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**POVERTY, SOCIAL EXCLUSION AND MENTAL HEALTH: FINDINGS
FROM THE 1999 PSE SURVEY**

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PREFACE

This Working Paper arose from the *1999 Poverty and Social Exclusion Survey of Britain* funded by the Joseph Rowntree Foundation. The *1999 PSE Survey of Britain* is the most comprehensive and scientifically rigorous survey of its kind ever undertaken. It provides unparalleled detail about deprivation and exclusion among the British population at the close of the twentieth century. It uses a particularly powerful scientific approach to measuring poverty which:

- incorporates the views of members of the public, rather than judgments by social scientists, about what are the necessities of life in modern Britain
- calculates the levels of deprivation that constitutes poverty using scientific methods rather than arbitrary decisions.

The *1999 PSE Survey of Britain* is also the first national study to attempt to measure social exclusion, and to introduce a methodology for poverty and social exclusion which is internationally comparable. Three data sets were used:

- The *1998-9 General Household Survey* (GHS) provided data on the socio-economic circumstances of the respondents, including their incomes
- The *June 1999 ONS Omnibus Survey* included questions designed to establish from a sample of the general population what items and activities they consider to be necessities.
- A follow-up survey of a sub-sample of respondents to the 1998-9 GHS were interviewed in late 1999 to establish how many lacked items identified as necessities, and also to collect other information on poverty and social exclusion.

Further details about the *1999 Poverty and Social Exclusion Survey of Britain* are available at: <http://www.bris.ac.uk/poverty/pse/>

1. INTRODUCTION

This paper explores data from the 1999 Poverty and Social Exclusion Survey, focusing on the relationship between experiences of poverty and social exclusion and mental health status. Mental illness is becoming an increasingly pressing issue in terms of global health, with a growing proportion of the world's population – in both the developed and developing world – suffering from some form of mental health problem. Depression, in particular, is a major difficulty and a significant cause of disability around the world (WHO, 1999; Eisenberg, 1997). Given the impact of mental health problems as a disabling condition and significant contributor to Disability-Adjusted Life Years (DALYs), there is an urgent need to understand the distribution of such difficulties and ways in which national and global health policies might reduce this burden.

Studies, both in Britain and elsewhere, have suggested an association between poor mental health and poverty or deprivation. Intuitively, one might expect a deterioration in mental well being to result from the experience of going without the goods and services that are seen as necessary or desirable in society, particularly in the long term. There is less research as yet which explores the impact of social exclusion on mental health and well being. However, again it might be expected that being excluded from mainstream society, for whatever reason, might impact negatively on mental health just as one might hypothesise that being part of a community of friends, neighbours or family might have positive effects on mental well being. The *1999 Poverty and Social Exclusion Survey of Britain*, with data on deprivation, on self-perceived poverty and social exclusion and on mental health status allows further discussion of the ways in which these experiences might be intertwined. The PSE survey offers an opportunity to explore in more detail specific aspects of poverty, such as poor housing, so that we might explore the relationship between discrete aspects of deprivation and mental health. It is

also possible to focus on the experiences of particular sub-groups of the poor – lone parents, for example – to ask whether influences of poverty on mental health differ for different groups. Similarly, with the data on social exclusion, the PSE offers an insight into specific aspects of exclusion and how these might affect mental health. Thus this paper explores not only exclusion from the labour market and economically driven exclusion, but also forms of exclusion which stem from socially derived responsibilities for caring for others and exclusion due to ill-health and disability.

2. CAUSALITY?

We begin this process with a discussion of the difficulties involved in an exploration of the relationship between poverty or exclusion and poor mental health. A number of studies have found an association between mental health, using a variety of measurements, and socio-economic status. Much of this research has been at area level rather than at the level of the individual – for example, studies have shown higher rates of psychiatric admissions and suicidal behaviour in areas with higher levels of area based deprivation and higher unemployment rates (Kammerling & O'Connor, 1993; Gunnell et al, 1995; Boardman et al, 1997; Croudace et al, 2000). Some of this research – finding strong associations between the more severe psychotic illnesses, including schizophrenia, and poorer residential areas - might be explained by 'drift' factors where severely mentally ill people become poor as a result of their illness. However, Boardman et al's study (1997) found a strong correlation between social indicators of deprivation at area level and psychiatric admissions not only for psychotic conditions but also for those defined as neurotic illnesses, where such drift may occur less often. Harrison et al (1998) in a population based study of over 38,000 respondents compared individual mental health status with area-based deprivation scores and found highly significant correlations between psychiatric symptoms and more deprived locations.

Evidence from ecological studies relating to an association between social exclusion and poor mental health largely stems from studies showing increased psychiatric admission rates in areas with high unemployment (Kammerling & O'Connor, 1993) or during periods when national unemployment rates are elevated (for example, Brenner, 1973). However, research has also found higher levels of both suicide and parasuicide in areas with high levels of 'social fragmentation' or anomie, where there might be expected to be higher levels of social exclusion at the individual level (Congdon, 1996; Whitley et al, 1999).

Ecological surveys – focusing on indicators at area level – do not show that there is an association between social indicators and the mental health of one individual. However, studies at the level of the individual using clinical data on diagnosis, self-reported mental health status or a psychiatric symptom screening instrument, also show an association between deprivation and mental health status. Lynch et al (1997), for example, found that people living in 'economic hardship' on a long-term basis, were much more likely to be suffering from clinical depression than those not living in economic hardship, and found 'little evidence of reverse causation' (p1889) over the twenty years of the study. The British OPCS Psychiatric Morbidity Survey (Meltzer et al, 1995) found higher rates of neurotic psychopathology – including depression, anxiety and phobias – amongst men and women with lower educational qualifications and in lower occupational groups. In the Bristol-based ALSPAC study of over 9000 mothers, those reporting material deprivation and less social support also reported more ill-health than those with adequate financial and social resources, with a particular connection between self-reported depression and availability of social support (Baker & Taylor, 1997).

3. MEASURING MENTAL HEALTH IN THE PSE

The 1999 Poverty and Social Exclusion Survey used the short version of the General Health Questionnaire, a screening instrument designed for use in general populations to detect the presence of symptoms of mental ill-health and in particular depression (Goldberg, 1978). In addition to the GHQ-12 the survey used a limited number of self-reported measures of mental ill-health, with questions relating to the respondent's feelings of isolation and depression. The 12 elements in the GHQ-12 focus on symptoms of depression, with 4 potential responses for each one ranging around either side of a 'usual' answer. For example, the first item asks, "*Have you recently been able to concentrate on whatever you're doing*" with the four possible responses being '*Better than usual*'; '*Same as usual*'; '*Less than usual*' and '*Much less than usual*'. Answers are treated in a bi-polar way, with 'better' and 'the same' receiving a zero score and 'less than' and 'much less than' receiving a score of 1. Thus a respondent may score anywhere between zero and 12 for this screening instrument.

