

# Mental health and child poverty

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The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the author and not necessarily those of the Foundation.

Joseph Rowntree Foundation  
The Homestead  
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York YO30 6WP  
**Website:** [www.jrf.org.uk](http://www.jrf.org.uk)

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First published 2006 by the Joseph Rowntree Foundation

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ISBN: 978 1 85935 491 9

This report is available as a pdf on the JRF website ([www.jrf.org.uk](http://www.jrf.org.uk))

## Summary

Mental illness is an under-recognised but significant contributory factor to child poverty. There is a lack of hard data but it is likely that there are approximately 1.25 million children in England and Wales living with parents or carers who have a mental health problem. Given the huge over-representation of people with mental health problems among those who are out of work (only 24% of people with long-term mental health problems are in employment), and amongst recipients of sickness and disability benefits (larger than the total number of recipients of Jobseekers' Allowance in England) it is a reasonable presumption that this situation must be producing hardship for many children: the conservative estimate made in this paper is 368,000. Redress for their situation requires action in relation to the position of people with mental health problems as benefit claimants, users of financial services and consumers. Among the priorities for reform are the need for benefit rules that are sufficiently flexible to accommodate the fluctuating and unpredictable nature of most mental illnesses; welfare to work programmes that have the depth of expertise and continuity to support parents with mental health problems back into work; and policies and practices in the financial services sector that adequately acknowledge the vulnerabilities of families where a parent is mentally distressed.

# 1. Introduction

A common theme in the UK poverty literature is the relationship between parental health problems and family poverty. 50% of disabled people have incomes below half the national average, this rises to 60% for disabled adults with children (Tunnard 2004). There is good reason to suspect that these figures would be even worse were the analysis to focus on families where there is a parent or carer<sup>1</sup> with a mental health problem, but there is surprisingly little published data specifically on this. Likewise, despite a deluge of mental health policy from New Labour, there is almost no consideration of its impact on child poverty. For example, a recently-published Child Poverty Action Group (CPAG) volume (Preston 2005) identifying the children most likely to be poor, gives numerous instances of social groups whose disadvantage is compounded by the incidence of poor mental health amongst parents, but without addressing parental mental illness and poverty in its own right.

Poverty and financial hardship are issues that are constantly cited anecdotally by users of mental health services and also in research (Mental Health Foundation 2001) . While we should avoid over-generalising the individual experiences of users of mental health services, and thereby adding to their stigmatisation, it is generally recognised that various forms of mental disorder impact on the economic welfare of individuals. Financial hardship and insecurity are sources of stress, which in turn is a contributory factor to the onset and severity of mental illness. There are several reasons why experiencing a mental disorder compromises people's capabilities in optimising their income and financial competence. They may be unable to retain a job, or face stigmatisation in securing employment. Individuals may have temporary or enduring impairments in their cognitive capacity to deal with financial affairs (this is notwithstanding the fact that not all mental disorders are cognitively impairing, and that some individuals who are relatively disordered might have 'islands' of cognitive capacity). Also, many mental disorders are fluctuating in their severity, or have patterns of remission and relapse, which adds to the complexity of individuals' needs and capabilities to manage.

Over and above factors that arise directly from mental distress, there is also substantial evidence that there are situational factors, for instance located in social security systems, financial services and work practices, that also

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<sup>1</sup> Throughout the paper the term 'parent' should be taken to apply also to carers undertaking a parenting role.

contribute to poverty among people with mental health problems (see Davis 2003; Plumpton and Bostock 2003; Citizens' Advice Bureau 2004). There are longstanding and unresolved debates as to the relative merits of 'social selection theories' that suggest that people who are prone to mental disorders drift downward into poverty, thereby further increasing their risk for mental illness, contrasted with 'social causation theories' implying a direct causal relationship between poverty and the triggering of mental illness. Whatever the relative merits of these positions (see Costello *et al* 2003; Rutter 2003), some general statements can be made about the vulnerability of people with mental health problems to financial adversity and poverty. These have been usefully summarised by Davis (2003) in a literature review commissioned by the Office of the Deputy Prime Minister's Social Exclusion Unit:

