POWER, POWERLESSNESS AND THE POLITICS OF MOBILITY: RECONSIDERING MENTAL HEALTH GEOGRAPHIES

ABSTRACT:

We use a qualitative, longitudinal study of 25 individuals with mental illness in the UK to better understand the relationships among mental health, power/lessness and im/mobility. Framed by the rise of the new mobilities paradigm and more specifically Cresswell's (2010) politics of mobility, we find that the extent to which the respective mobilities were expressions of internal free will or were undertaken as a result of external compulsion is a key demarcator of mental health. A key contribution is understanding the involuntary nature of (forced) immobility, or what we call entrapment. Entrapment is a punishing phenomenon, which causes distress to those unfortunate to experience it, and which can often be deepened rather than alleviated by those statutory bodies charged with providing care and support. The results speak to the need to recognize that (1) mobility is always relational and contextual, (2) (im)mobility is as much involuntary as voluntary, and that this has crucial implications for (mental) health, and (3) that the experience of individuals suffering from mental illness very much overlaps with what Philo (2017) called 'less-than-human geographies', providing a much-needed rebalance to the over-emphasis on well-being within health geography and (mental) health policy.

KEYWORDS: mobility; immobility; power; mental health; entrapment; less-than-human geographies

POWER, POWERLESSNESS AND THE POLITICS OF MOBILITY: RECONSIDERING MENTAL HEALTH GEOGRAPHIES

Introduction

The promotion of a new mobilities 'paradigm' (Sheller & Urry, 2006) has been presented as the zeitgeist of the social science research agenda for the early twenty-first century, where 'society' as an ontological approach is replaced with an alternative based on mobility (Adey, 2010). When mental health geography has treated mobility - or the lack thereof - as an explanatory factor in the spatial distribution patterns of mental ill-health, it has tended to do so in a rather one-dimensional manner: the incorporeal 'mentally ill' semi-voluntarily adrift across the urban plane, pushed and pulled by forces beyond their control. However, if this mobility is investigated less as part of a spatial patterning and more as part of the experiences of those involved in creating them – and the constraints imposed externally by various institutions - then we can begin to develop a *politics of mobility* in tension between power and powerlessness, moving and not moving, mental health and ill-health.

In this paper, we apply this politics of mobility to the geographies of individuals with mental health issues, particularly the tensions between (1) the voluntary and involuntary, and (2) between mobility and immobility, using the first element of Cresswell's (2010) politics of mobility, that of *force*. Taking interview material from 25 individuals with mental health problems in the UK, we focus on illustrative experiences of (im)mobility that reflect the extent to which each individual is able – or perhaps equally as important, *feels* able - to exercise some say over their residential circumstances within a larger power structure (Herbert, 2010; Jocoy & Del Casino, 2010). That is, the extent to which the respective mobilities discussed here

were expressions of internal free will or were undertaken as a result of external compulsion. Once we have established concepts of (im)mobility and power/lessness within mental health geographies, we outline the general mobility patterns that emerge from the 25 interviews, before proposing an in-depth investigation into the mobilities of 3 individuals in particular, surmising a few overall lessons. These include (1) mobility is always relational and contextual, (2) (im)mobility is as much involuntary as voluntary, and that this has crucial implications for (mental) health, especially through (involuntary) spatial entrapment, and (3) that the experiences of individuals suffering from mental illness very much overlaps with what Philo (2017) called 'less-than-human geographies', which involves a much-needed rebalancing away from the over-emphasis on well-being within (mental) health geography and mental health policies.

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A politics of mobility and mental health geographies

Mobility is always *relational*. That is, it is continually occurring with, against, through or alongside some other thing or things which are themselves far from static (Adey, 2010: 13). It is this 'friction' (Cresswell, 2010) against other things, allied to the idea of fluidity and change in pace (and place) that imbues movement with meaning and thus allows it to be theorized as mobility (Adey, 2010). The upending of traditional frameworks of fixity and boundedness, and their replacement with mobility has particular implications for the theory and practice of human geography (Cresswell, 2010). Accordingly, recent years have seen the growing prominence of scholarship on both the theoretical implications for geography of the mobilities 'turn', and on different ways that geography can engage with the mobilities research agenda (Adey, 2010; Bergman & Sager, 2008; Cresswell 2010, 2012; Merriman 2009).

However, and despite somewhat grandiose claims made on its behalf as representing an apex of liberation and powerfulness (e.g. DeVerteuil & Manley, 2017), mobility is not new, and is experienced and represented in both positive and negative ways, with the value placed upon it varying temporally, spatially and contextually (Cresswell, 2010). Rather than being primarily or solely concerned with where someone or something is coming from or going to, it is also interested in how it is experienced, what it feels like, and whether it is subject to any resistance (Cresswell, 2012). Further, mobility pays attention to the wider socially patterned, hierarchically organized and power-laden context in which mobility occurs (Vojnovic et al, 2019).