The GHQ-12 was developed from the longer versions of the General Health Questionnaire, which have up to 60 questions in them. Both the original 60 item list and the smaller versions, including the GHQ-12, use items statistically evaluated for their validity and sensitivity (Goldberg, 1978). The shorter version, the GHQ-12, was developed for use in situations such as the PSE 1999 where an extended number of such questions would be inappropriate or might reduce response rates and the value of findings. A number of studies have evaluated the validity of different versions of the GHQ against other screening, including the GHQ-12 which is now one of the most used versions, and have demonstrated that the instrument does successfully identify individuals whose depression would also be diagnosed by clinicians (Papassotiropoulos & Heun, 1999). It is however important to recognise that the GHQ does not give an indication of psychiatric 'caseness' in all instances – research also suggests that some of those identified by the GHQ

screening device as suffering from psychiatric morbidity would not be assessed as ill by the medical profession (see for example, Kessler et al, 1999; Middleton & Shaw, 2000). However, although there is some controversy over the use of the GHQ-12 as a simple indicator of clinically treatable psychiatric disorder (Heath, 1999) there is reasonable agreement that the device can indicate undue levels of distress, anxiety and depression. It is used here as an indicator of poor well-being which can then be explored alongside indicators of deprivation and exclusion.

The optimum cut-off score in studies of validity, testing the GHQ-12 against other screening devices and blind-rating of symptoms by clinically trained personnel, is between 3 and 4, where a GHQ-12 score of 4 to 12 indicates the presence of common mental disorders, and a score of 0 to 3 indicates no such ill health (Papassotiropoulos & Heun, 1999).

Overall, 3% of the PSE respondents had a GHQ score of between 10 and 12, that is, at the very highest end of the potential range, compared with just over half of the respondents who had a score of zero. Using a cut-off point of 3 and 4, where scores of 4 and over are seen as indicative of the presence of depression, 18% of respondents could be described as suffering from some form of common mental disorder. This compares reasonably well with other surveys. For example, the OPCS psychiatric Morbidity Survey (Meltzer,1995) found a prevalence of psychiatric symptoms on the general population of 23%. A study of mental health and poverty in Finland using the GHQ-12 detected mental ill-health in 18% of the population (Viinamaki et al, 1995).

There was a difference in the PSE sample in GHQ scores between men and women, with 16% of the male respondents defined as depressed compared with 20% of female respondents. There were also differences across age groups, as Table 1 below shows:

Table 1: Percent of respondents in each age group with GHQ score of 4 or more

Age group	Percentage with GHQ score of 4 or more
16-24	15.5
25-34	21.1
35-44	17.5
45-54	21.6
55-64	17.7
65-74	15.1
75 +	20.0
Sample=1534	

GHQ scores indicative of psychiatric morbidity varied across age groups, with the highest scores found amongst those aged 25-34, 45 to 54, and those aged 75 years and over.

There were also differences in risk of poor mental health by household type, a finding that is replicated in other studies. Adults living in family units with children had a higher risk of depression than those without children – nearly a fifth of those in such units had a GHQ score of 4 or more compared with 17% of non-parents. However, this may be explained by particularly high rates amongst lone parents. Lone parents were more likely than any other group to suffer from depression, with over a quarter scoring 4 or more on the GHQ (n=32), compared with 18% of the sample overall. Parents in couple households had an average risk of poor mental health: 18% (n=112) had a GHQ score of 4 or more. The higher rates of poor mental health amongst lone parents suggest the importance of the association with poverty and exclusion, as lone parents are more likely than parents in couple households to be both poor and suffer exclusion (Baker & Taylor, 1997; Brown & Moran, 1997). However, the burden of parenting is also greater in lone parent households and some research has found higher levels of mental ill-health even after controlling for poverty (Hope et al, 1999).

4. POVERTY, INCOME AND MENTAL HEALTH

A number of studies have found an association between poor mental health and the experience of poverty (Weich & Lewis, 1998a; 1998b; Whitley et al, 1999). A recent paper based on panel data (Weich & Lewis; 1998a) found that 'financial strain was a powerful independent predictor of both the onset and maintenance of episodes of common mental disorders, even after adjusting for more objective measures of standard of living' (p118). The PSE data similarly reveals a picture of increased symptoms of poor mental health amongst those suffering from poverty and deprivation.

Poverty is a term open to a number of different definitions. The PSE research used a number of different measures which were both scientific and which were compatible with definitions used both nationally and internationally. These included the consensual or indicator approach developed in earlier 'Breadline Britain' surveys (Mack & Lansley, 1985; Gordon & Pantazis, 1997), based on goods and activities seen as necessities by a majority; income thresholds, and subjective measures – based on respondent's views of their circumstances. Each of these measures is of interest in an exploration of the association between poverty and mental health.

Table 2 below shows the distribution of poverty amongst PSE respondents based on statistical analysis of key necessities which respondents were unable to afford (see Gordon et al, 2000). Column 1 shows the proportion of the overall sample who were poor, vulnerable to poverty and so on. Column 2 shows the distribution of those with common mental disorders by poverty classification. Thus whilst overall a quarter of PSE respondents were defined as poor, over a half of the survey's respondents with mental ill-health were in this group. Poor mental health is disproportionately found amongst the poorest in society.

Table 2: The distribution of poverty and poor mental health

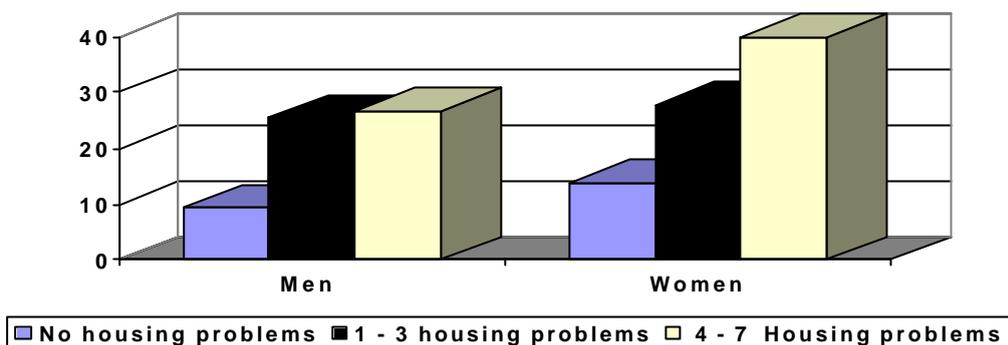
	PSE survey poverty classifications	Percent with GHQ score of 4 or more in each category
Poor	25.6	50.1
Vulnerable to poverty	10.3	8.2
Rising out of poverty	1.8	0.7
Not poor	62.2	40.7
Sample =1534	100	100.0

There are few differences between men and women in terms of the impact of poverty on mental health, with poverty presenting an increased risk of poor mental health for both.

