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Relationship between health, experience of discrimination, and social inclusion among mental health service users in Hong Kong

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Abstract

The study of the relationship between mental health and social inclusion has generated much interest among social services providers, policy makers, and academics (Huxley et al., 2008). This paper reports the subjective experience of social inclusion in various key life domains of 168 Chinese mental health services users in Hong Kong collected through a non-probability sample survey. A Chinese version of the Social and Communities Opportunities Profile (i.e. SCOPE-C) employing the same methodology as an earlier UK study was employed in the study. Face-to-face individual interviews were conducted between October 2013 and February 2014. Results indicated that participants perceived an average level of opportunities to participate in various life domains. Despite this, they were satisfied in general with the level of opportunities in these domains. Contradictory to Chan et al. (2014)'s findings, participation did not often encounter discrimination in their daily life. Their perceived general health was between average and good. The overall social inclusion, average satisfaction with opportunities, and average perceived opportunities had significant positive correlation with one another. These three SCOPE-C variables were positively correlated with respondents' physical health, but not mental health. These findings are discussed.

Keywords: social experience; community opportunities; life domains; discrimination; social exclusion; quantitative methods

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Introduction

Individuals with mental health problems often experienced social exclusion because of their inability to participate fully in social, economic, political, and cultural processes (Social Exclusion Task Force, 2006). Promoting the social inclusion among them has been considered as a key challenge for mental health care and the social work professionals (Department of Health, 1999). According to the World Bank's definition, social inclusion refers to "promoting equal access to opportunities, enabling everyone to contribute to social and economic programs and share in its rewards" (The World Bank, 2013).

The concept of social inclusion was first introduced to UK government policy in 1998 by establishing the Social Exclusion Unit (1998). In 2004, an influential report aimed at promoting social inclusion for people with mental health problems was published (Social Exclusion Unit, 2004). The report outlined a comprehensive program to improve health and well being through better employment and training, greater support to the families involved, and greater help to locate permanent homes for mental health patients during the recovery (Social Exclusion Unit, 2004). In Hong Kong, the inclusion spirit has never been stronger, as evidenced in policy addresses of the Chief Executive and by the establishment of a Community Investment and Inclusion Fund, which in 2010/11 alone funded projects worth more than HK$30 million (equivalent to about US$4 million). In view of the societal needs to promote social inclusion among marginalized groups, there is a need for a validated social inclusion measure used in different cultures. The existing

evaluative studies remain mostly related to social capital in the community rather than directly dealing with social inclusion. Developing a valid inclusion measure will help build the knowledge pool for the inclusion of ethnic minority and disabled groups, enhance the accountability of services, and provide objective measures of the service efficacy of different intervention programs. Such a development will benefit not only Hong Kong, but also offers potential for other parts of Asia where inclusion/exclusion issues are challenging.

Literature reviews

To date, there is no comprehensive reporting of data that presents the nature and extent of the social experience of people with mental health problems in Hong Kong. Such information will increase our understanding about the barriers that hinder social participation among them. It also helps individuals and agencies to provide a better service in a person's recovery (Mental Health Commission, 2009).

Social inclusion can be measured with life domains (Mental Health Commission, 2009). The Social Inclusion Questionnaire User Experience (SInQUE) was developed to measure social inclusion for individuals with severe mental illness (Mezey et al., 2012). SInQUE identified four domains that individuals should have in order to be included in society, including productivity, consumption, access to services, and social relations. Political participation was added as an indicator of social inclusion as inspired by Barry (2009). Both objective and subjective questions were asked as mental disorder was associated with objective fact of social exclusion and poverty, as well as the subjective feeling of being socially excluded (Payne, 2006). The SInQUE was administered to 66

patients with schizophrenia and schizoaffective disorder. It was found to have good concurrent and discriminant validity. Evident for the convergent validity was less robust. Only two domains, including change in productivity and social integration, showed positive correlation with duration of illness (Mezey et al., 2012).

