Well? What do you think?
A National Scottish Survey of Public Attitudes to Mental Health, Well Being and Mental Health Problems
WELL? WHAT DO YOU THINK?

A National Scottish Survey of Public Attitudes to Mental Health, Well Being and Mental Health Problems

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Scottish Executive Social Research
2002
The views expressed in this report are those of the researchers and do not necessarily represent those of the Department or Scottish Ministers.
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EXECUTIVE SUMMARY

INTRODUCTION

1. The Scottish Executive is committed to policies and initiatives designed to raise awareness of mental health issues and to promote positive mental health and well being. As part of the early work of the National Programme for Improving the Mental Health and Well Being of the Scottish population, a survey was commissioned to assess people’s understanding of mental health and well being, sources of information about mental health issues, experience and perceptions of mental health problems, and attitudes towards mental health problems and people who suffer from them. The contract was awarded to NOP Research Group’s Social and Political division. (See Chapter 1)

2. This project was based around an in-home random sample of 1381 interviews conducted with a representative sample of adults across Scotland. Since the sample size would not give robust data relating to minority ethnic people in Scotland, a ‘booster’ of 51 interviews with non-white people was included. Data was weighted to correct for differential chance of respondent selection and demographic imbalance. (See Chapter 2)

GENERAL HEALTH AND LIFESTYLE

3. Half of the people in the sample rated their general health as very good or excellent. The best health was enjoyed by those people who reported the least stress in their lives, people under the age of 55 and those living in affluent areas. (See Chapter 3.8)

4. Highest mental health and vitality scores were recorded for those people who reported that their lives had been relatively free of stress during the last year and those who felt they had complete control over factors affecting their mental health. Respondents living in professional/managerial households, people who found it easy to manage on their income and people with no long-standing health problems also scored highly. (See Chapter 3.11)

5. Long-standing limiting health conditions were most common among older people, those living on low incomes, people who found it hard to manage on their income, smokers and those who had experienced mental health problems. (See Chapter 3.12 and 3.13)

6. Stress, or the perception of it, declined with age. This may be due to educational and social changes that have led younger people to feel more comfortable in discussing stress. Reported stress levels were particularly high among people aged between 35 and 54 (especially women), respondents who had experienced mental health problems and people with low mental health/vitality scores. (See Chapter 3.14 and 3.15)

7. The heaviest users of GP services were older people, those who reported higher levels of stress and people who had experienced mental health problems. (See Chapter 3.16 and 3.17)

8. Smoking was most common in people who scored modestly on the mental health/vitality scales, and among people working in unskilled jobs or reliant on state benefits. (See Chapter 3.18 and 3.19)
9. Twelve percent of people in the sample reported having caring responsibilities for sick, disabled, elderly or frail people. The figure was higher among those who experienced a higher level of stress. (See Chapter 3.21)

10. Half of the people in the sample said that they knew many or most people in their neighbourhood. However, respondents who reported that they were stressed, those with low mental health/vitality scores and those who had little control over factors impacting on their own mental health were likely to know fewer people in the neighbourhood. (See Chapter 3.22 to 3.27)

PEOPLE’S VIEWS OF THEIR OWN MENTAL HEALTH AND WELL BEING

11. Asked to describe good mental health, the most common responses were: being happy (especially among people between the ages of 16 and 34), healthy (notably among those people with high mental health/vitality scores), being in control (particularly among men aged between 16 and 54 and those people on higher incomes), confident (notably among people between the ages of 16 and 24) and loved (especially women). (See Chapter 4.1)

12. Factors likely to have the most positive effect on mental health and well being included support from family and partners, being healthy (notably people over the age of 75), leisure and social life (particularly the 16 to 34 age group) and having a good income (especially those aged between 25 and 54). (See Chapter 4.2)

13. Factors likely to have a negative effect on respondents’ mental health and well being included stress (particularly in the 25-54 age group), physical illness (notably older women) and lack of money (the 25-54 age group again). (See Chapter 4.3)

14. The three main categories of factors that respondents felt would make the biggest difference to their own mental health and well being were financial (a view notably held by men), health (people aged 55 or older) and stress (people under the age of 55). (See Chapter 4.4 to 4.6)

15. Only 14% of people in the sample said that they had complete control over factors that could affect their own mental health and well being, although 57% thought that they had a good deal of control. People who had experienced mental health problems, and people between the ages of 25 and 54 were least likely to feel they had control over these factors. (See Chapter 4.7 to 4.9)

16. Respondents were asked to choose from a prepared list of suggestions how the government in Scotland might prioritise spending to improve the mental health of the Scottish population. The most popular options were: improving services for people with mental health problems (often mentioned by those in professional/managerial households), providing support to people at difficult times in their lives, helping people understand mental health (a view put forward particularly by those who had experienced mental health problems) and helping to end poverty (suggested most often by unskilled workers and those reliant on state benefits). (See Chapter 4.10 and 4.11)
PEOPLE’S EXPERIENCE OF MENTAL HEALTH PROBLEMS

17. More than two-thirds of people in the sample said that someone close to them had been diagnosed with a mental health problem at some time in their life. Depression was the most common diagnosis, followed by panic attacks, severe stress and Alzheimer’s Disease. Women, people aged 25-54, higher income groups and those people with high levels of stress were most likely to have this kind of contact. (See Chapter 5.1 and 5.2)

18. Just over a quarter of respondents (27%) said that they themselves had been diagnosed with a mental health problem at some time in their lives – again, depression was the most common condition. People who reported having the most stress in their lives, those with little or no control over factors affecting mental health and people who found it difficult to manage on their income were most likely to say that they had experienced mental health problems. (See Chapter 5.3 and 5.4)

19. A third of those people who reported that they had had a mental health problem diagnosed at some time in their lives said that they had experienced difficulties in terms of other people’s attitudes. These difficulties included being unable to participate in social events and experiencing verbal abuse at home and elsewhere. (See Chapter 5.5 and 5.6)

WHERE DO PEOPLE GET THEIR INFORMATION ON MENTAL HEALTH ISSUES?

20. Major sources of information about mental health issues included television news and current affairs, personal contact and experience (notably for those with experience of mental health problems), national newspapers (particularly for older men) and health professionals (especially for those who reported high levels of stress). (See Chapter 6.1 to 6.3)

21. More than 40% of people in the sample reported that they had seen, read or heard of advertising or promotional activity for mental health and well being in the last six months. The most ‘aware’ groups were younger people and those who had experienced mental health problems. (See Chapter 6.4)

22. Media portrayal of people with mental health problems was rarely seen as being entirely positive or entirely negative. However, the general view was that portrayal tended to be negative (a view held notably by 25-54 year olds). Only 10% of those who had experienced mental health problems thought that people with such conditions were positively portrayed. (See Chapter 6.5 and 6.6)

MENTAL HEALTH PROBLEMS: PEOPLE’S VIEWS, ATTITUDES AND OPINIONS

23. People in the sample were asked to respond to a series of statements about mental health problems. Responses were used in an aggregate analysis to develop a classification of overall views on mental health problems in order to measure levels of tolerance. Low scores (i.e. reflecting generally tolerant attitudes) were recorded for most people. However, mean scores for people over the age of 75 were significantly higher than for other age groups and
those with no experience of mental health problems scored significantly higher than those who did have such experience. (See Chapter 7.1 to 7.3)

24. The statements about mental health problems were also used in cluster analysis, in which people were grouped according to the way they responded to the attitude statements. The attitudes that people in each group held in common and the characteristics that they shared were then explored. This work will help to understand how activities to raise public awareness and tackle stigma might be targeted most effectively. While the attitudes of almost half the people interviewed placed them in the two most tolerant groups, one in five expressed opinions that placed them at the other end of the spectrum.

25. The cluster analysis showed one group of people who were in the middle of the spectrum, exhibiting a mixture of sympathy and concern. People in this group indicated that they might find it difficult to talk to people with mental health problems, they tended to think that the public should be protected from people with mental health problems and they would not want people to know if they were suffering from a mental health problem themselves. On the other hand, they thought that anyone can suffer from a mental health problem and agreed with the idea of equal rights. It is possible that this group will be most receptive to initiatives to improve awareness of and information about mental health problems. People in this group were most likely to be in work, and the news on television was likely to be their main source of information about mental health issues. (See Chapter 7.4 to 7.6)

26. Respondents were shown one of six vignettes which described symptoms associated with depression, schizophrenia or stress in a man (Robert) or woman (Shona). No diagnosis was included in the description. People were then asked a number of questions relating to the person described in the vignette. Respondents thought that many factors were likely to have caused Robert or Shona’s condition. Stressful or disturbing events were cited by more than 80% of respondents to all case studies. Some vignettes were associated with particular factors: symptoms of depression were seen as being linked with physical illness (particularly in Robert’s case) while schizophrenia was seen as being connected with chemical imbalance in the brain and, to a lesser extent, with genetic problems. (See Chapter 7.7 to 7.18)

27. Respondents were asked who would be the best person to help Robert or Shona (options included family members and friends and service users as well as a range of service professionals). The most commonly suggested source of help for the person in each vignette was the family doctor (GP). However, for those respondents considering symptoms associated with schizophrenia (and the depressed Shona) the GP’s input was seen to be less helpful. The specialist skills of a psychiatrist were more likely to be suggested to engage with Robert/Shona’s symptoms of schizophrenia. A qualified counsellor was a popular option with those considering Robert/Shona’s symptoms of depression. Family members received frequent mentions as potential sources of help for the person in the vignette, particularly the male version of each case study. (See Chapter 7.19)

28. Very few respondents thought that Robert or Shona should live alone, whatever the symptoms described. For the person suffering depression or stress, living at home with family members was a popular option (although not for the depressed Shona). Approximately half of the respondents who considered a person experiencing symptoms of depression or schizophrenia thought that Robert/Shona could live at home with professional help. Some respondents opted for the idea of special housing with professional support for
the person with schizophrenia, particularly those who considered the male version of the vignette. (See Chapter 7.20 and 7.21)

29. A quarter of those respondents who considered the symptoms of stress, half of those who looked at symptoms of depression and two-thirds of those responding to symptoms of schizophrenia thought it likely that Robert/Shona would harm him/herself.

30. Between 12% and 15% of people who considered the stressed Robert/Shona and depressed Shona thought that he/she might harm someone else. Robert with symptoms of depression was thought to be somewhat likely to cause harm to others by 21% of people who considered this vignette. Respondents who considered the vignettes which described symptoms of stress were less likely to believe Robert or Shona was likely to harm other people. However, almost 40% of those who were presented with the vignette describing the symptoms of schizophrenia thought that Shona and (more particularly) Robert might be violent to other people. (See Chapter 7.22 to 7.23)

31. There was overwhelming support for the idea that the depressed or stressed Robert/Shona should have the same rights as other people. However, 10% of respondents who considered the symptoms of schizophrenia in a man felt that Robert should not have such rights. (See Chapter 7.24)

32. Respondents were generally quite willing to have contact with and even make a friend of Robert or Shona, although there was less enthusiasm for the idea of him/her marrying into the family. Thirty-eight percent of people who responded to the male version of the vignette describing symptoms of schizophrenia said they would be unwilling for Robert to marry into the family. (See Chapter 7.25 to 7.31)

33. Almost all the people who considered vignettes describing symptoms associated with depression thought it likely that Robert/Shona was suffering from depression. More than 80% of people who had looked at symptoms of schizophrenia and stress also felt that Robert/Shona was depressed. There was less certainty about Robert/Shona experiencing schizophrenia, although more than 70% of people who had considered the relevant vignette felt that the symptoms were associated with schizophrenia. Ninety-five percent of people felt that the stressed Robert/Shona was, indeed, experiencing stress. However, 90% of those who had considered symptoms of schizophrenia and 95% of those who had been asked to think about symptoms of depression also felt that Robert/Shona was experiencing stress. (See Chapter 7.32 to 7.35)

**KEY MESSAGES FROM THE RESEARCH**

34. Findings in all the areas addressed by the survey provide useful information for national and local policy and practice. There were strong links between both general health and rates of mental health/vitality and a range of socio-economic factors. There were also links between levels of stress reported by respondents and their assessment of their own health, energy and state of mind.
35. People demonstrated awareness of factors that might influence their own mental health and well being (positively or negatively). There were significant differences in the factors considered important by people in different age groups. However, it was not possible to tell whether priorities change as people become older, or whether factors such as the language, education and social conditioning of different generations influence their responses to questions of this type.

36. There are various encouraging findings from the parts of the survey which dealt with people’s attitudes towards those who experience mental health problems. People in the sample were generally ready to socialise or work closely with a man or woman exhibiting the symptoms of depression, schizophrenia or stress. There was also widespread recognition that people with mental health problems are not to blame for their condition and should have equal rights with the rest of the population. However, there was some reluctance by some people to get too close (for example, to have a man with depression or schizophrenia marry into the family).

37. Analysis of people’s responses to a battery of attitudinal statements indicated that younger people were (broadly) likely to be more tolerant than people over the age of 75. Approximately a quarter of all respondents displayed a mixture of attitudes, suggesting that they could be amenable to initiatives to increase awareness and tackle stigma. Almost half of all respondents recognised that the media tend to deal negatively with mental health problems – three times as many as thought the media had a positive slant in this respect.

38. The sample size for the survey is robust and representative of the Scottish population, so there are no obvious caveats to be borne in mind when considering its findings. Although there was a relatively high refusal rate (23%) there was no evidence of visible bias in terms of the noted profile (ethnicity, evidence of children in the home etc) of those people who refused to participate. However, it is not possible to tell whether there are attitudinal biases in the weighted sample of participants.

39. In the course of the survey, respondents who said that they had personal experience of mental health problems were asked if they had ever decided not to disclose the condition during a variety of formal application processes. We respect the position of those who agreed that they had made such a decision, and accept that reluctance to reveal personal experiences may have influenced people’s responses to some of our wider survey questions. This reinforces the agenda for change and improvement in current attitudes to people who experience mental health problems.
CHAPTER ONE. INTRODUCTION

1.1 Mental health is one of three key clinical priority areas for the NHS in Scotland. Mental health problems are likely to affect one in five Scots in any one year (Scottish Executive, 2000) and approximately 15 per cent of the Scottish health budget in 2000-2001 was spent on mental health services (Philp et al., 2002). Policy is directed towards ensuring that flexible and appropriate services are available for people who develop mental health problems, when, where and how they need them (Scottish Office, 1997). The proposed Mental Health (Scotland) Bill introduces changes to legislation founded on principles of justice, autonomy, beneficence and non-malificence (Scottish Executive, 2001).

1.2 However, an effective health policy is not just one that gets better at treating more people who are already ill. A commitment exists within the health improvement and social justice strategies of the Scottish Executive’s policy agenda to raise awareness of mental health issues and to promote positive mental health and well being (Scottish Executive, 1999 and 2000, Scottish Office 1999). Effective prevention of mental health problems, and early identification and intervention when mental health problems occur, are also key policy aims. In the autumn of 2001 the Executive announced a National Programme for Improving the Mental Health and Well Being of the Scottish Population to focus on all these issues. The National Programme also links in with key national agencies to address the problems of the stigma and discrimination associated with mental illness (Well? Mental health and well being in Scotland. http://www.scotland.gov.uk/library5/health/mhm92-00.asp).

1.3 As part of its early work, the National Programme needed to investigate levels of mental health and well being in the Scottish population, and to examine people’s attitudes to a range of mental health issues. This study was commissioned to provide the National Programme with data that would allow its work to be targeted where and how attitudes and behaviour might be influenced. The contract was let to NOP Research Group’s Social and Political division, following a competitive tendering process.

1.4 The aims of the survey were as follows:

- To explore people’s understanding of mental health and well being;
- To assess people’s perceptions of mental health problems, including the stereotypes and myths surrounding mental illness;
- To examine where and how people acquire information about mental health issues;
- To measure the extent to which previous direct experience of mental health problems is related to people’s attitudes towards, and perceptions of, mental health problems.
CHAPTER TWO. RESEARCH METHODOLOGY AND ANALYSIS

2.1 The research involved face to face interviews with a representative sample of the Scottish population. Random sampling methods were used to select respondents: addresses for the survey were taken from the small user section of the Postcode Address File (PAF). Sampling points were 96 Enumeration Districts, selected from all parts of Scotland (including Highland and Island areas) with a probability proportional to size of the adult population. It was hoped to achieve a sample size of 1,500 adults aged 16 and over.

2.2 The sample size would not give robust data relating to minority ethnic people in Scotland. The 1991 Census showed that there were only two local authority areas in which minority ethnic people comprised more than 2.5% of the population. In order to increase the number of non-white respondents, a booster sample of 100 minority ethnic people was included in the study design. A separate selection of addresses was made from PAF in what were thought to be areas of relatively high concentration minority ethnic population.

2.3 The questionnaire for the survey was designed, initially, by an advisory group. The group included representatives from the Scottish Executive Health Department, the Health Education Board for Scotland, Glasgow University, Edinburgh University, the Public Health Institute Scotland and the National Anti Stigma Campaign. The draft document was further developed by NOP, in discussion with the Scottish Executive.

2.4 The questionnaire collected information on people’s general health and lifestyle, mental health and well being, personal experience of mental health problems and discrimination, sources of information about mental health issues, and attitudes towards mental health problems and the people who suffer from them. Emotional well being and energy/fatigue were assessed using questions from the SF-36 (Ware et al., 1994). Vignettes depicting people with symptoms associated with depression, schizophrenia or stress were adapted from scenarios created by Link et al. (1999) in their study of public recognition of mental illness. Each vignette was constructed to meet the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, for the disorder in question. The gender of the person in the vignette was randomly varied, and a name was assigned to each vignette subject (Robert or Shona).

2.5 The questionnaire was tested in a small pilot study with 16 respondents in four areas. Locations used in the pilot study were chosen to provide a mixture of inner city, suburban and rural locations including one area with a high concentration of minority ethnic people. The questionnaire was further refined before the main fieldwork stage of the study. (Further details of the questionnaire are provided in relevant sections of the report and the full questionnaire is reproduced in Annex D)

2.6 All fieldwork was conducted via Computer Assisted Personal Interviewing (CAPI), a technique which involves a computerised questionnaire that avoids the need for interviewers to manually check questionnaire routing and leads to both better data quality and rapid provision of the survey outputs. The average interview length was 30 minutes. Fieldwork was carried out between late July and early September 2002. (Information on survey administration, including response rates, is given in Annex B)
2.7 A total of 1381 interviews were conducted, some 120 less than the original target number. The shortfall may be explained by the fact that fieldwork had to be carried out during the summer holiday season (17% of addresses had no contact after 6 or more calls). The tight timescale for the research and the need to report top-line findings in early September meant that there was no opportunity to uniformly reissue non-contacts and ‘soft’ refusals for further calls and conversions. The main sample shortfalls appear to be among young people, and young men in particular. For more detail on the response rate, please see Annex B.

2.8 There was a relatively high level of refusals: 23% of all addresses. The rate was compared with refusal rates in two other recent surveys in Scotland: the 2001 Scottish Social Attitudes Survey was carried out during the summer season and the achieved sample size was similar; the refusal rate was 28% (Curtice and Petch 2002). However, findings from the most recent Scottish Household Survey (Scotland’s People: Results from the 2001 Scottish Household Survey: www.scotland.gov.uk/library5/society/spv6-04.asp) noted a refusal rate of 13%.

2.9 Where possible, interviewers coded reasons for refusal: of the 23% who refused to take part in the study, some 7% said they were (always) too busy, 6% were not interested in the subject and 3% did not want to talk about mental health issues. Where the refusing household was observed to include at least one older person, the proportion refusing because they did not want to talk about mental health issues was twice as high as among other refusing households. There was no evidence of visible bias in terms of the noted profile (ethnicity, evidence of children in the home etc) of those people who refused to co-operate with the survey but, of course, it is not possible to tell whether there are attitudinal biases in the weighted sample of participants.

2.10 Although there was some resistance to taking part in the survey, three-quarters of the final sample said that they would be willing to take part in future surveys for the Scottish Executive.

2.11 The ethnic minority booster sample generated only 51 interviews. This was mainly because the proportion of eligible households was considerably smaller than had been expected on the basis of 1991 Census data. The general expectation was that there would have been a rise in the numbers of people from ethnic minority groups living in the sampled areas. However, interviewers reported a number of cases in which properties owned by ethnic minority landlords were let to (white) students or young people. The main sample included 19 people from ethnic minorities and, while this group was included as part of the main sample analysis, the interviews were also added to the booster sample to produce a separate cell of data with 70 respondents.
2.12 Computer tables were prepared to a specification agreed with the Scottish Executive and were revised after the initial verbal debrief of the key findings on 4 September. The basic question responses and various derived variables were cross-analysed by a wide variety of cells, described below.