One way to focus these points is through Cresswell's (2010) *politics of mobility*. For him, mobility has been coded widely, "…as dysfunctional, as inauthentic and rootless and, more recently, as liberating, antifoundational, and transgressive in our own forms of representation" (Cresswell, 2010: 19-20). Drawing together insights from a variety of disciplines and perspectives, Cresswell (2010) attempts to delineate a 'politics' of human mobility. He suggests six key elements of mobility, each of which is mutually constituted with the social relations in and through which the mobility occurs. First, that mobility involves *force*, in which people respond to internal or external forces by choosing or being compelled by others to engage in some form of movement. Second, movement involves *velocity*, with differential social value accorded to different speeds. Third, there is a *rhythm* to movement, which can be simultaneously repetitive yet open to difference or alteration. Fourth, movement is not distributed evenly across space but occurs through *routes*. Fifth, movement involves *feeling* – movement is experienced through the human body. Sixth, that mobility cannot occur without *friction*, as it necessarily

involves coming into contact with other things and must come to an end at some point.

Human mobility remains intricately entwined with questions of power and identity, and operates not in a vacuum removed from prevailing policy prerogatives and structures but is deeply embedded within them: "There is a politics and geography of power bound up with practices and discourses of both mobility and fixity ... The geographies of mobilities are inseparable from particular materialities ... New connectivities and mobilities produce geographies of exclusion, disconnection, inequality, and immobility" (Merriman, 2009: 135). This politics further resonates with feminist takes on mobility and the politics of home (e.g. Brickell, 2012), which recognizes that 'mobility' is always a messy and contested theoretical starting point for research.

The element we apply is that mobility involves *force*. But what are the implications of Cresswell's insights for understanding mental health geographies? To broach this topic, we must first broach the longstanding literatures on housing, mental health and migration (e.g. Kearns & Smith, 1994; DeVerteuil et al, 2007; Lix et al, 2007; Smith, 2012). Most of this literature focuses on intra-urban migration, although a few have underlined the long-distance migration patterns (Philo and Parr, 2004). The mobility patterns of individuals experiencing mental health problems have often been represented as the migration to service-rich cities (Dear & Wolch, 1987), alongside the concept of hypermobility, in which individuals 'churn' through various institutional or community settings, and whose personal mental health histories are closely entwined with periods of psychiatric treatment, particularly inpatient treatment (e.g Hopper et al, 1997; DeVerteuil, 2003; DeVerteuil et al, 2007; Appleby & Desai, 1987). A series of primarily quantitative analyses in both North American

and European settings have attempted to bring a semblance of order to the often chaotic residential patterns that people experiencing mental health problems leave in their wake. The majority of studies show that individuals experiencing serious mental health difficulties have greater residential instability than the general population (e.g. Dembling et al, 2002; DeVerteuil et al, 2007; Lamont et al, 2000; Lix et al, 2006; Tulloch et al, 2011). At the urban scale, studies in Winnipeg (DeVerteuil et al, 2007; Lix et al, 2007) found that individuals experiencing serious mental health problems were also more likely to be moving in the opposite direction (e.g. to the inner city) when compared to general suburbanizing trend of the control cohort. This builds on longstanding ideas about the 'drift' hypothesis (Faris & Dunham, 1939; Dear & Wolch, 1987; DeVerteuil et al, 2007), whereby individuals developing mental illness drifted into inner-city areas as part of downward social mobility, seeking service-rich places that provide cheap housing and tolerate their behavior, and subsequently leading to some kind of geographical immobility *in situ*. This operates alongside the 'breeder' hypothesis, in which predisposed individuals are more likely to develop mental illness in chaotic, transient inner-city locales. While useful, this breeder hypothesis has little to say about mobility.

Worse yet, individuals with mental illness are over-represented among the homeless population, and suffer longer bouts of homelessness than other groups (Hopper et al, 1997; Knowles, 2000; DeVerteuil, 2003). The hypermobility associated with homelessness can be both strategic – as part of a self-determined strategy that allows individuals to secure their basic needs of survival – but can also be detrimental to their mental health. DeVerteuil (2003) as well as Schliehe (2017) underline the vulnerabilities inherent in this involuntary 'churn' among a variety of unrelated settings, speaking explicitly to Cresswell's (2010) 'force' but also to his idea of

'rhythm', in that churning involves repetitive and limited mobility in and out of housing, the street, health-related and carceral settings.