Similarly with age, there was an increased risk of mental ill-health for the poor compared with the non-poor for every age group. However, this risk is greatest amongst those under retirement age – around two fifths of the poor under 65 had a GHQ score of 4 or more.

Looking at subjective poverty there is also an association between poor mental health and the experience of poverty. Three fifths of those saying they felt poor all the time had a GHQ score indicative of depression, compared with 12% of those who reported that they would never say they were poor.

Figure 1: Self-reported poverty and mental health



Whether the measure used is based on the necessities people can afford or on a more subjective ‘feeling’ of being poor, the poor carry a higher risk of suffering from mental ill-health.

5. INCOME AND MENTAL HEALTH

Households on low incomes are more likely to be poor, not surprisingly, and people in low income households in the PSE survey also had poor mental health, whilst those in the highest income bracket had better than average mental health:

Table 3: Gross Weekly Household income (Harmonised)

Income £	Percent with GHQ score of 4 or more
0 – 100.00	26.1
100.01 - 200	19.2
200.01 - 300	22.5
300.01 - 400	20.9
400.01 - 500	14.0
500-01 - 700	15.7
Over 700	11.8

The PSE analysis produced a number of different measures of income and each one revealed higher rates of poor mental health amongst the poorest respondents.

LABOUR MARKET EXCLUSION AND MENTAL HEALTH

One of the major factors in poverty and deprivation is the experience of unemployment, and in particular long-term unemployment, and a number of studies have found an association between unemployment and poor mental health. In the OPCS Psychiatric Morbidity Survey, for example, respondents defined as unemployed were the most likely group to suffer high levels of all psychiatric disorders (Meltzer et al, 1995).

Unemployment is of course notoriously difficult to define and different definitions are used in different circumstances. In particular, there are difficulties in assessing the relationship between mental health and employment status for two reasons. One problem is the direction of causality. People with pre-existing mental health problems may be less likely to be in paid work or more likely to lose their paid work as a result of their poor mental health. Alternatively, unemployment may lead to a deterioration in mental health – and of course, both of these may apply. Studies using longitudinal data, however, have suggested that unemployment is more likely to predate the onset of depression than depression causing unemployment (Montgomery et al; 1999; Dooley et al, 1994; Wilson & Walker, 1993).

The second difficulty in assessing the link between unemployment and mental health is that distinctions between two categories – unemployed and ‘permanently unable to work’ are blurred – at times it may be better for an individual, either economically or emotionally, to be in one of these categories rather than another (Whiteside, 1988). Similarly, women with poor mental

health who are not in paid work may take on the status of housewife, unemployed or permanently sick – depending on their eligibility for benefits and their own feelings about these different categories.

Figure 2: Percent with GHQ score of 4+ for selected employment status categories



As Figure 2 shows, respondents who were permanently unable to work had the highest rates of poor mental health, whilst those defined as unemployed also had higher risks of mental ill-health compared with those in paid work.

Another way of exploring the question of employment is to use the respondent's own definition of their employment status and the length of time their unemployment has lasted. The PSE asked, *Looking back over the last ten years, for how long in total have you been unemployed?*

Amongst those who had been unemployed for at least 6 months or more during the past decade, 27% were defined as depressed by the GHQ (n=123), compared with 15% of those who had not experienced unemployment in the past ten years (n=100). Both men and women were more at risk of depression when they had experienced more than 12 months unemployment in the last

ten years – 28% of men with over 12 months unemployment had a GHQ score indicative of depression (n=50) and 31% of women (n=66).

6. DEPRIVATION AND MENTAL HEALTH

If poverty has a clear association with poor mental health, to what extent does deprivation also share this association? In this section we move beyond income and measures of poverty to explore specific aspects of deprivation which might be most expected to impact in a negative way on mental well-being.

6.1 POVERTY, LACK OF NECESSITIES AND POOR MENTAL HEALTH

The PSE survey also asked which, of a list of necessities, respondents did not have because they couldn't afford them. Certain items in the list of necessities were more associated with poor mental health. In particular there were much higher rates of mental ill-health amongst those who lacked such basic necessities as two pairs of all-weather shoes, and insurance on the contents of their homes. Table 4 includes items classified as necessities in the Omnibus survey.

Table 4: Lack of necessities and mental health - percent of respondents with GHQ score of 4+

Necessity	Percent with GHQ score of 4 or more
Regular savings	34.6
Replace worn out furniture	35.2
Money to keep home decorated	45.9
Money to spend on self weekly	46.3
Replace broken electrical goods	42.5
Two pairs of all weather shoes	54.9
Home Insurance	40.8
Fresh fruit & veg	71.2
Special outfit	49.8
Damp free home	37.4
Warm waterproof coat	65.3
Roast joint	45.2
Appropriate clothes for job interviews	37.4
Presents for friends & family	39.0

The PSE study explored these findings separately for men and women, although numbers are small and results should be interpreted with caution. However, it appears that some aspects of deprivation might affect one sex more than the other. Women were more at risk than men when they were unable to afford two pairs of all weather shoes, redecorating in the home and the cost of repairing or replacing items such as furniture and electrical goods. Rates of poor mental health were higher amongst men who were unable to afford to spend a little money on themselves.

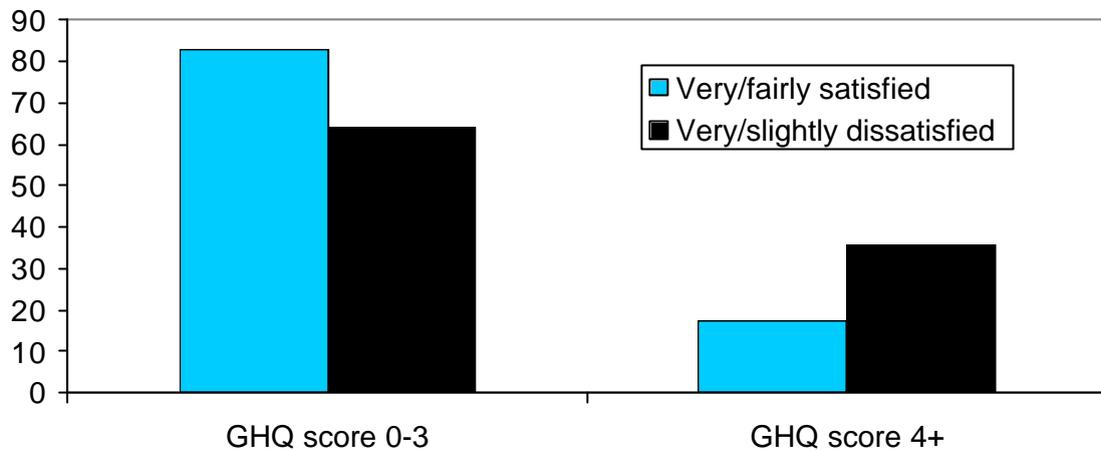
6.2 DEPRESSION AND HOUSING DIFFICULTIES

A number of studies have explored the association between poor housing and mental health problems. In terms of housing tenure, for example, people in local authority housing are more likely to suffer from poor mental health than those in owner occupied accommodation (Lewis et al, 1998; Meltzer et al, 1995). Poor quality housing – housing which is damp, or where there is a lack of security, or high levels of noise –has also been associated with higher levels