- Sex
- Age (7 groups – 16/24 through to 75+)
- Age interlocked with sex (6 groups – 16/34, 35/54 and 55+)
- IPA social class (4 groups - AB, C1, C2, DE)
- Ethnic minority respondents
- Working status (2 groups)
- Income (5 groups – ranging from less than £5,200 per annum to £36,400 or more)
- Ease of managing on income (3 groups– easy, manageable and difficult)
- Affluence of area (4 groups – most affluent to least affluent, based on 1991 Census data)
- Marital/relationship status (2 groups)
- Tenure (2 groups – own/buying and renting)
- Qualifications (7 groups – ranging from no qualifications through to professional qualifications)
- Urban/rural split (3 groups – urban, semi-rural and rural)
- Region (5 groups – Central West, Central East, South/Borders, Highlands and Islands and North-east).  

The sample for the survey was not large enough to break down findings by health board, so the regional groupings were developed to give some flavour of any broad differences across Scotland. The concentration of population in the central belt meant that any representative sample of this size would have modest numbers of interviews in the more rural areas of Scotland.

- Stress levels (4 groups– completely free of stress through to a large amount of stress)
- Long-standing limiting conditions (3 groups– limiting condition, non-limiting and none)
- Experience of mental health problems (3 groups – a problem of their own, someone close with a problem and no contact at all)
- Claimed level of control over things that affect mental health (4 groups – ranging from complete control to a little/none)

- Smoking behaviour (4 groups – all who smoke, heavy, medium/light and non-smokers)

Alcohol consumption was not included in the cross-analysis as the levels recorded were quite low and it was not thought that useful analysis could be conducted.

- Cluster solutions based on factor analysis of attitude statements (6 groups, see Chapter 7.4 to 7.6)
- Stigma scores based on attitude statements (4 groups– from highest to lowest, see Chapter 7.2 to 7.3)
- Health and vitality scores based on an excerpt from SF36 (4 groups – from highest to lowest, see Chapter 3)
- Vignette used during the interview (6 groups – examples of the symptoms of mental health problems, see Chapter 7)
2.13 The report highlights significant differences within the overall sample for each question asked. Some variables appear regularly as key discriminators (sex, age and the level of stress experienced by the respondent in the last year, for example) while others are rarely significant (for example, whether the respondent lives in an urban or rural location, or in a particular region of Scotland). Throughout the report, where the data is presented in detailed table format, significant figures appear in bold italics.

2.14 The data was also used by NOP’s Statistics department in a series of secondary analyses with the intention of identifying links within the data that might not necessarily emerge in standard cross-analysis. These analyses included the production of an index of mental health and vitality (see Chapter 3.10 and 3.11), an attitudinal or ‘stigma’ scale (see Chapter 7.2 and 7.3) and cluster analysis (see Chapter 7.4 to 7.6). Other statistical techniques were used to assess which would produce the most powerful discriminators within the data. Having examined various approaches, CHAID and Correspondence Analysis techniques were employed.

2.15 CHAID divides a population into two or more categories that have the greatest difference with regard to the dependent variable and then splits each of these groups until no more statistically significant differences are found. CHAID was used on the stigma scoring and also on mental health and vitality scores. Correspondence Analysis produces a graphical representation of the relationship between the row and column elements of a data table and was used on this occasion in examining attitudes to mental health and also in linking the vignettes of mental health symptoms with possible causes. The CHAID and Correspondence Analysis are detailed in Annex F and, where appropriate, findings are cross-referenced in the body of the report.
CHAPTER THREE. GENERAL HEALTH AND LIFESTYLE

DEMOGRAPHIC INFORMATION

3.1 Respondents were aged between 16 and 94 and the average age was 47 years. The male/female ratio was 46/54. Respondents in the main study sample overwhelmingly described themselves as white/Scottish (90%) with most of the remainder (7%) seeing themselves as white/other British. This reflects the wider population of Scotland.

3.2 Sixty two percent of the people in the sample were married or living as a couple. Almost a quarter of people were single, 9% were widowed and 7% were divorced or separated. Just over one-in-five of those people interviewed lived alone (22%) and nearly one-in-three had a child aged under 16 in the home. A little under 10% of respondents were pensioners living alone. The average number of adults per household was 2.2. Nearly two-thirds of people were owner-occupiers and almost all of the remainder were renting their homes. A very small number of people occupied their homes through work.

3.3 Twenty percent of respondents were in the professional or managerial social classes. At the other end of the scale, 32% were living in households in which the chief wage earner was in unskilled manual work, or in homes reliant entirely on state benefits. Over half of the people in the sample (53%) were in paid work. Other major groupings were those who were retired (25%), people who were long-term sick/disabled (7%) and those who were at home and not seeking work (6%).

3.4 A quarter of the people in the sample either did not know their household income or refused to state a figure. Some 7% of people interviewed said that their income was no more than £5,200 per annum; 9% of people lived in households with incomes in excess of £36,400 a year. The median figure was in the range of £15,600-£20,800.

3.5 Only 12% of the people in the sample said that it was very easy to manage on their household income, while 28% thought that it was fairly easy. Many people (38%) found their income manageable but 17% felt that it was very/fairly difficult for them to manage on their income.

3.6 Some 16% of those people interviewed said that their highest level of qualification was at O Grade/Standard Grade/GCSE or equivalent, while for 5% their highest was Higher Grade/A Level or equivalent. Fourteen percent had a highest qualification at GSVQ/SVQ level 1 or 2/BTEC First Diploma/City and Guilds or equivalent. Almost one person in ten had a highest qualification at HNC/HND/SVQ level 4 or 5 or equivalent while 8% had a degree and 15% had professional qualifications.

3.7 The 51 respondents in the ethnic minority booster sample were generally younger than the people in the main sample: a quarter of respondents were aged under 25 and a further third were aged under 35. Two-thirds of people in the ethnic minority sample were female and three-quarters of people lived in a household with at least one child. A quarter of people had degree-level qualifications and the same fraction said that they found it difficult to manage on their current household income.
Rating of general health

3.8 Half of the people in the sample (52%) rated their general health as being either excellent or very good, with almost a third (31%) rating it as being good. Relatively small numbers of people said that their general health was only fair (16%) or poor (8%). As shown in figure 3.1, there were significant variations by age, the amount of stress experienced by respondents in the last 12 months and by affluence of area. By allocating a point scoring system to each answer (e.g. excellent = 4 and poor = 0), we can identify some other differences. There were higher than average claimed levels of health among non-smokers, those in the AB (professional and managerial) social classes and people living in the most affluent areas. Associated with the latter finding, there was a relatively low health figure for those living in the western part of the central belt, in and around Glasgow. People living in the least affluent areas were most likely to say their health was poor or only fair, and almost 40% of people who reported that they were experiencing large amounts of stress also rated their general health as poor or fair.

Figure 3.1 : In general, would you say your health is…
Base: all = 1381
Mental health and vitality in the last four weeks

3.9 The next series of questions were about how respondents had been feeling during the past 4 weeks. For each statement, the people in the sample were asked to indicate how much of the time they had felt this way.

Table 3.1: For how much of the time during the past 4 weeks …
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Most %</th>
<th>Some %</th>
<th>A little %</th>
<th>None %</th>
<th>Don’t know %</th>
</tr>
</thead>
<tbody>
<tr>
<td>…did you feel full of life?</td>
<td>4</td>
<td>33</td>
<td>34</td>
<td>18</td>
<td>11</td>
<td>*</td>
</tr>
<tr>
<td>Did you have a lot of energy?</td>
<td>5</td>
<td>37</td>
<td>32</td>
<td>14</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Did you feel worn out?</td>
<td>4</td>
<td>13</td>
<td>33</td>
<td>27</td>
<td>22</td>
<td>*</td>
</tr>
<tr>
<td>Did you feel tired?</td>
<td>5</td>
<td>17</td>
<td>45</td>
<td>25</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Have you felt very nervous?</td>
<td>2</td>
<td>5</td>
<td>14</td>
<td>21</td>
<td>58</td>
<td>*</td>
</tr>
<tr>
<td>Have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>5</td>
<td>11</td>
<td>15</td>
<td>68</td>
<td>*</td>
</tr>
<tr>
<td>Have you felt calm and peaceful?</td>
<td>9</td>
<td>43</td>
<td>33</td>
<td>10</td>
<td>6</td>
<td>*</td>
</tr>
<tr>
<td>Have you felt downhearted and depressed?</td>
<td>2</td>
<td>4</td>
<td>19</td>
<td>23</td>
<td>52</td>
<td>*</td>
</tr>
<tr>
<td>Have you been happy?</td>
<td>16</td>
<td>58</td>
<td>20</td>
<td>4</td>
<td>2</td>
<td>*</td>
</tr>
</tbody>
</table>

(* = less than 0.5%)

3.10 Responses to this battery of questions were used to calculate mental health and vitality scores for each person. The first four of the statements in Table 3.1 comprised the vitality score and the other five statements made up the mental health score. Both scores were scaled from 0-100 and the overall mental health and vitality score was calculated using a weighted average of the two scores, with highest scores signifying best levels of vitality/mental health.

3.11 The average score across the overall sample was 67. However, there were a large number of variations across sample groups, notably by social class (highest scores among professional/managerial households), stress levels (lowest scores among those reporting themselves as most stressed), claimed level of control over mental health (high scores for those in complete control), ease of managing on income (low scores for those finding things difficult) and long standing limiting health conditions (low scores for people with these problems). There were also lesser variations by working status (those people not working scoring higher than those who were in work), smoking behaviour and the urban/non-urban split. Partly reflecting the latter finding, scores were lower in the central areas around Glasgow and Edinburgh. CHAID analysis confirmed that long-standing limiting conditions, levels of control over mental health and stress levels were the variables with the most significant differences. (See Annex F for more details)
Table 3.2: Overall scores on the mental health and vitality questions  
Base: all = 1381  
(NB – row not column %)

<table>
<thead>
<tr>
<th></th>
<th>Less than 50</th>
<th>50, less than 67</th>
<th>67, less than 80</th>
<th>80+</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AB</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DE</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress free</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large amount of stress</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy smokers</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-smokers</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-urban</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete control over mental health</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little or no control over mental health</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy to manage on income</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to manage on income</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long standing limiting condition</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No long standing condition</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Long-standing limiting conditions

3.12 The standard pair of Census questions was asked with regard to having long-standing illness, disability and infirmity. These included a check to discriminate between those who were limited in any way in terms of their activities. Almost four-in-ten of those interviewed reported having a long-standing problem and most of this group (representing 28% of the total sample) said that their activities were limited by their condition.

3.13 There were, again, variations across the sample groups, most markedly by age – see Table 3.3. There were also high levels of limiting conditions for those on low and hard-to-manage incomes, those with a history of mental health problems (45%), smokers and respondents living in the least affluent areas.

Table 3.3: Do you have any long-standing illness, disability or infirmity? By long-standing, I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time. IF YES: Does this illness, disability or infirmity limit your activities in any way?  
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>39%</td>
<td>18%</td>
<td>27%</td>
<td>31%</td>
<td>34%</td>
<td>58%</td>
<td>62%</td>
</tr>
<tr>
<td>- limited</td>
<td>28%</td>
<td>9%</td>
<td>20%</td>
<td>22%</td>
<td>24%</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>- not limited</td>
<td>11%</td>
<td>9%</td>
<td>7%</td>
<td>9%</td>
<td>10%</td>
<td>12%</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>61%</td>
<td>82%</td>
<td>73%</td>
<td>69%</td>
<td>66%</td>
<td>42%</td>
<td>38%</td>
</tr>
</tbody>
</table>

15
Stress over the last year

3.14 Just over half of the people in the sample (53%) reported that they had suffered from either a moderate or a large amount of stress in the past year – most of the remainder said that they had experienced only a small amount of stress in this period. Only 9% claimed to be completely stress-free in the last 12 months. There were, again, significant variations by main demographic groups, notably age and sex (as shown in Figure 3.2). For both men and women, the middle-aged group reported the highest levels of stress and the lowest scores on this variable were recorded for respondents aged 55 or older.

Figure 3.2: Which of these statements best describes the amount of stress or pressure you have experienced in the past year?
Base: all = 1381

3.15 Other groups reporting relatively high levels of stress included those with a long term limiting condition (33% of these respondents reported a large amount of stress), people having difficulties managing on their income (31%), respondents with low health/vitality scores (47%) and people with personal experience of a mental health problem (39%).
Visits to the GP/family doctor

3.16 A substantial majority of people (70%) said they had seen their GP/family doctor about their own health in the last 6 months, including a third who had been to the surgery in the last month. The lightest users of GPs were young and middle aged men and, to a lesser extent, middle aged women.

Table 3.4: When did you last see your family doctor/GP about your own health?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Male 16-34 %</th>
<th>Male 35-54 %</th>
<th>Male 55+ %</th>
<th>Female 16-34 %</th>
<th>Female 35-54 %</th>
<th>Female 55+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last week</td>
<td>11</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>In the last month</td>
<td>25</td>
<td>22</td>
<td>15</td>
<td>33</td>
<td>28</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>In the last 6 months</td>
<td>34</td>
<td>33</td>
<td>37</td>
<td>35</td>
<td>32</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>In the last year</td>
<td>13</td>
<td>17</td>
<td>14</td>
<td>9</td>
<td>19</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Longer ago</td>
<td>16</td>
<td>24</td>
<td>25</td>
<td>10</td>
<td>11</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Never</td>
<td>*</td>
<td>0</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>0</td>
<td>*</td>
</tr>
</tbody>
</table>

3.17 Those people with long-standing limiting conditions were, as might be expected, heavy users of GP facilities (61% had seen a doctor in the last month) as were people who scored poorly on the health/vitality measures (67%), those reporting large amounts of stress (50%) and people with personal experience of a mental health problem (51%).

Smoking

3.18 Nearly a third of those people interviewed said that they (at least occasionally) smoked cigarettes nowadays. The mean daily consumption figure among smokers was 15. Table 3.5 shows smoking prevalence and consumption by a number of different age groups – the highest levels of consumption were recorded for those aged 18-44.

Table 3.5: Do you smoke cigarettes nowadays? IF YES: On an average day, how many cigarettes do you smoke?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>18-24 %</th>
<th>25-34 %</th>
<th>35-44 %</th>
<th>45-54 %</th>
<th>55-64 %</th>
<th>65-74 %</th>
<th>75+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, daily</td>
<td>29</td>
<td>36</td>
<td>34</td>
<td>33</td>
<td>24</td>
<td>26</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Yes, occasionally</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>Mean number smoked</td>
<td>15</td>
<td>12</td>
<td>14</td>
<td>17</td>
<td>20</td>
<td>18</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>62</td>
<td>59</td>
<td>64</td>
<td>75</td>
<td>73</td>
<td>74</td>
<td>85</td>
</tr>
</tbody>
</table>
3.19 Other sample groups with a relatively high level of smoking prevalence included those in the DE social class (47%), respondents in the least affluent areas (48%), the lowest health/vitality grouping (43%) and to a lesser extent those with a history of mental health problems (34%). The ethnic minority sample showed a notably low level of smoking (11%).

Alcohol

3.20 Just over two-thirds of people interviewed stated that they drank alcohol nowadays and the weekly consumption figure in terms of units was 11. Table 3.6 shows the level of drinking across a variety of sex/age groups. In overall terms, men were found to drink more than women and older people less than younger people.

Table 3.6: Do you drink alcohol nowadays? IF YES: In a typical seven day week, how many units of alcohol would you drink, including weekends, anything you drink at home, in pubs, clubs or at parties?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Men 16-34 %</th>
<th>Men 35-54 %</th>
<th>Men 55+ %</th>
<th>Women 16-34 %</th>
<th>Women 35-54 %</th>
<th>Women 55+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69</td>
<td>79</td>
<td>85</td>
<td>67</td>
<td>73</td>
<td>70</td>
<td>45</td>
</tr>
<tr>
<td>Mean units</td>
<td>11</td>
<td>14</td>
<td>16</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>21</td>
<td>15</td>
<td>33</td>
<td>27</td>
<td>30</td>
<td>55</td>
</tr>
</tbody>
</table>

Caring responsibilities

3.21 Only a small minority of people in the sample (12%) said that they looked after a sick, disabled, elderly or frail person who lived either with them or in another household. The lowest levels of such responsibility were recorded for people under 35, but figures were otherwise quite consistent by age. Women aged 35-54 were the group most likely to have such responsibilities (23%). Sixteen percent of those people who reported a moderate or large amount of stress in their lives were carers (8% of carers reported little or no stress).
Living in the area and social capital issues

3.22 Well over half of the people in the sample (61%) had been living at their current address for at least ten years – only 12% had moved inside the last two years. The more recent movers were younger than average, perhaps because of factors associated with young adulthood itself: beginning work or changing jobs, for example, or starting/extending a family.

3.23 In order to explore the connectedness of neighbourhoods, a series of questions were asked in relation to social capital issues. The section began with a check on the extent to which respondents knew people in their neighbourhood, i.e. within 15 minutes walk of their home. Five percent of the sample said that they did not know any other people in the area, and nearly half of all respondents (45%) knew few, if any, other people. The rest of the people in the sample split quite evenly between those who knew many or most of their neighbours.

3.24 Table 3.7 shows a higher level of knowledge of neighbours for those people who said they were stress-free, those who had high vitality scores and for respondents who claimed to have complete control over the factors that can affect mental health.

Table 3.7: Would you say that you know… in your neighbourhood?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Stress free %</th>
<th>Large amount of stress %</th>
<th>Low mental health/ Vitality score %</th>
<th>High mental health/ Vitality score %</th>
<th>Complete control over mental health %</th>
<th>Little or no control over mental health %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the people</td>
<td>28</td>
<td>43</td>
<td>23</td>
<td>29</td>
<td>35</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>Many</td>
<td>22</td>
<td>23</td>
<td>20</td>
<td>21</td>
<td>23</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>A few</td>
<td>45</td>
<td>30</td>
<td>51</td>
<td>44</td>
<td>42</td>
<td>40</td>
<td>56</td>
</tr>
<tr>
<td>Do not know people</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

3.25 Those respondents aged 25-34 were generally less likely to know many people in their neighbourhood, perhaps because they also tended to be quite recent movers.

3.26 Over two-thirds of the people in the sample (70%) said that their neighbourhood was the sort of place where neighbours look out for each other. However, a quarter of respondents held the opposite view and the balance (notably those on the highest incomes and also in the rented sector) were unsure one way or the other. People with low vitality scores (34%) and those suffering from large amounts of stress (31%) were among the groups who reported that their neighbourhood was the kind of place where people were less likely to look out for each other.
Almost a quarter of the people in the sample (22%) said that they had been involved in a local organisation in some capacity on a voluntary basis over the last three years (i.e. carried out work for which they had not been paid, except for expenses). High participation was recorded for those aged 55-64 (32%), people in rural areas including the Highlands and Islands (30%) and respondents in the AB social class (37%).
CHAPTER FOUR. PEOPLE’S VIEWS OF THEIR OWN MENTAL HEALTH AND WELL BEING

Describing good mental health

4.1 A list of 15 words or phrases was used to assess how people viewed good mental health – respondents were invited to select between one and five options from a prompted list. Table 4.1 shows the rank order of responses, in descending order. The rank order of issues did not vary greatly by group but there were considerable variations in the actual scores. Young people, for example, were notably concerned about happiness and confidence. The over 75s, by contrast, were relatively more likely to mention coping and tolerance. Correspondence Analysis at this question confirmed that age was a more powerful discriminator than either sex or social class – see Annex F for more details. Further down the rank order, the idea of being successful had a positive message for ethnic minority respondents.

Table 4.1: Here are some words and phrases people have used to describe good mental health. Which do you think are the five words or phrases that best describe good mental health for you?
Base: all = 1381

<table>
<thead>
<tr>
<th>Word</th>
<th>All %</th>
<th>Highest percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td>67</td>
<td>• 16-34 years 77%</td>
</tr>
<tr>
<td>Healthy</td>
<td>59</td>
<td>• High mental health/vitality scores 68%</td>
</tr>
<tr>
<td>In control</td>
<td>54</td>
<td>• Male 16-54 61%</td>
</tr>
<tr>
<td>Confident</td>
<td>52</td>
<td>• 16-24 years 69%</td>
</tr>
<tr>
<td>Loved</td>
<td>49</td>
<td>• Female 55%</td>
</tr>
<tr>
<td>Calm</td>
<td>48</td>
<td>• Stress-free 62%</td>
</tr>
<tr>
<td>Coping</td>
<td>40</td>
<td>• Over 75s 51%</td>
</tr>
<tr>
<td>Tolerant</td>
<td>32</td>
<td>• Over 75s 46%</td>
</tr>
<tr>
<td>Understood</td>
<td>21</td>
<td>• Social class DE 24%</td>
</tr>
<tr>
<td>Resourceful</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Successful</td>
<td>13</td>
<td>• Ethnic minorities 37%</td>
</tr>
<tr>
<td>Connected/part of something</td>
<td>12</td>
<td>• AB 18%</td>
</tr>
<tr>
<td>Challenged</td>
<td>7</td>
<td>• Male 16-54 10%</td>
</tr>
<tr>
<td>Attractive</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
Positive and negative effects on mental health and well being

4.2 The questionnaire went on to ask, without prompting, about factors that might have a positive impact on the respondent’s mental health or well being. The idea of support (from family members and partners in particular) scored strongly, followed by good health, social and leisure activities, a good income and work. ‘Environmental’ factors (such as the weather and holidays) also made the top dozen responses, along with issues of stress and being in control. The main differences in attitudes by age are highlighted in Table 4.2 (in bold italics). For example, people over the age of 75 were particularly concerned about being healthy and respondents under the age of 25 were keen to emphasise the value of leisure activities and a social life and support from friends. The Correspondence Analysis confirmed that age was the key discriminator of views on positive effects on mental health. However, it is not possible to tell whether people’s views change as they grow older, or whether factors such as the language, education and social conditioning of different generations influence their responses to questions of this type.