This literature suggests that being mobile does not automatically endow individuals with greater power, not least because of the severe limitations placed on the exercise of individual agency (Jocoy & Del Casino, 2010). Indeed, homeless individuals with mental illness generally experience more complex needs, particularly if conjoined with addictions (many of which are actually examples of self-medication), and homeless episodes tend to be more enduring and traumatic (Sullivan et al, 2000; Culhane et al, 2002). The role of institutions is equally complex, with some imposing a modicum of residential stability (e.g. shelters, supportive housing) while others a cause of residential instability, particularly upon release (e.g. hospitals) (DeVerteuil, 2003).

Up to this point, it would appear that mental illness and residential instability are inseparable, and that this is generally seen to be negative. However, some studies have questioned whether residential mobility per se should always constitute a negative outcome for individuals with mental health problems, and have instead asked if in certain circumstances its counterpart - residential immobility or entrapment – might be seen to represent a greater threat to mental health (Drukker et al, 2005; Ross et al, 2000; Whitley & Prince, 2005). Ross et al (2000: 581) claim that in "affluent neighbourhoods, stability is associated with low levels of distress; under conditions of poverty the opposite is true". They argue that areas of high socio-economic deprivation will often see higher levels of social disorder and that, for these areas, stability does not result in lower levels of social disorder. Residents therefore may feel powerless to leave, and their entrapment in such places can have deleterious impacts on their mental wellbeing. These deprived areas are representative of

neighbourhoods of "last resort, where people remain, not because they choose to, but because they have no other options" (Warner & Pierce, 1993: 499; see also Drukker et al, 2005). Poor yet affordable housing can chain residents to insalubrious areas and buildings.

In this paper, we are particularly interested in the experiences of both mobility and immobility as they relate to power and powerlessness, health and ill-health. The precise lines of demarcation in these power relations remain unclear but certainly worthy of further study:

> Clearly, the relationships between mobility/immobility and power/powerlessness (i.e., mobile is to powerful as immobile is to powerless) do not operate in the same way for different groups in and across space-time. Although more power (e.g. gained from court rulings) might afford more mobility (e.g. citizens' inter-state migration), more mobility (e.g. homeless people forced to vacate public space) does not impart more power (Jocoy & Del Casino, 2010: 1947).

So, hypermobility can reflect a certain powerlessness among individuals with mental health problems, but can immobility as well? What role does individual agency play to shape one's mobility patterns? More critically, what do these tensions between power/lessness and im/mobility have to do with mental health? The literature offers some clues, but remains sketchy given the over-emphasis on the mobile to the detriment of the immobile (DeVerteuil et al, 2019), as well as promoting the study of mental well-being over mental ill-health.

To finish this section, we find it important to underline the actual politics of mobility. In effect, notions of individual (im)mobility, power and health must always be set within larger enabling and disabling contexts and power structures. A crucial

and motivating external factor for this study is the ongoing reconfiguration of the UK welfare state, which presents acute challenges for people with mental health problems who tend to suffer disproportionately higher rates of unemployment (Boardman & Rinaldi, 2013), and thus especially reliant on welfare benefits and services for support. Since 2010, restrictions on entitlement (including reassessments for ongoing entitlement) to sickness and disability benefits, reinforced by a focus on 'work-led' recovery, and dramatic changes to housing support for low-income people, all threaten those most reliant upon the welfare state. In the next section, we outline our methodological approach to address questions of im/mobility and power within this emerging context, relying on a qualitative study of individuals with mental health issues within a larger context of a reconfiguring welfare state in the UK.

Methods

This study was based on intensive PhD research undertaken through support from the University of Southampton, lasting 24 months. The logic behind the study was to better understand the mobility patterns of individuals with mental health illness within a context of fundamental benefits restructuring in the UK. Within this context, the methodological approach situates the present study squarely within qualitative studies in mental health geography, which have frequently made use of in-depth interviewing (e.g. Hopper et al, 1997; Parr, 2008) often supplemented by ethnographic approaches (Knowles, 2000; Parr, 1999, 2000). Seeking to humanize the hitherto largely disembodied 'mental patient', qualitative mental health geographers aimed to place their participants' subjectivity – through their voices and stories - at the center of their research. Hester Parr has cautioned researchers to be aware of the sensitivities surrounding the use of interviews with respondents with mental health problems. One

of the key challenges relates to the ability to seek out, record, and relay the voices of '[O]thers' whilst avoiding appropriating or taking ownership of those voices (Pinfold, 2000; DeVerteuil, 2003). However, in seeking to avoid being too *distant* from participants, there is the chance that we end up being too *close* to them and this, too, can be equally problematic - we may unwittingly shift our participants into the position of supplicant:

> As a geography researcher I am neither trained nor consistently available for participation in 'therapeutic' conversations, and therefore could potentially inflict damage upon an individual's own coping strategy. There is a great difference between being a source of support in the 'safe space' of an interview context and being a sole, identified, demarcated therapist (Parr, 1998: 346).

