context of health and disease, moralisation refers to the process through which neutral actions (those that are held to be neither morally good nor bad) are assigned moral significance (Kraaijeveld and Jamrozik, 2022, Rozin et al., 1997). A classic example of a behaviour that has become moralised over time is cigarette smoking, which historically was a morally neutral activity that has largely been reframed as immoral due to its damaging effects on smokers' health and the health of those around them (Rozin and Singh, 1999, Kraaijeveld and Jamrozik, 2022). Of particular relevance to this study is the moralisation of substance abuse and mental illness, which empirical research has shown to be heavily moralised conditions (Frank and Nagel, 2017, Haslam et al., 2007, Salter and Breckenridge, 2014, Brown, 2018). Moralised views of addiction and mental illness view these conditions as the product of immoral behaviour and reject medicalised perspectives in which they are viewed as a product of disease or brain deficiency (Brown, 2018). In Chapters 5 and 6, I discussed how some participants viewed medical models of mental health and drug use as exculpatory and ultimately harmful to the social order, because, according to those participants, these conditions were a product of poor choices derived from a moral failing on the part of the individual.

In the context of this study, symbolic violence that moralises DSA morbidity and mortality serves two purposes. First, moralising these issues offers a simple explanation in place of a complicated one. Rather than being the product of a complicated web of individual, cultural, and structural determinants, DSA morbidity and mortality are reduced to the natural outcome of social norms and attitudes that encourage irresponsible behaviour. That some

participants in this study favoured a simple explanation for DSA morbidity and mortality (e.g. that these outcomes are a product of one's poor choices) is not entirely surprising. Such views of mental health and addiction are widespread in society (Haslam et al., 2007, Lang and Rosenberg, 2017). Research from the field of cognitive psychology has shown that people tend to prefer simple causal explanations rather than complex ones (Lombrozo, 2007, Johnson et al., 2019). It is simply easier for some to accept that DSA morbidity and mortality are a product of individual actions than it is to accept that these outcomes are manifestations of broader social inequity. In this way, the role of slow violence and symbolic violence intersect. These individualised explanations are easier to accept because the choices of individuals are more easily observed and understood than the effects of slow structural violence (e.g. it is easier to accept that people die from drug overdoses because they were poorly raised, than it is to accept that a series of policies beginning 40 years ago are driving these deaths today). People are aware that conditions in their areas are declining, but because the changes that precipitated the decline happened so long ago it is difficult to identify; thus, a simple, individualised explanation is more readily accepted, and it is this simple explanation that symbolic violence provides.

By placing the blame on groups of people and individuals, moralising the issues of DSA morbidity and mortality absolves the political establishment and society at large of any blame for the suffering and death associated with DSA behaviours. When one has adopted an individualised, moral view of DSA behaviours, one begins to see DSA morbidity and mortality as the just result of poor decision-making. There was evidence of this worldview present in the findings of this study. Recall in Chapters 5 and 6 that some participants felt that drug addiction, poverty, and mental illness were a product of one's own choices and thus, society did not have a responsibility to offer help and support to people experiencing these things. This focus on individual behaviour encourages 'solutions' that are punitive in nature and distract from the broader systemic issues driving DSA morbidity and mortality. Recall in Chapter 6 that the language used by participants to describe people who "take advantage" of the benefits system by claiming they are disabled by a mental health condition is the same language that was used by Prime Minister Rishi Sunak when announcing reforms to the benefit system to curtail

support for disability caused by mental illness (Devlin and Gregory, 2024). There is also precedence in the existing research to support this view, that public discourse surrounding DSA morbidity and mortality is too focused on individual behaviours at the expense of addressing the systemic issues that drive those behaviours is not a new finding (Monnat, 2017, Segal et al., 2017). What the findings of this study can offer is a more holistic view that explains how symbolic violence that moralises the determinants of DSA morbidity and mortality perpetuates the cycle of structural violence.