Table 4.2: Thinking now about other things which might affect your health, what sorts of things have a positive or good effect on your mental health and well being?
Base: all = 1381 (Top 12 mentions)

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>16-24 %</th>
<th>25-34 %</th>
<th>35-44 %</th>
<th>45-54 %</th>
<th>55-64 %</th>
<th>65-74 %</th>
<th>75+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from/relationship with other family members</td>
<td>35</td>
<td>36</td>
<td><strong>39</strong></td>
<td>34</td>
<td>35</td>
<td><strong>36</strong></td>
<td>36</td>
<td>25</td>
</tr>
<tr>
<td>Support from/relationship with spouse/partner</td>
<td>22</td>
<td>17</td>
<td><strong>29</strong></td>
<td><strong>28</strong></td>
<td>22</td>
<td>23</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Being healthy</td>
<td>21</td>
<td>16</td>
<td>23</td>
<td>19</td>
<td>19</td>
<td>24</td>
<td>21</td>
<td><strong>32</strong></td>
</tr>
<tr>
<td>Leisure activities/social life</td>
<td>19</td>
<td><strong>35</strong></td>
<td>14</td>
<td>19</td>
<td>15</td>
<td>15</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Having enough money/good income</td>
<td>18</td>
<td>12</td>
<td><strong>25</strong></td>
<td><strong>24</strong></td>
<td>22</td>
<td>13</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Work/working</td>
<td>16</td>
<td><strong>22</strong></td>
<td><strong>24</strong></td>
<td><strong>20</strong></td>
<td>18</td>
<td>12</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Support from/relationship with friends</td>
<td>14</td>
<td><strong>29</strong></td>
<td>15</td>
<td>11</td>
<td>9</td>
<td>15</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Good weather</td>
<td>12</td>
<td>6</td>
<td>10</td>
<td>11</td>
<td>10</td>
<td>14</td>
<td><strong>19</strong></td>
<td>13</td>
</tr>
<tr>
<td>Avoiding stress</td>
<td>10</td>
<td>5</td>
<td><strong>13</strong></td>
<td>10</td>
<td><strong>15</strong></td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Being in control</td>
<td>9</td>
<td>5</td>
<td><strong>14</strong></td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Holidays/breaks</td>
<td>7</td>
<td>3</td>
<td>9</td>
<td>6</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Being calm</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>
4.3 On the other side of the coin, reported stress, physical illness and lack of money emerged as having particularly negative associations for mental health and well being. Many of the most common responses at this question were reversals of the answers given at the previous ‘positive’ question, including problems in relationships, bad weather and work pressures. Again, the analysis showed significant differences in views by age and these are highlighted in italics in Table 4.3 – the 25-54 year old age group were more concerned about stress, lack of money and work than people in the other age bands. Older people (and women in general) were more likely to mention physical illness having a negative impact on mental health and well being. Again, Correspondence Analysis confirmed the importance of age in interpreting responses to this question although, once more, it is not clear whether this is due to the age or generational differences.

Table 4.3: What, if any, things have a negative or bad effect on your mental health and well being?
Base: all = 1381 (Top 12 mentions)

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>16-24 %</th>
<th>25-34 %</th>
<th>35-44 %</th>
<th>45-54 %</th>
<th>55-64 %</th>
<th>65-74 %</th>
<th>75+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>25</td>
<td>21</td>
<td>33</td>
<td>31</td>
<td>31</td>
<td>18</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Illness (physical)</td>
<td>22</td>
<td>6</td>
<td>18</td>
<td>20</td>
<td>23</td>
<td>33</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Not enough money/low income</td>
<td>20</td>
<td>23</td>
<td>31</td>
<td>22</td>
<td>22</td>
<td>13</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Problems in relationship with other family members</td>
<td>16</td>
<td>14</td>
<td>17</td>
<td>20</td>
<td>19</td>
<td>20</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Bad weather</td>
<td>14</td>
<td>8</td>
<td>13</td>
<td>12</td>
<td>10</td>
<td>17</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Work/working/having too much work</td>
<td>14</td>
<td>13</td>
<td>22</td>
<td>21</td>
<td>20</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Problems in relationship with spouse/partner</td>
<td>9</td>
<td>7</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Not being in control</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Not working</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Problems in relationships with friends</td>
<td>6</td>
<td>12</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Lack of sleep</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Poor social life/not much to do/lack of facilities</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
Three things to make a difference to own mental health and well being

4.4 People were asked, again without prompting, to identify the three things that would make the biggest difference to their own mental health and well being. Generic issues were increased finance (mentioned by 39%) and good health (mentioned by 33%), followed by reduced stress (17%) and improved quality of life (14%). Work was mentioned both in the context of wanting a job and wanting to stop working. One in ten of the people in the sample mentioned a lottery win as the thing that would make the biggest difference to their mental health and well being. The Correspondence Analysis found that age was the strongest discriminator at this question but there were also variations by sex, so figures 4.1 and 4.2 show responses broken down by a combination of these variables.

Figure 4.1: What would be the three main things that would make the biggest improvement to your own mental health and well being? (1)
Base: all = 1381 (Limited to those mentioned by 7+%)

Figure 4.2: What would be the three main things that would make the biggest improvement to your own mental health and wellbeing? (2)
Base: all = 1381 (Limited to those mentioned by 7+%)
4.5 Financial issues were an important concern for men in general and for both men and women in the 16-34 age group. One man in five between the ages of 35 and 54 spontaneously mentioned winning the lottery as a major way of improving their mental health and well being. Health issues were more of a worry to older people, while people in the middle-aged group emphasised stress-related issues.

4.6 Women aged under 35 and men under 55 were notable for pointing out work issues as an area for improvement. Those people in work were more likely to cite financial issues than those who were not working. People with personal experience of a mental health problem were more likely than other groups to mention relationships with partners and other family members (20% compared with 10%).

**Level of control over things affecting mental health**

4.7 While only one person in seven said that they had complete control over the things that affect their mental health, well over half thought that they had a good deal of control. Around a quarter of the people in the sample felt that they had some control over this issue and 7% thought that they had little (5%) or no control (2%).

4.8 There were some clear differences by age, with those aged 25-54 having lower claimed levels of control than either younger or older people.

**Table 4.4: Thinking generally about all the things that affect your mental health, how much control do you feel you have over them?**

Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete control (4)</td>
<td>14</td>
<td>14</td>
<td>9</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>A good deal of control (3)</td>
<td>57</td>
<td>65</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>61</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>Some control (2)</td>
<td>21</td>
<td>14</td>
<td>25</td>
<td>25</td>
<td>2</td>
<td>19</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>A little control (1)</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>No control at all (0)</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mean score</td>
<td>2.8</td>
<td>2.9</td>
<td>2.6</td>
<td>2.7</td>
<td>2.7</td>
<td>2.8</td>
<td><strong>2.9</strong></td>
<td><strong>2.0</strong></td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>*</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

4.9 Those people with high vitality/mental health scores also performed strongly at this measure – 90% of the top group in the vitality classification claimed to have complete or a good deal of control over the factors that affect their own mental health. Exactly 50% of those who had experienced a mental health problem said that they had complete/good control over these factors, compared with 80% of those with no such experience.
Government spending priorities for improving mental health of the Scottish population

4.10 From a prompted list of six items (plus an “other specify” category), people in the sample were asked to pick the three most important areas for the government in Scotland to prioritise spending in order to improve the mental health of the Scottish population. Improving services and providing support at difficult times were the most commonly mentioned ideas, followed by improving understanding of mental health and dealing with poverty. Much smaller proportions of people in the study sample mentioned improving trust and respect in local communities, or helping to put an end to discrimination.

**Table 4.5: If the government in Scotland had to prioritise spending on just three areas that might improve the mental health of the Scottish population, which three from this card do you think are the most important?**

<table>
<thead>
<tr>
<th>Base: all = 1381</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Improve services for people who develop mental health problems</td>
</tr>
<tr>
<td>Support people at difficult times of their life</td>
</tr>
<tr>
<td>Help people to understand about mental health</td>
</tr>
<tr>
<td>Help to put an end to poverty</td>
</tr>
<tr>
<td>Improve trust and respect in local communities</td>
</tr>
<tr>
<td>Help to put an end to discrimination</td>
</tr>
</tbody>
</table>

4.11 Views were generally quite consistent across the sample groups, but Table 4.5 shows that those respondents from lower socio-economic groups were particularly concerned about ending poverty, while those in groups A, B and C1 were more likely to advocate improved services. Those with some experience of mental health problems (personally or in someone close to them) were relatively interested in helping people to understand about mental health.
CHAPTER FIVE. PEOPLE’S EXPERIENCE OF MENTAL HEALTH PROBLEMS

Experience of mental health problems

5.1 People were questioned about their own experience of mental health problems. First, they were asked if anyone close to them had ever had a mental health problem diagnosed by a doctor or other health professional. Seventy percent of the people interviewed said that they knew someone who had had a mental health problem diagnosed at some time in their life. The most common diagnosis was depression, followed by panic attacks, severe stress and Alzheimer’s Disease.

5.2 Women were more likely than men to say that someone close to them had been diagnosed with a mental health problem, particularly panic attacks. Experience of mental health problems in a close friend or relative was also reported to be more evident among 25-54 year olds than other age groups. People in the upper income groups and people who reported that they had a large amount of stress in their lives were also more likely than others to know someone with experience of such a problem. Respondents in the over 75 age group, those who saw themselves as stress-free and those with complete control over factors affecting their mental health all reported low contact with other people’s mental health problems.

Table 5.1: From what you know, has anyone close to you ever been told, by a doctor or other health professional, that they had one or other of these kinds of mental health problems?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Male %</th>
<th>Female %</th>
<th>Stress free %</th>
<th>Large amount of stress %</th>
<th>Income less than £5,200 %</th>
<th>Income £36,400 or more %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating disorders</td>
<td>11</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td>17</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Nervous breakdown</td>
<td>18</td>
<td>17</td>
<td>19</td>
<td>10</td>
<td>23</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Severe stress</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>10</td>
<td>34</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>5</td>
<td>21</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Manic depression (bipolar affective disorder)</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Panic attacks</td>
<td>26</td>
<td>22</td>
<td>29</td>
<td>9</td>
<td>41</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Alzheimer’s Disease/dementia</td>
<td>20</td>
<td>18</td>
<td>21</td>
<td>21</td>
<td>25</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Depression</td>
<td>44</td>
<td>42</td>
<td>45</td>
<td>25</td>
<td>56</td>
<td>39</td>
<td>60</td>
</tr>
<tr>
<td>Any other mental health problem</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Not sure of problem</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Any of these</td>
<td>70</td>
<td>66</td>
<td>73</td>
<td>50</td>
<td>84</td>
<td>66</td>
<td>80</td>
</tr>
<tr>
<td>None of these</td>
<td>29</td>
<td>32</td>
<td>26</td>
<td>49</td>
<td>15</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
5.3 More than a quarter of people in the sample (27%) said that they themselves had experienced a mental health problem at some time in their life. Depression was again the most common condition (18%) followed by panic attacks (10%), severe stress (8%) and anxiety disorders (5%) – no other condition was mentioned by more than 3% of the sample. Many of those people with personal experience of a mental health problem identified more than one condition that they had experienced.

5.4 Table 5.2 relates to personal experience of mental health problems among various sub-sample groups. Notable findings include the relatively high percentages of women (in general) and both men and women aged 25-64 who reported such experience. Those people who reported large amount of stress in their lives, little (if any) control over factors affecting their mental health, smokers, those with long term limiting conditions and respondents struggling on their incomes were most likely to have had a mental health problem diagnosed at some time in their lives. The most common single condition (depression) was recorded in a quarter of women aged 35-54 and, even more strikingly, by well over a third of those who claimed little or no control over the factors affecting mental health. Almost 40% of those people who said that they suffered a large amount of stress said they had been diagnosed with depression at some point.

Table 5.2: Have you ever been told, by a doctor or other health professional, that you personally have had one or other of these kinds of specific mental health problems?
Base: all = 1381
(NB – row not column %)

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Severe stress</th>
<th>Anxiety disorder</th>
<th>Panic attacks</th>
<th>Depression</th>
<th>None of these</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>23</td>
<td>8</td>
<td>5</td>
<td>10</td>
<td>18</td>
<td>68</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>8</td>
<td>4</td>
<td>13</td>
<td>21</td>
<td>64</td>
</tr>
<tr>
<td>Aged 25-34</td>
<td>31</td>
<td>10</td>
<td>6</td>
<td>14</td>
<td>23</td>
<td>61</td>
</tr>
<tr>
<td>Aged 35-44</td>
<td>33</td>
<td>12</td>
<td>8</td>
<td>12</td>
<td>22</td>
<td>62</td>
</tr>
<tr>
<td>Female 35-54</td>
<td>36</td>
<td>12</td>
<td>5</td>
<td>12</td>
<td>26</td>
<td>60</td>
</tr>
<tr>
<td>Social class AB</td>
<td>16</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>11</td>
<td>81</td>
</tr>
<tr>
<td>C1</td>
<td>29</td>
<td>12</td>
<td>5</td>
<td>10</td>
<td>18</td>
<td>65</td>
</tr>
<tr>
<td>C2</td>
<td>24</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>18</td>
<td>70</td>
</tr>
<tr>
<td>DE</td>
<td>34</td>
<td>9</td>
<td>8</td>
<td>15</td>
<td>21</td>
<td>61</td>
</tr>
<tr>
<td>Working</td>
<td>23</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>16</td>
<td>71</td>
</tr>
<tr>
<td>Not working</td>
<td>31</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>20</td>
<td>65</td>
</tr>
<tr>
<td>Long standing limiting condition</td>
<td>43</td>
<td>16</td>
<td>9</td>
<td>17</td>
<td>30</td>
<td>52</td>
</tr>
<tr>
<td>No long term condition</td>
<td>19</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>76</td>
</tr>
<tr>
<td>Heavy smokers</td>
<td>42</td>
<td>11</td>
<td>8</td>
<td>18</td>
<td>23</td>
<td>53</td>
</tr>
<tr>
<td>Non-smokers</td>
<td>23</td>
<td>7</td>
<td>3</td>
<td>8</td>
<td>16</td>
<td>72</td>
</tr>
<tr>
<td>Complete control over mental health</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>83</td>
</tr>
<tr>
<td>Good deal of control</td>
<td>22</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>14</td>
<td>74</td>
</tr>
<tr>
<td>Some control</td>
<td>43</td>
<td>14</td>
<td>7</td>
<td>15</td>
<td>30</td>
<td>52</td>
</tr>
<tr>
<td>Little/no control over mental health</td>
<td>53</td>
<td>23</td>
<td>20</td>
<td>31</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Easy to manage on income</td>
<td>20</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>13</td>
<td>76</td>
</tr>
<tr>
<td>Difficult to manage on income</td>
<td>45</td>
<td>13</td>
<td>9</td>
<td>21</td>
<td>32</td>
<td>50</td>
</tr>
<tr>
<td>Stress free</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>87</td>
</tr>
<tr>
<td>Large amount of stress</td>
<td>54</td>
<td>27</td>
<td>15</td>
<td>25</td>
<td>39</td>
<td>40</td>
</tr>
</tbody>
</table>
Other people’s attitudes towards mental health problems

5.5 Those people who said that they had personally experienced a (diagnosed) mental health problem were asked about their experience of other people’s attitudes towards their condition. Two-thirds of the group said that they had not had any trouble in this respect; however, a sizeable minority (32%) reported a variety of difficulties, as summarised in the Table 5.3.

Table 5.3: Have you experienced any of the following as a result of other people’s attitudes towards your mental health problem(s)?
Base: all who have ever had a diagnosed mental health problem = 440

<table>
<thead>
<tr>
<th>Experience</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically abused in public</td>
<td>3</td>
</tr>
<tr>
<td>Unable to/discouraged from going on holiday</td>
<td>3</td>
</tr>
<tr>
<td>Unable to/discouraged from participating in social events, such as going out with friends</td>
<td>12</td>
</tr>
<tr>
<td>Graffiti or rubbish targeted at the home</td>
<td>1</td>
</tr>
<tr>
<td>Verbally abused in public</td>
<td>8</td>
</tr>
<tr>
<td>Experienced discrimination at work</td>
<td>7</td>
</tr>
<tr>
<td>Unable to/discouraged from participating in children’s school-based activities</td>
<td>1</td>
</tr>
<tr>
<td>Been overlooked/refused for promotion</td>
<td>4</td>
</tr>
<tr>
<td>Physically abused within the family</td>
<td>4</td>
</tr>
<tr>
<td>Been refused a job</td>
<td>6</td>
</tr>
<tr>
<td>Unable to/discouraged from taking part in local community life</td>
<td>4</td>
</tr>
<tr>
<td>Verbally abused within the family</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Any of these</strong></td>
<td><strong>32</strong></td>
</tr>
<tr>
<td><strong>None of these</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

5.6 Although the base sizes involved are necessarily quite small, those people who had experienced anxiety disorders and panic attacks were more likely to feel unable to join in social events than those with other mental health problems. Verbal abuse was also associated with anxiety disorders.
Disclosing a mental health problem

5.7 A small minority (14%) of those people with personal experience of a mental health problem said that they had decided not to disclose the condition when making any one of a variety of applications. The sample sizes for each condition are too small to allow for further disaggregation.

Table 5.4: Have you decided not to disclose this problem/any of these problems when applying for any of these?
Base: all who have ever had a diagnosed mental health problem = 373

<table>
<thead>
<tr>
<th>Problem</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank loan</td>
<td>2</td>
</tr>
<tr>
<td>Driving licence</td>
<td>3</td>
</tr>
<tr>
<td>Education and training opportunities</td>
<td>3</td>
</tr>
<tr>
<td>Life insurance</td>
<td>2</td>
</tr>
<tr>
<td>Medical insurance</td>
<td>1</td>
</tr>
<tr>
<td>Mortgage</td>
<td>3</td>
</tr>
<tr>
<td>Travel insurance</td>
<td>3</td>
</tr>
<tr>
<td>Credit card</td>
<td>3</td>
</tr>
<tr>
<td>Job</td>
<td>10</td>
</tr>
<tr>
<td>Any of these</td>
<td>14</td>
</tr>
<tr>
<td>None of these</td>
<td>85</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
</tr>
</tbody>
</table>
CHAPTER SIX. WHERE DO PEOPLE GET THEIR INFORMATION ON MENTAL HEALTH ISSUES?

6.1 Various questions were asked to establish the ways in which people in the sample acquired information about mental health issues. First, people were asked which sources of information had been important to them in the past. Television news and current affairs was a major source, followed by personal contact/experience, national newspapers and health professionals.

**Most important sources of information about mental health issues**

**Figure 6.1:** Regardless of your own circumstances, I’m interested to know how you get your information about mental health and mental health problems. Which of the following have been important sources of information to you in the past?

Base: all = 1381. (NB – multiple answers allowed)

6.2 For those people who mentioned more than one source of information, the question was followed up with a request to pick the most important source. From both questions, the analysis arrived at a list of the single most important source of information for all respondents. The primary methods of gaining information were personal contact or personal experience (21%), television news and current affairs programmes (18%), health professionals (17%), national newspapers (8%) and work (7%). No other information source was mentioned by more than 5% of respondents.
6.3 Certain sources of information stood out above others for particular groups of respondents. Young women were more likely than other sex/age groups to regard education or studying as the most important source of information, while older male respondents were more likely than people in other age groups to see national newspapers as the most important source. Those who were working were more likely than non-workers to get their information from personal contact, whereas those with large amounts of stress were more likely to have received it from health professionals, compared to other sample groups. Those people who had experience of mental health problems were more likely, generally, to receive any information than those who had no experience.

Awareness of advertising promotion about mental health

6.4 More than 40% of people in the sample said that they had seen, read about or heard an advert or promotion about mental health/mental health problems in the last six months. Those people with some experience of mental health problems were more likely than others to have been aware of this type of activity, as were those respondents who claimed at least some control over factors impacting on mental health and well being. Older respondents were significantly less likely than younger people to be aware of any advertising or promotional activity.