- poverty impacts directly on the individual's mental health and well-being;
- a high proportion of people with mental health problems are unemployed and are dependant on state benefits;
- a history or current status of mental ill-health can lead to obstacles in accessing financial services;
- using mental health services (such as long-term or 'revolving door' hospital admissions) increases the problems encountered by individuals in managing their incomes;
- the impairments produced by mental illness increase the challenges and complexity of securing entitlements to benefits and managing personal finances.

Although there is a significant research literature to support and amplify these points in relation to working age adults, there is very little quantitative research that looks specifically at the impact on *children* of poverty that is associated with parental mental ill-health<sup>2</sup>. This paper draws together the generic literature on poverty and mental health, extrapolating where possible the implications for children. In most instances the inference is that where policies contribute to the poverty of working age adults with mental health problems, then it will also contribute to child poverty when those individuals are parents or carers for children.

This brief paper assembles the evidence where it exists, and points to gaps in the research, in relation to the following headings:

- Numbers of people with mental health problems and implications for family poverty.

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<sup>2</sup> Aldridge and Becker (2003) is an important qualitative study of the experience of children and young people caring for a parent or carer with mental health problems.

- Causal relationships between parental mental ill health and family poverty.
- Identifying the benefit traps and exclusions from financial services that contribute to poverty for families where a parent has a mental health problem.
- Strategies to divert parents with mental health problems from poverty.

## 2. How many parents have mental health problems?

There is some consensus about the level of mental disorder in society. The Health Survey for England 1996 (cited Sainsbury Centre for Mental Health, 2003: 6) gives a prevalence rate of 23 per cent for mental health problems among the adult population, where this is measured by the number of respondents assigned to levels 2 or 3 on the EuroQol dimension of anxiety/depression (21 per cent on level 2 (moderately anxious) and 2 per cent on level 3 (severe problems, extremely anxious or depressed)). This overall 23 per cent figure is exactly the same as the prevalence rate for mental health problems found in the Office for National Statistics (ONS) Psychiatric Morbidity Survey in 2000 (ONS, 2001). A prevalence rate of 23 per cent equates to just over 9 million adults in England, of whom 8.25 million have moderate mental health problems and 770,000 have severe problems.

ONS psychiatric morbidity data shows the pervasiveness of mental distress across all social groups and types of household, including those with and without children (Table 1). However, the excess of mental distress amongst lone parents is noteworthy and has been the subject of further analysis of the data (see below).

Table 1: Family unit of people with mental disorder compared with family unit of people without a mental disorder (%) in Great Britain

|                            | Not mentally ill | Any mental disorder* | Neurotic disorder | Probable psychotic disorder |
|----------------------------|------------------|----------------------|-------------------|-----------------------------|
| Family Unit                |                  |                      |                   |                             |
| Couple no children         | 33               | 25                   | 28                | 22                          |
| Couple and child(ren)      | 36               | 31                   | 34                | 17                          |
| Lone parent and child(ren) | 4                | 7                    | 9                 | 7                           |
| One person only            | 15               | 21                   | 20                | 43                          |
| Adult with parents         | 3                | 4                    | 1                 | 5                           |
| Adult with one parent      | 9                | 12                   | 8                 | 6                           |
|                            | 100              | 100                  | 100               | 100                         |