of mental ill-health, in particular depression (Hyndman, 1990; Hopton & Hunt, 1996). Such housing difficulties may affect physical health as well, of course, and mental health difficulties are often found together with poor physical health (Meltzer et al, 1995; Gomm, 1996). Housing problems may exist alongside poverty, or in isolation from it – and may also exist singly or in combination with each other.

The PSE survey asked respondents how satisfied they were with their current accommodation. As Figure 3 below shows, a higher proportion of respondents who were dissatisfied with their accommodation were depressed, compared with those who were fairly or very satisfied with their housing. More than double of those dissatisfied with their housing, compared with the survey as a whole, were suffering from depression.

Figure 3: Satisfaction with housing and mental health



However, it is not only satisfaction with accommodation that shows a relationship with depression. The survey also asked about the kinds of accommodation problems which might be present. In terms of total number of housing difficulties, as Table 5 below shows, those respondents in the PSE survey who were experiencing a number of problems with their accommodation were more likely to have a high GHQ score, that is, to be depressed. More than a third of those with 4 or more accommodation problems were depressed, compared with 12% of those with no such problems.

Table 5: Number of housing problems and percent with GHQ score of 4 or more

	No housing problems	1-3 Housing problems	4 + housing problems
Percent with GHQ score of 4 or more	11.7	26.7	32.4
Percent with GHQ score of 0 - 3	88.3	73.3	67.6
Number	875	618	34

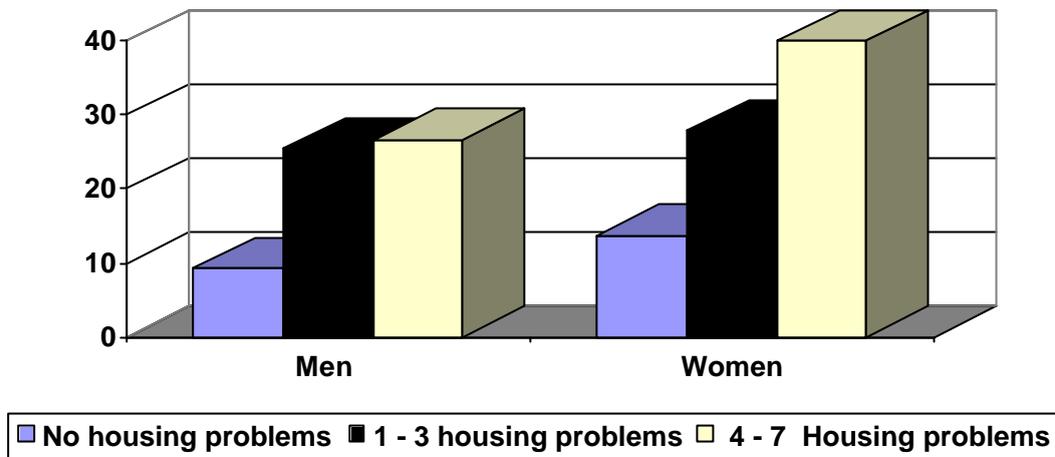
When we explore the kinds of accommodation problem which might impact on mental health, people whose housing is in a poor state of repair are more likely than those who report their housing as in a good state of repair to be suffering from depression (32% compared with 13%). The most commonly reported problem was 'shortage of space', which more than a fifth of respondents mentioned. This problem and others increased the risk of poor mental health:

Table 6: Type of accommodation problem and mental health

Most common problem	Number reporting the problem	GHQ score of 4 or more (%)
Shortage of Space	323	27.9
Rot in window frames	171	32.6
Damp walls, floors etc	122	33.0
Lack of adequate heating	95	26.9
No place to sit outside	86	27.3
No problems	875	12.1

As Table 6 suggests, whilst having no problems with accommodation is associated with better than average mental health, specific accommodation difficulties are all associated with higher risk of depression, although the impact varies. Women were more likely than men to have a GHQ score of over 4 amongst those with more accommodation difficulties:

Figure 4: Accommodation problems and mental health by sex: percent of men and women in each category with GHQ score of 4 or more



Age appeared to be unrelated to the impact of housing deprivation on mental health, in that for every age group more accommodation problems were associated with poorer mental health.

7. AREA AND MENTAL HEALTH

Poor housing often exists in a poor environment, and research suggests that area can also exert an effect on mental health (Tulle-Winton, 1997; Yen & Kaplan, 1999). Studies have found also higher rates of suicidal behaviour in socially fragmented areas (Congdon, 1996; Whitley et al, 1999).

Respondents in the PSE survey were asked how common a range of problems were in their area – including problems with noise, rubbish, vandalism and the state of building in the area. There was a clear relationship between area based poverty and individual poverty with those who were poor also more likely to live in poor neighbourhoods with area based problems. Again, higher than average rates of poor mental health were found amongst those respondents who lived in a poor environment. Thus whilst overall 18% of the survey sample had a GHQ score of 4 or more, this reduced to just over 11% of

those who reported no problems with their area (n=68), whilst a third of those reporting problems with noisy neighbours suffered from depression (n=67). Differences between male and female respondents showed that for every one of the categories of area deprivation a greater proportion of women than men were suffering from depression. Mental health was worse where there were several problems reported by respondents. Over a third of those who reported four or more problems in their area had a GHQ score indicative of mental disorder.