Table 6.1: In the last six months, have you seen, read about or heard an advert or promotion about mental health/mental health problems?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>35-54</th>
<th>65+</th>
<th>Experience of someone else having mental health problems</th>
<th>Have had own mental health problems</th>
<th>No experience of people with mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, seen</td>
<td>24</td>
<td>27</td>
<td>14</td>
<td>24</td>
<td>28</td>
<td>19</td>
</tr>
<tr>
<td>Yes, read about</td>
<td>12</td>
<td>14</td>
<td>9</td>
<td>14</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Yes, heard</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Yes but not sure</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Yes – any (summary)</td>
<td>43</td>
<td>47</td>
<td>29</td>
<td>45</td>
<td>46</td>
<td>34</td>
</tr>
<tr>
<td>No, none of these</td>
<td>55</td>
<td>53</td>
<td>70</td>
<td>53</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

32
Media portrayal of people with mental health problems

6.5 Respondents were asked how they thought the media portrayed people with mental health problems. Few people thought that the media showed people with mental health problems in a uniformly positive or negative way. However, far more respondents felt that this group tended to be shown in a negative light (44%) than thought the balance was more positive (15%). Many people said that both positive and negative slants could be observed quite equally.

6.6 Older respondents had a more positive (or perhaps a less negative) opinion of media portrayal of mental health problems than did the younger sample. Interestingly, there was little variation between opinions held by people in the four categories defined by the stigma scale (see Chapter Seven). However, it is worth noting that 13% of people in the highest category (who exhibited the least tolerant views) felt unable to answer the question. Only 11% of those who had experienced a mental health problem said they felt that, on balance, media portrayal of people with mental health problems was positive.

Table 6.2: Overall, how do you think the media, such as newspapers, television and radio, portray people with mental health problems?
Base: all = 1381

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>35-44 %</th>
<th>65-74 %</th>
<th>Low stigma %</th>
<th>High stigma %</th>
<th>Have had own mental health problems %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost always positively (+2)</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>More positively than negatively (+1)</td>
<td>12</td>
<td>8</td>
<td>19</td>
<td>15</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Both positively and negatively (0)</td>
<td>35</td>
<td>37</td>
<td>28</td>
<td>32</td>
<td>32</td>
<td>37</td>
</tr>
<tr>
<td>More negatively than positively (-1)</td>
<td>35</td>
<td>39</td>
<td>26</td>
<td>38</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Almost always negatively (-2)</td>
<td>9</td>
<td>11</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>All positive</td>
<td>15</td>
<td>10</td>
<td>28</td>
<td>18</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>All negative</td>
<td>44</td>
<td>50</td>
<td>34</td>
<td>46</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>Mean score</td>
<td>-0.4</td>
<td>-0.5</td>
<td>-0.1</td>
<td>-0.3</td>
<td>-0.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN. MENTAL HEALTH PROBLEMS: PEOPLE’S VIEWS, ATTITUDES AND OPINIONS

7.1 A major section of the interview covered issues relating to people’s attitudes to mental health problems. The section began with an attitude battery to assess the way in which people responded to statements about non-specific mental health problems. The statements, which were randomly rotated, are reproduced in Table 7.1. Notably, there was almost universal recognition that anyone can suffer from mental health problems and extensive support for equal rights for people who have mental health problems. However, half of the people in the sample agreed (at least to some extent) that they would not want people to know if they had a mental health problem, while a third of respondents thought that people with mental health problems were often dangerous.

Attitudes to mental health problems and calculating scores on a stigma scale

Table 7.1: I’m now going to read out some things people have said about mental health problems. Taking your answer from this card, I’d like you to tell me how much you agree or disagree with each of these statements.
Base: all = 1381

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree strongly %</th>
<th>Agree slightly %</th>
<th>Neither /nor %</th>
<th>Disagree slightly %</th>
<th>Disagree strongly %</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I was suffering from mental health problems, I wouldn’t want people knowing about it</td>
<td>18</td>
<td>32</td>
<td>17</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>The public should be better protected from people with mental health problems</td>
<td>10</td>
<td>25</td>
<td>23</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Anyone can suffer from mental health problems</td>
<td>83</td>
<td>15</td>
<td>1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>I would find it hard to talk to someone with mental health problems</td>
<td>4</td>
<td>16</td>
<td>11</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>People are generally caring and sympathetic to people with mental health problems</td>
<td>8</td>
<td>28</td>
<td>12</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>People with mental health problems are often dangerous</td>
<td>5</td>
<td>27</td>
<td>20</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>The majority of people with mental health problems recover</td>
<td>14</td>
<td>36</td>
<td>31</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>People with mental health problems should have the same rights as anyone else</td>
<td>69</td>
<td>19</td>
<td>7</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>People with mental health problems are largely to blame for their own condition</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>22</td>
<td>65</td>
</tr>
</tbody>
</table>
7.2 The series of statements was used in an aggregate analysis to develop a classification of overall views on mental health problems. A scoring system was used to reflect the positive/negative balance of each attitude statement – those in italics in Table 7.1 were scored with five points for strong disagreement, through to only one point for strong agreement (e.g. “Anyone can suffer from mental health problems”). The five remaining statements were scored in the opposite way (e.g. “People with mental health problems are often dangerous”). The overall scores therefore varied from a theoretical minimum of 9 points (relatively tolerant) to a maximum of 45 points (least tolerant). In practice, the lowest score was 10 and the highest was 34 – a clear majority of people scored between 19 and 26 points on the scale.

7.3 The banded score distribution is shown in Table 7.2 along with some of the key breakdowns from the data analysis. Those respondents with no experience of people with mental health problems had a significantly higher mean score than those who had such experience. Age had some association with the tolerance of views expressed: older respondents were more likely to have a high score, while the figure for 16-24 year olds in Table 7.2 was typical of all people aged under 65. CHAID analysis also showed the importance of both age and experience of mental health problems. It is worth noting that the mean score did not show a great deal of variation across the overall sample (for example, by working status, social class or the urban/non-urban split).

Table 7.2: Summary scores on the stigma scale
Base: all = 1381

<table>
<thead>
<tr>
<th>Experience of someone else having mental health problems</th>
<th>Have had own mental health problems</th>
<th>No experience of people with mental health problems</th>
<th>16-24</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most tolerant: up to 18 points</td>
<td>29</td>
<td>33</td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>19-21 points</td>
<td>27</td>
<td>26</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>22-26 points</td>
<td>34</td>
<td>32</td>
<td>27</td>
<td>42</td>
</tr>
<tr>
<td>Least tolerant: 27+ points</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Mean average points</td>
<td>21</td>
<td>20.6</td>
<td>20.5</td>
<td>22.2</td>
</tr>
</tbody>
</table>
Cluster analysis

7.4 The scale discussed above provides a useful way of summarising the views expressed by people in the sample. However, with a total of nine very different statements, there are various ways in which two people can give different answers but emerge with the same score on the scale. In order to investigate people’s attitudes in a little more detail, the nine statements were fed into a computer programme that produces up to 10 cluster solutions. This programme grouped people by the responses to the attitude statements that they appeared to hold in common. An efficiency score was calculated: this needed to be as large as possible to ensure that the clusters were distinct from one another. However, the size of the efficiency score needed to be balanced against robust sample sizes for each cluster. In this instance, a six cluster solution produced optimum results (the largest drop in efficiency score was between six and five clusters). Further details of the cluster breakdown is given in Annex F to this document.

7.5 Once the six clusters had been identified, the characteristics they shared were examined. There is a dilemma in reporting this aspect of the findings. On the one hand, to provide a profile of the characteristics of people in the various clusters, or to append a word or phrase to summarise the attitudes they appear to hold in common may be in itself stigmatising. On the other hand, detailed information about people who share certain attitudes is valuable in assisting the targeting of activities to raise public awareness and address issues of discrimination and stigma. The clusters were numbered: Cluster 1 (whose attitudes were most sympathetic towards and understanding of mental health problems and the people who suffer from them) through to Cluster 6 (who held the least sympathetic and least tolerant attitudes). Tables 7.3 and 7.4 sketch out the attitudes that people in each cluster appear to hold in common, along with the demographic characteristics they share.

7.6 As noted earlier, when discussing the stigma scale, there is considerable evidence of tolerant views among the people in the sample, with nearly half of all respondents sharing attitudes common to Clusters 1 or 2. However, a smaller set of people were much more negative in their views and one in five were at the far end of the spectrum, in Cluster 6. It seems probable that people who share the attitudes held by Clusters 5 and 6, who are likely to be older and to avoid exposure to mental health issues, will be difficult to reach through awareness raising initiatives. If opinions are to be influenced, there may be more scope to reinforce positive messages, not only with people who hold the attitudes common to Clusters 1 and 2, but with the clusters in the middle of the spectrum, notably people who are broadly non-judgemental, but are also scared of the effects of mental health problems.
Table 7.3: Summary of attitudes in cluster solutions and profile of the groups
Part 1 – most positive
Base: all = 1381

| Cluster 1  |  
| (26% of the total) |  
|  
| Do not see people who have mental health problems as a threat  
| Feel that they can talk to people who have mental health problems  
| Think that people with mental health problems can recover  
|  
| Demographics – AB, social class, 35-54 year olds and those in work  
| More likely to have stress in their lives  
| Have lowest scores on stigma scale  
| Feel that people with mental health problems receive negative media portrayal  
| Often get information on mental health from personal experience and contact  
| Want the government to help people understand about mental health  
|  
| Cluster 2  |  
| (20%) |  
|  
| Would not mind people knowing if they were suffering from a mental health problem  
| Think that people who have mental health problems do not recover  
| Think people with mental health problems should have the same rights as others  
| Do not think people with mental health problems are to blame for their problems  
|  
| Demographics – female and no children in household  
| Low scores on the stigma scale  
| Higher level of experience of mental health problems  
| Want government to help people understand about mental health  
| Get information about mental health from personal experience and contact  
|  
| Cluster 3  |  
| (23%) |  
|  
| Would not want people to know if they were suffering from a mental health problem  
| Find it hard to talk to people with mental health problems  
| Think the public should be better protected from those with mental health problems  
| More likely to think that people with mental health conditions are dangerous  
| BUT think anyone can suffer from a mental health problem  
| Think people with mental health problems should have the same rights as anyone else  
| Do not think people with mental health problems are to blame for their problems  
|  
| Demographics – in work  
| Get information on mental health issues from TV news  
| Describe good mental health as being in control  
| More likely to think that people with specific symptoms of mental health problems should live in specialist community-based units  
|
Table 7.4: Summary of attitudes in cluster solutions and profile of the groups
Part 2 – more negative
Base: all = 1381

| Cluster 4 (12%) | Do not agree very strongly that anyone can suffer from a mental health problem
| | Find it hard to talk to people who have such problems
| | More likely to think that people with mental health problems are largely to blame for their problems
| | Less likely to think that people with mental health problems should have the same rights as anyone else
| | Think that the general public are generally caring towards people with mental health problems
| | Demographics – 16-34s and men
| | Report lower level of stress in their lives
| | Low level of experience of mental health problems
| | Cluster 5 (10%) | Agree that people are to blame for their mental health problems
| | If they were suffering from a mental health problem they would not tell anyone
| | They find it hard to talk to people with mental health problems
| | They think people with mental health problem are dangerous
| | Demographics – over 75s and DE social class
| | More likely to report stress in their lives
| | Second highest scores on the stigma scale
| | Relatively low advertising/promotion recall
| | Least likely to want government to improve services for people with mental health problems
| | Cluster 6 (9%) | Do not agree very strongly that people with mental health problems should have the same rights as anyone else
| | More likely to think that people with mental health problems are dangerous
| | Tend to think that people need to be protected from those with mental health problems
| | Disagree that people with mental health problems recover
| | Demographics – over 75s
| | Have highest scores on the stigma scale
| | Often use national newspapers as source of information on mental health issues
| | Have the lowest agreement on equal rights for people with mental health problems
| | Least keen on contact with someone with a mental health problem |
Case study vignettes

7.7 The questionnaire included a substantial section dealing with a series of vignettes. These vignettes described some symptoms associated with three mental health problems (depression, schizophrenia and stress). Each vignette was varied by gender, so that there were six in total. One vignette was used per interview and the process was randomised so that more or less equal numbers of each scenario were covered during the data collection period. Having digested the description of the problems experienced by the person in the vignette (but without being given a diagnosis), respondents were asked questions about what they thought the cause of the person’s condition might be, and how willing they would be to engage with the person. They were also asked to say how they thought the person might be helped, and to estimate how likely it was that the person was experiencing depression, schizophrenia and stress.

7.8 The full text used for each vignette is shown below – the vignette was presented to the respondent in the form of a showcard. The formal clinical diagnosis (shown in brackets after each paragraph) was not included with the showcard text.

1. Robert has been feeling really down for the last few weeks. He wakes up in the morning with a flat heavy feeling that stays with him all day long. He doesn’t enjoy things the way he normally would. In fact, nothing gives him pleasure. Even when good things happen, they don’t seem to make Robert happy. He has to force himself to get through the day, and even the smallest things seem hard to do. He finds it hard to concentrate on anything and has no energy at all. Even though Robert feels tired at night, he still can’t sleep, and wakes up too early in the morning. Robert feels worthless and feels like giving up. Robert’s family has noticed that he hasn’t been himself for about the last month. He doesn’t feel like talking and isn’t taking part in things like he used to. (Depression (male))

2. Shona has been feeling really down for the last few weeks. She wakes up in the morning with a flat heavy feeling that stays with her all day long. She doesn’t enjoy things the way she normally would. In fact, nothing gives her pleasure. Even when good things happen, they don’t seem to make Shona happy. She has to force herself to get through the day, and even the smallest things seem hard to do. She finds it hard to concentrate on anything and has no energy at all. Even though Shona feels tired at night, she still can’t sleep, and wakes up too early in the morning. Shona feels worthless and feels like giving up. Shona’s family has noticed that she hasn’t been herself for about the last month. She doesn’t feel like talking and isn’t taking part in things like she used to. (Depression (female))

3. Robert is a man who was doing pretty well until about a year ago. But then things started to change. He thought that people around him were criticising him and talking behind his back. Robert was convinced that people were spying on him and that they could hear what he was thinking. Robert couldn’t work any more, and he stopped joining in with family activities. He retreated from everything, until he eventually spent most of his day in his room. Robert heard voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months. (Schizophrenia (male))
4. Shona is a woman who was doing pretty well until about a year ago. But then things started to change. She thought that people around her were criticising her and talking behind her back. Shona was convinced that people were spying on her and that they could hear what she was thinking. Shona couldn’t work any more, and she stopped joining in with family activities. She retreated from everything, until she eventually spent most of her day in her room. Shona heard voices even though no one else was around. These voices told her what to do and what to think. She has been living this way for six months. *(Schizophrenia (female))*

5. Robert is a man who was doing pretty well until about a year ago. While nothing much was going wrong in Robert’s life, he had a few problems that were really beginning to get to him. He started to feel worried, and a little sad, and had trouble sleeping at night. Things bothered him more than they bothered other people, and he started to get nervous and annoyed when things went wrong. Otherwise Robert is doing OK. He enjoys being with other people, and though he sometimes argues with his family, he has generally been getting on pretty well with them. *(Stress (male))*

6. Shona is a woman who was doing pretty well until about a year ago. While nothing much was going wrong in Shona’s life, she had a few problems that were really beginning to get to her. She started to feel worried, and a little sad, and had trouble sleeping at night. Things bothered her more than they bothered other people, and she started to get nervous and annoyed when things went wrong. Otherwise Shona is doing OK. She enjoys being with other people, and though she sometimes argues with her family, she has generally been getting on pretty well with them. *(Stress (female))*
Causes of the mental health problem

7.9 The series of questions about the vignette began by asking the respondent how likely they thought it that the situation had been caused by each of a number of factors. Table 8.5 shows a summary of the responses (very/somewhat likely) to each suggested cause of Robert/Shona’s condition, broken down by the vignettes considered by people in the sample. The modest sample sizes within each vignette category mean that there was little possibility to provide a valid disaggregation of responses by demographic group. Stressful or disturbing events were the most commonly suggested causes of the condition described in each vignette. Some vignettes were associated with particular factors: depression was linked with physical illness, for example, particularly in Robert’s case. Schizophrenia was seen by almost 80% of people in the sample as being connected with chemical imbalance in the brain. A link between schizophrenia and genetic problems was also suggested by approximately 60% of people who considered these vignettes. Correspondence Analysis confirmed these broad findings and also noted a negative association between the symptoms of schizophrenia and the situation being Robert/Shona’s own fault.

Table 7.5: Summary of all saying that the factor was very/somewhat likely to have been a cause of the situation.

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert’s/Shona’s own character or personality</td>
<td>51</td>
<td>48</td>
<td>55</td>
<td>61</td>
<td>68</td>
<td>71</td>
</tr>
<tr>
<td>Chemical imbalance in the brain</td>
<td>64</td>
<td>69</td>
<td>77</td>
<td>78</td>
<td>57</td>
<td>59</td>
</tr>
<tr>
<td>The way Robert/Shona was brought up</td>
<td>45</td>
<td>39</td>
<td>46</td>
<td>40</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Stressful or disturbing events in Robert/Shona’s life</td>
<td>92</td>
<td>92</td>
<td>89</td>
<td>88</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Genetic or inherited problem</td>
<td>54</td>
<td>51</td>
<td>62</td>
<td>60</td>
<td>51</td>
<td>48</td>
</tr>
<tr>
<td>Abuse Robert/Shona suffered as a child</td>
<td>61</td>
<td>54</td>
<td>59</td>
<td>59</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>Fate</td>
<td>29</td>
<td>25</td>
<td>26</td>
<td>24</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Physical illness</td>
<td>81</td>
<td>73</td>
<td>59</td>
<td>68</td>
<td>62</td>
<td>69</td>
</tr>
<tr>
<td>Robert’s/Shona’s own fault</td>
<td>22</td>
<td>14</td>
<td>15</td>
<td>19</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>
7.10 Tables 7.6 to 7.18 show the full range of responses to each of the suggested causes summarised in table 7.5. Most of the people who considered the vignettes describing symptoms of stress thought it likely that Robert/Shona’s own personality or character was a cause of the situation (Robert: 68%; Shona: 71%). Sixty percent of the people who considered the female version of the vignette describing symptoms of schizophrenia thought that Shona’s personality or character was a cause of her condition. At the other end of the spectrum, almost a quarter of people who considered the male vignette thought it very unlikely that Robert’s personality was a cause of his problems. Approximately half the people who looked at the vignettes relating to symptoms of depression thought that there was a link between the person’s character and the condition.

Table 7.6: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Robert’s/Shona’s own character or personality
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>16</td>
<td>11</td>
<td>23</td>
<td>19</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>35</td>
<td>37</td>
<td>33</td>
<td>41</td>
<td>49</td>
<td>54</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>24</td>
<td>23</td>
<td>15</td>
<td>22</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>21</td>
<td>25</td>
<td>24</td>
<td>14</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

7.11 Chemical imbalance in the brain was picked up as a likely cause of the situation by most of those who looked at each of the vignettes, especially those describing symptoms of schizophrenia.

Table 7.7: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Chemical imbalance in the brain
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>14</td>
<td>24</td>
<td>34</td>
<td>24</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>50</td>
<td>45</td>
<td>41</td>
<td>53</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>10</td>
<td>10</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Don’t know</td>
<td>17</td>
<td>13</td>
<td>14</td>
<td>10</td>
<td>17</td>
<td>13</td>
</tr>
</tbody>
</table>
7.12 There were few differences across the vignette groups with regard to the impact of Robert/Shona’s upbringing. Less than 50% of people attributed each condition to upbringing.

**Table 7.8: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: The way Robert/Shona was brought up**

Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>40</td>
<td>30</td>
<td>41</td>
<td>34</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>25</td>
<td>21</td>
<td>19</td>
<td>25</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>26</td>
<td>36</td>
<td>28</td>
<td>28</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

7.13 Approximately 90% of the people who considered each vignette felt that stressful events in Robert/Shona’s life were a likely cause of their condition. However, 14% of people who considered the female version of the vignette describing symptoms of stress felt that there was no link between the symptoms experienced by Shona and stressful or disturbing events in her life.

**Table 7.9: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Stressful or disturbing events in Robert’s/Shona’s life**

Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>40</td>
<td>48</td>
<td>38</td>
<td>30</td>
<td>42</td>
<td>31</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>53</td>
<td>44</td>
<td>52</td>
<td>59</td>
<td>48</td>
<td>54</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
7.14 A genetic or inherited problem was cited as a likely cause of the condition by about half of the people who considered the stress and depression vignettes. Sixty percent of people considering the vignette which described the symptoms of schizophrenia thought it likely that Robert/Shona had a genetic or inherited problem.

Table 7.10: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Genetic or inherited problem
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base: all = 1381</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>11</td>
<td>6</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>44</td>
<td>44</td>
<td>50</td>
<td>48</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>20</td>
<td>20</td>
<td>15</td>
<td>16</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>16</td>
<td>22</td>
<td>13</td>
<td>13</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>11</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>

7.15 Childhood abuse was mentioned as a likely cause of the condition by more than 50% of people considering each vignette, apart from the female version of the stress vignette.

Table 7.11: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Abuse Robert/Shona suffered as a child
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base: all = 1381</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>12</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>51</td>
<td>42</td>
<td>46</td>
<td>49</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>19</td>
<td>23</td>
<td>23</td>
<td>16</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>15</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>
7.16 Fate was viewed as a likely cause of the problem by approximately a quarter of the people who considered each vignette, and there were no significant variations by vignette type.

