



Attitudes to Mental Illness 2010 Research Report

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1. Summary

1.1 Introduction

This report presents the findings of a survey of attitudes towards mental illness among adults in England. Questions on this topic have been asked as part of TNS's face-to-face Omnibus since 1994. Surveys were initially carried out annually, then every three years from 1997-2003. Surveys have again been carried out annually since 2007.

The aim of these surveys is to monitor public attitudes towards mental illness, and to track changes over time.

1,745 adults (aged 16+) were interviewed in England in January 2010.

The questionnaire included a number of statements about mental illness. They covered a wide range of issues from attitudes towards people with mental illness, to opinions on services for people with mental health problems. Respondents were asked to indicate how much they agreed or disagreed with each statement.

Other questions covered descriptions of people with mental illness, relationships with people with mental health problems, personal experience of mental illness, likelihood of going to a GP with a mental health problem, talking to friends, family and employers about mental health problems, and perceptions of mental health-related stigma and discrimination.

For analysis purposes the attitude statements were grouped into four themes – Fear and exclusion of people with mental illness; Understanding and tolerance of mental illness; Integrating people with mental illness into the community; and Causes of mental illness and the need for special services.

1.2 Changes since 2009

There were several changes between 2009 and 2010:

- Opinions on some statements changed towards greater tolerance:
 - 'Locating mental health facilities in a residential area downgrades the neighbourhood' - % agreeing decreased from 21% to 18%.

- 'I would not want to live next door to someone who has been mentally ill' - % agreeing decreased from 11% to 9%.
 - 'Increased spending on mental health services is a waste of money' - % disagreeing increased from 83% to 87%.
- Opinions moved more in favour of integrating people with mental illness into the community:
 - 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' - % agreeing increased from 62% to 66%.
 - 'No-one has the right to exclude people with mental illness from their neighbourhood' - % agreeing increased from 79% to 84%.
 - On one item though, opinions moved less in favour of integration:
 - 'Mental hospitals are an outdated means of treating people with mental illness' - % agreeing fell from 37% in 2009 to 33% in 2010.
 - Agreement that one of the main causes of mental illness is a lack of self-discipline and will-power decreased from 18% in 2009 to 15% in 2010.
 - A higher proportion of respondents selected the following descriptions to indicate which they felt usually describe a person who is mentally ill:
 - Someone who has serious bouts of depression – from 54% to 58%
 - Someone who has to be kept in a psychiatric or mental hospital – from 52% to 57%
 - Someone who is incapable of making simple decisions about his or her own life – from 32% to 38%.
 - The percentage of respondents correctly stating that the proportion of people who would have a mental health problem at some point in their lives is 1 in 4, increased from 13% in 2009 to 16% in 2010.

1.3 Fear and exclusion of people with mental illness

- This section included a range of negative statements about people with mental illness. Overall the levels of agreement with these statements were low.

- The highest levels of agreement were with the statements ‘Anyone with a history of mental illness should be excluded from taking public office’ (20% agreed) and ‘As soon as a person shows signs of mental disturbance, he should be hospitalized’ (20% agreed).
- Acceptance of people with mental illness taking public office and being given responsibility has grown since 1994 – the proportion agreeing that ‘Anyone with a history of mental health problems should be excluded from taking public office’ decreased from 29% in 1994 to 20% in 2010, while agreement that ‘People with mental illness should not be given any responsibility’ fell from 17% to 12% over the same period.

1.4 Understanding and tolerance of people with mental illness

- Levels of understanding and tolerance of people with mental illness were generally high. The proportion of respondents with understanding attitudes on these statements ranged from 78% agreeing that ‘People with mental illness have for too long been the subject of ridicule’ to 93% for ‘We have a responsibility to provide the best possible care for people with mental illness’.
- Since 1994, the proportion of respondents voicing more tolerant opinions on several of these statements has decreased – for example, agreement that ‘We need to adopt a more tolerant attitude towards people with mental illness’ fell from 92% in 1994 to 87% in 2010.

1.5 Integrating people with mental illness into the community

- Levels of agreement with several of the statements in this section were high:
 - 84% agreed that ‘No-one has the right to exclude people with mental illness from their neighbourhood’
 - 80% agreed that ‘The best therapy for many people with mental illness is to be part of a normal community’
 - 78% agreed that ‘Mental illness is an illness like any other’
 - 75% agreed that ‘People with mental health problems should have the same rights to a job as anyone else’.
- There was far less agreement that ‘Most women who were once patients in a mental hospital can be trusted as babysitters’ (26% agree), ‘Less emphasis should be placed on protecting the public from people with mental illness’ (34% agree) and ‘Mental hospitals are an outdated means of treating people with mental illness’ (33% agree).

- Attitudes to several of the statements in this section were significantly more positive in 2010 than they were in 1994:
 - 'The best therapy for many people with mental illness is to be part of a normal community' – agreement has increased from 76% in 1994 to 80% in 2010
 - 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' – agreement has increased from 62% in 1994 to 66% in 2010
 - 'Most women who were once patients in a mental hospital can be trusted as babysitters' – agreement has increased from 21% in 1994 to 26% in 2010
 - 'Mental illness is an illness like any other' – agreement has increased from 71% in 1994 to 78% in 2010
 - 'No-one has the right to exclude people with mental illness from their neighbourhood' – agreement increased from 76% in 1994 to 84% in 2010.

- Attitudes towards mental illness were significantly more positive in 2010 than in 2009 for two statements in this section:
 - 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' - % agreeing increased from 62% in 2009 to 66% in 2010
 - 'No-one has the right to exclude people with mental illness from their neighbourhood' - % agreeing increased from 79% in 2009 to 84% in 2010.

- On one statement, 'Mental hospitals are an outdated means of treating people with mental illness' – agreement decreased from 42% in 1994 to 33% in 2010.