8.3.2 Cultural Violence: Class and Gender

Participants were aware that symbolic violence had been inflicted upon their communities through the media, though they did not use that term specifically. I discussed in Chapter 6 how participants believed their communities (and the residents therein) were stigmatised. Participants felt that the stigma and marginalisation surrounding their communities ultimately derived from class-based stigma, which had been perpetuated by news media and through the rhetoric used by public figures when speaking about their areas; this is symbolic violence. That symbolic violence is inherently tied to the perpetuation of class and place-based stigma is not a new finding. A wealth of research exists exploring the ways through which news media, entertainment, and political rhetoric produce and reinforce stigma on the basis of class and place (Shildrick, 2018, Myles and Myles, 2010, Kearns et al., 2013, Greer and Jewkes, 2005). The relevance of symbolic violence, and the stigma that it fosters, to the subject of inequalities in rates of DSA morbidity and mortality is twofold. First, participants described how the stigmatisation of places and people contributes to the sense of hopelessness that participants felt underpinned DSA behaviours. In that way, symbolic violence contributes to the above-average rates of DSA morbidity and mortality in Middlesbrough and South Tyneside.

Secondly, symbolic violence downplays the significance of these problems to society at large by ‘othering’ the people and places most affected. The overarching message is clear: DSA morbidity and mortality are problems of the poor, and the poor are impoverished because of their own moral failing. This message is so effectively conveyed that many people, even some of those experiencing severe poverty (like many of the participants in this study), believe it to

be true despite overwhelming evidence to the contrary (Shildrick and MacDonald, 2013). Recall that in Chapter 3 when reflecting on my positionality as a researcher, I discussed how participants often told me before the start of their interview that they were not "clever" or that they would likely not know enough to be useful to my study. This is a clear example of how the messages of symbolic violence become internalised and are subtly perpetuated by the very people most affected. Once these messages are entrenched in the public consciousness, the natural outcome is that policies and practices that further entrench poverty and harm the most vulnerable members of society can be implemented without significant objection.

Structural and symbolic violence also influences the harm caused by other cultural determinants identified by participants, namely normative masculine gender roles. In Chapter 6, I discussed participants' belief that normative masculine gender roles in their areas had been significantly influenced by the areas' industrial legacies, a belief which was consistent with available evidence surrounding gender roles and industry in other industrialised areas (Nayak, 2006, Nixon, 2006, Nixon, 2009). As discussed in Chapter 6, participants believed that normative masculine gender roles in their area placed significant emphasis on the ability of men to serve as the 'breadwinner' for their families, but that this was no longer possible in the post-industrial economy; the failure to achieve this gendered cultural expectation was believed to be distressing and result in moral injury that men coped with through DSA behaviours. While the gender norms described by participants were a cultural construct, it is clear that the harmful effects of this cultural construct cannot be fully understood without considering its interaction with structural violence. In the years following deindustrialisation, very little meaningful effort was made to stimulate economic growth and promote the development of alternative employment sectors in former industrial areas (Kitson and Michie, 2014, McCann, 2016, MacKinnon, 2020). This lack of investment in economic development coincided with a reduction in welfare benefits and a scaling back of social supports (Scott-Samuel et al., 2014, Albertson and Stepney, 2020).

In combination, the lack of economic development and reduction in welfare spending created an environment in deindustrialised areas in which poverty was common, chances of economic advancement were low, and there was little in the way of a social safety net; these

factors were a direct result of structurally violent neoliberal economic policies. The normative gender roles that positioned men as the primary breadwinners for their families were, before deindustrialisation, aligned with an economic environment where such a role was realistically attainable through participation in industrial labour. In this context, the cultural expectation that men should be the breadwinner for their household, in and of itself, was not inherently harmful to men. Structural violence took that economic environment away and left men in deindustrialised areas with few realistic opportunities for economic stability or advancement, which, according to participants, left men feeling worthless, hopeless, or distressed and engaging in DSA behaviours to cope.

That the failure to achieve economic stability had such a detrimental effect on men in Middlesbrough and South Tyneside is an example of symbolic violence. Poverty and unemployment are often explained in individualised terms (MacDonald and Marsh, 2005, Macdonald et al., 2014), indeed, there was evidence of this worldview present in some participants' narratives in this study. This is symbolic violence at work, reframing a demand-side problem (that there is low job availability) as a supply-side problem (that unemployed men are lazy or unwilling to work) (Rootham and McDowell, 2016). In the context of DSA morbidity and mortality, the issue lies not with the masculine gender role per se, but with the structural violence that suppressed the economic environment and the symbolic violence that then conferred judgement and shame on the men who were left unable to fulfil their culturally expected roles. While cultural determinants like gender roles are not a product of structural violence themselves, their interaction with structural and symbolic violence produces harm.