\*Any mental disorder' includes drug and alcohol dependency

Source: Office for National Statistics 2002; Table 3.1

As Table 2 shows, there is a higher rate of mental disorder of all types among lone parents than for adults living as a couple with children. Lone parents are almost three times more likely than couples with children to have more serious functional psychoses (this includes disorders such as schizophrenia and bipolar affective disorder) or drug dependence, and are nearly twice as likely as couples with children to have a neurotic disorder. In their secondary analysis of data from the British National Survey of Psychiatric Morbidity, to look at lone parenthood, depression and social exclusion, Targosz *et al.* (2003) confirmed that lone mothers had prevalence rates of depressive episodes of 7 per cent, roughly three times higher than any other group. These increased rates of depressive conditions were not apparent after controlling for measures of social disadvantage, stress and isolation. The authors concluded that the high rates of material disadvantage and of depressive disorder had considerable implications for mental health and social policy. The same study found that men living either as a couple with children or in lone parent families have lower rates of neurotic disorder, functional psychosis and drug dependence than women in equivalent situations.

Table 2: The prevalence of mental disorder among parents in the general population in Great Britain

| Type of mental disorder | <i>Couples with children</i> |          | <i>Lone parent with children</i> |          |
|-------------------------|------------------------------|----------|----------------------------------|----------|
|                         | Rate per 1,000               | Rate (%) | Rate per 1,000                   | Rate (%) |
| Neurotic disorder       | 155                          | 15.5     | 281                              | 28.1     |
| Functional psychoses    | 4                            | 0.4      | 11                               | 1.1      |
| Alcohol dependence      | 27                           | 2.7      | 38                               | 3.8      |
| Drug dependence         | 9                            | 0.9      | 24                               | 2.4      |
| All                     | 195                          | 19.5     | 354                              | 35.4     |

Source Melzer et al 1995, adapted Aldridge and Becker 2003 p.31

If we apply these percentages on household types and mental disorder from the Psychiatric Morbidity Surveys to 2001 census figures 'numbers of dependent children by household type' this gives some approximate numbers of children living in households where a parent has a mental

disorder. Calculated on this basis there could be approximately 946,000 children in England and Wales living with a lone parent with a mental disorder, and approximately 1,333,500 children living in a two parent household where at least one parent has a mental disorder.

### **3. The relationship between parental mental health and child poverty**

The relationships between parental mental health and poverty can be summarised under various (sometimes overlapping) headings:

#### **Mental illness differentially affects people in poverty**

Fryers *et als'* (2003) systematic review of large scale epidemiological studies of social inequalities and common ('neurotic') mental disorders shows that these disorders are significantly more frequent in socially disadvantaged populations. The most consistent associations of common mental disorders were with unemployment, less education and low income or material standard of living. The rarer 'psychotic' disorders are also distributed unequally by social position (Melzer *et al* 1996).

#### **Mental ill-health and labour market disadvantage as significant contributors to child poverty**

Adults with long-term mental health problems have the highest unemployment rate for any of the main groups of disabled people – only 24 per cent of adults with long-term mental health problems are in work (Office for National Statistics 2003; Smith and Twomey 2002). In an unpublished paper for DWP, Stickland (cited Tunnard 2004: 19) states that only 10 per cent of those with 'mental illness, phobias and panic attacks' and 23 per cent of those with 'depression and nerve problems' are in employment. Parents with mental health problems will experience labour market disadvantage not only through unemployment but also through 'inadequate employment' (i.e. employment underutilising an individual's capabilities) plus absenteeism and lost earnings for those in work but with a relapsing problem (for summary of issues see Rogers and Pilgrim 2003: 116-122).

#### **Social security dependence, mental health and child poverty**

The corollary of low income, unemployment and labour market insecurity is that many people with mental health problems are dependent for their income on social security transfers. Over 900,000 adults in England claim sickness and disability benefits for mental health conditions; this group is larger than the total number of unemployed people claiming Jobseekers' Allowance in England (Social Exclusion Unit 2004). Parents relying on long-term benefits because they are unable to work due to a mental health

problem will be claiming an incapacity benefit. The main incapacity benefits involved are Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and Income Support with a disability premium (ISdp). Based on unpublished data supplied by DWP, at May 2005 there were 198,900 parents in receipt of these benefits who had a 'mental and behavioural disorder' as defined by the World Health Organisation's ICD 10 (see Table 3). These parents were in turn responsible for the care of at least 368,000 children. This is an underestimate of the total number of children whose parents are claiming because of a mental disorder, as it has not been possible to capture the number of IS claimants with a mental disorder not claiming IB or SDA. It also does not include the parents receiving the disability element of working tax credits by virtue of experiencing a mental disorder, the numbers for which are not available.