We sought to locate a space that allows a degree of detachment whilst maintaining 'sympathetic understanding' toward respondents, yet still capable of promoting an understanding of their mental health, mobility and wellbeing under contemporary conditions of welfare retrenchment (Wolch & Philo, 2000).

In late 2014, we recruited a sample of interviewees in the Greater London area by working through gatekeeper voluntary sector organizations, with the aim of securing thirty participants who could speak to issues of residential mobility and benefits reform. We contacted various local mental health charities to enlist their support. Of the several dozen approached, two offered their assistance, and for both we met informally with service users before seeking their agreement to be interviewed. The first research site, based in Inner London, yielded eight interviews; the second, based in a large regional city, provided ten. Additionally, interest in participation was issued via the online newsletter of a national service user-led

organization, generating about a dozen expressions of interest from across the UK. After narrowing the list to those participants with whom it was practical to engage in the research, a further seven interviewees were recruited, giving a total of twenty-five participants.

Our intention was to pick research locations that were potentially typical of inner-city environments with high levels of poverty, challenging housing conditions and a prevalence of alleviating services, thereby combining the drift and breeder hypotheses. The residential circumstances of twenty-one participants met these criteria. The remaining four lived in smaller towns or cities in the south of England, and for each case these were either the most populous settlement in the respective county or the county town, and thus potentially service-rich. We sought to recruit sufficient numbers of 'information-rich' (Mifflin & Wilton, 2005) participants through which "[t]he living and telling of life as stories highlights the individual choices unique to each biography, [and] in which individual life trajectories are as significant as the broader (social) spatial and policy concerns in which they are cast" (Knowles, 2000: 10), but which nonetheless also allowed the larger structural factors (e.g. housing, welfare) that could be linked post-study to issues of im/mobility, power/lessness and mental health (DeVerteuil, 2003; Marr et al., 2009).

Notwithstanding attrition, each interviewee was re-interviewed after six and twelve months to generate a biographical picture that would elucidate both the longitudinal and episodic aspects (May, 2000) of experiences of (im)mobility. This longitudinal element served to anchor individual mobilities to larger structural forces that point-in-time snapshot surveys frequently fail to capture. Due to delays in participant recruitment, and the cumulative effects on the overall time allowed for the overall fieldwork, it was only feasible to re-interview eight participants across three

different occasions. A further thirteen were interviewed twice (initially and again at the six-month stage), with the remaining five only being questioned once. For the subsequent analysis, we focused on the tensions among experiences of (im)mobility, power/lessness, and un/health, emphasizing three case studies that captured the range of experiences across the sample, using pseudonyms.

Results

Residential mobility here was defined as a person having experienced a residential move of at least one nights' duration in the eighteen-month 'retrospective' period preceding the date of first interview and/or in the time which elapsed between the initial and final interviews. A minority, or nine interviewees, met these criteria. This lower-than-anticipated number is probably related to the sampling/methods of recruitment difficulties commented upon in the methods section. As Table 1 shows, three primary reasons for the mobility could be discerned: hospitalization, precarious housing, and extenuating home circumstances. These scenarios, and the particular events allied to them in respect of each interviewee, are explored in more detail in the results that follow.

Table 1 Participants' residential mobility

Reason given for residential mobility	**Participant(s)**	**Predominately a voluntary or involuntary form of mobility?**
Hospitalisation	Harry Jessica Ruth	Involuntary Voluntary Involuntary

	Yann	Involuntary
Precarious housing situation	**David** **Christine** Stephen	Involuntary Involuntary Voluntary and Involuntary
Home circumstances	Laura **Liam**	Voluntary Voluntary

An array of experiences - current, incipient, previous, or feared homelessness; eviction and displacement; circulation; repeated hospitalizations; entrapment; voluntary itinerancy - is evident across the accounts. Yet they share the degree to which the lives of most service users are governed by feared or actual residential instability, but sometimes voluntary mobility as well for 3 of the 9 mobile respondents. The remaining 16 interviewees were immobile during the specified period of the study (though most had multiple experiences of hospitalisation and generalised disruptions to their living arrangements during the course of their lives) for a variety of reasons. These ranged from being involuntarily entrapped in certain residential situations given deep-seated poverty, to voluntarily 'staying put' that sat well with certain respondents at this point in their lives. For the purposes of this paper, we focus on the group of 9 who experienced at least some mobility, but also immobility, during the time under examination.