In the context of structural violence and DSA morbidity and mortality, symbolic violence serves a critical function. Structural violence degrades the social environment to the point that the determinants of DSA morbidity and mortality arise, but the prolonged and subtle nature through which the social environment is degraded makes the root causes of the degradation difficult to observe. Symbolic violence further obscures the root causes of structural violence by offering straightforward, individualised explanations for the harms caused by social structures and institutions, frames the harms as the just outcome of poor decision-making, and facilitates

further punitive action. In serving this function, symbolic violence allows the cycle of structural violence to continue.

8.4 The Cycle of Structural Violence

8.4.1 A Novel Concept Map

Figure 8.1 depicts the cycle of structural violence demonstrated in this study. In this concept map, which is a novel theoretical framework derived from the findings of this study, structural violence sits at the bottom of the graphic, indicating its foundational role in creating the social environment in which the determinants of DSA morbidity and mortality arise. In the context of this study, the structural violence present is constituted by neoliberal economic policies, such as those of the Thatcher administration and austerity. The temporality of structural violence prolongs the duration through which the harm of structural violence is inflicted, which makes those harms difficult for observers to attribute to a specific cause. Slow violence is connected to symbolic violence, highlighting the role that symbolic violence plays in obscuring structural violence and offering alternative, heavily moralised explanations for the harm it causes. In turn, symbolic violence is connected to structural violence, as the explanations offered by symbolic violence are used to absolve social structures from blame and to rationalise further structural violence (e.g. welfare reforms). Structural, slow, and symbolic violence are all connected, indicating their cyclical nature and the way in which they interact to perpetuate harm. A theoretical framing of the determinants of DSA morbidity and mortality as products of a cycle of structural violence underscores the need to address these as issues rooted in social injustice. DSA morbidity and mortality are a manifestation of broader social inequity, created and perpetuated through the interaction of structural, slow, and symbolic violence. Effective interventions seeking to prevent deaths from these causes must address the structural violence that entrenches poverty, reduces social mobility, removes social supports in northern communities and has given rise to the determinants leading to the initiation of DSA behaviour.