The SInQUE, however, has a limitation of long duration (about 45 minutes), and has limited applications to individuals with less severe forms of mental disorder and different diagnoses (Mezey et al., 2012). Descriptive statistics indicated that severe mental health patients suffered from higher rates of exclusion the year prior to their first psychotic admission and at the time of the interview. Participants had low rates of employment and did not integrate well with friends, family, and the community. Among the five tested domains, the productivity domain reported the lowest scores (Mezey et al., 2012).

A framework of life domains that are most indicative of social inclusion has been developed in the United Kingdom (Huxley et al., 2006). It includes family activity, social networks, employment, income and financial services, community participation, housing, transport, mental and physical health, education and training, and civil/justice (Huxley et al., 2006). The framework focuses on the availability of opportunity that a person can access to exercise his or her right as well as the person's subjective perception of satisfaction toward the opportunity in various life domains (Huxley et al., 2006). Based on a concept mapping qualitative study and a quantitative study, a social inclusion index titled Social and Community Opportunities Profile (SCOPE) was developed and put to test in UK (Huxley et al., 2012). It has the advantage of being relatively short, with robust psychometric properties.

This paper reports the results of a measure of social inclusion using SCOPE-C for individuals with severe mental illness. SCOPE-C was developed from UK's short version of the Social and Communities Opportunities Profile (SCOPE) questionnaire (Huxley et al., 2012). The Chinese version was constructed using the same methodology of employing a concept mapping study (Chan et al., 2014) and adjusting selected questions to fit the Hong Kong context. Results of the concept mapping study identified six major themes related to social inclusion, including material resources, work, social diversity, discrimination, communication, and participation in community activities (Chan et al., 2014). The final version of the SCOPE-C consisted of 56 questions, including questions on discrimination in everyday life and health conditions.

Interest in cross-cultural measurement issues has grown rapidly since the turn of the century. Although psychologists have taken the lead, social work researchers have recognised the importance of developing cross-cultural measurement for the profession, especially for work with minority, mental health patients, and immigrant groups. Both professions recognise the same bias and equivalence issues in cross-cultural measurement.

Developing a valid SCOPE-C can have theoretical and social contributions. The advantages of cross-cultural comparison include testing the boundaries of knowledge and stretching methodological parameters; highlighting important similarities and differences; and the promotion of institutional and intercultural exchange and understanding (Ember & Ember, 2001).

In terms of social contribution, a valid measurement tool for Hong Kong is able to raise service accountability, service efficacy, and to promote evidence-based practice and service evaluation. This is particularly important as rehabilitation services are undergoing

a re-structuring in the direction of integration and a more community based approach. It is expected social and healthcare services, government or non-government organizations, will benefit from the study. It will also benefit future research in the form of handy baseline measures for helping professions and healthcare services, providing reliable yardsticks for policy making on social inclusion, and enabling multiple sites to take part in international studies in connection with outcome measures.

Method

Participants

Altogether 168 participants were recruited through five mental health associations in Hong Kong. They were all service users of mental health service centers or halfway houses. They had been diagnosed as severe mental health patients and had received more than 6 weeks of mental health treatment. Their problems had been stabilized, making interviewing possible.

The characteristics of participants at baseline are shown in Table 1. All participants were Chinese. There are roughly equal numbers of female and male participants. Participants' age ranged from 20 to 65 at baseline (M = 43.95; SD = 11.21). Most of them have been living 36 (1^{st} quartile) to 53 (3^{rd} quartile) years (M = 39.23; SD = 14.30) in Hong Kong. More than 40 percent of them were living in halfway houses and about one-third of them were living in public rental housing. Sixty percent of them were employed. Another 20 percent were unemployed because of long term health issues, and a further 16 percent were unemployed for other reasons. Two-third received social welfare and the

remaining one-third had earned income. Most participants' highest qualifications were secondary form 3 or secondary form 5. A majority usually speak Cantonese at home.