Table 7.12: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Fate
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>23</td>
<td>23</td>
<td>18</td>
<td>19</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>13</td>
<td>16</td>
<td>14</td>
<td>14</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>50</td>
<td>49</td>
<td>55</td>
<td>54</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

7.17 A physical illness was thought by a majority of each vignette group to be a likely cause of the condition described. This was notably the case for those people considering the symptoms of depression (especially the male version of this vignette).

Table 7.13: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Physical illness
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>23</td>
<td>20</td>
<td>12</td>
<td>11</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>60</td>
<td>54</td>
<td>46</td>
<td>57</td>
<td>49</td>
<td>61</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>11</td>
<td>12</td>
<td>22</td>
<td>18</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>5</td>
<td>10</td>
<td>16</td>
<td>9</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
7.18 Between 14% and 22% of people who responded to each of the vignettes saw the situation as likely to be Robert/Shona’s own fault. This view was held by one-in-three of respondents aged over 75. Those people who considered the male version of the depression vignette were the most likely to feel that Robert was to blame for his condition; those who considered the female version of this vignette were least likely to hold this view.

Table 7.14: In your opinion, how likely is it that Robert’s/Shona’s situation might be caused by each of the following: Robert’s/Shona’s own fault
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>4%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>17%</td>
<td>13%</td>
<td>13%</td>
<td>16%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>26%</td>
<td>29%</td>
<td>21%</td>
<td>21%</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>50%</td>
<td>55%</td>
<td>62%</td>
<td>56%</td>
<td>47%</td>
<td>48%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Help for Robert/Shona

7.19 Having looked at possible causes of the mental health problems, the questionnaire went on to ask for suggestions about who would be best placed to help Robert/Shona. (The options supplied to respondents are listed in table 7.15.) The most commonly suggested source of help for the person in almost all the vignettes was the family doctor (GP). However, for those respondents considering symptoms associated with schizophrenia (and the depressed Shona) the GP’s input was seen to be less helpful. Approximately half of those people who considered the vignettes describing symptoms of schizophrenia and, in particular, those who viewed the male version of the vignette, felt that the specialist skills of a psychiatrist would be helpful. Qualified counsellors were also often mentioned, particularly to address the symptoms of depression. Family members were suggested as important sources of support for all three broad symptom groups.

Table 7.15: Say it was possible for any of the people on this card to help Robert/Shona. Who would be the three best people to do this?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone in the family</td>
<td>42 %</td>
<td>38 %</td>
<td>42 %</td>
<td>31 %</td>
<td>47 %</td>
<td>41 %</td>
</tr>
<tr>
<td>A friend or neighbour</td>
<td>23 %</td>
<td>28 %</td>
<td>15 %</td>
<td>19 %</td>
<td>22 %</td>
<td>33 %</td>
</tr>
<tr>
<td>A nurse</td>
<td>3 %</td>
<td>3 %</td>
<td>4 %</td>
<td>5 %</td>
<td>2 %</td>
<td>4 %</td>
</tr>
<tr>
<td>A home help/carer/care assistant</td>
<td>3 %</td>
<td>4 %</td>
<td>9 %</td>
<td>6 %</td>
<td>5 %</td>
<td>6 %</td>
</tr>
<tr>
<td>A psychiatrist</td>
<td>29 %</td>
<td>33 %</td>
<td>52 %</td>
<td>46 %</td>
<td>27 %</td>
<td>22 %</td>
</tr>
<tr>
<td>A psychologist</td>
<td>15 %</td>
<td>20 %</td>
<td>27 %</td>
<td>26 %</td>
<td>16 %</td>
<td>19 %</td>
</tr>
<tr>
<td>A family doctor</td>
<td>66 %</td>
<td>56 %</td>
<td>55 %</td>
<td>55 %</td>
<td>63 %</td>
<td>66 %</td>
</tr>
<tr>
<td>A social worker</td>
<td>9 %</td>
<td>5 %</td>
<td>12 %</td>
<td>5 %</td>
<td>8 %</td>
<td>8 %</td>
</tr>
<tr>
<td>A qualified counsellor</td>
<td>59 %</td>
<td>58 %</td>
<td>47 %</td>
<td>53 %</td>
<td>53 %</td>
<td>52 %</td>
</tr>
<tr>
<td>A voluntary organisation or charity</td>
<td>7 %</td>
<td>11 %</td>
<td>4 %</td>
<td>8 %</td>
<td>6 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Someone with the same problem</td>
<td>33 %</td>
<td>34 %</td>
<td>21 %</td>
<td>28 %</td>
<td>37 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Someone else</td>
<td>1 %</td>
<td>*</td>
<td>1 %</td>
<td>2 %</td>
<td>2 %</td>
<td>*</td>
</tr>
<tr>
<td>(No one)</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>-</td>
<td>1 %</td>
<td>*</td>
<td>1 %</td>
<td>-</td>
<td>*</td>
</tr>
</tbody>
</table>

Where Robert/Shona should live

7.20 People were asked to say where it would be best for Robert/Shona to live. Very few respondents thought that he or she should live alone in their own home, especially where he or she was suffering from symptoms of depression. Much larger percentages of people were in favour of Robert/Shona being at home with support from family or friends – this option was backed by almost half of those presented with symptoms of depression and stress. However, only a quarter of those who considered the vignettes detailing symptoms of schizophrenia thought that Robert or Shona should be supported in their home by family members or friends.
7.21 About half of the people who looked at vignettes describing the symptoms of depression or schizophrenia backed Robert/Shona living at home with help from professionals, as did approximately 40% of those presented with the description of stress. Only a small number of respondents advocated caring for Robert or Shona in a residential or nursing home or in hospital. However, 20% of those who looked at the vignette describing schizophrenia symptoms in a male and one-in-eight of those presented with the female version of the vignette were in favour of the use of special housing with professional support in the community.

Table 7.16: If all the options on this card were possible, where do you think it would be best for Robert/Shona to live?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in their own home by themselves</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>In their own (or family’s) home, with support from family members or friends</td>
<td>43%</td>
<td>39%</td>
<td>24%</td>
<td>26%</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>In their own (or family’s) home, with help from professionals (for example, community mental health teams)</td>
<td>44%</td>
<td>49%</td>
<td>49%</td>
<td>50%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>In special housing with professional support in the community</td>
<td>8%</td>
<td>6%</td>
<td>21%</td>
<td>13%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>In a residential or nursing home</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>In hospital</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
<td>*</td>
</tr>
<tr>
<td>Somewhere else</td>
<td>-</td>
<td>-</td>
<td>1%</td>
<td>*</td>
<td>*</td>
<td>-</td>
</tr>
<tr>
<td>(Wherever he/she wants)</td>
<td>1%</td>
<td>-</td>
<td>-</td>
<td>1%</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>*</td>
<td>1%</td>
<td>*</td>
<td>1%</td>
<td>-</td>
<td>1%</td>
</tr>
</tbody>
</table>
Harming themselves or other people

7.22 Just over half of those who were presented with symptoms of depression thought that it was very/somewhat likely that Robert/Shona would do something harmful to him/herself. The same applied to only around a quarter of those who looked at cases of stress symptoms. However, about two-thirds of those respondents who were faced with symptoms of schizophrenia said that Robert/Shona was likely to harm him/herself.

Table 7.17: In your opinion, how likely is it that Robert/Shona would do something harmful or violent to him/herself?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>10</td>
<td>11</td>
<td>10</td>
<td>18</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>41</td>
<td>44</td>
<td>54</td>
<td>50</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>32</td>
<td>24</td>
<td>22</td>
<td>19</td>
<td>44</td>
<td>39</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>11</td>
<td>18</td>
<td>12</td>
<td>8</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

7.23 Few respondents to any of the vignettes thought that Robert or Shona was very likely to harm or be violent to other people. Between 12% and 15% of people who considered the stressed Robert/Shona and the depressed Shona thought that he or she might harm someone else. Robert with symptoms of depression was thought to be somewhat likely to cause harm to others by 21% of people who considered this vignette. However, more than a third of those who were presented with the vignettes describing the symptoms of schizophrenia thought that Shona and (more particularly) Robert might be violent to other people.

Table 7.18: In your opinion, how likely is it that Robert/Shona would do something harmful or violent to other people?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very likely</td>
<td>*</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>21</td>
<td>11</td>
<td>35</td>
<td>31</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>41</td>
<td>39</td>
<td>37</td>
<td>36</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>33</td>
<td>46</td>
<td>21</td>
<td>21</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>
Rights for Robert/Shona

7.24 Almost all respondents who looked at the vignettes describing the symptoms of stress or depression thought that Robert/Shona should have the same rights as anyone else. A large majority of the people who were shown the vignette describing schizophrenia symptoms held the same view although 10% of those considering the male with these symptoms disagreed with the statement.

Table 7.19: Do you think that Robert/Shona should have the same rights, for example at work, as anyone else?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>93</td>
<td>94</td>
<td>83</td>
<td>86</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

‘Willingness’ scenarios

7.25 A series of situations were put to respondents and they were asked to say how willing they would be to engage with the person in the vignette in each situation. In almost every case, younger people were more willing than older respondents to engage with Robert or Shona. Predictably, those who had higher scores on the stigma scale were less keen on any contact; people who had not personally experienced a mental health problem were also reluctant to engage with the person in the vignette. Detailed analysis of each scenario follows but the first table in this section summarises the percentages who were very/fairly willing to have contact with Robert/Shona. In each of the given situations, respondents considering the vignettes which described symptoms of stress were significantly more positive about contact than were those who considered the other vignettes. Overall, respondents were more willing to have contact with females experiencing these conditions than they were with males.
Table 7.20: Summary of all (very/fairly) willing to have certain contact with Robert/Shona
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move next door to Robert/Shona</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Spend an evening socialising with Robert/Shona</td>
<td>63</td>
<td>74</td>
<td>63</td>
<td>68</td>
<td>83</td>
<td>78</td>
</tr>
<tr>
<td>Make friends with Robert/Shona</td>
<td>74</td>
<td>77</td>
<td>65</td>
<td>80</td>
<td>88</td>
<td>91</td>
</tr>
<tr>
<td>Start working closely with Robert/Shona</td>
<td>60</td>
<td>71</td>
<td>60</td>
<td>65</td>
<td>83</td>
<td>74</td>
</tr>
<tr>
<td>Have Robert/Shona marry into the family</td>
<td>30</td>
<td>46</td>
<td>28</td>
<td>42</td>
<td>54</td>
<td>56</td>
</tr>
<tr>
<td>Do Robert/Shona a favour if he/she asked you to</td>
<td>88</td>
<td>88</td>
<td>91</td>
<td>95</td>
<td>96</td>
<td>96</td>
</tr>
</tbody>
</table>

7.26 Over 60% of the people who looked at symptoms of depression in a male said they would be willing to move next door to Robert. Those who considered the female version of the vignette were even more likely to hold this view (74%). More than half of the people who considered the vignettes detailing symptoms of schizophrenia had positive views about Robert or Shona as a neighbour (62% and 68% respectively said they would be willing to live next door to a person with these symptoms). The symptoms of stress caused least difficulty for respondents: more than 80% of the people who considered these vignettes were willing to live next door to Robert or Shona.

Table 7.21: How willing would you be to move next door to Robert/Shona?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>21</td>
<td>37</td>
<td>17</td>
<td>24</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>41</td>
<td>37</td>
<td>45</td>
<td>44</td>
<td>49</td>
<td>46</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>24</td>
<td>16</td>
<td>18</td>
<td>20</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>7</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>*</td>
</tr>
</tbody>
</table>
7.27 Respondents were generally willing to spend an evening socialising with Robert or Shona, especially if he or she was suffering the symptoms of stress. About two-thirds of people said they would be very/fairly willing to spend an evening socialising with the depressed Robert/Shona, and approximately 70% of those shown the vignettes describing the symptoms of schizophrenia were willing to socialise. Those people who saw the female version of this vignette were more positive about socialising than those who considered the male version.

Table 7.22: How willing would you be to spend an evening socialising with Robert/Shona?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of...</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>16</td>
<td>31</td>
<td>15</td>
<td>23</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>20</td>
<td>37</td>
<td>53</td>
<td>52</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

7.28 More people expressed themselves willing to make friends with the depressed or stressed Robert (in particular) and Shona (to a lesser extent) than were keen to spend an evening socialising with them. Those shown the vignettes which described the symptoms of schizophrenia were generally as likely to make friends with Robert/Shona as they were to socialise with them.

Table 7.23: How willing would you be to make friends with Robert/Shona?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of...</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>20</td>
<td>29</td>
<td>13</td>
<td>25</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>14</td>
<td>11</td>
<td>20</td>
<td>9</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>
7.29 Clear majorities (60%+) of the people shown each vignette were very/fairly willing to start working closely with Robert/Shona. The percentage for those considering symptoms of depression in a woman (Shona) was higher than for the depressed Robert, while Robert experiencing stress was accepted more readily as a potential colleague than the stressed Shona.

Table 7.24: How willing would you be to start working closely with Robert/Shona?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>13</td>
<td>30</td>
<td>13</td>
<td>19</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>15</td>
<td>16</td>
<td>19</td>
<td>19</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>13</td>
<td>8</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

7.30 The generally high levels of tolerance and acceptance noted above were less in evidence when respondents were presented with the idea of Robert or Shona marrying into the family. For those considering symptoms of depression (Robert) and schizophrenia (Robert), only about 30% were willing to be linked with the man in the vignette in this way. Attitudes were more positive among those presented with the female versions of these vignettes. Just over half of those who looked at vignettes detailing symptoms of stress were willing to have Robert/Shona marry into their family.

Table 7.25: How willing would you be to have Robert/Shona marry into the family?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>7</td>
<td>19</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>25</td>
<td>27</td>
<td>23</td>
<td>32</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>29</td>
<td>31</td>
<td>30</td>
<td>31</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>13</td>
<td>11</td>
<td>22</td>
<td>12</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>19</td>
<td>10</td>
<td>16</td>
<td>12</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
7.31 People in the sample were, in general, willing to do Robert/Shona a favour if asked to do so: more than 85% of those shown each vignette expressed a positive attitude. Very few respondents said they were actually unwilling to do Robert/Shona a favour.

Table 7.26: How willing would you be to do Robert/Shona a favour if they asked you to?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very willing</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Fairly willing</td>
<td>43</td>
<td>49</td>
<td>30</td>
<td>40</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>Neither willing nor unwilling</td>
<td>10</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>Fairly unwilling</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>Very unwilling</td>
<td>*</td>
<td>1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
</tr>
<tr>
<td>(Don’t know)</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Describing Robert/Shona’s condition

7.32 As noted above, respondents had read a description of the symptoms Robert or Shona was experiencing, and had answered questions relating to the symptoms without receiving a formal clinical diagnosis for the condition. The section on the vignettes concluded by asking people how likely it was that Robert or Shona was experiencing depression, schizophrenia or stress. So that the respondent would not feel led by the offer of a single diagnosis, all three mental health problems were suggested, regardless of the vignette that had been considered.

7.33 Almost everyone presented with the symptoms of depression said that it was likely that Robert/Shona had been experiencing depression. Smaller but still substantial majorities of those who saw the other vignettes also felt that Robert/Shona was depressed.

Table 7.27: How likely do you think it is that Robert/Shona is experiencing depression?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>69</td>
<td>65</td>
<td>59</td>
<td>54</td>
<td>45</td>
<td>39</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>28</td>
<td>29</td>
<td>34</td>
<td>32</td>
<td>48</td>
<td>52</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>0</td>
<td>*</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
7.34 People were generally less certain when asked if Robert/Shona had been experiencing schizophrenia (even if this was the vignette they had been considering). However, more than 70% of those who had been shown these symptoms said that it was likely that he/she was suffering from schizophrenia. Only around a quarter of those who were given the symptoms of depression or stress thought it likely that Robert/Shona had schizophrenia.

Table 7.28: How likely do you think it is that Robert/Shona is experiencing schizophrenia?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>20</td>
<td>3</td>
<td>42</td>
<td>38</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>26</td>
<td>31</td>
<td>7</td>
<td>9</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>30</td>
<td>32</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>Don’t know</td>
<td>16</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>

7.35 Almost all of those who looked at the vignettes describing symptoms of stress (95%) said that it was likely that Robert/Shona was experiencing stress. However, the same view was held by about 90% of those who were presented with symptoms of schizophrenia and by 95% of those who were shown the vignette with depression symptoms.

Table 7.29: How likely do you think it is that Robert/Shona is experiencing stress?
Base: all = 1381

<table>
<thead>
<tr>
<th>Respondent shown vignette describing symptoms of…</th>
<th>Depression (male)</th>
<th>Depression (female)</th>
<th>Schizophrenia (male)</th>
<th>Schizophrenia (female)</th>
<th>Stress (male)</th>
<th>Stress (female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very likely</td>
<td>56</td>
<td>49</td>
<td>53</td>
<td>47</td>
<td>60</td>
<td>54</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>39</td>
<td>46</td>
<td>37</td>
<td>42</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
CHAPTER EIGHT. CONCLUSIONS

8.1. The broad aims of the survey were to assess people’s understanding of mental health and well being, to investigate the sources of information about mental health issues that are useful to them and to gauge their experience of and attitudes to mental health problems. Findings in all these areas provide useful information for local and national policy and practice and for the continuing and future work of the National Programme to Improve Mental Health and Well Being.

8.2. Strong links were found between both general health and rates of mental health/vitality and a range of socio-economic factors. There were also links between levels of stress reported by respondents and their assessment of their own health, energy and state of mind.

8.3. People demonstrated awareness of factors that might influence their mental health and well being (positively or negatively). There were significant differences in the factors considered important by people in different age groups. However, it was not possible to tell whether priorities change as people become older, or whether factors such as the language, education and social conditioning of different generations influence their responses to questions of this type.

8.4. There was no direct correlation between the factors claimed by respondents to have a negative effect on their mental health and well being and the things they felt could make the biggest difference to it. For example, although people between the ages of 25 and 54 were significantly more likely to cite stress as a major negative component of their lives than people in other age groups, this effect was not observable when people considered factors that could make a difference to their mental health and well being. Financial concerns dominated their wish list although, of course, it is possible that greater financial security could be seen as contributing to a less stressful life.

8.5. There are various encouraging findings from the parts of the survey which dealt with people’s attitudes towards those who experience mental health problems. People in the sample were generally ready to socialise or work closely with a man or woman exhibiting the symptoms of depression, schizophrenia or stress. There was also widespread recognition that people with mental health problems are not to blame for their condition and should have equal rights with the rest of the population. However, there was some reluctance to get too close (for example, to have a man with depression or schizophrenia marry into the family).

8.6. Analysis of people’s responses to a battery of attitudinal statements indicated that younger people were (broadly) likely to be more tolerant than people over the age of 75. Those people whose attitudes appeared to be most firmly entrenched were the least keen to have contact with people with mental illness. However, almost a quarter of all respondents displayed a mixture of attitudes, suggesting that they would probably be amenable to initiatives to increase awareness and tackle stigma. Almost half of all respondents recognised that the media tend to deal negatively with mental health issues – almost three times as many as believed there was a positive slant.
8.7. The sample size for the survey is robust and representative of the Scottish population. While there are no obvious caveats to be borne in mind when considering its findings, there are one or two issues which should be flagged. First, there was a relatively high refusal rate for the survey (23%). Although there was no evidence of visible bias in terms of the noted profile (ethnicity, evidence of children in the home etc) of those people who refused to participate, it is not possible to tell whether there are attitudinal biases in the weighted sample of participants.

8.8. Second, it should be noted that respondents who said they had personal experience of mental health problems were asked (during the interview) whether they had ever decided not to disclose the condition during a variety of formal application processes. A small minority agreed that they had done so. Bearing this in mind, it is possible that people may have been chosen to withhold information about their personal experiences when they were answering some of our wider survey questions. We respect their position and feel that this reinforces the agenda for change and improvement in current attitudes to people who experience mental health problems.
REFERENCES


ANNEX A. DETAILS OF THE RESEARCH METHODOLOGY AND QUESTIONNAIRE DEVELOPMENT

The main sample for the study was a clustered design, using addresses taken from the small user section of the Postcode Address File (PAF). The sampling frame was stratified geographically by local authority and then by electoral division. Within each division, there was a further stratification by type of Enumeration District (ED). A total of 96 EDs were then selected as sampling points with a probability proportional to the number of addresses. All parts of Scotland including the Highlands and the Islands were included in the sample frame.

In each sampled ED, 30 addresses were selected, clustered by using every fifth address after a random start point. Where there were insufficient addresses within a selected ED to generate the necessary sample, the cluster was extended to include an adjoining ED of similar profile. At each address, interviewers had to screen for eligibility to remove non-residential properties from the sample. Where, for example, more than one flat was found at the exact sampled address, one unit was sampled at random using a Kish Grid of all units (whether occupied or not). The same process was used in the selection of one household in multi-household addresses. Respondent selection was again based on the Kish Grid, from a listing of all resident adults aged 16 and over. A copy of the paper Contact Sheet for the main survey is included in a Annex D to this report.