Three specific case study interviews are contrasted in this paper, as they illustrate especially well facets of the tensions among im/mobility, power/lessness and mental health, as well as larger structural constraints upon individual agency and the politics of mobility. Each demonstrates the extent to which having a degree of personal control over residential circumstances is crucial for service users' attempts to

maintain stability in their mental health. This underlines the extent to which questions of (im)mobility cannot be divorced from questions of power/lessness (Jocoy & Del Casino, 2010). For Christine, who had, in short order, been evicted and abandoned in temporary accommodation, and Liam, who for over a decade been stuck in inadequate accommodation, their enforced and unwanted housing situations ill-served their mental health needs; indeed, at their worst, they were a cause for active suicidal ideation. This is followed by David, whose experiences sit at the hard edge of mental health users' experiences of hospitalization, eviction, rough sleeping, hostel dwelling, substance addiction and self-harm.

Involuntary mobility begets involuntary immobility: Christine's story

> I was made homeless in the run-up to the Olympics, when landlords were getting extortionate rents. I went to the council, you had to go through the eviction procedure. So the same day you are evicted you go to the council and they give you temporary accommodation which, before you even see it, you have to accept it, and this was the place. And I was under the impression it would only be for a few months. (Christine, 58, mental health service user, East London)

When we first travelled to an inner suburb of East London to which Christine had been displaced, her time in 'temporary' accommodation had topped two years. The two-bedroom private rental flat she had previously shared with her teenage daughter had become a one-bedroom flat in a converted Victorian house occupied by other temporarily-housed families. Among the first remarks Christine made when asked to discuss her housing circumstances was to emphasize her powerlessness over her fate

– "you get no choice" - and to describe the process of experiencing eviction and being relocated in temporary accommodation:

> It was a nightmare…I became really, really ill, especially when I discovered that the council force you – the landlord has to take you through the court proceedings to formally evict you. I didn't realize, that on the day you're evicted I thought you had the whole day to get your stuff out, but you don't you have to go there and then. So, I went from there to here whilst my stuff went to South London [to go into storage]. It was awful, awful, I cried for days, and when I saw this place, I absolutely hated it.

For Christine her dislodgment was doubly damaging, involving a displacement from both home *and* local area, as the local authority, pleading an acute shortage of appropriate housing, placed her into a different but adjacent borough that was unfamiliar to her, and where she knew no-one. This geographical shift in location had quite particular ramifications, none of which were conducive to Christine being able to help stabilize her already fragile mental health.

First, Christine's teenage daughter attended a good secondary school close to where she had been living and Christine was loath to have to move her daughter closer to their new home, particularly as she had been led to believe that 'temporary' accommodation meant precisely that. Her daughter thus had to make a substantial unsupervised journey to and from the school each day and Christine's relative distance from her daughter during the day was a particular source of worry. Second, the accommodation into which Christine and her daughter had been decanted was palpably failing to meet either of their needs. Christine was sleeping on a sofa bed in the sitting room, allowing her daughter the privacy afforded by the single bedroom. Consequently,

> I have no space for myself. So, for example, when I do become depressed or anxious, I can't bear stimulation – I can't bear lights, noise, stimulation, anything – so I need a space, if I had a space to just to be quiet for a couple of hours, a space of my own, it would make all the difference. But I don't. I have to sleep here in this room, everything I do is between here [sitting room] and there [pointing to the adjoining kitchen].

Third, the inadequacy of Christine's accommodation is compounded both by the refusal of her 'home' local authority to accept her need to be rehoused, and by the difficulties of being 'temporarily' placed out of borough:

> Yeah, they basically said that they don't accept that living here has an impact on my mental health. I've sent in letters from the psychiatrist on two occasions, I've also sent in letters from my psychotherapist, and my GP, but apparently living here doesn't have an impact on my mental health. They seem to have their own policies now – disregard everything and just carry on doing what they're doing. Despite the fact that I have been suicidal several times, went to see the psychiatrist several times – I was really, really down – and also physical complaints because I have to sleep on the sofa. I have arthritis, and my back hurts, I suffer with insomnia. It makes it difficult if you're in temporary accommodation in a different borough, because the services that are linked to the borough you're from you can't use them because you don't live there. You have to use the services in the borough in which you're living, but they often don't have any contacts with the borough you're from, and the people they should be contacting they don't know who they are. So that takes even longer to get anywhere.

Christine was understandably bitter about her treatment and the lack of acknowledgement by the local authority of her particular requirements, and worn down by the constant battle to try to make headway against a tide that seemed to be carrying her ever further from her goal of stability and security for her, and her daughter. When we met for the second time in early Spring 2015, Christine has been in her 'temporary' accommodation for over three years and believed that

> I don't stand much of a chance of moving from here anytime soon. I've done everything I can to get some kind of priority but it hasn't made *any* difference *whatsoever* ... I've kind of given up hope – it feels kind of pointless sometimes and what's the point of doing anything or trying anything [else]. [But] why should I accept that this is ok? I know this is better than the way some people live, I know there's whole families to one room, maybe I should think myself lucky, but *why* should I when it's just not good enough. It's just not good enough.