1.6 Causes of mental illness and the need for special services

- Since 1994 there has been a steady increase in the proportion agreeing that there are sufficient existing services for people with mental illness, from 11% in 1994 to 23% in 2010.
- The proportion agreeing that 'there is something about people with mental illness that makes it easy to tell them from normal people' decreased fairly steadily from 29% in 1994 to 19% in 2010.

- Agreement that one of the main causes of mental illness is a lack of self-discipline and will-power stood at 15% in 2010, the same as in 1994, although there was a significant decrease from 18% in 2009 to 15% in 2010.

1.7 Difference in opinions by age, sex and social grade

- Opinions among respondents of different age, sex and social grade groups were examined.
- Women tended to be more tolerant towards mental illness than men.
- Respondents in the DE (semi-/unskilled manual occupations) groups tended to be more negative towards mental illness than those in the AB (professional/managerial occupations) groups.
- The older age group (aged 55+) tended to have more negative attitudes towards mental illness in respect of the statements about fear and exclusion of people with mental illness. However, in respect of understanding and tolerance of people with mental illness, the youngest group (16-34s) were least tolerant. The youngest group were also more negative towards mental illness when considering the causes of mental illness and the need for special services.
- Similar patterns of responses by age, sex and social grade were observed in earlier years of the survey.

1.8 Ways of describing someone who is mentally ill

- Respondents were presented with a list of descriptions and were asked to indicate which they felt usually describes a person who is mentally ill. Comparisons on these questions are only possible from the 2003 survey onwards.
- The description most likely to be selected was 'someone who is suffering from schizophrenia' – 64% selected this in 2010.
- The next most often selected were 'someone who has serious bouts of depression' (58%) and 'someone who has a split personality' (57%).
- The descriptions least likely to be selected were 'someone who is incapable of making simple decisions about his or her own life' at 38%, and 'someone who is prone to violence' at 36%.
- There were significant increases from 2003 to 2010 in the proportions selecting several of these descriptions:
 - Someone who is suffering from schizophrenia – from 56% to 64%

- Someone who has to be kept in a psychiatric or mental hospital – from 47% to 57%
- Someone who has a split personality – from 53% to 57%
- Someone who is incapable of making simple decisions – from 32% to 38%
- Someone prone to violence – from 29% to 36%.
- The proportion selecting several of these descriptions increased significantly from 2009 to 2010, reversing decreases seen between 2008 and 2009:
 - Someone who has serious bouts of depression – from 54% to 58%
 - Someone who has to be kept in a psychiatric or mental hospital – from 52% to 57%
 - Someone who is incapable of making simple decisions about his or her own life – from 32% to 38%.

1.9 Types of mental illness

- Respondents were asked to say to what extent they agreed that depression, stress, schizophrenia, bipolar disorder (manic depression), drug addiction and grief are types of mental illness.
- Nearly nine out of ten respondents recognised schizophrenia as a mental illness, as did over eight out of ten for bipolar disorder and depression.
- The lowest proportion was for drug addiction, although 44% of respondents agreed that this was a type of mental illness.
- There were no significant differences between 2009 and 2010.

1.10 Attitudes to people with mental illness

- There was a high level of agreement that mental health problems can be treated, with around eight out of ten respondents agreeing that psychotherapy and medication can be effective treatments for people with mental health problems.
- 69% agreed that most people with mental health problems want to have paid employment.
- 61% agreed that 'If a friend had a mental health problem, I know what advice to give them to get professional help'.
- Three out of five respondents agreed that people with severe mental health problems can fully recover.

- Opinion on whether most people with mental health problems go to a healthcare professional to get help was more mixed, with 54% agreeing.
- There were no significant differences between 2009 and 2010.

1.11 Personal experience of mental illness

- Around a third of respondents said they currently or ever had a close friend with a mental health problem.
- 16% said they currently or had ever lived with someone with a mental health problem.
- Over four-fifths agreed that in future they would be willing to continue a relationship with a friend who developed a mental health problem. Around seven out of ten would be willing to live nearby to or work with someone with a mental health problem. Future willingness to live with someone with a mental health problem was lower at 58%.
- 56% of respondents mentioned that someone close to them (family, friend or themselves) had experienced some kind of mental illness. This was most commonly a friend (16%) or a member of their immediate family (15%).
- Respondents tended to underestimate the proportion of people who would have a mental health problem at some point in their lives. The proportion of respondents correctly stating 1 in 4 increased from 13% in 2009 to 16% in 2010. The largest group of respondents (24%) thought the proportion was 1 in 10, with 42% of respondents thinking it was less than this.
- Eight out of ten respondents said they would be likely to go to their GP for help, if they felt that they had a mental health problem.
- Over two-thirds of respondents said they would be comfortable talking to a friend or family member about their mental health, for example, telling them they had a mental health diagnosis and how it affects them.
- Respondents were far less likely to say they would feel comfortable talking to an employer than to friends and family – 39% would feel comfortable talking to an employer, compared with 69% who would feel comfortable talking to friends and family.

1.12 Mental health-related stigma and discrimination

- Nearly nine out of ten respondents said that people with mental illness experience stigma and discrimination. Around a half (51%) said they

experience a lot of discrimination, and a further 36% that they experience a little discrimination.

- Around a half of respondents (48%) said that mental health-related stigma and discrimination has not changed in the past year.
- Among the 32% who thought that discrimination had changed, opinion was fairly evenly divided on whether it had gone up or gone down, with 15% saying discrimination has increased, and 17% that it has decreased.

2. Introduction

Since March 1993 the Department of Health has placed a set of questions on TNS's Face-to-Face Consumer Omnibus. From 1993 to 1997 the questions were asked annually, then every third year until 2003. The survey has been repeated annually since 2007, under management of Shift. These surveys act as a tracking mechanism and in this report the most recent results are compared with those from previous years.