An additional sample was drawn to boost the otherwise very small number of ethnic minority respondents in the final data – only 10-30 such interviews were anticipated. The 1991 Census data was analysed to identify those EDs with the highest non-white populations and, from a list of the top 30 such locations, every second was selected to form the booster sample – one more was later added. All of these EDs had, at the time of the Census, at least 25% of their population from ethnic minority groups – the average was more than 40% and the general expectation was that the proportions would have grown during the last decade.

In the booster EDs, 30 addresses were again selected and the sampling process was very similar to that used on the main study, although white-only households were screened out of the process. Again the ethnic minority booster Contact Sheet is included in this volume.

The questionnaire was initially designed by an advisory group, including representatives from the Scottish Executive Health Department, the Health Education Board for Scotland, Glasgow University, Edinburgh University, the Public Health Institute Scotland and the National Anti Stigma Campaign. The draft was further developed by NOP and a version was agreed with the Executive before piloting.

The tight timetable meant that the three pilot interviewers were briefed and debriefed over the telephone by the NOP executive team. Each of these fieldworkers carried out one full day of interviewing in different parts of Scotland including inner city, suburban and rural locations – the 16 pilot respondents were a broad cross-section of the adult population and included several ethnic minority adults along with a number of people with personal experience of mental health problems.

The pilot survey led to a number of changes to the questionnaire which was approved by all parties and finalised for operation via Computer Assisted Personal Interviewing (CAPI). The average interview length on the main stage of the survey was 30 minutes. The final questionnaire is shown in Annex E in this report.
ANNEX B. SURVEY ADMINISTRATION

In advance of fieldwork, a letter on Scottish Executive headed paper was sent to the “Occupier” at all sampled addresses – the version of this document used for the main sample is reproduced in Annex C to this report. All fieldwork on this project was conducted by fully-trained interviewers from the NOP fieldforce, working to the criteria of the Interviewer Quality Control Scheme. Each address received at least six calls (including at least two in the evening or at the weekend) before it was treated as a non-contact. Contact Sheets were returned to NOP while interview data was downloaded via modem from the CAPI machines. Information on number of households and individuals was recorded onto the CAPI system for use at the weighting stage. A total of 1381 interviews were conducted with the main sample between late July and early September along with 51 interviews on the ethnic minority booster sample. The contact rate details are shown in Table B.1.

Table B1

<table>
<thead>
<tr>
<th>Main survey</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued sample</td>
<td>2880</td>
</tr>
<tr>
<td>Less invalid addresses (non-residential)</td>
<td>159</td>
</tr>
<tr>
<td>Remaining sample</td>
<td>2721</td>
</tr>
<tr>
<td>Successful interviews</td>
<td>1381</td>
</tr>
<tr>
<td>Refusal before respondent selection</td>
<td>430</td>
</tr>
<tr>
<td>Refusal after respondent selection</td>
<td>235</td>
</tr>
<tr>
<td>Not available after 6+ calls</td>
<td>485</td>
</tr>
<tr>
<td>Too ill</td>
<td>36</td>
</tr>
<tr>
<td>Away during fieldwork</td>
<td>43</td>
</tr>
<tr>
<td>Needed mother tongue interviewer (not possible inside fieldwork period)</td>
<td>9</td>
</tr>
<tr>
<td>Withdrawn (interviewers threatened)</td>
<td>52</td>
</tr>
<tr>
<td>Other outcomes</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minority ethnic booster survey</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued sample</td>
<td>480</td>
</tr>
<tr>
<td>Less invalid addresses (non-residential and white-only households)</td>
<td>269</td>
</tr>
<tr>
<td>Remaining sample</td>
<td>211</td>
</tr>
<tr>
<td>Successful interviews</td>
<td>51</td>
</tr>
<tr>
<td>Refusal before respondent selection</td>
<td>12</td>
</tr>
<tr>
<td>Refusal after respondent selection</td>
<td>8</td>
</tr>
<tr>
<td>Not available after 6+ calls (likely to include some more non-eligible households)</td>
<td>85</td>
</tr>
<tr>
<td>Too ill</td>
<td>1</td>
</tr>
<tr>
<td>Away during fieldwork</td>
<td>4</td>
</tr>
<tr>
<td>Needed mother tongue interviewer (not possible inside fieldwork period)</td>
<td>12</td>
</tr>
<tr>
<td>Other outcomes</td>
<td>38</td>
</tr>
</tbody>
</table>

The main survey data was weighted firstly by differential chance of selection for interview and then by the most recently available demographic profile supplied by the Scottish Executive. The effective sample size was calculated as 79.8% of the total figure, i.e 1102.

The resulting maximum sampling errors (on a finding of 50%) are shown in Table B2, both for the total sample and for some sub-samples. The errors also allow for the estimated impact of clustering the sample as described in the previous section (a factor of 1.25). The target sample size for the main survey was 1500 and the smaller achieved sample meant that the quoted errors are slightly larger than they otherwise would have been (e.g. the maximum error on the overall sample would probably have been +/- 2.5%, rather than +/- 2.7%).
### Table B2

<table>
<thead>
<tr>
<th>Description</th>
<th>Margin of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>1381 = 1100 effective (i.e. the total main sample)</td>
<td>+/- 2.7%</td>
</tr>
<tr>
<td>438 = 350 effective (e.g. least affluent areas)</td>
<td>+/- 6.5%</td>
</tr>
<tr>
<td>225 = 180 effective (e.g. saw the male depression vignette)</td>
<td>+/- 9.1%</td>
</tr>
</tbody>
</table>
Dear Householder

National Scottish Survey of Public Attitudes to Mental Health, Well Being and Mental Health Problems

This letter is being sent to ask for your help with an important survey being conducted across Scotland. Your address has been randomly selected on the basis of your postcode to take part in the survey, which is being carried out as part of the Scottish Executive’s National Programme for Improving the Mental Health and Well Being of the Scottish Population. The survey is designed to explore what the people of Scotland think about mental health, well being and mental health problems. We hope you will agree to a face-to-face interview, lasting about 30 minutes.

The survey questionnaire has been designed by a multi-disciplinary group of experts and the interviews are being carried out by the NOP Research Group. If you agree to talk to the NOP researcher, everything you say will be treated in total confidence. No data will be seen by anyone outside the survey team. Naturally, you can refuse to answer any question you do not wish to respond to and you will be free to stop the interview at any time if you wish. If you have any queries about the survey you can leave a message for Sarah McHugh at NOP on freephone 0800 279 0770 and she or a colleague will call you back. If you call please quote our reference at the top right of the letter.

The Scottish Executive is committed to policies designed to improve the mental health and well being of the people of Scotland, improve awareness of mental health problems and tackle the stigma and discrimination associated with mental illness. The (anonymised) results of the survey will be published in due course by the Scottish Executive so, by agreeing to participate in the survey, you will be playing an important part in the work. We hope you will agree to be interviewed. An interviewer from NOP Research will be calling on you soon.

Yours sincerely

Gregor Henderson
National Programme Director

Fiona Tyrrell
Public Health Division
ANNEX D: CONTACT SHEET

NOP/433988 NATIONAL SCOTTISH SURVEY OF PUBLIC ATTITUDES TO MENTAL HEALTH, WELL BEING AND MENTAL HEALTH PROBLEMS

CONTACT SHEET

Point No: «Point_»
Address number: «Point_» «Addr_»

Issue
Interviewer Name:
Number:

DAY (1-7)
TIME (1-4)
DATE (1-31)
MONTH (1-12)

OUTCOME of call and any other comments

DAY MON = 1 • TUES = 2 • WED = 3 • THURS = 4 • FRI = 5 • SAT = 6 • SUN = 7
TIME Up to 12 noon = 1 • 12 noon/4 pm = 2 • 4/6pm = 3 • 6PM ONWARDS = 4

TOTAL NUMBER OF CALLS (WRITE IN BOX)

You must record at least 6 attempts in total to make appointment/complete interview before abandoning address. At least one call must be an evening and one at a weekend plus one further evening or weekend call.

CONTACT CODES:

FINAL OUTCOME

Refused before respondent selection
Refused after respondent selection
Entry to block/scheme refused by warden etc
Occupied, no contact at address after 6+ calls
No contact with selected resident, 6+ calls
Occupier in but not answering door after 6+ calls
Unsure if occupied, no contact after 6+ calls
Property vacant
Property derelict
Property demolished
Non-residential property
Property not found
Too ill to participate
Away during fieldwork
Mother tongue required
Other

REFUSAL INFORMATION

Never does surveys
Interview takes too long
Taken part in too many surveys
Interview is too intrusive
Too busy at this time
Always too busy
Worried about misuse of information
Worried about confidentiality
Worried about safety/security
Survey is a waste of money
Not interested in helping government
Not interested in the subject matter
“Nothing in it for me”
Don’t want to talk about mental health
Other (WRITE IN)

REASON FOR REFUSAL (MULTICODE OKAY)

Composition: Elderly in the household
Family with children
Other
Sex of person refusing: Male
Female
Ethnic origin: White
Other

Remember to return ALL contact sheets to the office (productives and failures) as soon as possible. Check all relevant sections have been coded.
* DWELLING INFORMATION AND SELECTION *

Q1. Code property type of printed address:

- House/bungalow – detached  □
- House/bungalow – semi-detached  □
- House/bungalow – mid terrace  □
- House/bungalow – end terrace  □
- Purpose built flat/maisonette(s) - building less than six floors  □
- Purpose built flat/maisonette(s) - building six or more floors  □
- Conversion flat/maisonette(s)  □
- Hostel or bed and breakfast  □
- Other (WRITE IN)  □

Q2. Does the precise address on the contact sheet consist of just one house, or flat? (IF NOW PART OF A LARGER PROPERTY CONSIDER THAT LARGER PROPERTY)

- Yes  □ GO TO HOUSEHOLD SELECTION (Q4)
- No – more than one house or flat  □ ASK Q3

Q3. Write in total number of houses/flats, then select one at random using the Kish Grid opposite, and write in selected number:

<table>
<thead>
<tr>
<th>Total number of houses/flats</th>
<th>Number selected from Kish Grid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* INTRODUCTION *

Good morning/afternoon/evening. My name is .... from NOP Research Group. We are carrying out a survey for the Scottish Executive to find out what people in Scotland think about issues to do with their own, and other people’s, mental health and well being. You may recently have received a letter from the Executive about the survey. IF NECESSARY, SHOW COPY OF THE LETTER. Anything you say will be treated in the strictest confidence and your name and address will not be disclosed to anyone. (IF CONCERN RAISED BY RESPONDENTS, ADD...including the Scottish Executive or your own doctor). You can, of course, refuse any question that you prefer not to answer.

* HOUSEHOLD SELECTION *

Q4. Can I just check, how many households live here? By household I mean a person, or group of people who normally live here, who share a living or sitting room, or share at least one meal a day.

- One household only  □ GO TO Q6
- More than one household  □ ASK Q5

Q5. Ask respondent for details of households – write in total number of households, then select one at random using the Kish Grid at the bottom of the opposite page, and write in selected number

<table>
<thead>
<tr>
<th>Total number of households</th>
<th>Number selected from Kish Grid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**RESPONDENT SELECTION**

Q6. I’d like to interview one of the people aged 16 or over who live in this household, and in order to choose fairly, I’d like to ask a few questions. Can you tell me how many people (aged 16 or over) currently live here as part of this household?

<table>
<thead>
<tr>
<th>One only</th>
<th>Two or more</th>
<th>□ COMPLETE INTERVIEW</th>
<th>□ COMPLETE DETAILS BELOW AND Q7</th>
</tr>
</thead>
</table>

Total number of household members 16+

Number selected from Kish Grid
(FILL IN NAMES BELOW AND SELECT USING KISH GRID AT BOTTOM OF PAGE)

Q7. We have a special way of selecting which person to interview and in order to choose fairly can you please tell me the first name or initial of each member of the household (aged 16 or over). LIST NAMES/INITIALS BELOW IN ALPHABETICAL ORDER

**HOUSEHOLD MEMBER**

<table>
<thead>
<tr>
<th>FIRST NAME OR INITIAL</th>
<th>CODE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

INCLUDE:
- People normally living here away for up to 6 months
- People away at work for whom this is main address
- Boarders and lodgers

EXCLUDE:
- People 18+ living elsewhere for study/work
- Spouses separated and no longer resident
- People away for 6 months or more

NO SUBSTITUTIONS ONCE SELECTED

CONTINUE WITH INTERVIEW WITH SELECTED HOUSEHOLD MEMBER; REMEMBER TO COMPLETE FINAL OUTCOME AND BACK PAGE

KISH GRID

USE KISH GRID BELOW FOR SELECTIONS AT Q3, Q5 AND Q7.

INSTRUCTIONS: SELECT NUMBER USING GRID: Ring the last digit of the five-digit address number in the left hand column, and ring the digit in the first row corresponding to the number of possible units you are selecting from. Read along the circled row and down the circled column, where they meet gives the number of the selected unit or person

Q3: NUMBER OF HOUSES/FLATS AT ADDRESS
Q5: NUMBER OF HOUSEHOLDS
Q7: NO. OF ADULT HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>PLEASE RING</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<td>2</td>
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</tr>
</tbody>
</table>

NOTES

If more than 9 houses/flats (for Q3), households (for Q5), or adults (for Q7) at address call office for instructions

Continue with screening procedure at next question after selection

If situation is complex, or you are at all unsure of how to count houses/flats, households, or householders, contact head office for guidance

Once a selection has been made no substitutions are allowable
We need your name so that we can contact you for quality control purposes, or so that we can invite you to take part in further research about health issues. I would also like to record a telephone number for you.

TITLE: ................... FIRST NAME: ...................... SURNAME: ..................................................

TELEPHONE (INC STD CODE): ........................................................................................................

IF DEFINITELY REFUSE ALL RECONTACT TICK BOX □

WRITE IN COMMENTS:

If we were repeating this research in two years time and were not able to find you is there anybody who would know where you are?

NAME: ..............................................................................................................................................

RELATIONSHIP TO RESPONDENT: ....................................................................................................

ADDRESS: ........................................................................................................................................

.................................................................................................................................................... POSTCODE

PHONE NUMBER (INC STD CODE) ....................................................................................................

Are any changes required to the printed address to enable us to identify it again?

Yes □ COMPLETE CHANGES BELOW

No □ GO TO Q12

WRITE IN NEW DETAILS ONLY AGAINST CHANGED LINES

NEW FIRST - - - - - - - - - - - - - - - -
LINE 1 «Add1»
LINE 2 «Add2»
LINE 3 «Add3»
LINE 4 «Add4»
LINE 5 «Add5»
POSTCODE «Postcode»

Which of the following explain the changes you have made to the address? MULTICODE OK

Address split into more than one home □
Address merged into a larger property □
Address changed (e.g. “Flat 1” to “Flat A”) □
Address wrong (e.g. misspelt) □
Other (WRITE IN) □

Are there any further details which would be helpful to an interviewer to make further contact? e.g. for unusual properties details of how to reach the property. Do not include obvious details or directions to properties that can be easily located on a street map.
ANNEX E: FINAL QUESTIONNAIRE

NATIONAL SCOTTISH SURVEY OF PUBLIC ATTITUDES
TO MENTAL HEALTH, WELL BEING AND MENTAL HEALTH PROBLEMS

Section A – general health and lifestyle

A1. I’d like to start by asking some questions about your general health and lifestyle. First of all, in general, would you say your health is…READ OUT

Excellent
Very good
Good
Fair
Or poor?

A2. The next questions are about how you have been feeling during the past 4 weeks. Taking your answer from SHOWCARD A, for how much of the time during the past 4 weeks…

All of the time
Most of the time
Some of the time
A little of the time
None of the time
(Don’t know)

ROTATE ORDER:
Did you feel full of life?
Have you been very nervous?
Have you felt so down in the dumps that nothing could cheer you up?
Have you felt calm and peaceful?
Did you have a lot of energy?
Have you felt downhearted and depressed?
Did you feel worn out?
Have you been happy?
Did you feel tired?
A3 Do you have any long-standing illness, disability or infirmity? By long-standing, I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time.

Yes
No – GO TO A5

IF YES
A4. Does this illness, disability or infirmity limit your activities in any way?

Yes
No

ASK ALL
A5. Taking your answer from SHOWCARD B, which of these statements best describes the amount of stress or pressure you have experienced in the past year?

Completely free of stress
Small amount of stress
Moderate amount of stress
Large amount of stress
(Don’t know)

A6. When did you last see your family doctor/GP about your own health?

In the last week
In the last month
In the last 6 months
In the last year
Longer ago
Never
Not registered with a doctor

A7. Do you smoke cigarettes nowadays? PROBE FOR CODE

Yes, daily
Yes, occasionally but not every day
No – GO TO A9

IF YES
A8. On an average day, how many cigarettes do you usually smoke?

ENTER NUMBER

ASK ALL
A9. Do you drink alcohol nowadays?

Yes
No – GO TO A11
Refused – GO TO A11
A10. SHOWCARD C (UNITS) In a typical seven day week, how many units of alcohol would you drink, including weekends, anything you drink at home, in pubs, clubs or at parties?

ENTER NUMBER OF UNITS

ASK ALL
A11. Can I just check, do you look after any sick, disabled, elderly or frail people living in this or another household?

Yes
No

A12. How long have you lived in this neighbourhood? By this I mean within about 15 minutes walk of here.

Less than a year
One year, less than 2 years
Two years, less than 5 years
Five years, less than 10 years
10 years, less than 20 years
20 years or more

A13. Would you say that you know.... READ OUT AND CODE ONE ONLY

Most of the people in your neighbourhood
Many of the people in your neighbourhood
A few of the people in your neighbourhood
Or that you do not know people in your neighbourhood?
(Don't know)

A14. Would you say this neighbourhood is a place where neighbours look out for each other?

Yes
No
Don't know

A15. Have you been involved in any local organisation on a voluntary basis over the last three years (that is work for which you are not paid, except for expenses)?

Yes
No
Section B – mental health

B1. I’m now going to ask you some questions about mental health and well being. By this I mean how you feel about yourself. SHOWCARD D Here are some words and phrases people have used to describe good mental health. Which do you think are the five words or phrases that best describe good mental health for you? CODE UP TO FIVE ONLY

Coping
Successful
Confident
Happy
Loved
Resourceful
Connected/part of something
Healthy
Calm
Understood
Attractive
Challenged
Tolerant
In control
(Don’t know)
B2. Thinking now about other things which might affect your health, what sorts of things have a positive or good effect on your mental health and well-being? DO NOT PROMPT. Anything else?

Work/working
Not working
Where you live/your neighbourhood
Having enough money/good income
Support from/relationship with spouse/partner
Support from/relationship with other family members
Support from/relationship with friends
Avoiding stress
Being healthy
Enough rest/sleep
Holidays/breaks
Being in control
Being calm
Leisure activities/social life
What you eat/your diet
Giving support to/having a caring role for others
Good weather
Other (PLEASE SPECIFY)
Don’t know

B3. And what, if any, things have a negative or bad effect on your mental health and well-being? DO NOT PROMPT. Anything else?

Work/working/having too much work
Not working
Where you live/your neighbourhood
Not enough money/low income
Problems in relationship with spouse/partner
Problems in relationship with other family members
Problems in relationships with friends
Poor social life/not much to do/lack of social or leisure facilities
Illness (physical)
Stress
Lack of sleep
Not being in control
Bad weather
Giving support/having a caring role for others
What you eat/diet
Other (SPECIFY)
Don’t know
B4. What would be the three main things that would make the biggest improvement to your own mental health and well being? DO NOT PROMPT – CODE UP TO 3 ONLY.

Work
To get a job
To stop working
Change jobs
Financial
More money/higher income
Clear/pay off debts
Win the lottery
Relationships
(Better) relationships with partner/spouse
(Better) relationships with other family members
(Better) relationships with friends/to have more friends
Health
Better health
Better/healthier diet
Responsibilities
To be less busy
Stress
Less stress
More time to myself
Quality of life
Local environment
Less crime/feeling less at risk of crime
Transport
Access to facilities/services
Better home
Moving home
Other (PLEASE SPECIFY)

B5 Thinking generally about all the things that affect your mental health, how much control do you feel you have over them? SHOWCARD E

Complete control
A good deal of control
Some control
A little control
No control at all
(Don’t know)
B6. SHOWCARD F. Now, if the government in Scotland had to prioritise spending on just three areas that might improve the mental health of the Scottish population, which three from this card do you think are the most important? CODE UP TO THREE ONLY

Help people to understand about mental health
Support people at difficult times of their life
Improve services for people who develop mental health problems
Help to put an end to poverty
Help to put an end to discrimination
Improve trust and respect in local communities
Other (PLEASE SPECIFY)
(Don’t bother/none of their business)
(Don’t know)

Section C – mental health problems

C1. I’m now going to read out some things people have said about mental health problems. Taking your answer from this card. I’d like you to tell me how much you agree or disagree with each of these statements. SHOWCARD G

Agree strongly/Agree slightly/Neither agree nor disagree/Disagree slightly/Disagree strongly

ROTATE ORDER OF STATEMENTS
‘If I was suffering from mental health problems, I wouldn’t want people knowing about it’
‘The public should be better protected from people with mental health problems’
‘Anyone can suffer from mental health problems’
‘I would find it hard to talk to someone with mental health problems’
‘People are generally caring and sympathetic to people with mental health problems’
‘People with mental health problems are often dangerous’
‘The majority of people with mental health problems recover’
‘People with mental health problems should have the same rights as anyone else’
‘People with mental health problems are largely to blame for their own condition’
C2. From what you know, has anyone close to you ever been told, by a doctor or other health professional, that they had one or other of these kinds of mental health problems? Just read out the letter or letters from the card. SHOWCARD H. CODE ALL THAT APPLY.