Table 3: Numbers of IB/SDA, and IB/SDA and ISdp claimants with a mental and behavioural disorder and child dependants, May 2005

|                              | IB/SDA |  | IB/SDA and ISdp |  |
|------------------------------|--------|--|-----------------|--|
|                              | All    | Claimants with a mental and behavioural disorder | All             | Claimants with a mental and behavioural disorder |
| All                          | 285.6  | 113.6  | 203.3           | 85.3   |
| Number of dependant children |        |  |                 |  |
| 1                            | 137.8  | 56.0   | 95.5            | 41.3   |
| 2                            | 83.6   | 32.7   | 59.1            | 24.4   |
| 3                            | 39.6   | 15.3   | 29.5            | 11.8   |
| 4                            | 16.0   | 6.3  | 12.4            | 5.0  |
| 5+                           | 8.7    | 3.3  | 6.9             | 2.7  |

1. Numbers are rounded to the nearest hundred and are expressed in thousands
2. Diagnosis Group is taken from ICD10 published by the World Health Organisation
3. Figures for IB/SDA claimants also claiming ISdp are an underestimate since IS claimants not also claiming IB/SDA cannot be picked up
4. Source: Information Directorate WPLS 100% data, May 2005.

## **Parental poverty as a causal factor in mental illness**

Stressful life events such as family bereavement, marital separation, or loss of employment often cluster before the onset of mental illness and influence the course of the illness. Brown and Harris's (1978) classic study of depression among working class women identified unemployment and the care of three or more children as vulnerability factors which, with others, were likely to lead to depression. As cited above, Targosz *et al.* (2003) found that lone parents were three times more likely to experience depression than women with no dependent children.

## **Poor environments**

Various reports have cited neighbourhood deprivation as contributing to the prevalence of mental disorder, with anxiety, depression and phobias generally more prevalent in poor neighbourhoods. Ghate and Hazel (2002), based on a survey of 2,000 families living in poor parenting environments, found that community-level poverty is a mediating factor in parental mental health. Though the literature on mental health and social inequalities routinely cites neighbourhood poverty as a causal factor, a note of methodological caution is merited: a recent study (Propper *et al.* 2004) finds that the extent of association between neighbourhood and levels and changes in mental health is limited and that the characteristics of individuals and their households are more important for mental health.

### **3. Benefits, welfare to work programmes, and financial exclusions that can affect parents with mental health problems**

Thirty-five per cent of people receiving incapacity benefit are living with mental/behavioural disorders, most of whom have depression, anxiety or other neuroses (Social Exclusion Unit 2004). As stated above, in May 2005 there were 198,900 parents with mental health problems, living on IB, SDA or ISdp, responsible for at least 368,000 children. These parents with mental health problems experience a range of obstacles and exclusions in relation to managing their benefits, returning to work and accessing financial services.

#### **Benefits**

Analysis of the Labour Force Survey longitudinal datasets shows that the onset of mental health problems significantly increases the risk of employment loss, compared to other health conditions or impairments (Burchardt 2003). The number of people coming into Incapacity Benefit citing mental health problems as their main disability almost doubled between 1995 and 2004, from 475,000 to 848,000 (Social Exclusion Unit 2004: 62). Consequently mechanisms and rules relating to returning to work and entitlement are critically important for families where a member has a mental health problem.