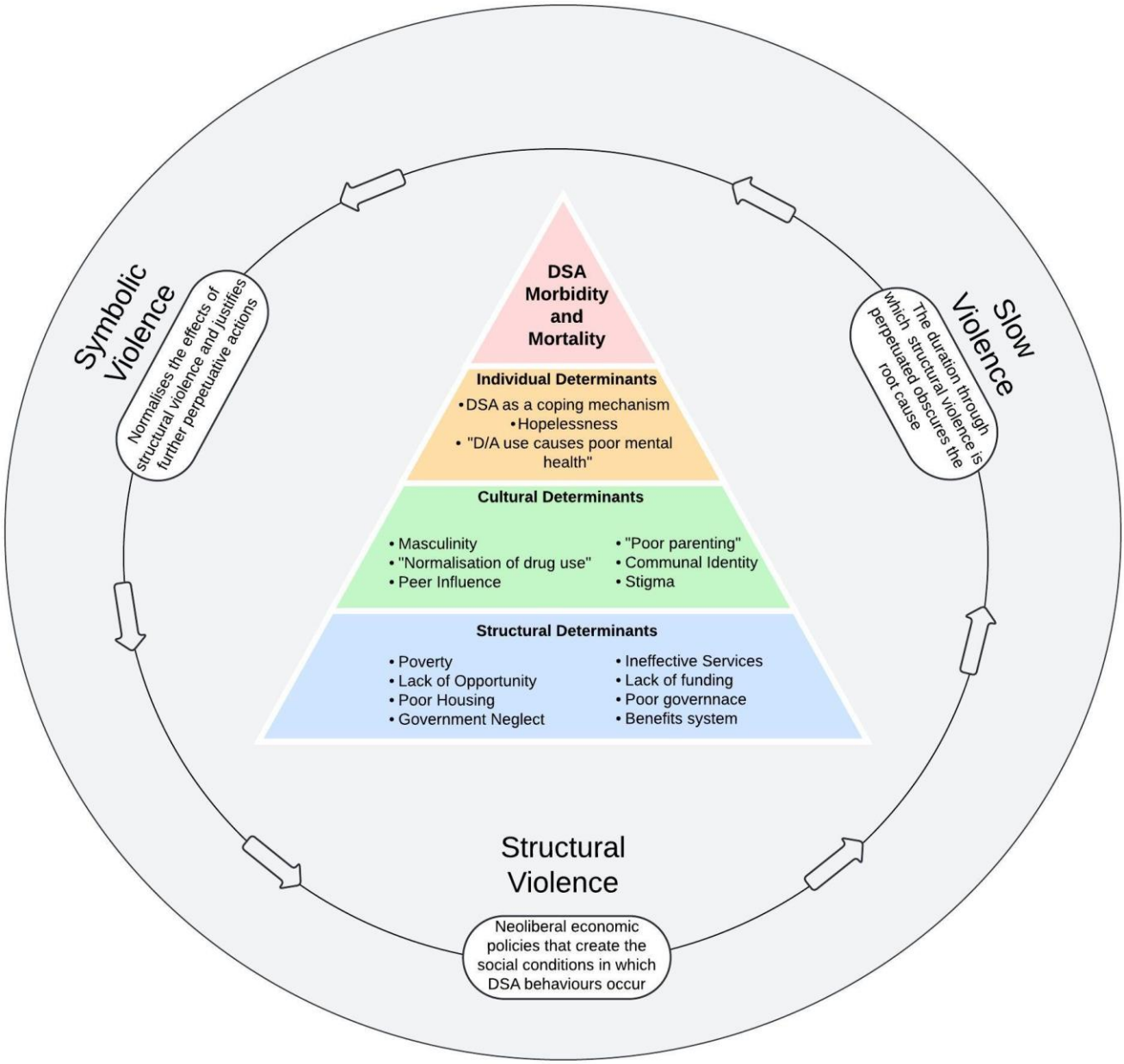


Figure 8.1: Concept map of the determinants of DSA morbidity and mortality within the cycle of structural violence. Structural, slow, and symbolic violence create and perpetuate a cycle in which the determinants of DSA morbidity and mortality arise.

8.4.2. Outcomes of the Cycle of Structural Violence

In Figure 8.1, the individual, cultural, and structural determinants of DSA morbidity and mortality, as identified by participants, are placed within the context of the cycle of structural violence. The cycle of structural violence has created the social environment which allows these determinants to persist in Middlesbrough and South Tyneside. This context shows that DSA morbidity and mortality are manifestations of broader social inequities created and maintained by the cycle of structural violence. The determinants of DSA morbidity and mortality are not unique in their underlying causes, and any number of health inequalities could likely fit within the centre of this concept model. For example, smoking in the UK or deaths due to gang violence in the US, both of which have been framed by researchers as a product of prolonged structural violence (Lewis and Russell, 2013, Swaner, 2022).

There is no reason that the harm inflicted by the cycle of structural violence should be limited to health inequalities. I propose that the riots that occurred in Middlesbrough and other deprived communities throughout the country in August 2024 (see Chapter 4, section 4.1.1 for background) can be understood as a product of the cycle of structural violence. Anti-immigration rhetoric has been a cornerstone of right-wing politics since the Brexit movement in 2016 and these messages have resonated with many in deprived, deindustrialised communities (Hobolt, 2016, Goodwin and Milazzo, 2017). These communities have experienced structural violence in the form of neoliberal economic policies, slow violence has obstructed the root cause of the harm inflicted, and symbolic violence in the form of anti-immigration sentiment has offered a simple narrative to explain the present suffering. Past riots in deprived communities, such as those that occurred in 2011, have also been tied to the long-term socioeconomic decline and can be viewed as a symbolic protest against a growing sense of social alienation and economic exclusion (Hall and Winlow, 2014). In the context of these riots, the cycle of structural violence created a powder keg in affected areas that primed them for social unrest and a shocking precipitating event lit the fuse. This interpretation of the 2024 and 2011 riots suggests that the cycle of structural violence causes harm beyond health inequalities and may underpin political and social unrest more broadly.