The sample size for the earlier surveys was c. 2,000 adults, selected to be representative of adults in Great Britain, using a random location sampling methodology. The 1996 and 1997 surveys had larger samples of c. 6,000 adults in each. Since 2007 the sample base has been England rather than Great Britain, with c. 1,700 adults interviewed. For the 2010 survey, 1,745 adults in England were interviewed. In order to provide direct comparisons over time, the results from the earlier surveys were re-calculated to be based on England only. However the data for the 1993 survey was not available and so this report includes data from surveys since 1994 only.

Interviews were carried out face-to-face by 149 fully trained interviewers using Computer-Assisted Personal Interviewing (CAPI), and were carried out in respondents' homes. Interviewing took place between January 20th-24th inclusive.

Data were weighted to be representative of the target population by age, gender and working status.

Respondents in these surveys were presented with a number of statements about mental illness. They covered a wide range of issues from attitudes towards people with mental illness, to opinions on services provided for people with mental health problems. Respondents gave their answers using five point Likert scales to indicate how much they agreed or disagreed with each of the statements. The statements used originated in local studies based in Toronto and the West Midlands. The core of the questionnaire has remained the same for all surveys in this series. Over time a number of other questions have been added, including questions about personal experience of mental illness and descriptions of people with mental illness. Some new questions were added in 2009 to tie in with the evaluation of the 'Time to

Change' anti-discrimination campaign, by the Institute of Psychiatry. Some additional questions, on perceptions of stigma and discrimination, were added in 2010.

To summarise, sections in the survey, and the years in they were first included, are as follows:

- Attitudes towards mental illness – 1993
- Descriptions of a person with mental illness – 1997 (revised in 2003)
- Relationships with people with mental health problems – 2009
- Attitudes to people with mental health problems – 2009
- Types of mental illness – 2009
- Person closest to respondent who has had mental illness – 1994 (revised in 2009)
- Proportion of people who may have a mental health problem – 2003
- Consulting a GP about a mental health problem – 2009
- Talking to friends and family about mental health – 2009
- Talking to an employer about mental health – 2010
- Mental health-related stigma and discrimination – 2010.

The attitude statements in this report are reported as the proportions 'agreeing' or 'disagreeing'. The 'agree' category combines the responses 'Agree strongly' and 'Agree slightly'. The 'disagree' category combines the responses 'Disagree strongly' and 'Disagree slightly'.

Detailed tabulations of all questions have been provided in a separate volume, available via Robert Westhead at Shift – robert.westhead@nmhdu.org.uk.

Full details of the survey methodology are given in Appendix I. A copy of the questionnaire is included in Appendix II.

Where findings are reported as 'significant' in the following chapters in this report this always means that the findings were statistically significant at the 95% confidence level or higher. Commentary is made only on differences which were statistically significant. All the differences reported in the Summary were statistically significant at the 95% confidence level or higher. If a finding is statistically significant we can be 95% confident that differences reported are real rather than occurring just by chance. Significance of differences has been tested using the two-tailed t-test for independent

samples. The whole percentages shown in the report are usually rounded, but the significance tests have been carried out on the true percentages. This means that a difference in the report of say 3 percentage points may be significant in some cases but not in others, depending on the effect of rounding.

3. Attitudes to mental illness

3.1 Determining the factors

In order to group the 27 attitude statements for analysis purposes, a factor analysis was carried out on the 2008 survey. This is a statistical analysis which examines correlations between items in order to group the items into themes or factors. The factor analysis identified four factors. Full details of the analysis are included in the 2008 survey report¹.

The factors have been labelled based on the main themes of the statements:

- Factor 1 – Fear and exclusion of people with mental illness
- Factor 2 – Understanding and tolerance of mental illness
- Factor 3 – Integrating people with mental illness into the community
- Factor 4 – Causes of mental illness and the need for special services.

In the sections that follow, statements are grouped in these factors for analysis purposes.

3.2 Fear and exclusion of people with mental illness

3.2.1 Introduction

Statements analysed in this section are those which make up the first factor, comprising negative attitudes towards people with mental illness, which are categorised as representing fear of people with mental illness, and desire to exclude them from mainstream society.

These statements have all been included in each wave of the survey since 1994.

The statements covered in this section are:

- Locating mental health facilities in a residential area downgrades the neighbourhood
- It is frightening to think of people with mental problems living in residential neighbourhoods
- I would not want to live next door to someone who has been mentally ill

¹ Attitudes to Mental Illness 2008 Research Report, TNS UK for the Care Services Improvement Partnership, Department of Health 2008.

- A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered
- Anyone with a history of mental problems should be excluded from taking public office
- People with mental illness should not be given any responsibility
- People with mental illness are a burden on society
- As soon as a person shows signs of mental disturbance, he should be hospitalized