[Insert Table 1 about here]

Procedure

Ethical approval was approved by the University's Committee on the Use of Human and Animal Subjects in Teaching and Research. Prior to the individual interviews, participants signed an informed consent statement. The face-to-face individual interviews were conducted by two interviewers in Cantonese, a common dialect used by the participants in Hong Kong. All interviews were conducted at the premises of the mental services centers. The second interviews were conducted two weeks later. A third round of interview was scheduled at six months after the first interview (i.e. April to July 2014). Participants would receive a payment of HK $150 (equivalent to US $20) as a token of appreciation after participating in all three rounds of interviews. Interviews for the first two rounds were conducted between October 2013 and February 2014.

Measures

Demographic questions were adjusted based on the Hong Kong 2011 Population Census (Hong Kong Census and Statistics Department, 2012). A pilot test was conducted with five mental health services users. All the five participants did not have difficulty to understand and answer the questions in SCOPE-C. The interviewing time lasted between 20 to 40 minutes.

SCOPE-C. Translation of the SCOPE scales into the Chinese version of SCOPE scales (SCOPE-C) was conducted following the MAPI guideline (IBM Corporation, 2011).The steps in this process include: conceptual definition; forward translation; backward translation; pilot testing; and proofreading of the final version. Eight domains of inclusion and general social inclusion, including (1) leisure and participation, (2) housing and accommodation, (3) work, (4) financial situation, (5) safety, (6) education, (7) self-reported health, as well as (8) family and social relationships, consisted of both subjective items (satisfaction with opportunities and perceived opportunities) and objective items. Only the subjective items were analyzed and reported in the present paper. The objective items were reported in another paper (***, under review). Satisfaction with opportunities for each social domain were rated from 1 (extremely restricted opportunities) to 7 (plentiful opportunities). All the 11 items on satisfaction with opportunities and one overall inclusion item are shown in Table 2. Perceived opportunities for each domain were rated from 1 (feeling terrible) to 5 (feeling delighted). The five perceived opportunities items are displayed in Table 3.

Other scales. In view of the fact that discrimination was frequently mentioned as an indicator of social exclusion (Chan et al., 2014), participants were asked to answer the Every Discrimination Scale and the Short Form Health Survey. The Every Discrimination Scale had 9 items ranged from 1 (Never) to 6 (Almost everyday). All items are displayed in Table 4. This scale has been demonstrated reliable and valid (Krieger et al., 2005).

The SF-12v2 had 12 items that measured general physical as well as mental health (Ware, Kosinski, & Keller, 1995; 1996). It consisted of eight health domains including

physical functioning, role participation with physical health problems, bodily pain, physical health, vitality, social functioning, role participation with emotional health problems, and mental health. Only two domains (physical health and mental health) were analyzed in the present study. Previous research showed that the SF-12 heath survey was a valid measure for Chinese people (Lam, Tse, & Gandek, 2005).

Results

Satisfaction with opportunities

The means and standard derivations for the 11 satisfaction with opportunities items in various social domains at test and re-test are shown in Table 2. Paired t-test was conducted to find if there were significant changes over the two-week period. Satisfaction with opportunities ranged from 4.16 to 5.03 at baseline. Participants were most dissatisfied with the perceived opportunities to work among those who were employed as well as those who were out-of-work. Participants were most satisfied with opportunities for contact with family as well as opportunities for leisure activities. The Crobach's alpha coefficient for the 11 items of satisfaction with opportunities was 0.82. The average of the 11 items was 4.68, indicating a general satisfaction with opportunities in various social domains. The Pearson correlation (r) for satisfaction with opportunities between test and re-test were all positive and statistically significant. It indicates that the items demonstrated test-retest reliability. Paired t-test results indicated that there is no change in satisfaction with opportunities during the two-week period. The mean of the one-item overall social inclusion was 4.61, indicating a positive perception of social inclusion among the participants. Again, the social inclusion item demonstrated acceptable test-

retest reliability. It can be seen clearly that the scores collected at the two time points (i.e. test, and retest) are significantly correlated, while the difference between the two time points are mostly insignificant, except satisfaction with the opportunities to be involved with community groups/organisations which is significantly lower at retest. The difference in this item may be due to either chance error in the use of t-Test, or a genuine difference due to change in social circumstances.