#### *Returning to work*

- **Linking rules.** The Social Exclusion Unit report on mental health (2004: 61) has reported that the linking rules are not widely understood. We have commented on the fluctuating nature of most mental disorders, which exposes parents with mental health problems to interrupted patterns of employment. The Citizens Advice Bureau (2004) similarly reports that people with mental health problems have particular difficulties in getting benefit reinstated. There are also reports of disability living allowance being stopped when individuals return to work.
- **Permitted work.** When people cannot return directly to full-time work, undertaking permitted work while claiming benefits (incapacity benefit or income support) is a way back into employment. Incapacity benefit rules allow people to take on 'permitted work' but these are insufficiently flexible

to be of real help to people with mental health problems (Mental Health Foundation 2001). The rules are complex and people with mental health problems may need assistance to navigate them. The rules are also rigid and formulaic, making little or no allowance again for the fluctuations of capability that are often experienced by parents with mental health problems, specifically.

### *Financial incentives for work*

If people lack skills and work continuity they are less likely to achieve higher rates of pay on returning to work.

- Only 25% of people on incapacity benefit would be at least £40 a week better off if they moved into working more than 30 hours per week. People with mental health problems are less likely to be in full-time work and so less likely to benefit even by this amount.
- People moving into work from income support lose passported benefits, e.g. free prescriptions, other free health provision and free school meals.
- Earning disregards are too low as incentives to take on part-time work of less than 16 hours per week.
- Given that some parents with mental health problems will never be able to work full-time (or will be unable to do so for long periods) the hours threshold for working tax credit could be reduced to below 16 hours for disabled people.

### *Unpaid work*

A feature of the voluntary sector mental health service user movement has been the encouragement to users to become engaged in voluntary work, advocacy, education and so on. Such activity is regarded as therapeutic and self-empowering. It can also be part of a recovery process leading to paid employment (Aston *et al.* 2003: 30). However, engagement in unpaid work can result in parents being called by DWP for interviews that involve consideration of prosecution and benefit withdrawal, with negative impacts on their mental health.

### *Welfare to work*

Government determination to deliver employment opportunity for all, as a main plank in tackling social exclusion and poverty, has led to a number of pilots and programmes to help incapacity benefit recipients to enter, re-

enter or remain in paid work. All these are potentially helpful to parents with mental health problems and some of the evaluative research that is beginning to emerge points to some of the issues that are relevant to those parents. The most important programmes are the New Deal for Disabled People (NDDP), the Job Retention and Rehabilitation pilot (JRRP) and Pathways to Work.

- NDDP

This is the major employment programme available to people claiming incapacity benefits. It is a voluntary programme that aims to help people with health conditions and disabilities move into sustained employment. The first synthesis report of NDDP (Stafford 2004) shows that having a mental health condition was reported by one-third of participants, although participants were less likely to have a mental health condition than people in the IB population generally. Children were living with 21 per cent of participants. In terms of outcomes, people with mental health conditions were generally less likely to start work than those without; also participants leaving their jobs were more likely to have a mental health condition. Qualitative evidence from clients, job brokers and Jobcentre Plus staff suggest that people with mental health problems need access to more specialist help and support than NDDP has provided (Corden *et al.* 2003). A contributory factor in these outcomes can be the negative views of employers that mental illness is a particularly difficult area of disability (Aston *et al.* 2003).

- JRRP

This is a programme that is trialling ways of helping people on sick leave to return to work. The overall evaluation of the pilot is awaited, but there are some published reports on specific aspects of the pilot (e.g. Nice and Thornton 2004; Mowlam and Lewis 2005) which have implications for parents with mental health problems. A study of employers' management of long-term sickness absence found that employers cited uncertainty about attendance due to mental ill-health difficult to manage (Nice and Thornton 2004: 1). A study within the same programme of GPs' work with patients on sick leave found limited awareness of services to support return to work, and that sickness certification and work rehabilitation are under-resourced aspects of GPs' work (Mowlam and Lewis 2005).