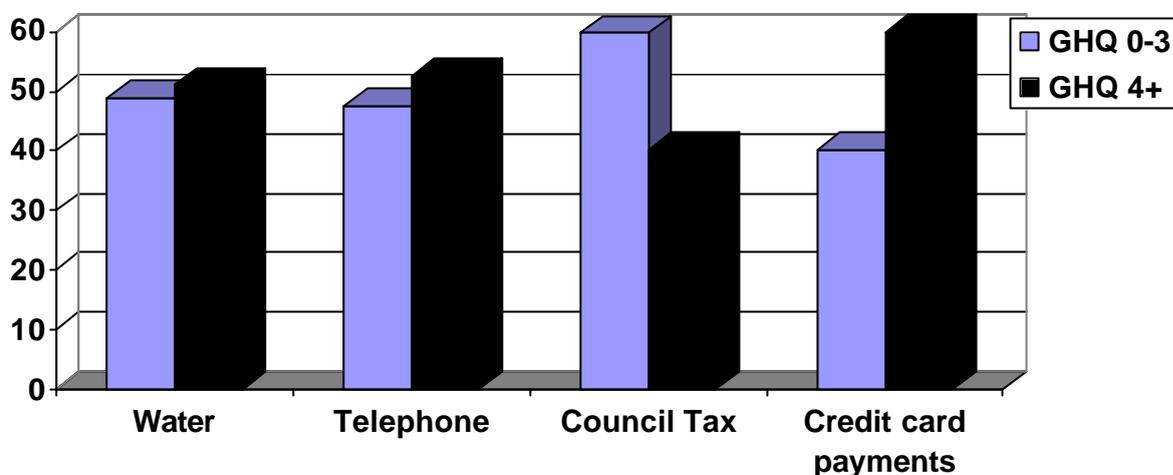
8. DEBT AND MENTAL HEALTH

Being in debt and the consequences of debt, such as utility disconnection and having to cut back on other expenses, might also be expected to be associated with poor mental health.

The PSE survey asked about debt to utility companies and others in the past year, whether the respondent had ever used less than they needed of certain basic services, and also whether the respondent had ever been disconnected from a basic service such as gas or electricity.

As Figure 5 below shows the likelihood of depression is greater amongst those who have been in debt to one or more of the different utilities and services, in the past year. The three most common services on which respondents owed money were water (n=81), council tax (n=95) and telephone (n=72). For each of these kinds of debt respondents in such a situation were more likely to score over 4 on the GHQ, indicating mental health problems. Over half of those who had owed money on their phone bill in the past year were depressed. However nearly four fifths of those owing money on their mortgages in the past year were suffering from depression (n=25), which may relate to the more serious implications of mortgage arrears, in terms of eviction and possible homelessness.

Figure 5: Debt on selected utilities / services and mental health



Amongst those who had owed money in this way in the past year, women were more likely to have owed money in the past year on water bills and telephone services, whilst more men were more often in debt for the Council Tax.

Respondents were also asked if they had had to borrow at times in the past year from agencies or people other than banks and building societies, *'in order to pay for your day-to-day needs?'* Whilst 89% of the sample had not had to do this, those who had had to borrow in this way had poorer mental health. More than 120 people had had to borrow from family just to meet their daily needs – and of these 44% were suffering from poor mental health. Similarly 68 people had had to borrow from friends, and nearly half of these had poor mental health.

9. FINANCIAL EXCLUSION AND MENTAL HEALTH

One of the ways in which exclusion can operate is exclusion from financial services. People who are poor more often are excluded from basic financial

services such as having a bank account – a form of exclusion which increases the costs of paying bills for the poor, who are then unable to take advantage of cheaper means of paying for utilities such as direct debit payments. Very few people in survey said that they couldn't use bank because couldn't afford it. However, amongst those who did not have a bank account rates of mental ill-health were higher. In total 76 people said that neither they nor their partner had a bank account, and a quarter of these were suffering from depression compared with 16% of those who said both they and their partner had a bank account.

10. SOCIAL EXCLUSION AND MENTAL HEALTH

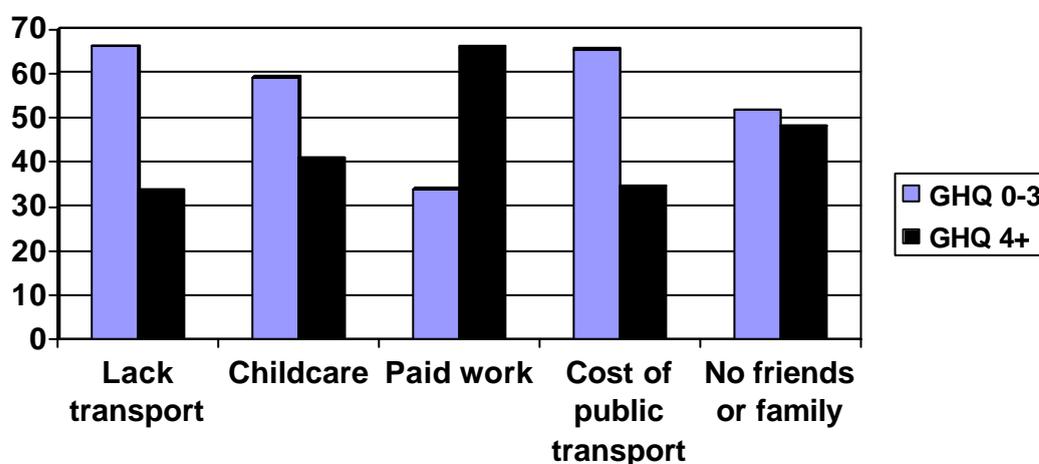
At this point we turn to consider a relatively unexplored issue, the association between social exclusion and mental health. Social exclusion might be expected to increase risk of mental health difficulties and indeed research has suggested that good social relationships and community involvement can act to protect people in poor material circumstances from adverse effects to their mental health. Brown & Harris (1978) found that women who had a 'close confiding relationship' with their partners were less at risk of depression, even in the face of adverse life events, than women without such a relationship. Other more recent studies have found that good social relationships or having social support can protect individuals (West, 1995; Gomm, 1996; Baker & Taylor, 1997; Schoevers et al, 2000). Seguin et al (1995) for example, found greater levels of depression amongst mothers who had poor material circumstances and no source of social support during pregnancy. Brown & Moran (1997) found single mothers had a greater risk of experiencing severe life events which were linked with the onset of depression but that women with low self-esteem and less support were the most at risk. Similarly, Smith et al (1993) found that the presence of social support could offset the mental health effects of such disadvantage as poor housing, although this depended on the severity of housing deprivation

experienced. This section explores in particular the social dimensions of exclusion and mental health.

11. SOCIAL EXCLUSION AND SOCIAL RELATIONS

Isolation from others, whether friends, neighbours or family, and the reasons for it, constitutes one form of social exclusion. Exclusion of this kind might be the result of a range of factors – including both absence from paid labour and participation in paid labour that restricts opportunities for being with others. The PSE survey asked respondents *Have there been times in the past year when you have felt isolated and cut off from society for any of the [following] reasons?* Over three quarters of respondents (n=1197) had not felt isolated in the past year, and a lower than average proportion of these (13%) were suffering from depression. Of those who had felt such a sense of isolation however, a greater proportion also scored a GHQ score indicative of depression. Higher rates of depression were found amongst those who reported feeling isolated at times in the past year due to a range of reasons:

Figure 6: Reasons for isolation from others and mental health



Those who reported feeling isolated as a result of the lack of personal transport were more than 3 times as likely as the sample as a whole to have a GHQ score indicative of depression. Those reporting isolation as a result of childcare responsibilities were more than twice as likely as the whole sample to be depressed, as were those feeling isolated due to a lack of family and friends. Similarly, isolation as a result of discrimination – including racism, sexism, disability related discrimination and homophobia – also was connected with increased rates of depression, although few people reported this.