[Insert Table 2 about here]

Perceived opportunities

The means and standard derivations for the 5 perceived opportunities items in various social domains at test and retest are shown in Table 3. Perceived opportunities ranged from 2.65 to 3.55 at baseline. Participants were most dissatisfied with the perceived opportunities to increase income. They were most satisfied with perceived opportunities for involvement with community groups and organizations. The Crobach's alpha coefficient was 0.67, indicating acceptable internal consistency. The average of the 5 items was 3.01. It indicated that the perceived opportunities in various social domains were neither very few nor a lot. Again the Pearson correlation coefficient (r) for perceived opportunities between test and re-test were all positive and statistically significant while none of the five perceived satisfaction items in the social domain shows any significant changes during the two-week period, as indicated by insignificance of Paired t-Tests.

[Insert Table 3 about here]

Everyday discrimination

The means and standard derivations for the 10 items in the Everyday Discrimination Scale at test and re-test are shown in Table 4. Mean scores of frequency of discriminating acts happened to the participants ranged from 1.53 to 2.28 (1 = never; 2 = not more than once a year; 3 = several times a year). Participants did not often encounter discrimination in their daily lives. If discrimination did occur, participants were most likely perceived that they were not treated as courteously and as respectfully as others. Relatively speaking, participants seldom experienced name calling, threatening, bad service at retail premises, or being suspected of dishonesty. Our findings show that except one item, all other items of the everyday discrimination show insignificant changes of score between test and re-test in a 2-week period. Again, paired t-Test results demonstrated good test-retest reliability. The Crobach's alpha coefficient was 0.83, indicating good internal consistency.

[Insert Table 4 about here]

Health Conditions

The SF-12v2 had two sub-scales measuring general physical health and mental health reported by the respondents. The mean score for physical and mental health were 2.75 on 5-point scale and 4.30 on 6-point scale respectively.

Community opportunities, social inclusion, and health

The overall social inclusion, average satisfaction with opportunities (SatOpps), and average perceived opportunities (POpps) at baseline were significantly correlated with each other (see Table 5). Overall social inclusion was positively correlated with satisfaction with opportunity in all eleven social domains. Overall social inclusion was positively related to three out of five domains for perceived opportunities. Overall social inclusion had a higher correlation with satisfaction with opportunities than perceived opportunities. The three key SCOPE-C variables, including perceived opportunities, satisfaction with opportunities, and overall social inclusion, were significantly correlated with physical health. Interestingly, the three key SCOPE-C variables did not correlate with mental health. The three key of SCOPE-C variables were not significantly correlated with the Everyday Discrimination Scale.

[Insert Table 5 about here]

Discussion

Like all studies, ours is subject to limitations. For example, all the participants recruited to the study were diagnosed with severe mental health problems. Their mental states were stabilized during the interviewing period. They were not the most acutely disturbed individuals. Over 40 percent were living in halfway houses under the care of a community mental health team. More than one-third of them were living in public rental housing. Only twenty percent of them were living in accommodation in the housing market. Two-third of them received social welfare as their major source of income. For those who worked, a majority of them were working in sheltered workshop, again under the care of a community mental health team. Less than one quarter of the sample were

engaged in employment in the free job market. In other words, the sample was a group of mental health services users living in a protected community environment, with quite sufficient support in terms of accommodation and financial means. It is not clear whether similar results would be obtained for individuals with less severe forms of mental disorders, or individuals who are seeking for accommodations and jobs in the market. With this in mind, we examine the results in the context of the research literature.