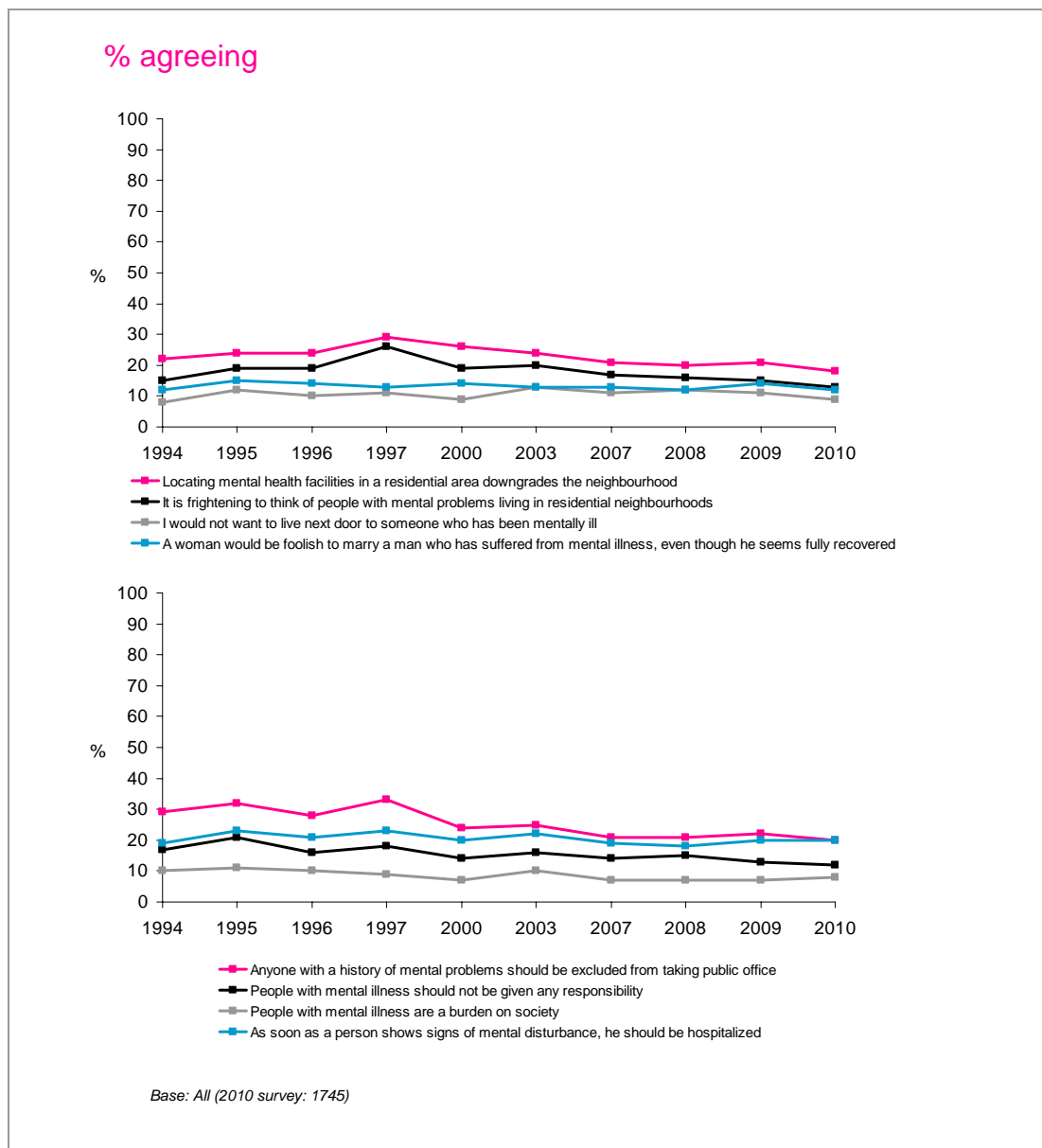
Analysis in this section focuses on the percentage of respondents agreeing with each of these statements.

3.2.2 Trends over time

Figure 1 shows the levels of agreement with these statements from 1994 to 2010.

Overall, the levels of agreement with these negative statements about people with mental illness were low, ranging in 2010 from 8% to 20%. The highest levels of agreement in 2010 were with the statements 'Anyone with a history of mental illness should be excluded from taking public office' (20%) and 'As soon as a person shows signs of mental disturbance, he should be hospitalized' (20%) (Figure 1).

Figure 1 Fear and exclusion of people with mental illness, 1994-2010



Levels of agreement with several of these negative statements has fallen since 1994. In particular, the proportion saying that locating mental health facilities in a residential area down grades the neighbourhood decreased from 22% in 1994 to 18% in 2010. The proportion agreeing that ‘It is frightening to think of people with mental health problems living in residential neighbourhoods’ has also fallen, from 15% in 1994 to 13% in 2010. Acceptance of people with mental illness taking public office and being give responsibility has grown – the proportion agreeing that ‘Anyone with a history of mental problems should be excluded from taking public office’ decreased from 29% in 1994 to 20% in 2010, while the proportion agreeing that ‘People with mental illness

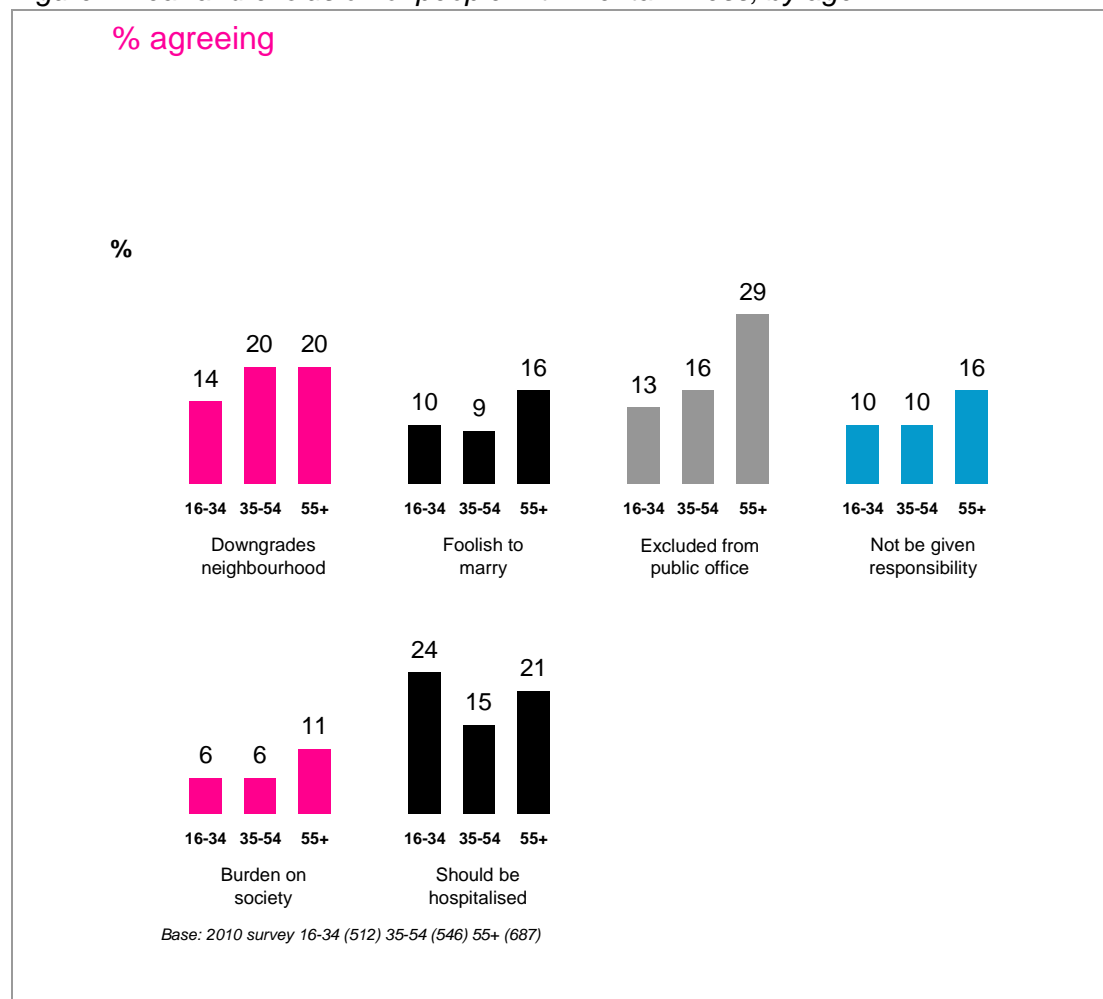
should not be given any responsibility' decreased from 17% to 12% over the same period.