Christine's story very much showed how one involuntary move to an inappropriate and inadvertent place could then lead to involuntary entrapment, elements of which spill over into Liam's story below.

Liam's entrapment

> I can't stand living here and I have no prospect of moving. For me, my flat is a prison. The only reason why I am not dead is that there are no ligature points in my flat. I am so unhappy there. (Liam, 48, mental health service user, Central London)

Thus Liam introduced us to his feelings about his domestic situation when we first met in January 2014. Like Christine, Liam had become seemingly marooned in

inadequate accommodation, was involved in a long-running dispute with his housing association over his predicament, and felt his mental health was being severely compromised by the 'pokey' size of his flat, further lessening his ability to maintain a family life with his wife and young daughter who had left to live overseas:

> No sane, rational person would say that my accommodation is suitable for a family of three because it's just too small ... [as] my property was renovated in 1998 so since there was no minimum size set out [in law], my housing association took advantage of that and made a property that would be suitable for an elderly couple but that's not suitable for a family home. And that's one of the consequences – my family don't live with me – and that is a great source of personal anguish, that I am separated from my family.

Liam had been resident in the flat since 1998, and despite over two hundred viewings from prospective tenants with whom he and his family could switch, no offers had been made. In each of our three interviews, Liam said he had "no prospect" of moving and was effectively resigned to remaining a "prisoner of [name of central London borough]". His dissatisfaction with his housing situation, with residing in central London with its attendant noise, crowds and pollution, had led him to attempt suicide and he was filled with a distant longing to return to the rural Scotland of his childhood:

> I live in Zone 1 in Central London, I have no choice but to be in crowds. I would love to be 'far from the madding crowd'. I would love to be back in Scotland where I grew up in a small village. I would love to be back there. This is why I call myself a prisoner. I don't have the economic means to change my life. I don't have the opportunities ... I've given up on life.

Liam's position was compounded by the long dispute with his housing association, by whom he felt to himself to be persecuted. Liam considered himself to be a victim of 'harassment' by his neighbors. He explained:

> They said I was making noise in the middle of the night. As you know, I am trying to write a book and so – my first thought was that the typing on my keyboard must be disturbing my neighbors, said I was making noise at two o'clock in the morning, three o'clock in the morning, five o'clock in the morning. Well, how can I prove I was asleep? How can I prove I was not doing something at that time? So to gather evidence, someone said put a noise monitor and that was supposed to go into the flat of the people making the complaint. They said no. As an alternative they asked whether I would be prepared to accept the noise monitor in my property and I said yes. Now, if you go to court you have to have evidence. [They] are taking everything my neighbors say as gospel and everything I say as unreliable. I have a bit of previous experience with the housing association. If you complain your landlord will take revenge and evict you. And that applies to social landlords as much as private ones. It really is an Orwellian nightmare if you're in public [housing] sector.

The situation Liam finds himself in was one that is unenviable in the extreme. Unlike Christine who is ostensibly still in temporary accommodation, and therefore *might* be moved to something more appropriate, Liam's housing tenure is permanent, his sense of entrapment complete, with detrimental effects on his mental health. He found some relief from his unhappiness in his writing (in the course of our interviews he became a published author) and through his activities connected with the wider service user and anti-psychiatry movements.

Mobility as a result of precarious housing: David

A little over two years before first making contact in July 2014, his life having been "taken over by drug use", and having endured a breakdown, three serious suicide attempts and three periods of hospital admission, David, a former trader in the City of London, found himself sleeping rough. At the time of our first interview that September, he had been for sixteen months living in a one-bedroom private rented flat in inner west London, supported by housing benefits. When we spoke next, at the end of March 2015, David was facing the prospect of imminent eviction.

Returning to the period before the first interview, and after two months of living on and around the streets of Central London, wandering the city at night for safety reasons and sleeping in parks during the day, David was taken into hospital:

> I was sectioned while they helped me get off the drugs, I was in hospital for thirty-odd days. The hospital didn't really assist me in any shape or form in regards to getting accommodation and in the end they put me in a bed and breakfast to actually get me out of the hospital. I had another meltdown [and] I went into A&E and they put me back into hospital. I was there for about a week and half and the ward manager pushed the Council and they agreed to put me into a hostel in the borough so that I was near my support network.

The hostel, a privately run 164-bed hostel in Central London, provided David with the minimum of a roof over his head, but little more. His descriptions confirm previous studies that have noted that hostel dwellers tend to be "isolated from mainstream care and hostels to be places where disorder is 'contained' but not alleviated" (Craig & Timms, 2000: 208). To David, it was a "hell-hole" in which neglectful owners, eager to minimize running costs in advance of an imminent sale and conversation into luxury flats, routinely ignored basic maintenance and cleanliness. Loathing the

communal parts of the hostel and finding the box-like atmosphere of his room further constricting his impoverished senses of wellbeing and dignity, David was delighted when, after seven months, he was moved on to supported accommodation in Central London; and from there, three months hence, to his private flat.