First of all, the sample showed a general satisfaction with the personal contacts with families and friends, recreational activities, and involvement in community groups. In terms of living environments, they were satisfied with the opportunities for housing and living safely. Their greatest discontent was with the material resources obtained through employment and the opportunities to find jobs in the free labour market. Some respondents mentioned that the pay rise of the hourly wage at the sheltered workshop was not sufficient to catch up with the increase in daily living expenses. Some respondents reported that they tried to apply for jobs with more attractive income. However, they were not recruited because they were not able to fit-in with the highly competitive work environment in Hong Kong. The important emphasis on work for social inclusion and dissatisfaction with lack of means to improve income are both consistent with the findings of the concept mapping study conducted among the mental health services user group (Chan et al., 2014). Regarding perceived opportunities, participants did not find any of the five social domains provided them with good opportunities. Again, they perceived the lowest opportunities to increase income and to get a suitable job. We can see clearly how jobs are highly valued in Asia as a condition of feeling included. It is understandable that jobs provide not only the means of living, but also structured living

patter, workplace human relations, and sense of achievement and being a contributing member to the family and the community as a whole. However, the same labour market that provides also is taxing in terms of job demands and efficiency and will not choose the labour with the slightest sign of slow productivity.

The strong link of overall satisfaction with opportunities and perceived opportunities indicated the construct validity of the SCOPE-C. Among all the social domains measured, employment and financial means occupied a dominant position in determining the experience of social inclusion. This finding is consistent with the results reported on the sources of burdens on families of individuals with mental illness (Tsang, Tam, & Chan, & Chang, 2003). Tsang et al.'s (2003) study indicated that people with mental illness experienced much burden related to stigma and difficulties when trying to obtain competitive employment. It also echoed Sharac, Mccrone, Clement, and Thornicroft's (2010) finding that stigma regarding mental health problems would lead to a negative economic impact, due to adverse impact on employment and income.

Even though perceived opportunities were not high, participants were often satisfied with the "not so good" opportunities; this indicates either a sense of unwilling acceptance, or coming to term with the less than ideal reality. It is another question whether we should help them to accept a lower-than-expected reality or to provide sufficient employment support and opportunities. Perhaps too much has been emphasized for the former than the latter option. There is still much room for policy to expand their opportunities in gainful employment, and for practice to empower them to to make a change to their difficult situation.

Contradictory to the literature on stigmatization of people with mental illness, the current study did not report high level of discrimination in participants' daily lives. We think that the explanations are two-fold. First, a majority of the sample were living or working in a sheltered environment supported by a team of community social workers. The extent of personal interactions beyond this environment is limited. Second, the Everyday Discrimination Scale did not contain items related specifically to the work context, where most of the discrimination takes place. The Equal Opportunities Commission each year received an average of 100 complaints of disability discrimination on the ground of mental illness, among which 70 percent were employment related discrimination (Equal Opportunities Commission, 2013). So, the Everyday Discrimination Scale may not be a sufficient or relevant measure to capture the social experience of exclusion in the work context. Some participants remarked that they were seldom being discriminated when they were playing the role of customers in the local community shops.

Our current study found that overall social inclusion was correlated positively with physical health. However, there was lack of correlation between overall social inclusion and mental health. One possible explanation is that the relative mental health stability of the respondents meant that there was a lack of variance in the mental health compared to the physical health scores. Individual mental health of people in a purpose-built environment is catered for better than physical ill-health so one might expect more variation in physical health and accordingly a reduction in social inclusion where physical or chronic illness is present and an enhancement of inclusion when it is absent.

Conclusion

The study has demonstrated that the concept of social inclusion seems to travel between cultures, which will permit comparative research to take place (paper in preparation). Nevertheless, the sample here in Hong Kong, even though from several different NGOs, was relatively homogeneous, and the findings still carry important messages. First of all, these respondents come from relatively sheltered environments aimed at maintaining their mental health. It is not surprising, therefore that there should be less of an association between inclusion and mental health and a greater association between lower inclusion and physical health problems which may be chronic or undertreated. Another consequence of sample homogeneity is the lower experience of stigma and discrimination than we observed in the concept mapping study. While it is the case that the EDS may not have adequate coverage of work and other issues, it is also possible that the sheltered nature of the environments means that people do not face the same stigma and discrimination that they would face if they were in mainstream communities and workplaces. This is consistent with the suggestions of Warner and Mandiberg (2004) that more closed environments with much peer support positively support individual recovery, and are often preferable to having a single mainstreaming solution for all. For those who have more potential to journey on to work in the labour market, the real challenge in policy lies in how to bridge successfully the transition from a protected environment to the larger community.