That both Middlesbrough and South Tyneside have been subjected to the cycle of

structural violence begs a question: Why, if both communities have been affected by the same cycle of structural violence, do they show such different rates of DSA morbidity and mortality? Recall that in Chapter 4, subsection 4.3, I presented the latest available mortality data that shows that South Tyneside has significantly above-average rates of alcohol-specific mortality, but relatively low rates of drug-related deaths and suicides when compared to Middlesbrough. It may seem that two places, subjected to the same cycle of structural violence, should produce the same outcomes; if they do not and the cycle of structural violence framework cannot explain why, that would seem to indicate a fundamental liability of the concept. I reject that assertion on two grounds. First, South Tyneside and Middlesbrough are, of course, two different places. Deindustrialisation occurred later and more rapidly in Middlesbrough than in South Tyneside. Middlesbrough has a more tumultuous political history and a culture of infighting within the town council that is not present in South Tyneside. Middlesbrough is more geographically isolated than South Tyneside, whose proximity to Newcastle upon Tyne may afford greater economic opportunity to its residents. Any one of these factors (or a combination therein) may help to explain the divergent rates of DSA morbidity and mortality present in the two towns. It is not reasonable to expect that any concept model could account for all of the subtle differences in culture, history and economic opportunity between two places. Second, I do not think it is surprising that when subjected to a similar set of circumstances, people react in different ways. People are too complex to be expected to behave in the same ways or rely on precisely the same coping mechanisms or means of escape.

To focus on why people who are suffering ultimately make different choices to cope or to escape turns our focus back to the affected individuals and away from the cycle of structural violence that is ultimately responsible for their suffering. This shift in focus is problematic for two reasons. First, it allows us to avoid a direct reconciliation with the fact that the way society is currently structured inflicts suffering and death on people living in vulnerable places. Second, in shifting our focus from the cycle of structural violence that has caused the suffering, to the individuals experiencing it, we begin to individualise the problems and thereby perpetuate the symbolic violence that is a critical component of the overall cycle. I do not think it is of particular importance to identify precisely why people in South Tyneside tend to choose alcohol

when people in Middlesbrough tend to choose drugs. What is important is that participants in both towns have, in broad strokes, identified the same set of forces that have marginalised their communities and created profound suffering; these forces are deeply engrained in society and addressing them is a matter of social justice.

8.5 Strengths and Limitations

8.5.1 Strengths

Research on DSA morbidity and mortality in the UK has exclusively used quantitative methods to analyse trends in mortality rates and to examine geographic distributions in morbidity and mortality. While the existing research has provided valuable insight into how DSA morbidity and mortality are distributed throughout the country, notably absent from the literature are the voices of people living and working in affected areas. It is worth noting that this is a deficiency of the literature surrounding DSA morbidity and mortality more generally, as research on these topics in the US has also been dominated by studies using quantitative methods. This study provides novel findings surrounding how DSA morbidity and mortality are understood and explained by people living and working in communities experiencing above-average rates of deaths from these causes. The findings in and of themselves are a novel contribution to the literature, but the study methods and theoretical framing of structural violence can also serve as a framework through which future qualitative researchers investigating DSA morbidity and mortality, or health inequalities more broadly, could approach their research and findings.

The findings of this study are grounded in participants' real-world experiences of living and working in the areas most affected by DSA morbidity and mortality. By drawing on lived experiences, the research offers in-depth findings and authentic perspectives that have allowed for a holistic understanding of the ways in which inequalities in DSA morbidity and mortality have manifested in these areas. Additionally, data were collected from a sample that included stakeholders from a broad range of related fields and community members of various ages and backgrounds. This diverse sample further strengthens the credibility of the findings, ensuring

that the conclusions drawn are comprehensive and reflective of the wide array of viewpoints and experiences present in these areas. Despite the broad range of lived experience represented in the sample, there was little variance in participants' opinions on the determinants of DSA morbidity and mortality (i.e. most participant narratives contained elements of individual, cultural, and structural determinants), suggesting that participants narratives were not heavily influenced by their professional background, age, or level of formal education.

The study findings are comprehensive and are well supported by both empirical and theoretical literature from a range of academic disciplines. This consistency with the broader literature is significant as it validates the selected methodology and enhances the reliability of the findings. The depth of the findings allows for a nuanced understanding of DSA morbidity and mortality, contributing valuable insights into an active field of research that is of interest to academics and policymakers both within the UK and internationally. The framing of the findings through the lens of structural violence is an evocative, novel approach to 'deaths of despair' research that encourages direct engagement with the fact that such deaths are heavily influenced by political and economic decision-making. This study has generated significant findings that will be adapted for publication (one paper is currently under second review). That the findings will be adapted for publication and made publicly available underscores the study's contribution to advancing knowledge and its potential impact on future research and practice.