- Pathways to Work

In October 2003, based on proposals outlined in the Green Paper *Pathways to Work: Helping People Into Employment*, the Government introduced Incapacity Benefit pilots – Pathways to Work – in three

Jobcentre Plus districts, with a further four introduced in 2004. Pathways to Work includes several elements of which at least two have relevance to parents with mental health problems: work-focused interviews and personal advisers.

- Work-focused interviews: although people with a severe mental illness are exempt from these, for those with less severe conditions various difficulties may arise. An evaluation of work-focused interviews found that people with mental health conditions expressed the view that work was being discussed at a point when other issues such as family problems and their health were their priorities (Corden *et al.* 2005). A range of apprehensions produced by their disorder – aversion to dealing with mail, fear of travelling, social phobias – may lead them to fail to attend interviews with consequential possible reduction in their benefit. Though the interview regulations state that sanctions should not be applied to illness-related behaviour, there is considerable scope for discretion by officers and no right of review.
- Jobcentre Personal Advisers: although there is much to commend a scheme providing personal support for people making a return to work, systematic reviews of employment support for people with mental health problems have found that support needs to continue beyond the point of employment and to be open-ended in length (Crowther *et al.* 2001). Effective schemes for work support emphasise the need for engagement of all parties, including employers, and a high level of specialist skill on the part of the adviser.
- Financial changes in pilot schemes: the schemes are piloting some positive innovations including access to a discretionary fund to help with costs associated with return to work; a return to work credit payable for 52 weeks which will be disregarded for tax, national insurance, housing and council tax benefit; and extension of the four week housing benefit run to cover people in receipt of incapacity benefit (Knight *et al.* 2005). Whether this will meet the transition from weekly benefit to employment income needs awaits the findings of evaluation.

## *Tax credits*

The new tax credits – Working Families Tax Credit and Disabled Person's Tax Credit – which were launched in 1999, had a pivotal role in the government's commitment to tackle child poverty and deliver employment opportunities for all. These have been replaced by Working Tax Credit (WTC) and Child Tax Credit, though the disability element for adults in the WTC has been rolled along from what was previously DPTC. Consequently, evaluations of DPTC remain relevant for achieving child poverty reduction targets. In a survey of recipients (Atkinson *et al.* 2003) one half of respondents had dependent children. Mental illness was reported by 13 per cent and 22 per cent reported depression and anxiety – both figures are much higher prevalence rates than disabled people in work generally. Although DPTC was clearly very helpful to some parents with mental illness, a qualitative research study found that demonstrating eligibility was a problem for some people who had to describe the effects of their mental health conditions (Corden and Sainsbury 2003: 9). This was especially if previously they had experienced difficulties in explaining the impact of their mental illness for incapacity benefits review or DLA applications (Corden and Sainsbury 2003: 33).

## **Proposed reforms of Incapacity Benefit**

There is great apprehension within the mental health sector that proposed reforms of Incapacity Benefit will differentially impact on people with mental health problems. There is concern that the often cited doubling of the number of claimants of Incapacity Benefit because of mental health problems between 1995 and 2004 is seen by policy makers as a 'soft target' for reducing public spending, rather than a reflection of greater recognition of common mental disorders, and changes in working practices and conditions of employment which are creating higher rates of common mental disorders. These anxieties are reinforced by the Green Paper, *A New Deal for Welfare: Empowering People to Work (2006)* by offering rewards for those GPs who 'improve outcomes with a direct link to Incapacity Benefit'. Under these proposals Incapacity Benefit will be replaced with an employment and support allowance. Those with more manageable conditions (itself a contentious judgment) will be required to undertake work-related interviews, agree an action plan and engage in work-related activity. Those failing to meet the terms of the benefit will have their income reduced ultimately to the level of jobseeker's allowance.

Mental health organisations (e.g. Mind and Rethink) have already voiced their apprehensions that the pressures inherent in the new system will have adverse outcomes for people with mental health problems.

## **Financial exclusion: purchasing, credit, insurance and debt**

There are a number of areas in which parents with mental health problems are vulnerable as consumers.