Comparison study can be conducted in the future to explore the influence of cultural factors on social inclusion among Hong Kong and UK mental health services users.

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Table 1.
Characteristics of Study Participants at Baseline (n = 168)

Variable	*n*	%
Gender		
Male	88	52.4
Female	80	47.6
Type of accommodation		
Halfway house	71	42.3
Public rental housing units	62	36.9
Private residential (whole house/flat)	14	8.3
Subsidized sale flats	12	7.1
Private residential (room/cockloft/bed space)	4	2.4
Non-domestic quarters	2	1.2
Villas/bungalows/modern village houses	1	0.6
Simple stone structures/traditional village houses	1	0.6
Staff quarters	1	0.6
Owned or rented		
Sole tenant	127	77.0
Owner-occupier without mortgage and loan	22	13.3
Rent free	7	4.2
Co-tenant/main tenant/sub-tenant	6	3.6
Owner-occupier with mortgage or loan	3	1.8
Employment status		
In paid employment (full time or part time)	100	59.5
Long term sick or disabled	32	19.0
Unemployed	27	16.1
Retired from paid work	4	2.4
Looking after family or home	4	2.4
Self employed	1	0.6
Source of income		
Social welfare	111	66.1
Earned income (employment, investment, property rental)	39	23.2
Other source of income	7	4.2
Prefer not to say	7	4.2
No source of income	3	1.8
State pension or pension from a former employment	1	0.6
The highest qualification		
No schooling/pre-primary	3	1.8
Primary	31	18.5
Secondary form 3	41	24.4

Secondary form 5	62	36.9
Secondary form 7	9	5.4
Diploma/certificate	17	10.1
Sub-degree course	1	0.6
Degree course	4	2.4
Place of birth		
Hong Kong	126	75.0
Mainland China	40	23.8
Macao	2	1.2
Language/dialect usually speak at home		
Cantonese	148	88.6
Hakka	6	3.6
Putonghua (Mandarin)	3	1.8
Fukien	3	1.8
Chiu Chau	2	1.2
Sze Yap (Toi Shan, SanWui, Hoi Ping, Yan Ping)	2	1.2
Shanghainese	1	0.6
Hunan	1	0.6
Haifeng	1	0.6

Note. Numbers do not add to 168 due to missing data.

Table 2.
Means and Standard Deviations of Satisfaction with Opportunities in Different Social Domains as well as overall social inclusion (test and re-test)

	Test		Retest			*Paired-*
Variable	*M*	*SD*	*M*	*SD*	*r*	*t*
SatOpps for leisure activities	5.00	0.90	4.86	1.02	0.24**	1.49
SatOpps to be involved with community groups/organisations	4.93	0.81	4.72	0.87	0.29***	2.59*
SatOpps for suitable housing	4.62	1.12	4.56	1.23	0.54***	0.65
SatOpps to work (for employed participants)	4.27	1.06	4.25	1.25	0.38***	0.17
SatOpps to work (for unemployed participants)	4.16	1.28	3.95	1.33	0.68***	1.30
SatOpps to increase income	4.27	1.25	4.27	1.28	0.31***	0.00
SatOpps to live safely in area	4.97	0.98	4.95	0.86	0.39***	0.32
Satisfaction with educational opportunities	4.29	1.12	4.39	1.00	0.42***	-1.07
SatOpps for physical health care	4.66	0.99	4.65	0.93	0.47***	0.16
SatOpps for mental health care	4.63	1.04	4.63	0.95	0.44***	0.00
Subjective opportunities for contact with family	5.03	1.21	5.00	1.30	0.57***	0.28
Subjective opportunities for contact with friends	4.70	1.14	4.86	1.08	0.31***	-1.51
Average of the above items	4.68	0.65	4.66	0.68	0.71***	0.45
Overall social inclusion	4.61	1.24	4.50	1.15	0.61***	1.30

Note. 7-point scale. Higher means represent higher satisfaction.