8.5.2 Limitations

Despite the valuable insights generated in this study, there are inherent limitations to the study design and methodology. In selecting two case study sites, I restricted the amount of time available for me to become deeply immersed in the field, as I had to conclude my fieldwork in both places in time to produce my thesis. As a result, I had approximately six months to identify appropriate recruitment techniques, contact participants, and conduct interviews with stakeholders and community members in each site. While this timeframe was sufficient to allow me to collect meaningful data surrounding peoples' understandings of and explanations for inequalities in DSA morbidity and mortality, more time would have allowed me

to collect richer data. Were I to conduct this study again, I would adopt an ethnographic approach in a single case study site. An ethnographic approach would allow me to become deeply immersed in my selected community, and the extended timeframe would allow me to observe how the determinants participants identified interact to produce DSA morbidity and mortality in real time. Ethnographic data would also strengthen the theoretical concept of the cycle of structural violence, as participants could provide greater insight into the ways through which symbolic violence is inflicted upon them and how, in turn, this facilitates further structural violence.

In interpreting the findings of this study, it is important to consider the sample from which they were derived. While I made every possible effort to engage with a wide range of stakeholders and community members of diverse backgrounds, the recruitment methods used may have failed to reach some communities of people within the case study sites. For example, stakeholders were recruited largely through formal and informal professional networks, which may have inadvertently restricted sampling to only the most networked individuals. There may be groups of stakeholders outside of these networks who view these problems differently that were not reached by recruitment efforts. Similarly, while the community groups I visited and services I recruited through in Middlesbrough and South Tyneside were open to all residents of their respective areas, these groups may feel unwelcoming to, not be known by, or be otherwise inaccessible to people of particular backgrounds or experiences (e.g. refugees and asylum seekers, people who live with a disability, and gender diverse populations). This limitation could similarly have been mitigated had I chosen to work in only one case study site, as I would have had more time available to establish myself in the community and to connect to groups of people who may have been difficult to access.

It is also notable that inherent to this study's design was the exclusion of the groups of people most directly affected by the outcomes of interest, those engaging in DSA-related behaviours. While participants were not excluded on the basis of having experienced one of these problems in the past, I made no effort to actively engage people currently experiencing DSA-related problems. The exclusion of these people was a product of ethical constraints and the need to safeguard participants from harm. I had neither the professional experience, time,

nor resources necessary to safely engage with highly vulnerable individuals, such as those who actively use substances or those at acute risk of suicidal behaviour. While the exclusion of such groups was necessary to ensure ethical research practice, it is a significant weakness of the research as a whole. The findings of this study are generally comprised of people sharing their thoughts and experiences about why *other* people engage in DSA behaviours or experience-related outcomes. People with ongoing lived experience with DSA-related behaviours may view the underlying causes of DSA morbidity and mortality differently than members of the general public. Such research would also provide additional insight into why people of similar backgrounds, make different decisions regarding whether or not to initiate DSA behaviours. The lack is a deficiency that is common throughout 'deaths of despair' research, and the gap in the literature surrounding how people living with these problems understand and explain them remains unfilled.

8.6 Implications for Future Research

The findings of this research have important implications for future researchers studying DSA morbidity and mortality. As previously discussed, there is currently a gap in the evidence surrounding how DSA morbidity and mortality are understood by people at the highest risk of experiencing these outcomes—people engaging in DSA behaviours. Future researchers must make efforts to engage people with direct lived experience. Failure to engage with people at high risk of DSA outcomes continues to marginalise vulnerable groups by excluding their voices from a conversation that is ultimately about them. While there are considerable ethical and logistical challenges in accessing these groups due to their vulnerability, researchers working in close collaboration with qualified healthcare and mental health providers to ensure participant safety could generate important insights into how the people most affected by these issues understand their root causes and propose to solve them.

