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Exploring evidence for a prospective relationship between common mental disorder and meeting residential mobility preferences

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ABSTRACT

This study investigates evidence of a selective influence of mental health in meeting residential mobility preferences. Data from two waves of Understanding Society (the UK Household Longitudinal Study) were used to identify four preference-mobility groups ('desired stayers', 'entrapped', 'desired movers', 'displaced'). Associations between mental health (symptoms of common mental disorder, CMD) and preference-mobility groups were measured both before and after residential moves. Those identified with CMD at baseline were at greater risk of being both in the 'entrapped' and the 'desired mover' groups, relative to the 'desired stayer' group in the following year. The association between preference-mobility group and subsequent poorer mental health was found among both groups that failed to meet their mobility preferences ('entrapped' and 'displaced'). This study finds evidence for a selective influence of mental health - such that those with poorer mental health are less likely to achieve a desired residential move, and highlights the importance of considering a bidirectional relationship between residential mobility and mental health.

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1. Introduction

Alongside implications for the labour market, labour mobility and the distribution of economic resources (Hickman, 2010; Caldera Sánchez et al., 2011), understanding factors associated with residential mobility has important significance for the spatial distribution of illness (Norman et al., 2005). The characteristics of people who move or do not move, and the characteristics of the origins and destinations to and from which they move, are linked to social stratification (Forrest, 1987; Burrows, 1999; Coulter et al., 2011) and to socio-spatial patterning in health outcomes (Norman et al., 2005, Curtis et al., 2009). The impact of health on residential mobility and the ability to adapt to changes in residential needs or circumstances is less well considered. While the 'healthy migrant' effect is the more commonly made connection between health and mobility and often refers to long distance or international migration, this assumption is challenged in studies of internal migration finding instances of a negative relationship between health and mobility. Specifically, research has shown that middle aged and older movers are less healthy than their non-migrant counterparts and movers within more deprived areas are less healthy than movers within less deprived areas (Verheij et al., 1998; Larson et al., 2004; Norman et al., 2005). Further, other research has found that individuals with poorer health in more deprived areas may experience 'selective entrapment' or 'immobility'. The studies suggest that this may reflect socio-structural mechanisms contributing to an unequal distribution of health, though have thus far considered mainly physical health (Smith, 1990; Smith and Easterlow, 2005; Norman et al., 2005).

The literature on residential mobility most commonly links moving with life events and associated changes to residential needs - such as family formation, relationship break up, or job loss (Clark and Ledwith, 2006; deGroot et al., 2011). Economic cost-benefit factors are also considered – this equilibrium includes both push and pull factors such as whether or not there is an affordable supply of suitable housing in a desired location, or the availability of jobs and higher wages elsewhere (Böheim and Taylor, 2002; Hickman, 2010). There is likely to be socio-economic differences in an individual's or household's ability to respond to triggers to

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residential mobility and to meet their moving preferences (Coulter et al., 2011). As indicated above, alongside the predominant – economic – models of residential mobility, other non-economic factors may be important. While residential immobility may affect mental health among those who desire to move by trapping people in undesirable living environments, people with pre-existing mental health problems may also be less able to move out of such an environment. This could be because they more commonly have fewer socio-economic resources and/or fewer psychosocial resources to address the barriers and difficulties of moving house (Taylor and Seeman, 1999; Weich and Lewis, 1998). Alternatively, socio-economic disadvantage among people suffering with poorer mental health – with a higher prevalence associated with lower education, unemployment and adverse material circumstances (Fryers et al. 2003)–may render them more residentially mobile due to insecure housing conditions.

Lastly, understanding the motivations behind mobility and how these relate to mental health is of interest since there are known discrepancies between moving desires and behaviours (Lu, 1999; Coulter et al., 2011; Coulter, 2013). Focusing on mobility alone would fail to distinguish those who move despite not wishing to (the 'displaced') and those who did not move despite desiring to relocate (the 'entrapped').

This study uses two years of data from Understanding Society (the UK Household Longitudinal Study, herein referred to as UKHLS) to examine whether there is evidence for an association between common mental disorder (CMD) (e.g., depression and anxiety disorders) and meeting mobility preferences. To acknowledge that there may be a bidirectional relationship; analyses will consider evidence in support of a selective influence of mental health on meeting mobility preferences as well as the influence of meeting mobility preferences on subsequent mental health.