Yes:
J. Depression
G. Manic depression (bipolar affective disorder)
A. Eating disorders (anorexia, bulimia)
D. Schizophrenia
F. Anxiety disorders
I. Alzheimer's Disease/Dementia
E. Personality disorders
B. Nervous breakdown
H. Panic attacks
C. Severe stress
K. Any other mental health problem (PLEASE SPECIFY)
(Yes, been told he/she had problem but don’t know what it was called)

(No, none of these)
(Don’t know)
(Refused)

C3. Have you personally ever experienced a mental health problem?

Yes
No
Don’t know
Refused – GO TO D1

C4. Have you ever been told, by a doctor or other health professional, that you personally have had one or other of these kinds of specific mental health problems? Just read out the letter or letters from the card. ROTATED SHOWCARD I

J. Depression
G. Manic depression (bipolar affective disorder)
A. Eating disorders (anorexia, bulimia)
D. Schizophrenia
F. Anxiety disorders
I. Alzheimer's Disease/Dementia
E. Personality disorders
B. Nervous breakdown
H. Panic attacks
C. Severe stress
(No, none of these)
(Not been told by a doctor)
(Don’t know)
(Refused) - GO TO D1

IF YES AT C3 AND NONE/NOT BEEN TOLD BY A DOCTOR/DON’T KNOW AT C4 – OTHERS GO TO FILTER BEFORE C6

C5. You said that you had experienced a mental health problem. How would you describe this problem?

ENTER VERBATIM
IF YES AT C3 OR ANY A-J CODED AT C4 – OTHERS GO TO D1

C6. Have you experienced any of the following as a result of other people’s attitudes towards your mental health problem(s)? SHOWCARD J. Just read out the letter or letters from the card.

C. Unable to/discouraged from participating in social events, such as going out with friends
H. Unable to/discouraged from participating in children’s school-based activities
L. Unable to/discouraged from taking part in local community life
B. Unable to/discouraged from going on holiday
K. Been refused a job
I. Been overlooked/refused for promotion
F. Verbally abused in public
M. Verbally abused within the family
A. Physically abused in public
J. Physically abused within the family
E. Graffiti or rubbish targeted at the home
G. Experienced discrimination at work
N. Other (SPECIFY)

(No, none of these)
(Don’t know)
(Refused)

C7. Have you decided not to disclose “this problem/any of these problems” (CAPI: VARY THIS WORDING: DEPENDING ON THE NUMBER OF ANSWERS AT C4) when applying for any of these? SHOWCARD K – CODE ALL THAT APPLY. Again, just read out the letters from the card.

D. Life insurance
G. Travel insurance
E. Medical insurance
A. Bank loan
H. Credit card
F. Mortgage
B. Driving licence
I. Job
C. Education and training opportunities

(None of these)
(Don’t know)
(Refused)

Section D – sources of information about mental health problems

D1. There are many ways in which people get information about mental health issues. Regardless of your own circumstances, I’m interested to know how you get your information about mental health and mental health problems. SHOWCARD L. Taking your answers from the card, which of the following have been important sources of information to you in the past?

Personal contact or personal experience
Work
Education/studying
National newspapers
Local newspapers
Books/leaflets/magazines
Television news and current affairs programmes
Television soaps
Other TV
Radio
Word of mouth
Health professionals
Other (PLEASE SPECIFY)

(None of these)
(Don’t know)

IF MORE THAN ONE MENTIONED AT D1 – OTHERS GO TO D3

D2. Which one of these sources of information would you say was the most important for you? SHOWCARD L AGAIN IF NECESSARY

Work
Education/studying
National newspapers
Local newspapers
Books/leaflets/magazines
Television news and current affairs programmes
Television soaps
Other TV
Radio
Word of mouth
Health professionals
Other (PLEASE SPECIFY)

(None of these)
(Don’t know)
ASK ALL

D3. In the last six months, have you seen, read about or heard an advert or promotion about mental health/mental health problems? IF YES, PROBE FOR SOURCE

Yes, seen
Yes, read about
Yes, heard
Yes but not sure (whether seen, read or heard)
No, none of these
Don’t know

D4. Overall, how do you think the media, such as newspapers, television and radio, portray people with mental health problems? SHOWCARD M. CODE ONE ONLY

Almost always positively
More positively than negatively
Both positively and negatively
More negatively than positively
Almost always negatively
(Don’t know)

Section E – examples of mental health problems

This card describes someone who has a mental health problem – please read through it or I can read it out of you prefer. I’d then like to ask you some questions about what you think might be wrong and how the person might be helped. SHOWCARD FROM 1-6

1. Robert has been feeling really down for the last few weeks. He wakes up in the morning with a flat heavy feeling that stays with him all day long. He doesn’t enjoy things the way he normally would. In fact, nothing gives him pleasure. Even when good things happen, they don’t seem to make Robert happy. He has to force himself to get through the day, and even the smallest things seem hard to do. He finds it hard to concentrate on anything and has no energy at all. Even though Robert feels tired at night, he still can’t sleep, and wakes up too early in the morning. Robert feels worthless and feels like giving up. Robert’s family has noticed that he hasn’t been himself for about the last month. He doesn’t feel like talking and isn’t taking part in things like he used to.

2. Shona has been feeling really down for the last few weeks. She wakes up in the morning with a flat heavy feeling that stays with her all day long. She doesn’t enjoy things the way she normally would. In fact, nothing gives her pleasure. Even when good things happen, they don’t seem to make Shona happy. She has to force herself to get through the day, and even the smallest things seem hard to do. She finds it hard to concentrate on anything and has no energy at all. Even though Shona feels tired at night, she still can’t sleep, and wakes up too early in the morning. Shona feels worthless and feels like giving up. Shona’s family has noticed that she hasn’t been herself for about the last month. She doesn’t feel like talking and isn’t taking part in things like she used to.

3. Robert is a man who was doing pretty well until about a year ago. But then things started to change. He thought that people around him were criticising him and talking behind his back. Robert was convinced that people were spying on him and that they could hear what he was thinking. Robert couldn’t work any more, and he stopped joining in with family activities. He retreated from everything, until he eventually spent most of his day in his room. Robert heard voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.
4. Shona is a woman who was doing pretty well until about a year ago. But then things started to change. She thought that people around her were criticising her and talking behind her back. Shona was convinced that people were spying on her and that they could hear what she was thinking. Shona couldn’t work any more, and she stopped joining in with family activities. She retreated from everything, until she eventually spent most of her day in her room. Shona heard voices even though no one else was around. These voices told her what to do and what to think. She has been living this way for six months.

5. Robert is a man, who was doing pretty well until about a year ago. While nothing much was going wrong in Robert’s life, he had a few problems that were really beginning to get to him. He started to feel worried, and a little sad, and had trouble sleeping at night. Things bothered him more than they bothered other people, and he started to get nervous and annoyed when things went wrong. Otherwise Robert is doing OK. He enjoys being with other people, and though he sometimes argues with his family, he has generally been getting on pretty well with them.

6. Shona is a woman, who was doing pretty well until about a year ago. While nothing much was going wrong in Shona’s life, she had a few problems that were really beginning to get to her. She started to feel worried, and a little sad, and had trouble sleeping at night. Things bothered her more than they bothered other people, and she started to get nervous and annoyed when things went wrong. Otherwise Shona is doing OK. She enjoys being with other people, and though she sometimes argues with her family, she has generally been getting on pretty well with them.
E1. In your opinion, how likely is it that Robert's/Shona's (CAPI TO USE NAME FROM VIGNETTE IN REST OF SECTION) situation might be caused by each of the following?

SHOWCARD N

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
(Don't know)

ROTATE ORDER
Robert's/Shona's own character or personality
Chemical imbalance in the brain
The way Robert/Shona was brought up
Stressful or disturbing events in Robert's/Shona's life
Genetic or inherited problem
Abuse Robert/Shona suffered as a child
Fate
Physical illness
Robert's/Shona's own fault

E2. SHOWCARD O. Say it was possible for any of the people on this card to help Robert/Shona. Who would be the three best people to do this? CODE UP TO THREE ONLY.

Someone in the family
A friend or neighbour
A nurse
A home help/carer/care assistant
A psychiatrist
A psychologist
A family doctor
A social worker
A qualified counsellor
A voluntary organisation or charity
Someone with the same problem
Someone else (PLEASE SPECIFY)
(No one)
(Don't know)
E3. If all the options on this card were possible, where do you think it would be best for Robert/Shona to live? SHOWCARD P. Please choose one answer only.

Living in their own home by themselves
In their own (or family's) home, with support from family members or friends
In their own (or family's) home, with help from professionals (for example, community mental health teams)
In special housing with professional support in the community
In a residential or nursing home
In hospital
Somewhere else (PLEASE SPECIFY)
(Wherever he/she wants)
(Don’t know)

E4. SHOWCARD Q. In your opinion, how likely is it that Robert/Shona would do something harmful or violent to…(i)…him/herself? (ii)…other people?

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
(Don’t know)

E5. Do you think that Robert/Shona should have the same rights, for example at work, as anyone else?

Yes
No
Don’t know

E6. SHOWCARD R. How willing would you be to…

Very willing
Fairly willing
Neither willing nor unwilling
Fairly unwilling
Very unwilling
(Don’t know)

ROTATE ORDER OF STATEMENTS
Move next door to Robert/Shona?
Spend an evening socialising with Robert/Shona?
Make friends with Robert/Shona?
Start working closely with Robert/Shona?
Have Robert Shona marry into the family?
Do Robert/Shona a favour if they asked you to?
ROTATE ORDER OF E7/E8/E9
E7. SHOWCARD S AGAIN (AND THE SCENARIO SHOWCARD). How likely do you think it is that Robert/Shona is experiencing depression?

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
(Don’t know)

E8. SHOWCARD S AGAIN (AND THE SCENARIO SHOWCARD). How likely do you think it is that Robert/Shona is experiencing schizophrenia?

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
(Don’t know)

E9. SHOWCARD S AGAIN (AND THE SCENARIO SHOWCARD). How likely do you think it is that Robert/Shona is experiencing stress?

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
(Don’t know)

Section F – demographic information
Finally, I’d like to ask some questions about you and your household …

F1. How old are you?

ENTER AGE – ESTIMATE IF NECESSARY (INCLUDE A CODE TO BE MARKED WHEN ESTIMATE USED)

F2. INTERVIEWER CODE: RESPONDENT IS...

Male
Female
F3. SHOWCARD T. Which **one** of these best describes you? SINGLE CODE ONLY

- White
  - A. Scottish
  - B. Other British
  - C. Irish
  - D. Any other White background
- Mixed
  - E. Any mixed background
  - Asian, Asian Scottish, or Asian British
  - D. Indian
  - E. Pakistani
  - F. Bangladeshi
  - G. Chinese
  - H. Any other Asian background
  - Black, Black Scottish, or Black British
  - I. Caribbean
  - J. African
  - K. Any other Black background
  - Other ethnic background
  - L. Any other ethnic background.

(Refused)
(Don’t know)

F4. Which of these describes your marital status? READ OUT

- Single
- Married or living as couple
- Widowed
- Or divorced or separated?
(Refused)

F5. Taking your answer from SHOWCARD U, which one of these best describes your home?

- Owned outright
- Being bought on a mortgage
- Rented from Council
- Rented from a housing agency/association/trust
- Rented from a private landlord
- Rented from another organisation
- Live rent free/comes with the job
(Don’t know)
F6. How many people aged 16 and over live in your household?
ENTER NUMBER

F7. And how many people aged under 16 live in your household?
ENTER NUMBER

F8. In which of the following income categories does your net annual household income fall, that is after tax and other deductions? SHOWCARD V. Just read out the letter from the card.

<table>
<thead>
<tr>
<th>Weekly</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Under £60 per week</td>
<td>Under £3,120 per year</td>
</tr>
<tr>
<td>I £60 and less than £100</td>
<td>£3,120 and less than £5,200</td>
</tr>
<tr>
<td>E £100 and less than £200</td>
<td>£5,200 and less than £10,400</td>
</tr>
<tr>
<td>G £200 and less than £300</td>
<td>£10,400 and less than £15,600</td>
</tr>
<tr>
<td>A £300 and less than £400</td>
<td>£15,600 and less than £20,800</td>
</tr>
<tr>
<td>C £400 and less than £500</td>
<td>£20,800 and less than £26,000</td>
</tr>
<tr>
<td>F 500 and less than £600</td>
<td>£26,000 and less than £31,200</td>
</tr>
<tr>
<td>B £600 and less than £700</td>
<td>£31,200 and less than £36,400</td>
</tr>
<tr>
<td>H £700 and above</td>
<td>£36,400 or more</td>
</tr>
<tr>
<td>(Refused)</td>
<td></td>
</tr>
<tr>
<td>(Don’t know)</td>
<td></td>
</tr>
</tbody>
</table>

F9. How easy or difficult do you find it to manage on your household’s income? SHOWCARD W

Very easy
Fairly easy
Manageable
Fairly difficult
Very difficult
(Don’t know)
F10. OCCUPATION OF CHIEF INCOME EARNER
a. Which member of your household, related to you, would you say is the CHIEF INCOME EARNER, that is the person with the largest income, whether from employment, pensions, state benefits, investments or any other source? Self: □ Spouse/Partner □ Other adult (specify) □ ........................................

b. Is the CHIEF INCOME EARNER:
   Working (either full or part time) 1
   Retired/not working with PRIVATE PENSION/MEANS 2...ASK Qc
   Unemployed less than 6 months 3
   Unemployed more than 6 months 4
   Retired with STATE BENEFIT/PENSION ONLY 5...CODE SOCIAL GRADE AS ‘E’
   Not working with STATE BENEFIT ONLY 6
   Student 7 CODE SOCIAL GRADE AS ‘C1’

c. OCCUPATION OF CHIEF INCOME EARNER
   Job title
   Job description
   Industry Size of Company
   Qualifications
   If manager/supervisor/self-employed - No of people responsible for

F11. Which, if any, of these qualifications do you have? SHOWCARD X AND CODE ALL THAT APPLY

‘O’ Grade, Standard Grade, Intermediate 1, Intermediate 2, GCSE, CSE, Senior Certificate or equivalent
Higher Grade, CSYS, Scottish Group Award at Higher, ‘A’ Level, AS Level, Advanced Senior Certificate or equivalent
GSVQ/SVQ Level 1 or 2, SCOTVEC/National Certificate Module, ONC, BTEC First Diploma, City and Guilds Craft, RSA Diploma or equivalent
HNC, HND, SVQ Level 4 or 5, RSA Higher Diploma or equivalent
First degree, Higher Degree
Professional qualifications (e.g. teaching, accountancy)
(None of these)
(Don’t know)

F12. Which of these apply to you? SHOWCARD Y. CODE ALL THAT APPLY

A In paid work
B Local or government training scheme (GTS)
C Modern Apprenticeship
D Registered unemployed/signing on for JSA
E Not registered unemployed but seeking work
F At home/not seeking work
G Long-term sick or disabled
H Retired
I Full-time education
Other (PLEASE SPECIFY)

F13. Thank you very much for your help with the survey. Finally, would you be willing to participate in further health surveys for the Scottish Executive?

Yes
Maybe
No
ANNEX F1 - CHAID INTERPRETATION

CHAID divides a population into two or more categories that have the greatest difference with regard to the dependent variable; in this case this is the Mental Health and Vitality score or the Stigma score. It then splits each of these groups until no more statistically significant differences are found. The prime advantage of CHAID is that it repetitively searches through large numbers of linked data fields to identify the most important discriminators.

MENTAL HEALTH AND VITALITY CHAID

The Mental Health and Vitality score was derived through statements from Q2 in Section A. The 9 questions that were asked here were used to produce separate Mental Health and Vitality scores for each respondent. Both scores were scaled on to a 0-100 scale and the overall Mental Health and Vitality score was calculated using a weighted average of the 2 scores (both questions were given equal weighting i.e. 50/50%).

CHAID analysis was then used to find out which variables are driving the high and low Mental Health and Vitality scores for each person, e.g. is it demographic factors, previous experience of mental health problems etc. With the exception of the Cluster and Stigma groups, all of the breaks on the tables were put into the CHAID analysis.

The variable that had the most significant differences with regards to the Mental Health and Vitality score was Illness. This split in to 2 groups (or nodes). The first node contained those respondents who stated that they had a limiting illness. This represented 412 respondents and the average Mental Health and Vitality score for this group was 52.7, somewhat below the mean score for the total sample. The second node consisted of respondents who had no long standing illness or no limiting illness. This accounted for the remaining 947 respondents and they had a mean Mental Health and Vitality score of 70.1.

If we carry on with this node, it then splits the sample of 947 further with the variable ‘Control’. This has split in to 3 groups:

- Complete control. N = 158, SF-36 average = 77.9
- Good deal of control. N = 572, SF-36 average = 71.0
- No control, A little control, Some control, Don’t know. N = 217, SF-36 average = 62.2
The first two of these nodes then split further with the variable ‘Stress’ which relates to the amount of stress they had experienced in the past year while the third node split on the variable ‘Ease’ which relates to the ease of managing on the household income.

Going back to the node consisting of respondents with a limiting illness, this split also by ‘Control’ and in to 2 groups.

- Complete control, Good deal of control. N = 233, SF-36 average = 58.7
- No control, A little control, Some control, Don’t know. N = 179, SF-36 average = 43.1

The first of these nodes split again with respect to the ‘Stress’ variable (Completely free, Small amount vs. Moderate and Large amount) while the second split by Social Class (ABC1 v C2DE).

In terms of the group of respondents who have the highest average Mental Health and Vitality score, they can be described as follows.

- No long standing illness or No limiting illness
- Complete control
- Find it easy managing household income

There are 84 respondents within this group and they have a Mental Health and Vitality score average of 80.4

They are closely followed by the group described as:

- No long standing illness or no limiting illness
- Good deal of control
- Completely free of stress

There are 50 respondents within this group and they have a Mental Health and Vitality Score average of 79.1

In terms of the group of respondents who have the lowest average Mental Health and Vitality score, they can be described as follows.

- Limiting illness
- Some control, Little control or No control
- Large amounts of stress

There are 90 respondents within this group and they have a Mental Health and Vitality score average of 37.9.
STIGMA SCALE

The Stigma Scale was derived from statements in Q1 from Section C, and was scored using the following method.

The following statements received a score of 5 if the respondent agreed strongly, 4 if they agreed slightly, 3 if they neither agreed nor disagreed, 2 if they disagreed slightly and 1 if they disagreed strongly:

- ‘If I was suffering from mental health problems, I wouldn’t want people knowing about it’,
- ‘The public should be better protected from people with mental health problems’, ‘I would find it hard to talk to someone with mental health problems’,
- ‘People with mental health problems are often dangerous’ and
- ‘People with mental health problems are largely to blame for their own condition’.

Conversely, the remaining statements received a score of 1 if the respondent agreed with the statement strongly, 2 if they agreed slightly, 3 if they neither agreed nor disagreed, 4 if they disagreed slightly and 5 if they disagreed strongly:

- ‘People are generally caring and sympathetic to people with mental health problems’,
- ‘Anyone can suffer from mental health problems’,
- ‘The majority of people with mental health problems recover’ and
- ‘People with mental health problems should have the same rights as anyone else’.

Therefore, the higher the score, the more respondents tended to stigmatise those with mental health problems.

The scores ranged from 10 to 35. The respondents were then split into 4 groups: Those with scores between 10-18 points (28.8%), 19-21 (27.1%), 22-26 (34.1%) and 27+ (10%). All the breaks from the tables (except the cluster groups) were put into the CHAID to see which variables would come out as the most significant predictors.

The variable that had the most significant differences with regards to the Stigma groups was ‘Experience of Mental health’. This split into 3 groups (or nodes).
The first node contained those respondents who stated that they had no experience of mental health. This represented 339 respondents and mainly consists of respondents who had a Stigma score between 22-26 (43.1%). The second node consisted of respondents whose only experience of mental health is themselves. This accounted for 59 respondents and mainly consists of respondents who had Stigma scores between 19-21 (44.1%). Of the 3 nodes, this also has the highest number of 27+ respondents with 15.3%. The third node consists of the remaining 961 respondents and mainly consists of respondents who had Stigma scores between 10-18 (33.2%), though 31.6% of the respondents are also in the 22-26 bracket.