12. PARTICIPATION IN THE COMMUNITY AND MENTAL HEALTH

One of the major factors in social exclusion is the ability to participate in community life – both leisure activities and public life – and the extent to which this is constrained for individuals. For many individuals chronic illness or disability affect such participation. As Oliver (1996) and others have observed, this is the result of a society which is disabling or exclusionary – for example, the inadequacy of transport systems, pavements and public buildings for people with mobility difficulties. The disabling nature of public space can also arise due to stigma and discrimination, which affects the ability of people suffering some conditions to enter this space, or to feel relaxed when outside the home. Thus whilst the ‘stereotype’ of people with a disability encourages a focus on people in wheelchairs and access to public buildings such as cinemas or football grounds – important issues in themselves – it is important to remember also that for many with chronic health conditions the disability arises for other, more varied reasons. The PSE survey asked a number of questions about people’s health conditions and the ways in which on-going health difficulties might impede social participation, and other working papers in this series discuss these.

Here we focus on difficulties in participation in leisure activities such as going to the cinema, library, shops, a restaurant, or a football match, as a result of limiting health conditions. Being unable to take part in such activities was associated with a higher of depression. Over a third of those with limiting health conditions who reported that they had difficulty in such activities had a GHQ score indicating the presence of poor mental health. For example two fifths of those reporting difficulty in going shopping had a GHQ score of 4 or more (n=39) and over a third of those unable to go to a cinema (n=30) had a score of 4 or more. Whilst to some extent this measures the impact of not being able to participate in specific activities, these are also indicators of a wider isolation – poor mental health is associated not only with being unable to go shopping but also what that represents to the individual and as an indicator of wider exclusion. Respondents who reported being unable to participate in these activities mentioned on average just over two activities each and respondents tended to be limited in more than one way with cumulative effect on mental health.

13. TIME STRESS AND MENTAL HEALTH

One of the major causes of social exclusion is the lack of time free from responsibility to engage in activities that increase participation. Paid work may increase inclusion by increasing financial security and reducing poverty, or by increasing the individual's feelings of self-worth, belonging, and also increasing the numbers of social contacts. For some, however, paid work reduces inclusion because it reduces opportunities for social activities – due to long hours or anti-social hours for example or because paid work leaves the individual too tired to participate in community or family life. Paid work for some can also be carried out in 'exclusionary' locations – evening cleaning work for example often leaves the cleaner without contact with others.

The PSE asked the question, “Which of the following would you agree with?” and listed a range of time related questions, as in Table 7 below. Only 30% (n=449) replied that they didn’t agree with any of the statements listed, whilst 70% (n=1076) agreed with at least one of these. Respondents who did not agree with any of the time questions had lower than average risk of poor mental health, whilst those who did agree had higher than average risks of poor mental health, as the table shows.

Table 7 looks at the relationship between mental health and time poverty or time stress as a composite variable –moderate time stress is experienced by those answering yes to between four and six questions and extreme time stress is experienced by those answering yes to 7 or more of the questions.

Table 7: Time stress and mental health

	All with GHQ score of 4 or more (%)	Men with GHQ score of 4 or more (%)	Women with GHQ score of 4 or more (%)
No time stress	10.9	9.8	12.0
Moderate time stress	32.5	32.6	32.5
Extreme time stress	54.9	45.8	61.5

Overall higher rates of poor mental health are found amongst those experiencing greater time stress, with over half of those experiencing extreme time stress having a GHQ score indicative of depression. Fewer men than women experience time stress and a greater proportion of women under extreme time stress are suffering from poor mental health.

In the study, time stress was reported more often by the poor, a finding which appears counter-intuitive but which might be explained by tasks taking longer to perform where money is tight – shopping takes longer if you need to check prices more carefully, or make a special trip on public transport to a cheaper store. Time stress appeared also to be related to mental well-being.

More than twice as many of the poor suffered from extreme time stress in comparison with the non-poor. People suffering a combination of time stress and poverty were more at risk of poor mental health than others – nearly three quarters of the poor who were also under extreme time stress had a GHQ score indicative of mental health difficulties.

Table 8: Time stress, poverty and mental health

	Not poor - GHQ score over 4 (%)	Poor - GHQ score over 4 (%)
No time stress	8.4	21.2
Moderate time stress	21.2	51.4
Extreme time stress	39.3	73.1

Differences were observed between men and women for specific aspects of time poverty but these were slight. For example, 29% of women compared with 24% of men reported feeling constantly under stress trying to accomplish more than they could handle. For both sexes this resulted in an increased risk of poor mental health. More women said they would like to spend more time alone (17% compared with 9% of the men) and this also increased the risks of poor mental health.

It is possible that time poverty has a greater impact on women than men as a result of caring responsibilities, as women more frequently have the major responsibility for the care of children and other dependants, and also for domestic labour. When looked at by household type, pensioner households were less likely to have time worries, whilst lone parents and parents in two parent households were more likely to report time worries. This is not surprising – time poverty is most acute for parents.

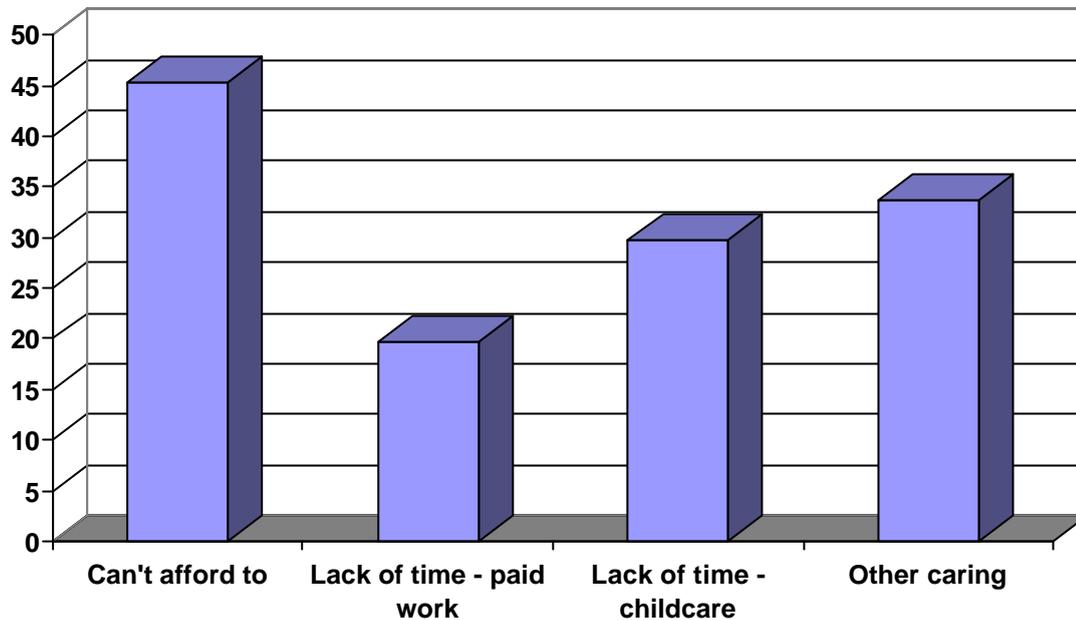
We speculated earlier that household type might explain the differences between men and women's responses to the time poverty questions and the