Despite this apparent progress toward stability, at the close of the September conversation David explained that he was in an already protracted dispute over the failure of the landlord to ensure the proper upkeep of the property, and was being menaced with an eviction notice. As a consequence, his advancement away from shaky residential settings into more sustainable accommodation and toward longer-term stability of mental health was threatening to stall. When we spoke the following March, matters had come to a head and he had been served a court order instructing him to vacate the property. He surmised that the eviction rested on two issues: the landlord wanting a "trouble free tenant" and an increase the rent, which would place the weekly rental cost of the flat outside the maximum permitted under housing benefit reforms. In conversation he picked up this point:

> [F]rom conversations I've had with other people in the area it seems to me that people who are on housing benefit are being slowly squeezed out of the borough. Because obviously [this] is a place where people want to live but the allowance is not enough ... because there is obviously more and more demand on rental accommodation.

As a result of the anxiety engendered by his situation, David has been spending time away from his home, mostly with friends. Asked how he was, David explained that "I was supposed to come home last night but I actually didn't bother coming home because the thought of going there at the moment really upsets me". He was crystal clear about his potential predicament: "Well, I am essentially going to be made

homeless, yeah. That means going into a hostel or bed and breakfast and sort of going back to the beginning again". In concluding our conversation, David struck a note of defiance amid the resignation, echoing the sentiments expressed by service users in other, similar studies (DeVerteuil, 2003; Herbert, 2010; Knowles, 2000). For him, as for other service users interviewed through this research in similar situations similar, his current quandary represented merely another involuntary obstruction on the torturous path to recovery and around which he would have to find an alternative route.

Discussion and Summary of Findings

Mobility, and its counterpart immobility, is always felt relationally and contextually. From our study, it was largely through involuntary influences that individual residential circumstances were felt and experienced. More specifically, Christine's and Liam's cases are illustrative of several important points from the literature. First, they illustrate that residential entrapment serves to damage further already damaged people (Drukker et al, 2005; Ross et al, 2000; Whitley & Prince, 2005). Second, that entrapment can result from the active emplacement of people whose health has already been compromised into deeper deprivation and exclusion (Smith & Easterlow, 2005), reflecting the inherent powerlessness in the downward social mobility of the 'drift' hypothesis and the subsequent churning within service-rich inner-city areas. Periods of these kinds of involuntary mobility can exist alongside, and may eventually presage, involuntary immobility via entrapment.

Third, that a saturated, high-cost housing market like the Inner London borough from which Christine was displaced, almost ensures that future opportunities

to move ‘back’ will be severely constrained. And fourth, that such displacement undermines

> the degree to which the social geographic dimensions of people’s location allows them to build networks of relations that improve their life chances and their health chances ... [and which] increases the likelihood that less affluent people may be ‘prisoners of space’, lacking connections to opportunities outside their immediate neighbourhood environment (Dunn, 2000: 356).

Similarly, David, whose particular trajectory though the mental health and homeless systems further reflects the housing and mental health literatures (DeVerteuil, 2003; Hopper et al, 1997; Knowles, 2000), in that fluctuations in mental health are clearly implicated in examples of instability in residential circumstances, leading to ‘churn’ and hyper-mobility and/or hospitalization. This raises important questions as to whether deteriorations in the health of the kind that have in the past presaged residential mobility - with all the personal distresses and costs these entail - may yet go unnoticed by over-stretched and under-resourced services.

Overall then, the residential (im)mobility patterns of mental health service users are most easily understood with reference to questions of power and control, in particular the *ultimately involuntary nature* of most of the patterns described herein, though certainly not all (see Table 1). This sheds light on some crucial power structures that impinge upon individual agency, including the housing market, the benefits system, the health system, and large-scale displacing events such as the 2012 London Olympics. This volatility is mediated by potent forces internal and external, which exist in spaces both real and imagined – especially the rental market, housing policy and benefits policy - beyond the purview of service users’ control. Thus, it is

through the extent of these involuntary influences that the individual residential circumstances of study participants have predominately been felt and experienced.

Clearly, this is not an entirely novel finding, but it remains a valuable one, especially in the current era of welfare retrenchment in which compulsory relocations can be foisted upon benefit recipients. Yet a certain individual agency remained for those who moved or stayed voluntarily - mental health service users practice particular forms of mobility in their attempt to maintain mental health stability, once more demonstrating the desirability of allowing them to help judge which residential circumstances are in the best interests of their own health and wellbeing. The results speak to the intimately relational nature of mobility and immobility, power and powerlessness, that run alongside Philo's (2014) and Murray's (2018) work using Foucault to frame the parallel experiences of people with learning disabilities. From this historical work, both authors underline the thoroughly entangled set of dialectics between mobility and immobility as always partly beneficial and moral, but also always partly detrimental and immoral, depending on the circumstances.