Since 2009, agreement that 'Locating mental health facilities in a residential area downgrades the neighbourhood' decreased from 21% to 18%. The proportion agreeing that they would not want to live next door to someone who has been mentally ill decreased from 11% in 2009 to 9% in 2010.

3.2.3 Differences by age, sex and social grade

Looking at the three age groups 16-34, 35-54 and 55+, there were significant differences by age group in agreement with several of these statements in 2010 (Figure 2). Statements from this section where there were no significant differences by age group are not shown on the chart.

Figure 2 Fear and exclusion of people with mental illness, by age



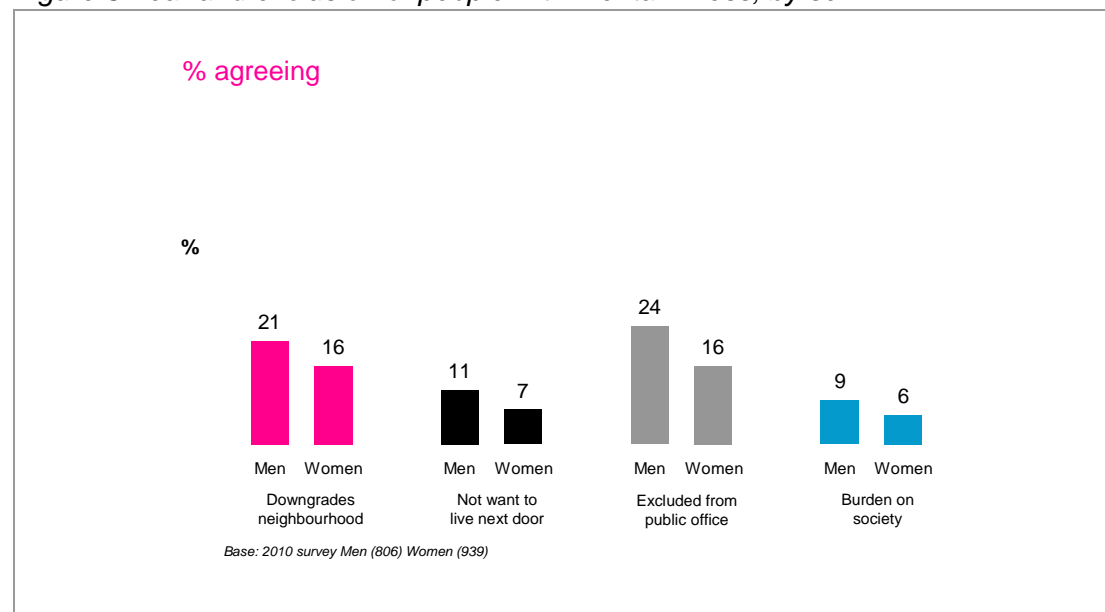
In general the oldest group (age 55+) had the most negative attitudes towards people with mental illness, being significantly more likely than younger groups to agree that a woman would be foolish to marry a man who has suffered from mental illness, that anyone with a history of mental illness should be excluded from public office, that people with mental illness should not be given any responsibility, and that people with mental illness are a burden on society.

Those aged 16-34 were less likely than the older groups to say that locating mental health facilities in a residential area downgrades the neighbourhood.

Those aged 35-54 were least likely to agree that as soon as a person shows signs of mental disturbance, he should be hospitalised.

Statements in this section where there was a significant difference in 2010 between men and women in the proportion agreeing are shown in Figure 3.