If we carry on with this node, it then splits the sample of 961 further with the ‘Age’ variable. This has split into 2 groups: Aged 65+ and Under 65.

The 65+ node has an increase in the number of respondents with a Stigma score of 19-21 or 27+ and a decrease in the number of respondents with a Stigma score of 10-18.

The Under 65 node splits further using the variable ‘Ease of managing income’ and has split into 2 nodes characterized by respondents answering Easy to manage vs. Difficult and manageable.

Going back to the node, which included only those respondents who had no experience of mental health, they also split using the variable ‘Ease of managing income’ and again by the same criteria (Easy to manage vs. Difficult and manageable). Those respondents who found their household income easy to manage were split further by the variable ‘Illness’. This split into 2 nodes, splitting the respondents who had said they had a limiting or not limiting illness against those who have no long standing illness.

In terms of the group who has the highest proportion of respondents with a Stigma score of 10-18, they can be described as follows.

- Experience of mental health: Someone else and self or someone else only
- Under 65
- Find managing household income easy

There are 322 respondents within this group and 37.6% of them have a score of 10-18.

In terms of the group who has the highest proportion of respondents with a Stigma score of 19-21, they can be described as follows.

Experience of mental health: Self only

There are 59 respondents within this group and 44.1% of them have a score of 19-21.
In terms of the group who has the highest proportion of respondents with a Stigma score of 22-26, they can be described as follows.

- Experience of mental health: No experience
- Find managing household income easy
- No long standing illness

There are 53 respondents within this group and 56.6% of them have a score of 22-26.

In terms of the group who has the highest proportion of respondents with a Stigma score of 27+, they can be described as follows.

- Experience of mental health: No experience
- Find managing household income easy
- No long standing illness

There are 53 respondents within this group and 18.9% of them have a score of 27+. 
Chart F1b: CHAID Analysis for Stigma Score

- **Experience of mental health**
  - Self only
  - Someone else and self, Self only

- **Easiness of managing income**
  - Not limiting
  - Some one else and Self

- **Age group**
  - >55-64
  - <=55-64

**Node 0**

- **Category % n**
  - 22-26 pts: 34.14 464
  - 10-18 pts: 28.77 391
  - 19-21 pts: 27.08 368
  - 27+ pts: 1 0.01 136
  - Total: 1359

**Node 1**

- **Category % n**
  - 22-26 pts: 4 3.07 146
  - 10-18 pts: 1 8.29 62
  - 19-21 pts: 2 3.89 81
  - 27+ pts: 1 4.75 50
  - Total: 339

**Node 2**

- **Category % n**
  - 22-26 pts: 48.50 65
  - 10-18 pts: 19.76 29
  - 19-21 pts: 17.96 30
  - 27+ pts: 1 5.70 27
  - Total: 172

**Node 3**

- **Category % n**
  - 22-26 pts: 44.74 51
  - 10-18 pts: 18.42 21
  - 19-21 pts: 25.44 29
  - 27+ pts: 1 1.40 13
  - Total: 114

**Node 4**

- **Category % n**
  - 22-26 pts: 56.60 30
  - 10-18 pts: 22.64 12
  - 19-21 pts: 1.89 1
  - 27+ pts: 1 8.87 10
  - Total: 53

**Node 5**

- **Category % n**
  - 22-26 pts: 44.74 51
  - 10-18 pts: 18.42 21
  - 19-21 pts: 25.44 29
  - 27+ pts: 1 5.70 27
  - Total: 172

**Node 6**

- **Category % n**
  - 22-26 pts: 48.50 65
  - 10-18 pts: 19.76 29
  - 19-21 pts: 17.96 30
  - 27+ pts: 1 5.70 50
  - Total: 172

**Node 7**

- **Category % n**
  - 22-26 pts: 4 3.07 464
  - 10-18 pts: 3 20.55 464
  - 19-21 pts: 1 1.72 464
  - Total: 1359

- **Adj. P-value = 0.0000, Chi-square = 48.0198, df = 6**

**Node 8**

- **Category % n**
  - 22-26 pts: 1 0.01 136
  - 10-18 pts: 1 0.01 136
  - 19-21 pts: 2 0.03 136
  - 27+ pts: 1 0.01 136
  - Total: 136

- **Adj. P-value = 0.0000, Chi-square = 48.0198, df = 6**

**Node 9**

- **Category % n**
  - 22-26 pts: 1 0.01 136
  - 10-18 pts: 1 0.01 136
  - 19-21 pts: 2 0.03 136
  - 27+ pts: 1 0.01 136
  - Total: 136

- **Adj. P-value = 0.0000, Chi-square = 48.0198, df = 6**
ANNEX F2 – CLUSTER ANALYSIS

QC1 was used to create an attitudinal segmentation. Between 2 and 10 cluster solutions were produced by an NOP in-house attitudinal segmentation computer program, using the K-Means algorithm, and for each cluster solution an efficiency score was generated. The efficiency score is calculated by looking at the relationship between the Between sum of squares and the Total sum of squares. In order to be sure that the clusters are very distinct, the Between sum of squares needs to be as large as possible.

In the case of the analysis carried out for this research project, the biggest drop in efficiency was between the 6 and 5 cluster solution, indicating that this was the point at which the cluster groups were not as distinct as the 10, 9, 8 and 7 cluster solution and we would be losing valuable information. The 8,9 and 10 cluster solutions were rejected as they produced a cluster solution which represented approximately 1% of the sample and would not be representative of the true population. The 7 cluster solution also produced a cluster which was too small to be examined. The 6 cluster solution produced robust sample sizes for each cluster and also produced the most sensible results.
## Chart F2a: Cluster profiles

### Cluster profiles

<table>
<thead>
<tr>
<th>Cluster</th>
<th>1 Cluster</th>
<th>2 Cluster</th>
<th>3 Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: If suffering from Mental hea</td>
<td>.</td>
<td>.</td>
<td>x.</td>
</tr>
<tr>
<td>2: Public should be better prot</td>
<td>xxxxxx.</td>
<td>.xxx</td>
<td>.xxxxx</td>
</tr>
<tr>
<td>3: Anyone can suffer from menta</td>
<td>.xxx</td>
<td>*xxxxxxxxxxxxx.</td>
<td>.xx</td>
</tr>
<tr>
<td>4: Would find it hard to talk t</td>
<td>xxxxxx.</td>
<td>.xxxx</td>
<td>.xx</td>
</tr>
<tr>
<td>5: People generally caring to p</td>
<td>xx.</td>
<td>.xxx</td>
<td>x.</td>
</tr>
<tr>
<td>6: People with mental health pr</td>
<td>xxxxxxx.</td>
<td>.x</td>
<td>.xxxxxx</td>
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<tr>
<td>7: The majority of people with</td>
<td>.xxxxxxxx</td>
<td>x.</td>
<td>xxx.</td>
</tr>
<tr>
<td>8: Should have the same rights</td>
<td>xxxx</td>
<td>xxx</td>
<td>*xxxxxxxxxxxxx.</td>
</tr>
<tr>
<td>9: They are largely to blame fo</td>
<td>xxxxx</td>
<td>xxx</td>
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</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>4 Cluster</th>
<th>5 Cluster</th>
<th>6 Cluster</th>
</tr>
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<tbody>
<tr>
<td>1: If suffering from Mental hea</td>
<td>.xxxxxx</td>
<td>xxxxxxxx.</td>
<td>.xxxx</td>
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<tr>
<td>2: Public should be better prot</td>
<td>.xxxxx</td>
<td>.xxx</td>
<td>.xxxx</td>
</tr>
<tr>
<td>3: Anyone can suffer from menta</td>
<td>.xxxx</td>
<td>.xxx</td>
<td>.xxx</td>
</tr>
<tr>
<td>4: Would find it hard to talk t</td>
<td>.xxxxxx</td>
<td>xxxx</td>
<td>.xxxx</td>
</tr>
<tr>
<td>5: People generally caring to p</td>
<td>.x</td>
<td>.</td>
<td>.x</td>
</tr>
<tr>
<td>6: People with mental health pr</td>
<td>.xxxx</td>
<td>.x</td>
<td>.xxxx</td>
</tr>
<tr>
<td>7: The majority of people with</td>
<td>x.</td>
<td>xxxxx</td>
<td>.</td>
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<tr>
<td>8: Should have the same rights</td>
<td>.xxx</td>
<td>.xxx</td>
<td>.xxxxxx</td>
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<tr>
<td>9: They are largely to blame fo</td>
<td>xxx.</td>
<td>xxx.</td>
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<td>Size</td>
<td>Sentences</td>
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<td>------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>353</td>
<td>6: People with mental health pr -0.844 7: The majority of people with 0.760</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2: Public should be better prot -0.687 4: Would find it hard to talk to -0.561</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>174</td>
<td>3: Anyone can suffer from mental -2.043 4: Would find it hard to talk to 0.409</td>
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<td></td>
<td>2: Public should be better prot 0.346 8: Should have the same rights -0.331</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>128</td>
<td>8: Should have the same rights -2.405 6: People with mental health pr 0.554</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2: Public should be better prot 0.525 7: The majority of people with -0.326</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>296</td>
<td>1: If suffering from Mental hea 0.648 4: Would find it hard to talk to 0.577</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2: Public should be better prot 0.531 3: Anyone can suffer from mental 0.369</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>283</td>
<td>1: If suffering from Mental hea -0.855 7: The majority of people with -0.676</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4: Would find it hard to talk to -0.434 8: Should have the same rights 0.368</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>125</td>
<td>9: They are largely to blame for 2.369 6: People with mental health pr 0.450</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4: Would find it hard to talk to 0.399 1: If suffering from Mental hea 0.355</td>
<td></td>
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</table>
ANNEX F3 – CORRESPONDENCE ANALYSIS INTERPRETATION

Correspondence Analysis, also known as Brand Mapping, is a technique used to graphically represent the relationships between the row and column elements of a data table (or, in other words, the downbreaks and the crossbreaks). In the case of this research project, brand mapping has been employed to improve our ability to see relationships between the demographics/behavioural breaks on the data tabulations, and the various attitudes towards mental health explored in Q B1, 2, 3, 4 and 6. We also employed Correspondence Analysis to map the 6 vignettes against the 9 situations that might be causing them, in order that we could identify key relationships, both positive and negative, between the vignettes and the situations.

Correspondence Analysis is essentially a data reduction exercise, as it allows us to distil a table containing many relationships to a simple 2 dimensional chart. When examining a data table the natural tendency is to simply look for numbers that stand out, for example the highest and the lowest figures. When put into a map, we can clearly see the relationships that exist between attitudes and demographic or behavioural factors.

In terms of interpretation, attitudes and behaviour/demographic factors that lie close to the centre of the map have ‘average’ profiles. Attitudes and behaviour that lie on the edge of the map have exceptional profiles. Attitudes that lie close to each other have similar profiles across the behavioural/demographic factors and are also likely to be perceived similarly, e.g. in control and happy. And behaviour/demographics that lie close to each other have similar profiles across attitudes.

Using the QB1 map as an example we can understand the relationships between any behaviour factor and attributes by drawing a line through the behavioural factor that passes through the centre point. The closer an attitude is to that line, the more association it has with the behavioural factor. If it is on the same side of the vertical axis as the behavioural factor then it has a positive association with it (i.e. they are saying that the word or phrase in question best describes good mental health for them), and if it is on the opposite side of the vertical axis it has a negative association (i.e. they have not agreed that the word or phrase best describes good mental health for them).

In the case of QB1, using the method above, the map shows that the 75+ group has positive associations with Coping, Tolerant and Resourceful, meaning that they were more likely than any other group to mention that they associated these three things with good mental health, and negative associations with Connected or Challenged, meaning that they were less likely to mention these.

The following pages details the interpretation of each map.
QB1(a) INTERPRETATION

“Here are some words and phrases that people have used to describe good mental health. Which do you think are the five words or phrases that best describe good mental health for you?”

The first thing to point out when examining this map is that there is far less discrimination concerning attitudes towards what words or phrases best describe good mental health by sex or social class than there is by age. This can be seen by the fact that the age groups are spread out over the map along Axis 1, whereas the sex and social grade breaks are mainly clustered around the centre point, indicating that they have average profiles.

Starting in the lower, right hand quartile of the chart, and drawing a line from 16-24 to the centre point, it can be seen that the 16-24 age group are the most likely to associate “Confident”, “Successful”, “Happy” and “In Control” with positive mental health. They are the least likely age group to say that “Resourceful”, “Tolerant” or “Coping” are words or phrases that they associate with positive mental health.

Conversely, it is the 75+ age group that most associates the phrases of “Tolerant”, “Coping” and “Resourceful” with positive mental health. People in this group are far less likely to mention “Challenged” or “Connected/Part of something”.

97
Coping
Successful
Confident
Happy
Loved
Resourceful
Connected/part of something
Healthy
Calm
Understood
Attractive
Challenged
Tolerant
In control
Confident
Successful
Male
Female
Age, Sex, Class

Axis 1 57.7%
Axis 2 12.7%
QB1(b) INTERPRETATION

“Here are some words and phrases that people have used to describe good mental health. Which do you think are the five words or phrases that best describe good mental health for you”?

Those in the “Completely free of stress” group are more likely to positively associate “Resourceful” and “Calm” with good mental health, but less likely to associate it with being “Challenged” whilst those in the “Large amounts of stress” group positively associated good mental health with being “Connected/part of something” and didn’t associate it with being “Healthy”.

Those who are in “Complete control” and also those classified as being under a “Small amount of stress” positively associated good mental health with being “Healthy” but not with the words “Coping” or “Understood”.

Working status also seems to have an effect on attitudes. Those who were “Working”, perhaps not surprisingly, positively associated good mental health with the word “successful” and negatively associated it with “tolerant”, whilst those who were “Not working” held the opposite associations.

Those who were classified as having “Some control” positively associated good mental health with “Coping”.

99
**QB2(a) INTERPRETATION**

“Thinking now about other things which might affect your health, what sorts of things have a positive or good effect on your mental health or well being?”

In terms of other things that have a positive effect on mental health or well being, again, age seems to be the largest discriminatory factor.

Beginning with the younger age group, 16-24 year olds are the most likely to associate “Relationships with friends” and “Leisure activities/social life”, and less likely to associate “Avoiding stress” and “Holidays/Breaks” with positive mental health.

As people become older the things that they associate with positive mental health change. The 25-54 age group were most positively associated with “Having enough money/good income”, and “Relationship with Spouse/Partner”, but negatively associated with “Leisure Activities/Social Life” and “What you eat/Diet”.

The 65-74 age group positively associated completely different things with good mental health, specifically “Good Weather” and “Where you live”, and finally, illustrating the differing priorities and lifestyles for the older age group, the 75+ respondents positively associated good mental health with “Being Healthy” and “Calm” but negatively associated it with “Working” and “Relationship with spouse”.

100
QB2(b) INTERPRETATION

“Thinking now about other things which might affect your health, what sorts of things have a positive or good effect on your mental health or well being?”

Not surprisingly, those who are working positively associated good mental health with working. The opposite is true for those not working.

Those classified as being “Completely free of stress” positively associated good mental health with “What you eat/Diet” and “Being calm”, and negatively associated it with “Having a caring role to others” – also negatively associated with good mental health by those classified as having “Little/No Control”.

QB3(a) INTERPRETATION

“And what, if any, things have a negative or bad effect on your mental health or well being?”

Age and Social Grade both seem to be key discriminators here. Beginning with Social Grade, AB’s most positively associated “Working/Having too much work” and “Stress” with poor mental health, whereas DE’s and 65-74 year olds negatively associated both of these, particularly “Working” with poor mental health.

A social life is important to 16-24 year olds, with a “Poor Social life”, and “Problems with relationships with friends” being associated with poor mental health, in addition to “Not enough money/low income”. Illness is not perceived as an influential factor by this group.

For the 25-34 year age group, they associate “Not having enough money” and “Not working” and “Problems with spouse/partner” with poor mental health, but as with the 16-24 age group, “Illness” is not associated with it.

At the other end of the age scale Illness does become associated with poor mental health, amongst the 55-64, 65-74 and 75+ age groups. All three groups also associate it with “Bad Weather”. Neither of these age groups seem to associate “Not having enough money” with poor mental health.
QB3(b) INTERPRETATION

“And what, if any, things have a negative or bad effect on your mental health or well being?”

Those who are classified as “Completely free of stress” positively associate “Bad weather”, and negatively associate “Too much work” and “Not enough money” with poor mental health. Conversely, those classified as “Large amounts of stress” had the opposite associations, being less likely to associate poor mental health with “bad weather” and more likely to associate it with “not enough money” and “Problems in relationship with spouse/partner”.

Those with “A little/no control” had positive associations with “not working” and negative associations with “lack of sleep”, but this pattern was completely reversed when examining those in “Complete control”.

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QB4a INTERPRETATION

“What would be the three main things that would make the biggest improvement to your own mental health and well being?”

Again, age is the main discriminator here, meaning that the things that would make the biggest improvement to mental health and well being are dependant on the age of the respondents.

Beginning with the younger age groups, 16-24 year olds are more likely to cite “Better relationship with friends”, “More money/higher income”, “Better home” and “To get a job” as things that would make the biggest improvement to their mental health and well being, and less likely to mention “Better health” and “Better health for other person”.

Those aged 25-34 were most likely to mention “More time to myself” and “More money”, but not “Better health”.

Reflecting the lifestage of those aged 35-54, this group positively associated “Less stress”, “Change jobs”, “Less busy”, and “Stop working” as things that would improve their mental health, and negatively associated a “healthier diet”.

As people get older, not surprisingly, health becomes more important. Those aged 65-74 years positively associated with “Better health”, “Transport” and “Less risk from crime”, but negatively associated with “Clear off the debts” and “Better relationship with spouse”.

By the time they are 75+, people positively associate “Better health”, “Access to facilities” and “Less risk from crime” as things that would make the biggest improvement to their mental health, and, as with the 65-74 year age group, don’t associate such things as “Clear off the debts” and “Better relationship with spouse”
QB4b INTERPRETATION

“What would be the three main things that would make the biggest improvement to your own mental health and well being?”

There are two key discriminators here. Firstly, working status. Those who were working were most likely to say that “To stop working” and to “Change jobs” would make the biggest improvement to their mental health. Those not working were more likely to be positively associated with “Better home”, “Local environment” and “Access to facilities”.

Those categorised as being “Completely free of stress” positively associated with “Win lottery”, “Clear debts” and “Healthier diet”, but negatively associated with “Less stress” and “Better relationship with spouse”. The opposite was true for those categorised as having “Large amounts of stress”.

Those with “a little or no control” positively associated with “Better home” and “Get a job”, but were not associated with “Winning lottery” or “Clearing debts”
"Now, if the government in Scotland had to prioritise spending on just three areas that might improve the mental health of the Scottish population, which three from this card do you think are the most important?"

Both age and social grade are discriminatory factors in terms of attitudes towards government spending in this area.

Both social grade AB and 45-54 year olds cited “Improve services” as a government spending priority, and were not likely to mention “support people at difficult times” and “put an end to poverty”.

Interestingly, both 16-24 year olds and those aged 75+ negatively associated with “Help people to understand about mental health”, whereas those aged 35-44 years and social grade C1 cited this as an area that the government should prioritise spending in.

Those in the lower social grades - DE and C2, cited both “Support people at difficult times” and “Help put an end to poverty” as areas that needed financing, but were less likely to cite “Improve services”.

Respondents aged 65-74 years also felt that to “Support people at difficult times” was an important area for government spending, but they also were not likely to cite “Improve services”
“Now, if the government in Scotland had to prioritise spending on just three areas that might improve the mental health of the Scottish population, which three from this card do you think are the most important?”

Those “Completely free of stress” were most likely to mention “End to discrimination” and “End to poverty” as priorities for government spending, and not to mention “Help people to understand about mental health”.

Those with “Little or no control” positively associated with “Improve trust and respect” and “Support people at difficult times” but this pattern was reversed for those with “Some control”.

Finally, those categorised as being under “Large amounts of stress” were most likely to quote “Supporting people at difficult times”, but not to associate with “Put an end to poverty”
ATTITUDES TO VIGNETTES

Vignette 1 and 2 – Male and Female Depression

Both of these vignettes are positively associated with “Physical Illness”, “Stressful or disturbing events” and “Abuse suffered as a child”.

Factors less associated with depression include “Own character or personality” and to a lesser extent, “The way they were brought up”.

Vignette 3 and 4 – Male and Female Schizophrenia

The schizophrenia vignettes were strongly associated with “Chemical imbalance in the brain” and “Genetic or inherited problems”, but was negatively associated with both “Physical illness” and “Own fault”.

Vignette 5 and 6 – Male and Female Stress

Male and female stress are both positively associated with “Own fault” and “Own character or personality”, but negatively associated with “Chemical imbalance in the brain”, “Genetic or inherited problems” and “Abuse suffered as a child”.

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Well? What do you think?
A National Scottish Survey of Public Attitudes to Mental Health, Well Being and Mental Health Problems