- **Purchasing**

Generally there is a lack of remedy when purchases are made or contracts entered into when individuals are mentally unwell. This is compounded by a lack of relevant checks when obtaining credit. Both of these issues are of particular relevance for people with bipolar affective disorder when they are in a 'manic' phase and prone to overspending. The remedies to these problems lie not in discriminating against parents in obtaining credit but in ensuring good practice in assessing people's ability to make repayments.

- **Insurance**

A whole range of exclusions apply, for instance payment protection cover may not extend to mental illness. Despite policies containing blanket mental health exclusions they are still often sold to people with mental health problems.

- **Unmanageable debt**

This is a pervasive and common problem for people with mental health problems (Mental Health Foundation 2001). Survey evidence of the financial circumstances of mental health service users has found that debt problems are commonplace, with a third or more of those sampled having debt problems (Davis 2003: 12). In a debt survey conducted in Northumberland the most common types of debt found among service users were rent arrears, shopping catalogues, loans and credit cards (Sharpe and Bostock 2002). Health crises can contribute to mismanagement of debt, and worsening of the debt problems exacerbates poor health, and so on. This cycle is deepened by inappropriate debt collection practices, and inability to make repayment offers because of low or fluctuating income.

## **5. Actions which could address child poverty linked to parental mental illness**

In summary, most discussions of obstacles to the achievement of targets for reducing levels of child poverty have hitherto failed to consider the impact of parental mental illness on family income. This paper has begun to estimate the scale of the problem for children whose impoverishment is linked to the mental illness of their parents. It has then outlined a range of issues which if addressed could ameliorate the circumstances of those parents and their children.

### **Benefit reform**

- DWP should review the workings of the benefit system with a view to understanding negative impacts on parents with mental health problems, including linking and the provision of mental health awareness training for all relevant staff.
- Rules and procedures relating to the transition from benefits to work should be reviewed to simplify them and create greater flexibilities for more gradual transition from benefits to work.
- Incapacity Benefit and Disability Living Allowance assessment and claiming processes should be reviewed to ensure that they are sensitive to the needs of parents with mental health problems. This might include redesigning forms to make them more appropriate for reporting mental health problems and reducing the intensity of re-assessment to reduce stress and anxiety.
- Continue to evaluate welfare to work pilots with specific attention to New Deal for Disabled People, Job Retention and Rehabilitation Pilot and Pathways to Work with sub-analysis of mental health service users to identify whether the apparent overall benefits of the schemes are reaching parents with mental health problems.
- Other reviews of benefit procedures that have been outside the scope of this paper but which would be helpful include:
  - ensuring that Housing Benefit departments and social landlords support parents with mental health problems with applications;
  - increasing the level of Incapacity Benefit and Income Support for hospital in-patients who have been in hospital longer than 52 weeks;
  - extending the scope of and eligibility for Social Fund loans and grants;

- extending help with prescription charges for people with mental health problems by including mental illnesses in the list of conditions qualifying for free prescriptions, and by giving eligibility for people with mental health problems on Incapacity Benefit entitlement to free prescriptions.

## **Consumer and debt issues**

Again there are pervasive issues of raising awareness of mental health problems and reducing stigmatisation of parents with diagnosed mental health problems. This underlines the need for industry codes of practice endorsing the need for staff to have mental health awareness training and encouraging credit trade associations to develop guidance on identifying and supporting vulnerable individuals whose mental health problems may be exacerbating credit repayment difficulties. Also action is needed to encourage insurers to review compliance of its members with the Disability Discrimination Act to ensure non-exclusion of parents with mental health problems from taking out policies or making claims.

This raft of proposals would impact on a range of public and private organisations. Their impact, on the whole, applies to most adults with mental health problems and estimating the proportion of the costs of reform that would apply to parents or carers of children, the numbers of children whose poverty would be ameliorated, and the costs of those reforms urgently require continuing research.

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