Additionally, given my concerns surrounding the term "deaths of despair" (discussed in Chapter 2, section 2.1.2), and my findings that these deaths are largely driven by structural forces, I propose that future research should avoid using the term "deaths of despair". Inherent

to the term is an emphasis on individual feelings and experiences, which shifts our collective focus towards individuals and away from the structural drivers of these deaths. In this way, the DoD label is itself a manifestation of symbolic violence within the academic literature, and future researchers should seek to use a term that more directly identifies the structural forces responsible for these deaths. In a forthcoming publication arising from this thesis, I will seek to articulate these concerns about the DoD label and seek to propose an alternative term to describe deaths from these causes.

While there are opportunities for future research within this field, consideration of my findings in relation to the existing health inequalities literature encourages us to consider an important question. How much more research do we need? The factors driving health inequalities in British society are now well understood. Research into countless health outcomes, across a broad range of settings and populations, has all indicated the same thing; health inequalities are ultimately a product of social inequity more generally that is a result of decisions that prioritise profit over wellbeing (Smith and Anderson, 2018, Bambra et al., 2019). Researchers examining health inequalities, and social inequity more generally, have been saying the same thing in different ways for generations (Green et al., 2018, Black, 1980, Marmot, 2013, Linsley and Linsley, 1993). As long as researchers act as if there is more to learn about the root causes of health inequalities, we absolve the political establishment of the need to take action and distract society at large from reconciling with the fact that the way society is currently structured produces suffering and death for some to benefit others. I am concerned that continuing to conduct research examining the root causes of health inequalities, only to find the same things that countless researchers have found before, is to risk becoming complicit in the symbolic violence that allows structural violence to continue.

Future research should place a greater priority on public involvement and co-produced research, listening to their preferred solutions, and supporting grassroots efforts to enact change. Co-produced research would ensure that the voices of those most affected by health inequalities are heard within academia and by society more broadly. These populations offer unique insights into the challenges they face and could help to identify the sort of systemic changes needed to promote social equity, which are often neglected by traditional, top-down

research approaches. Involving these people in the research process, particularly in producing research outputs, would provide the opportunity to both develop solutions to the structural determinants of DSA morbidity and mortality and to identify the mechanisms needed to implement them. By involving community members in the research process, findings can be disseminated in ways that serve the needs of affected communities, and in doing so promote systemic change. This would involve a shift away from traditional research outputs, such as academic papers, conference presentations, and technical reports, towards outputs that people living in affected areas believe would serve their interests in advancing social equity.

Research surrounding health inequalities and social inequity more generally should be leveraged to actively support initiatives aimed at systemic change. The voices of individuals affected by health inequalities are often marginalised and downplayed in public discourse and within the political process. Researchers can play a vital role in amplifying the voices of community members, improving access to resources, and building networks between academia and grassroots organisations so that academic knowledge and resources can be used to support collective action. In effect, I believe that future research on health inequalities should not only seek to deepen our understanding of these issues but also actively contribute to the empowerment and mobilisation of people living in affected communities. By aligning research efforts with grassroots perspectives and initiatives, we can support meaningful, community-driven change and hold the political establishment accountable for addressing the root causes of health inequalities. A collaborative, action-oriented approach is critical for translating research into tangible improvements in health equity and advancing social justice.

8.7 Conclusion

Participants in this study have provided clear answers to the research questions that guided this study. From participant's narratives, it is clear that above average rates of DSA morbidity and mortality in Middlesbrough and South Tyneside are attributable to structural, cultural, and individual level determinants that overlap and intersect to produce DSA morbidity and mortality. Structural determinants, like the effects of deindustrialisation, decisions of the

Thatcher administration in the 1980s, and austerity policies were of particular importance in creating the lived environment in which people were suffering and in which they would turn to DSA behaviours for relief. Participants in this study believed that many of these structural factors had a disproportionate impact on Northern communities like Middlesbrough and South Tyneside, and the empirical evidence discussed throughout this thesis supports that view. Through the theoretical framing of the cycle of structural violence, I have demonstrated that geographic inequalities in these deaths are not natural, they are manifestations of the social inequity that is perpetuated and maintained by the cycle of structural violence.