Table 3.
Means and Standard Deviations of Perceived Opportunities in Different Social Domains (test and re-test)

	Test		Re-test			*Paired-*
Variable	*M*	*SD*	*M*	*SD*	*r*	*t*
Perceived Opps for involvement with community groups and organisations	3.55	1.15	3.46	1.10	0.33***	0.80
Perceived Opps for suitable housing	3.04	1.23	3.07	1.15	0.45***	-0.32
Perceived Opps for suitable work	2.83	1.20	2.80	1.12	0.53***	0.29
Perceived Opps to increase income	2.65	1.15	2.63	1.18	0.48***	0.27
Perceived Opps for education	2.97	1.21	3.04	1.16	0.49***	-0.68
Average of the above items	3.01	0.78	3.00	0.85	0.67***	0.10

Note. 5-point scale. Higher means represent higher perceived opportunities.

Table 4.
Means and Standard Deviations of Everyday Discrimination Scale (test and re-test)

	Test		Re-test			*Paired-*
Variable	*M*	*SD*	*M*	*SD*	*r*	*t*
You are treated with less courtesy than other people are	2.28	1.42	2.16	1.41	0.63***	1.20
You are treated with less respect than other people are	2.19	1.37	2.19	1.50	0.50***	0.06
People act as if they're better than you are	2.17	1.42	2.14	1.39	0.57***	0.25
You are called names or insulted	1.86	1.32	1.91	1.43	0.69***	-0.59
People act as if they think you are not smart	1.81	1.23	2.03	1.37	0.55***	-2.16*
People act as if they are afraid of you	1.69	1.14	1.61	1.10	0.51***	0.87
You are threatened or harassed	1.62	1.18	1.81	1.47	0.60***	-2.02*
You receive poorer service than other people at restaurants or stores	1.62	1.00	1.64	1.12	0.59***	-0.25
People act as if they think you are dishonest	1.53	0.89	1.40	0.96	0.35***	1.53
Average of the above items	1.87	0.82	1.90	0.90	0.79***	-0.52

Note. 6-point scale. Higher means represent higher perceived discrimination.

Table 5.
Pearson correlations between SCOPE-C, Everyday Discrimination Scale, Physical Health and Mental Health

Variables	Overall Social Inclusion	Everyday Discrimination Scale	Physical Health	Mental Health
Average of the SatOpps items	0.51***	-0.06	0.35***	0.14
SatOpps for leisure activities	0.19*	-0.02	0.10	0.15
SatOpps to be involved with community groups/organisations	0.25**	0.01	0.07	-0.03
SatOpps for suitable housing	0.17*	0.07	0.10	-0.04
SatOpps to work (for employed participants)	0.24*	0.22*	0.19	0.00
SatOpps to work (for unemployed participants)	0.52***	-0.12	0.37**	0.13
SatOpps to increase income	0.33***	-0.05	0.26**	-0.02
SatOpps to live safely in area	0.22**	0.02	0.26**	0.13
Satisfaction with educational opportunities	0.33***	-0.04	0.13	0.08
SatOpps for physical health care	0.29***	-0.10	0.18*	0.09
SatOpps for mental health care	0.33***	-0.16*	0.21**	0.10
Subjective opportunities for contact with family	0.33***	0.00	0.20*	0.11
Subjective opportunities for contact with friends	0.49***	-0.09	0.16*	0.15
Average of the Perceived Opps items	0.32***	-0.06	0.28***	0.02
Perceived Opps for involvement with community groups and organisations	0.36***	0.06	0.10	0.08
Perceived Opps for suitable housing	0.12	-0.13	0.24**	-0.10
Perceived Opps for suitable work	0.17*	-0.03	0.30***	0.10
Perceived Opps to increase income	0.22**	-0.07	0.11	-0.01
Perceived Opps for education	0.14	-0.02	0.16*	0.02

Note. * $p < .05$; ** $p < .01$; *** $p < .001$.