A key contribution is understanding the involuntary nature and drawbacks of mobility but especially immobility and entrapment. Entrapment is a punishing phenomenon, which causes significant distress to those unfortunate to experience it, and which can often be deepened rather than alleviated by those statutory bodies charged with providing care and support, such as hospitals and the social housing sector. The negative impact that feelings of seemingly permanent residential entrapment has had on the mental health of participants in this study echoes the findings of other studies (DeVerteuil et al 2007; Drukker et al, 2005; Lix et al, 2006; Ross et al 2000; Whitley & Prince, 2005) and also help to confirm "how the intimate

and personal spaces of home – and their loss – are closely bound up with, rather than separate from, wider power relations" (Brickell, 2012: 229).

Further, these other studies counter what could be seen as a surfeit of academic and policy attention on seeking and promoting mental well-being (e.g. Stewart-Brown et al., 2011; David Cameron's 'happiness' agenda of 2010 in the UK). This academic and policy agenda largely ignores the circumstances of those who must endure long-term, irreversible and devastating mental ill-health. This agenda also aligns with the general thrust of 'more-than-human' geographies, which are all about surplus, vitality and well-being, adding rather than subtracting from human existence. In sharp contrast, Philo's (2017: 258) cautionary tale of 'less-than-human' geographies behooves us to recognize

> what diminishes the human, cribs and confines it, curtails or destroys its capacities, silencing its affective grip, banishing its involvements: not what renders it lively, but what cuts away at that life, to the point of, including and maybe beyond death. It is to ask instead about what *subtracts* from the human in the picture.

So rather than an approach around the seeking and valorizing of (mental) well-being above all other realities, research in mental health geographies ought neither ignore nor avoid the institutional miseries and abandonment that assail those with durable and persistent mental un-wellness, of their less-than-human geographies. This more balanced approach recognizes the two-sided nature of mobility, power and mental health for those individuals with profound mental illness, of individual agency but also constraints from larger power structures (see also Knowles, 2000). We can take the overlaps between persistent mental un-wellness and less-than-human geographies as a jumping-off point to frame a host of other negative circumstances around

enforced mobility and immobility, of drift and churn frequently leading to entrapment. These can include, for example, homeless persons who are consigned to monotonously cycle among a series of castoff places, from the street and shelters to drop-in centers, jails and prisons, cheap housing and psychiatric hospitals (DeVerteuil, 2003).

Returning to Cresswell's (2010) idea of force within the politics of mobility, the determining factor in the multi-layered interaction between mobility and mental health outcomes appears to rest on the extent to which each individual is able – or perhaps equally as important, *feels* able - to exercise some say over their residential circumstances (Herbert, 2010; Jocoy & Del Casino, 2010). That is, the extent to which the respective mobilities discussed here were expressions of free will or were undertaken as a result of external, usually institutional, compulsion. This is the chief contribution of this research to the wider literature on mental health and residential mobility. As the larger literature makes clear, mobility and immobility do not represent extremes on a good-bad continuum. For some, (im)mobility can enhance health outcomes; for others, restrict it. Overall for the service users interviewed, their experiences of becoming residentially mobile were predicated on instability in factors outside their direct control (primarily health relapses and evictions) and their experiences of residential immobility were of enforced stays in inhospitable places. Freedom of (im)mobility reflect broader social and cultural environments that privileges some over others, and therefore it is unsurprising that service users largely dependent on welfare benefits for what tenuous residential stability they have should find themselves on the underprivileged side of the politics of mobility.

With Cresswell (2010) in mind, we can see how power and identity have important impacts on mental health, and future research needs to incorporate a more

nuanced and critical take on mobility, agency and health, of the uneven politics of mobility and power, particularly as they relate to the downside of entrapment in particular places. A new research agenda around entrapment could make up for some of the limitations of the present study. For instance, the age of participants slanted upward, averaging 54 years old. Perhaps younger service users, by dint of their being at an earlier stage in their journeys through a mental health landscape, might have different experiences? Moreover, future attention needs to be paid to the emerging impacts of welfare reform in the UK, particularly the looming threats of cuts to housing and disability allowances that might potential unravel the built-up entrapments illustrated in the research. With welfare reform a policy juggernaut that cannot easily be stopped, there is a need for further studies that (a) focus specifically on the long-term impacts of reform on the health and material wellbeing of service users, (b) attempt a more quantitative assessment of the potential impact on residential mobility, and (c) that look at the impacts of austerity on the broader field of informal services and facilities more generally.

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