impact of these on mental health. In particular, this might relate to parenting - women suffer more from the impact of time poverty on their mental health because of their responsibilities in the home. Amongst lone parents the small number of respondents, particularly with male lone parents, allow only tentative exploration. Lone fathers appeared less affected by time stress than lone mothers, whilst in two-parent households a greater proportion of women reported time stress, and a greater proportion of women under time stress had poor mental health than of the men under such time stress.

14. SOCIAL RELATIONSHIPS AND MENTAL HEALTH

Respondents were also asked about factors preventing them from seeing friends and families as much as they would like to. Nearly two fifths of the sample (39%, n=587) said that they were able to see friends and family as often as they liked, and amongst this group there was a lower rate of depression than in the sample as a whole. However, those who felt unable to see friends and family as much as they wanted to had a greater risk of poor mental health. The most common reason restricting social relationships was '*lack of time due to paid work*' cited by 27% (n=407) of respondents and amongst this group, 19.7% had a GHQ score of 4 or more, a slightly greater proportion than in the sample as a whole. Those who stated that distance prevented them from seeing friends and family as much as they liked also had a very similar rate of depression to the overall figure. However, of the 138 saying that they lacked time due to childcare 30% had a GHQ score of 4 or more.

Figure 7: Mental health and factors restricting social relationships



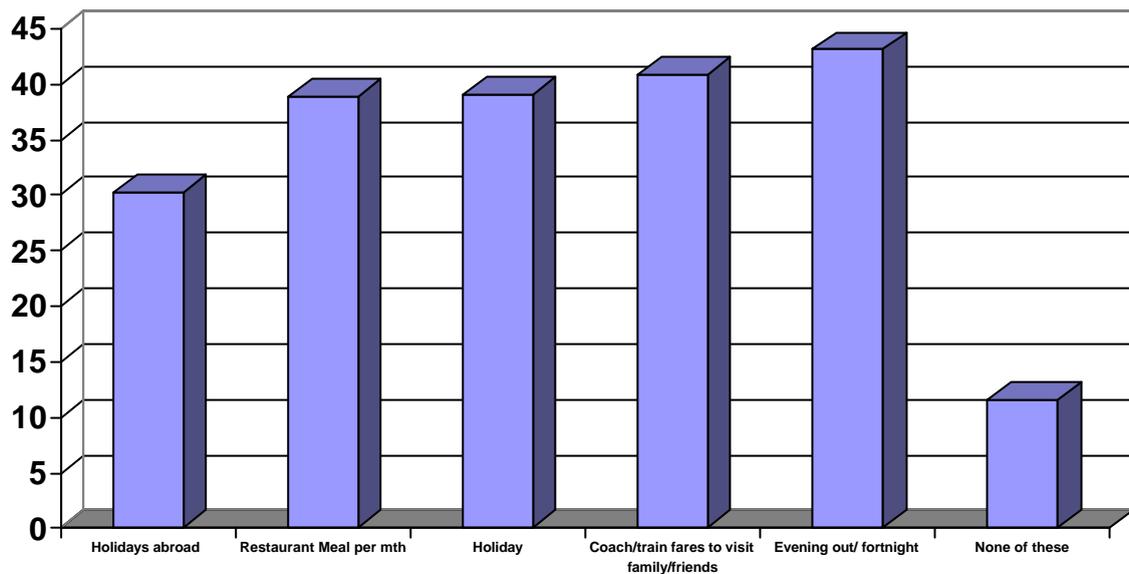
Amongst respondents with poor mental health, lack of money was the factor most often seen as restricting social relationships: 104 respondents gave this answer, 46% of whom had a GHQ score of 4 or more. Lack of money to take part in social relationships, whether this is due to travel or entertaining costs, lack of suitable clothes or other factors, has an effect on ordinary social participation such as meeting with friends and family, and is also associated with substantially poorer mental health.

15. SOCIAL ACTIVITIES AND MENTAL HEALTH

The survey also asked about activities such as an evening out or a hobby or leisure activity. Whilst a majority of respondents – 63% - were able to afford all of the activities suggested in the survey, over a third were unable to afford even one of these. Again, the mental health of those able to afford activities was better than the health of those respondents who could not.

More of the sample who couldn't afford activities such as a meal in a restaurant, holiday away from home, or fares to enable them to visit friends or family were also suffering from poor mental health.

Figure 8: Social activities and mental health: Percent who can't afford activity with GHQ score of 4 or more



Again, there are differences between men and women with more women reporting being unable to afford some activities – for example, 19% of females compared with 12% of males said they could not afford coach fare. In addition, the association with mental health varied – whilst mostly women had poorer mental health for each of the responses, a higher proportion of men than women had poor mental health when unable to afford going to the pub once a week (51% of men who couldn't afford this had a GHQ over 4 compared with 35% of the women).

15. CHILDREN, PARENTING IN POVERTY AND MENTAL HEALTH

For those parents whose children were living in circumstances of poverty, the risk of poor mental health was higher. Amongst the parents unable to afford

one of the necessities in this part of the questionnaire, a higher proportion had a GHQ score of 4 or more (30%, n=44).

The most common necessities reported as missing by parents were a computer suitable for homework (22%) and computer games (9% of parents). Very few parents reported being unable to afford meals and bedding, and few reported not being able to buy toys and books for their children. This is not necessarily because these parents are not poor in other ways but because parents will often sacrifice their own needs to meet those of children – particularly basic needs such as food and clothing but also socially sanctioned needs such as children’s toys and leisure equipment. It is not surprising that the items least often afforded are also those which are amongst the most expensive.

16. INTRA-HOUSEHOLD DEPRIVATION AND MENTAL HEALTH

One of the findings from earlier studies that was of interest here was the question of intra-household deprivation, where some members of the household go without certain goods and services in order to increase the amount available for others. Most commonly parents go without on behalf of children and women are also more likely to go without than men (Payne, 1991).