Figure 3 Fear and exclusion of people with mental illness, by sex



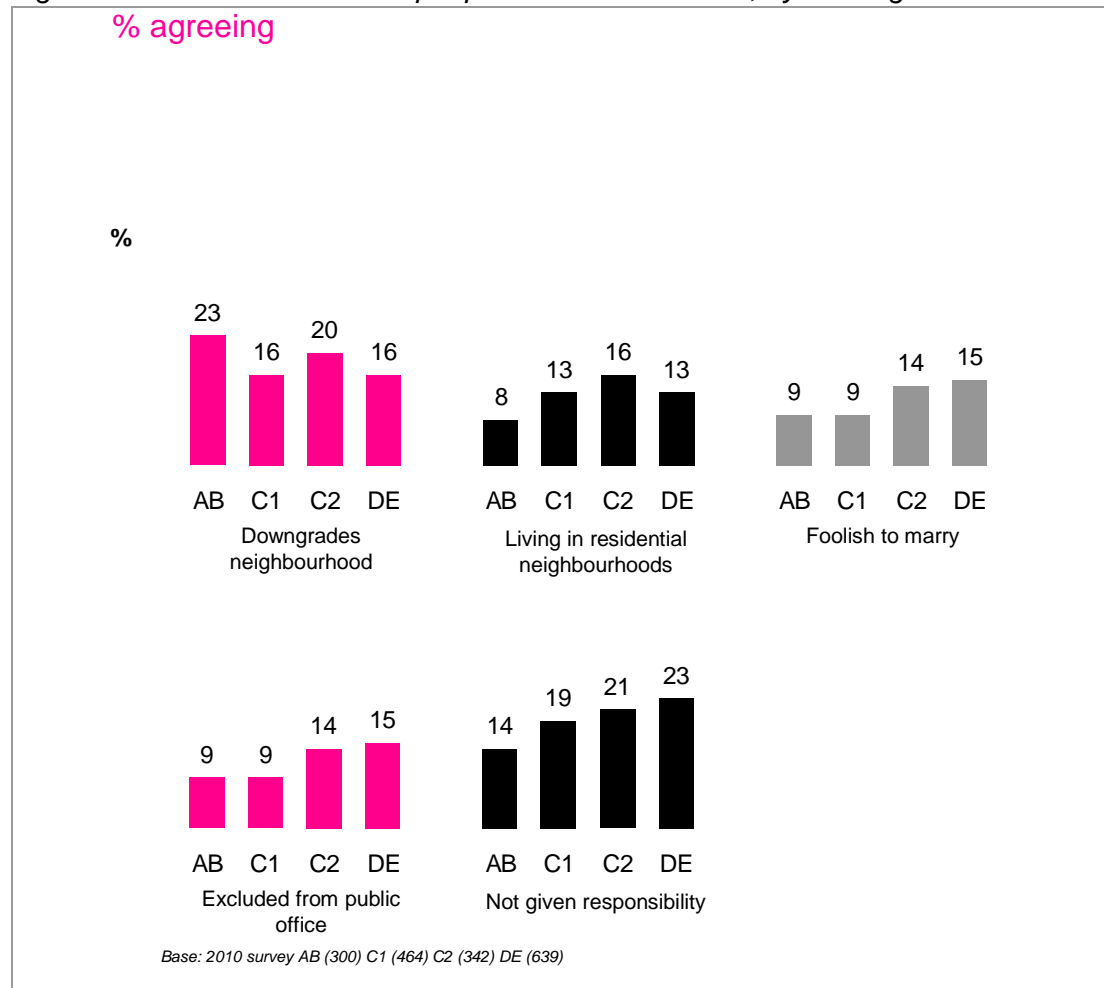
Where there was a difference between men and women, women were less negative towards people with mental illness.

Women were less likely than men to agree that locating mental health facilities in a residential area downgrades the neighbourhood, that they would not want to live next door to someone with mental illness, that people with mental illness should be

excluded from public office, and that people with mental illness are a burden on society.

Figure 4 shows differences by social grade in 2010 for those statements in this section for which there were any significant differences.

Figure 4 Fear and exclusion of people with mental illness, by social grade



In several of these statements, respondents in the C1, C2 and DE social grades were more negative towards people with mental illness than those in the AB group.

Respondents in the C1, C2 and DE groups were significantly more likely than ABs to agree that it is frightening to think of people with mental health problems living in residential neighbourhoods, and that people with mental health problems should not be given any responsibility.

Respondents in the C2 and DE groups were more likely than ABs and C1s to agree a woman would be foolish to marry a man who has suffered from mental illness, and that people with mental health problems should be excluded from public office.

In contrast, AB respondents were more likely than the other groups to agree that locating mental health facilities in a residential area downgrades the neighbourhood.

3.3 Understanding and tolerance of mental illness

3.3.1 Introduction

Statements included in this section are those which make up the second factor, characterised as representing understanding and tolerance of mental illness. These statements have all been included in each survey since 1994.

Analysis in this section focuses on the understanding/tolerance dimension of each statement. For some statements this is the percentage agreeing, for others it is the percentage disagreeing. This is indicated for each statement in the list below.

The statements included are:

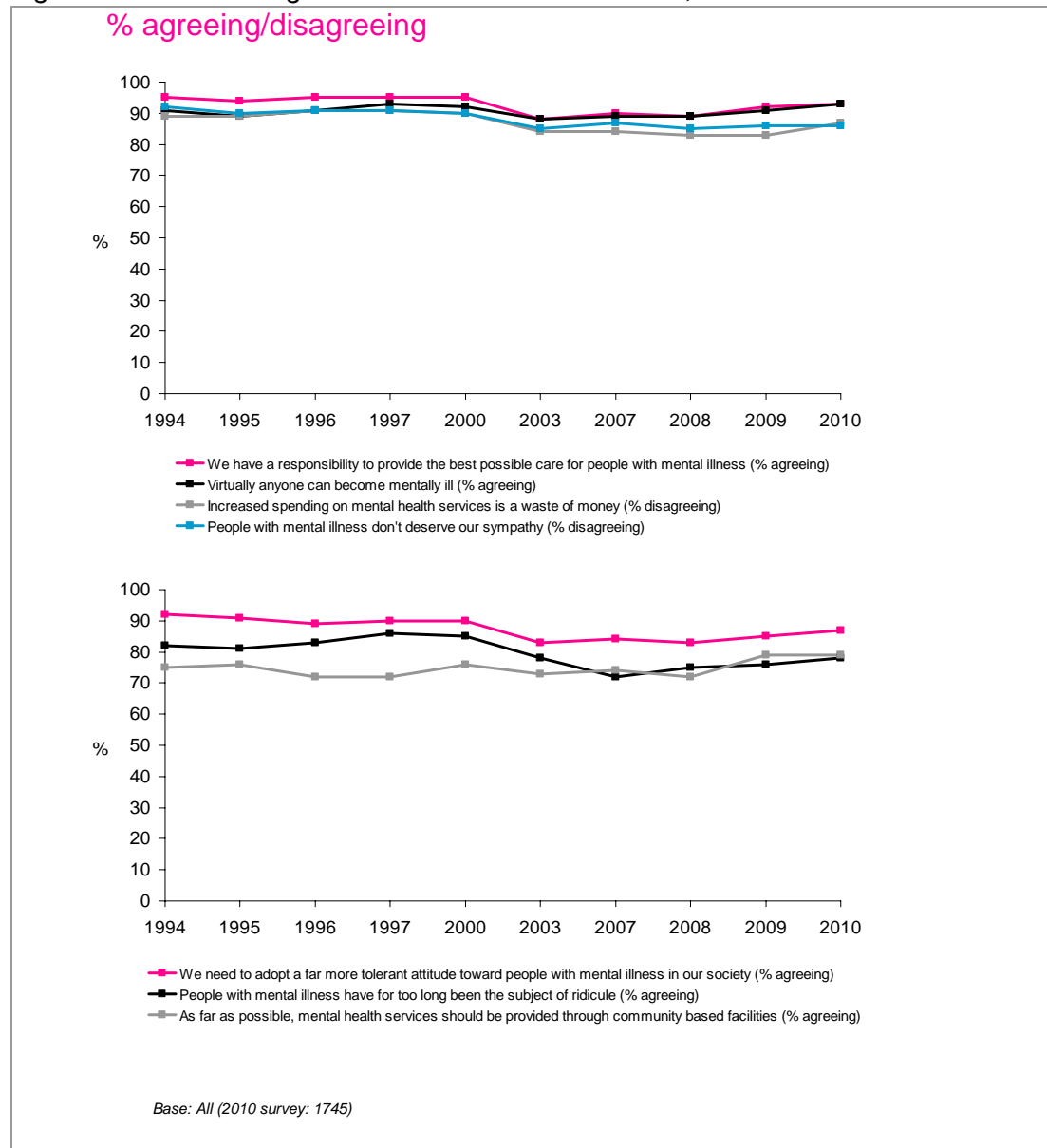
- We have a responsibility to provide the best possible care for people with mental illness (*% agreeing*)
- Virtually anyone can become mentally ill (*% agreeing*)
- Increased spending on mental health services is a waste of money (*% disagreeing*)
- People with mental illness don't deserve our sympathy (*% disagreeing*)
- We need to adopt a far more tolerant attitude toward people with mental illness in our society (*% agreeing*)
- People with mental illness have for too long been the subject of ridicule (*% agreeing*)
- As far as possible, mental health services should be provided through community based facilities (*% agreeing*)

3.3.2 Trends over time

Levels of understanding and tolerance of mental illness were generally high. The proportions of respondents with understanding attitudes on these statements ranged in 2009 from 78% for 'People with mental illness have for too long been the subject of

ridicule' to 93% for 'We have a responsibility to provide the best possible care' and 'Virtually anyone can become mentally ill' (Figure 5).

Figure 5 Understanding and tolerance of mental illness, 1994-2010



Since 1994, the proportion of respondents voicing more tolerant opinions on several of these statements has decreased. The proportion disagreeing that 'People with mental illness don't deserve our sympathy' fell from 92% in 2004 to 86% in 2010. The proportion disagreeing that 'Increased spending on mental health services is a waste of money' also fell, from 89% in 1994 to 87% in 2010. Agreement that we need to adopt a more tolerant attitude towards people with mental illness fell from 92% in 1994 to 87% in 2010, and agreement that 'People with mental illness have for too long been the subject of ridicule' decreased from 82% in 1994 to 78% in 2010.

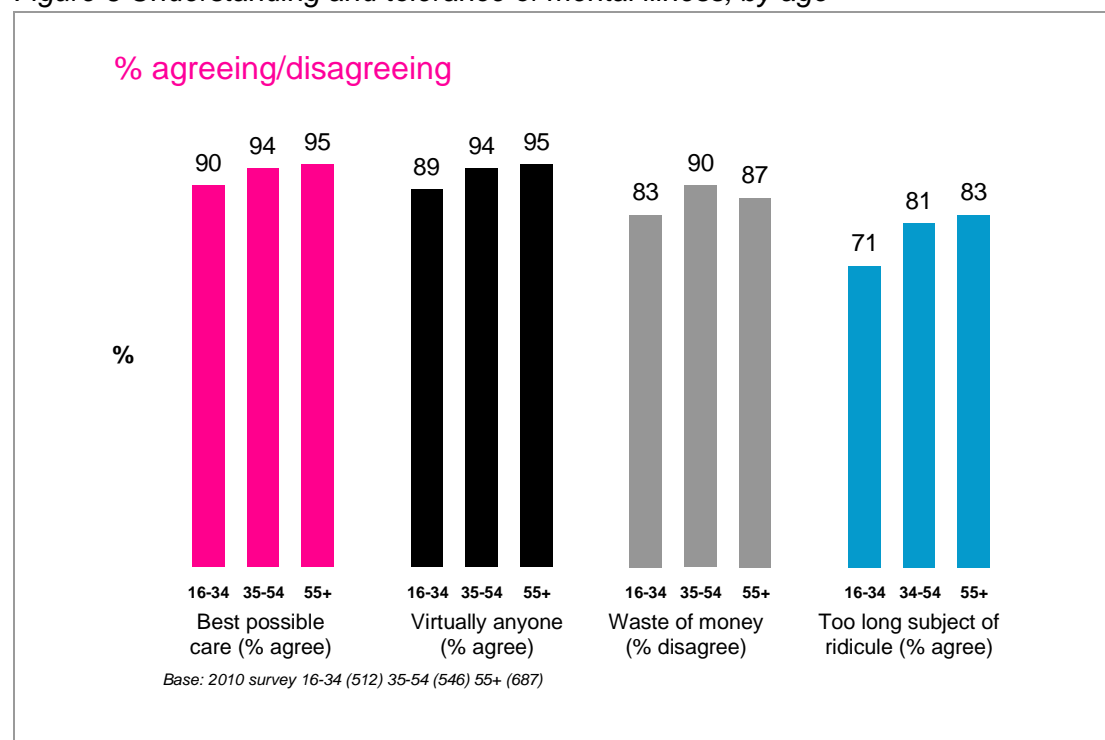
In contrast to this, an indicator of increased tolerance is that the proportion agreeing that virtually anyone can become mentally ill increased from 91% to 93%, and agreement that mental health services should be provided through community-based facilities increased from 75% to 79%, from 1994 to 2010.