The study aims address three questions: 1) Is baseline mental health associated with meeting moving preferences by the following wave after accounting for baseline individual socio-demographic and economic characteristics? 2) Is meeting moving preferences associated with subsequent mental health after controlling for baseline mental health? 3) Do the reasons for moving among those who did and did not express a moving desire differ by baseline mental health status?

2. Methods

UKHLS is a nationally representative longitudinal panel survey of approximately 40,000 households across the UK; data are collected via face-to-face interviews by trained interviewers and self-completion surveys at 12 month intervals. All those residing in originally sampled households and the offspring of females are permanent members of the survey and followed over time. Co-residents of permanent members are also interviewed so long as they are living with a permanent member at the time of interview. The data collection period for each wave spans 24 months thus there is overlap in data collection period for each wave (McFall, 2013). An ethnic minority boost sample (EMBS) of approximately 4,000 households is included and from wave 2, participants of the British Household Panel Survey were also included. Full details of the sampling design are available (Berthoud et al., 2009; Lynn, 2009).

The first wave of data was collected between 2009 and 2010. The current study only uses data from the two most recent waves – waves 2 (data collected between 2010 and 2011) and 3 (between 2011 and 2012). Overall response rates were 76.2% in wave 2 and 76.1% at wave 3 (Lynn et al., 2012). The analysis sample included adults (aged 16+ years) who took part at both waves 2 and 3 ($N=44{,}178$). Those who completed proxy interviews ($n=3651$) and those with incomplete data on wave 2 moving preferences and wave 3 mover status ($n=51$) were excluded such that the analytical sample size was $N=40{,}476$.

2.1. Meeting moving preferences

Whether or not participants met their moving preferences was determined using information on moving preferences at wave 2 and mover status at wave 3. Moving preferences were assessed with the item: *'If you could choose, would you stay here in your present home or would you prefer to move somewhere else?'* Responses are coded 1 "stay here" and 2 "prefer to move". Mover status at wave 3 was elicited from variables indicating whether or not the individual was interviewed at the last wave and whether or not the household in which the individual was interviewed had moved address since the last wave. Four groups were identified: those who preferred to stay at wave 2 and who had not moved by wave 3 ('desired stayers'); those who indicated a moving preference at wave 2 and who had moved by wave 3 ('desired movers'); those who indicated a moving preference at wave 2 and who had not moved by wave 3 ('entrapped'); and, those who indicated that they wanted to stay at wave 2 but had moved by wave 3 ('displaced').While the term 'displacement' often refers to the 'squeezing out' of a certain group by another such as in the case of gentrification processes, or to residents uprooted during area regeneration, here it is specifically used to define those who made a residential move in a given year but who had indicated at the previous time point that they would prefer not to.

2.2. Mental health

The 12-item General Health Questionnaire (GHQ-12) is a widely used screen for CMD encompassing comorbid symptoms of anxiety and depression that was intended for use in large scale community studies (Goldberg and Williams, 1988). The GHQ-12 has been validated against standardised clinical interviews and is considered as a unidimensional construct (Stansfeld and Marmot, 1992). Each item has four response categories on a Likert scale ranging from 'not at all' to 'much more than usual'. The current study uses the binary 'GHQ-method' of scoring (Goldberg and Williams, 1988) such that those responding to an item as 'rather more' or 'much more' than usual are scored as 1 and those responding as 'not at all' or 'no more than usual' are scored as 0. Scores are summed and ranges from 0 to 12. In line with the Health Survey for England (HSE), this study distinguishes those whose summary score is zero (indicating no evidence of probable CMD), from those who score 1–3 (less than optimal mental health) and those who score 4 or more (probable CMD) (Craig and Mindell (2013)).

2.3. Socio-demographic and economic characteristics

The following individual level characteristics were considered: age group (years), sex, ethnicity, relationship status, employment status (employed (including self-employed), unemployed, or outside the labour market (e.g. on maternity leave and retired), benefits receipt, number of own children living in the household, educational attainment, and financial difficulties. Participants were asked how they viewed their financial situation and categorised as 'living comfortably/doing alright', 'just about getting by', or 'quite/very difficult'. Further questions identified whether or not participants had had any problems paying for their rent or mortgage in the past year; whether they had problems paying council tax; and, whether they had got behind with any bills. A variable was created to indicate the total number of problems reported (0–3).

Household data distributed to individuals included tenure, equivalised gross monthly household income (adjusted using the OECD

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