In the PSE study we asked how many people had personally gone without various goods or activities - clothes, food, shoes or leisure activities for example – as a result of shortage of money. In response, 24% of the respondents said that money was never tight, whilst 35% said that they never go without. The remainder went without at least one of these resources – over a quarter, for example, had not gone out in the last year due to a shortage of money, and an increased proportion of these respondents were suffering from poor mental health (33%, n=126). When broken down by sex, slightly more

men than women said that money was never tight, and men were less likely to have gone without a night out once a fortnight (23% of men, n=171, had cut back on going out compared with 27% of women, n=214). More women who had had to cut back on going out had mental ill health than the men – 36% compared with 29%. Women were more likely than men to say they had cut back on clothes for themselves (20% compared with 13%), and shoes for themselves (13% compared with 7%) and in both cases the impact on mental health of going without was greater for women. A similar proportion of men and women said that they had gone without a holiday (25% of men and 24% of women) and again mental health was poorer among those who had gone without compared with the sample as a whole.

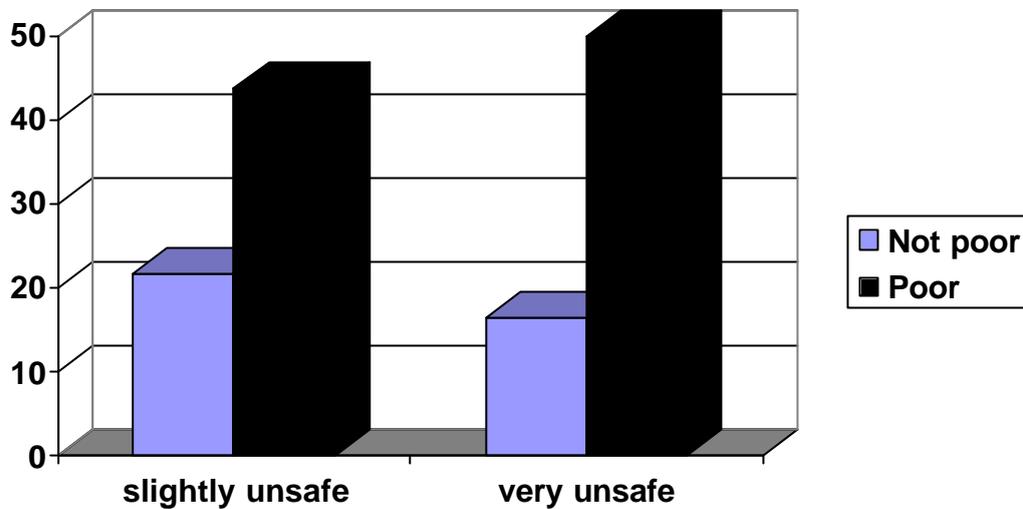
Although respondents were more likely to report that their children never went without in times of need (61%, n=293), those who did report that their children had had to go without in the past year due to lack of money had poorer mental health.

POVERTY, CRIME AND MENTAL HEALTH

Respondents in the PSE survey who were poor were also more likely to have been the victims of crime and to fear crime. More of the poor than the non-poor respondents had experienced someone breaking into their home, vandalism or deliberate damage to their car or their home, and more had experienced theft from their person.

It is not only the experience of crime, however, but also the fear of crime which is greater amongst the poor. For example, overall 30% of respondents reported feeling unsafe walking in the dark (n=452), 27% (n=312) of the non-poor felt this way, compared with 37% (n=141) of the poor. However, there was also an association with mental health:

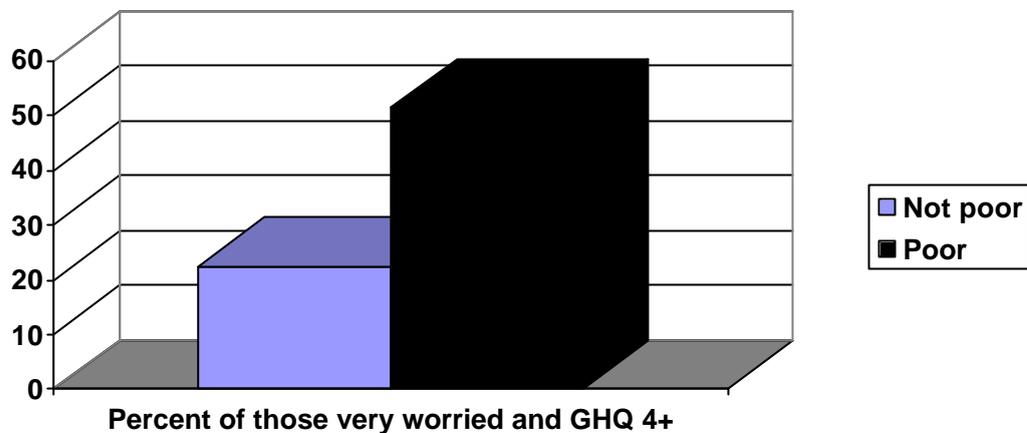
Figure 9: Percent of 'poor' and 'not poor' feeling unsafe walking alone in the dark with GHQ score of 4 or more



The poor were more than twice as likely as the non-poor to have a GHQ score indicative of mental ill-health, amongst those who did not feel safe in the dark. This may relate to the advantages of material wealth which minimise the occasions when the respondent has to be in the dark – having a car or the means to pay for a taxi at night reduces the risks of attack as well as the feeling of vulnerability. It may also be related to area – most attacks occur close to home, and the poor were more likely than the non-poor to be living in areas with high crime rates.

Similarly, whilst both the poor and not poor worried about being burgled, there was a closer association with poor mental health amongst the poor.

Figure 10: Percent of 'poor' and 'not poor' who were very worried about burglary with GHQ score of 4 or more



The data showed a similar relationship between poverty and poor mental health for those fearing personal theft or being mugged.

CONCLUSION

The relationship between poor mental health and various aspects of poverty, deprivation and exclusion is clearly complex. However, the 1999 PSE study provides evidence that, using a range of measures, people who are poor circumstances are also likely to be suffering from poor mental health and common mental disorders. In addition, the increased risk of poor mental health is found amongst those reporting social exclusion, not only those who are socially excluded from labour market activity but also those excluded from other activities. Particular aspects of deprivation are also associated with higher risks of common mental disorders – poor housing conditions and are deprivation for example. The risks appear to differ for men and women, and for those who are parents. Nonetheless, the PSE data suggests that all who experience poverty and exclusion are at an increased risk of suffering from poor mental health.

Whilst this data cannot resolve the issue of the direction of causality, the very fact that poverty and exclusion are associated with mental well being in this way should be enough to raise concern and more specifically to raise questions about appropriate policy responses to address this health inequality.

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