Viewing the findings of this study through the lens of the cycle of structural violence unveils the profound impact of systemic inequality. Such a framing allows for a clear understanding of how each theme in this study results from or perpetuates, a cycle of violence that has inflicted suffering and death upon marginalised people in vulnerable communities. This study has demonstrated how neoliberalism has ultimately created and maintained the inequalities in wealth and opportunity that drive the inequalities in DSA mortality in Middlesbrough and South Tyneside. While framing this finding through the lens of the cycle of structural violence is evocative, the finding itself is hardly unique. It is well established that people born into different social circumstances experience avoidable differences in outcomes across virtually all domains of health (Marmot, 2013, Goldblatt, 2024, Bambra, 2016, Lewer et al., 2020, Bambra, 2019, Marmot et al., 2020). Quantitative evidence shows that inequalities in DSA morbidity and mortality follow well-established geographic patterns of health and wealth inequalities more generally (Walsh et al., 2021, Camacho et al., 2024). The findings of this study indicate that DSA morbidity and mortality are simply manifestations of much broader inequalities in health and wealth that have become ingrained in British society.

It is neither natural nor unavoidable that some places experience dramatically higher rates of DSA morbidity and mortality than others. These health inequalities are a product of decisions that prioritise the wealth and well-being of the few at the expense of the many. There are strong economic arguments to be made that inequity is bad for society as a whole, but there is also a simple, unavoidable truth; these inequalities are not fair. It is not fair that where one is born has a dramatic effect on one's economic prospects, lifespan and manner of death. It

is not fair that political and societal structures permit those living in deindustrialised, northern communities to bear a disproportionate burden of suffering and death from drug, suicide, and alcohol-specific causes. Addressing inequalities in DSA morbidity and mortality in Middlesbrough, South Tyneside, and other affected communities requires a direct reconciliation with whether or not we wish to live in an equitable society that allows everyone, regardless of where they are born, the same opportunities for health and well-being. Ultimately, addressing DSA morbidity and mortality inequalities is a matter of social justice, rooted in the need to rectify fundamental inequities within society.

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Appendix A: Topic Guides

Below are the topic guides that were used while conducting interviews with community members and stakeholders.

Participant

- Can you tell me a bit about yourself?
    - How long have you lived in PLACE? Do you like it here?
    - If participant is employed- what do you do for work?

Case Study Site

- Can you tell me a bit about PLACE and the people who live here?
    - What is it like to live in PLACE?
    - What are some of the biggest challenges you think people in PLACE face?
    - How have you seen PLACE change during your lifetime?
        - What impact do you think this has had on the people living here?

Beliefs about Causation

- Do you think PLACE has a problem with deaths and illness from self-harm, alcohol use, and drug abuse?
    - Do you see poverty as playing a role in these problems?
        - In what ways?
    - Do you see mental health as playing a role in these problems?
        - In what ways?
    - Do you think these problems are more common in PLACE than elsewhere?
        - Why or why not?
    - We know that these problems often disproportionately impact men. Do you have any thoughts on why that may be?

Solutions

- What do you see being done in the community to address these issues?
    - What has been done well?
    - What has been unsuccessful?
- Thinking very broadly now— lets imagine you had unlimited resources at your disposal. What changes would you make to solve the problems with drugs, suicide, and alcohol in this community?

- Is there anything else you would like to tell me about all of this before we end the interview?

Participant

- Can you tell me a bit about yourself?
    - Do you live locally? How long have you lived here?
- Can you tell me about your work and what you do?

Case Study Site

- Can you tell me a bit about South Tyneside and the people who live here?
    - What are some of the biggest challenges you think people here face?
    - What factors about South Tyneside have changed over the last several decades? What impact do you think these have had on the people living here?
    - What are your thoughts on the mental and emotional wellbeing of people in South Tyneside in general?
    - Can you tell me about the drinking culture here? Is it different from other places?

Beliefs about Causation

- What do you think is driving deaths and illness from suicide, alcohol use, and drug abuse in South Tyneside?
    - Are there factors that make people more susceptible to these problems? What do you think those are, and what makes you think they're important?
        - Economic Factors? Mental Health?
    - What factors make people more resilient to these problems?
    - We know that these problems often disproportionately impact men. Do you have any thoughts on why that may be?

Solutions

- What is being done in the civic level to address these issues? At the service level? Community level?
    - What has been done well? What has been unsuccessful?
    - What do you think the major barriers/limitations to addressing these issues in South Tyneside are?
- Thinking very broadly now— lets imagine you had unlimited resources at your disposal. What changes would you make to solve the problems with drugs, suicide, and alcohol in this community?

- Before we close, is there anything else that you'd like to tell me that you didn't get a chance to say during the interview?