There has been a significant change in attitudes between 2009 and 2010 in only one statement in this section – ‘Increased spending on mental health services is a waste of money’ – the proportion disagreeing with this statement increased from 83% in 2009 to 87% in 2010 (although in the context of a decrease since 1994 overall).

3.3.3 Differences by age, sex and social grade

There were significant differences by age group in 2010 for four of the statements in this section (Figure 6).

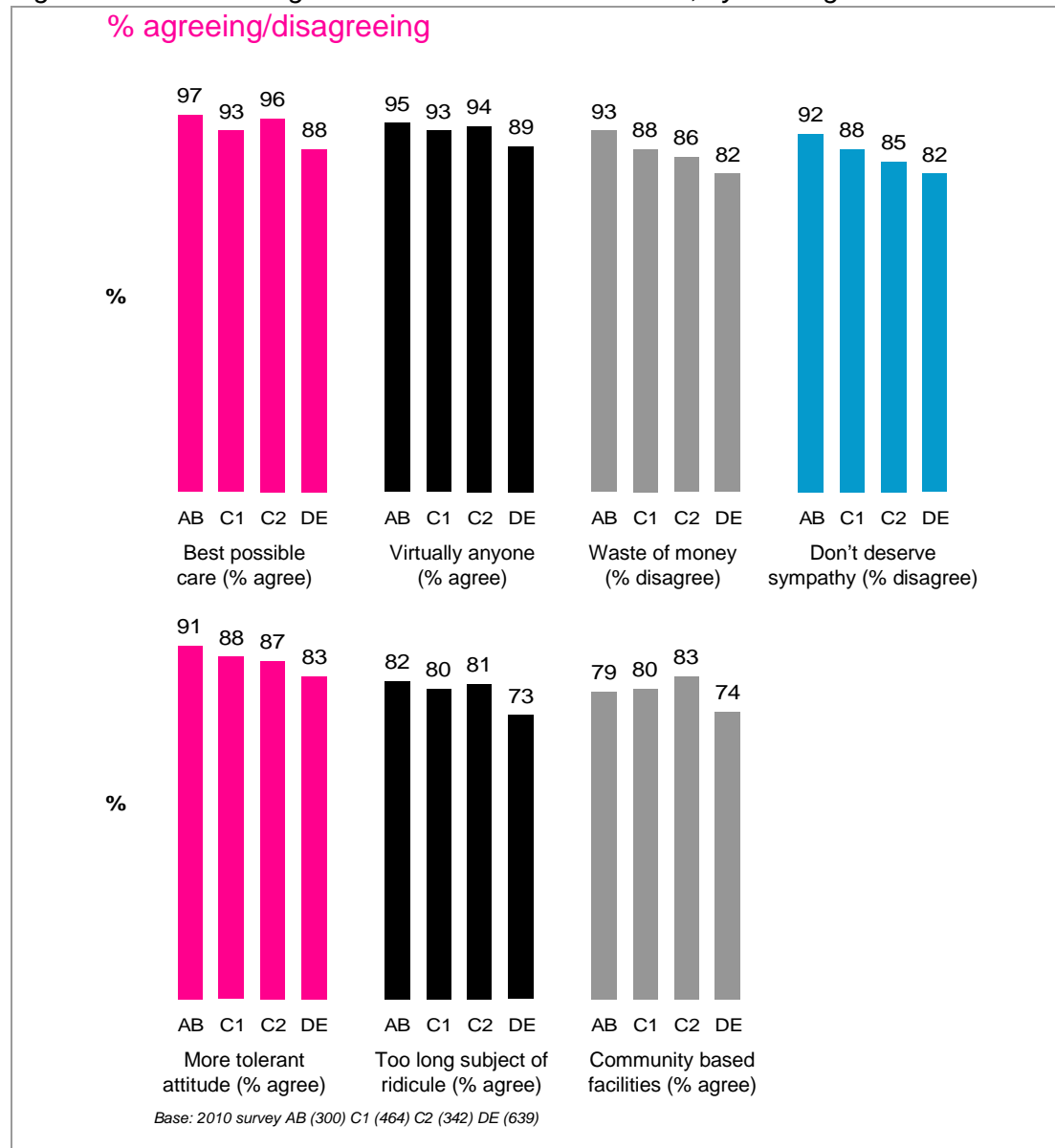
Figure 6 Understanding and tolerance of mental illness, by age



As Figure 6 shows, the youngest age group (16-34) were significantly less likely than the 35-54 and 55+ groups to have understanding/tolerant attitudes on these four statements. There were no significant differences between the 34-54 and 55+ age groups.

Looking at social grade, there were significant differences by social grade in 2010 for all of the statements in this section (Figure 7).

Figure 7 Understanding and tolerance of mental illness, by social grade



In general, respondents in the DE group were less likely than other groups to adopt understanding/tolerant attitudes towards mental illness for most of these statements.

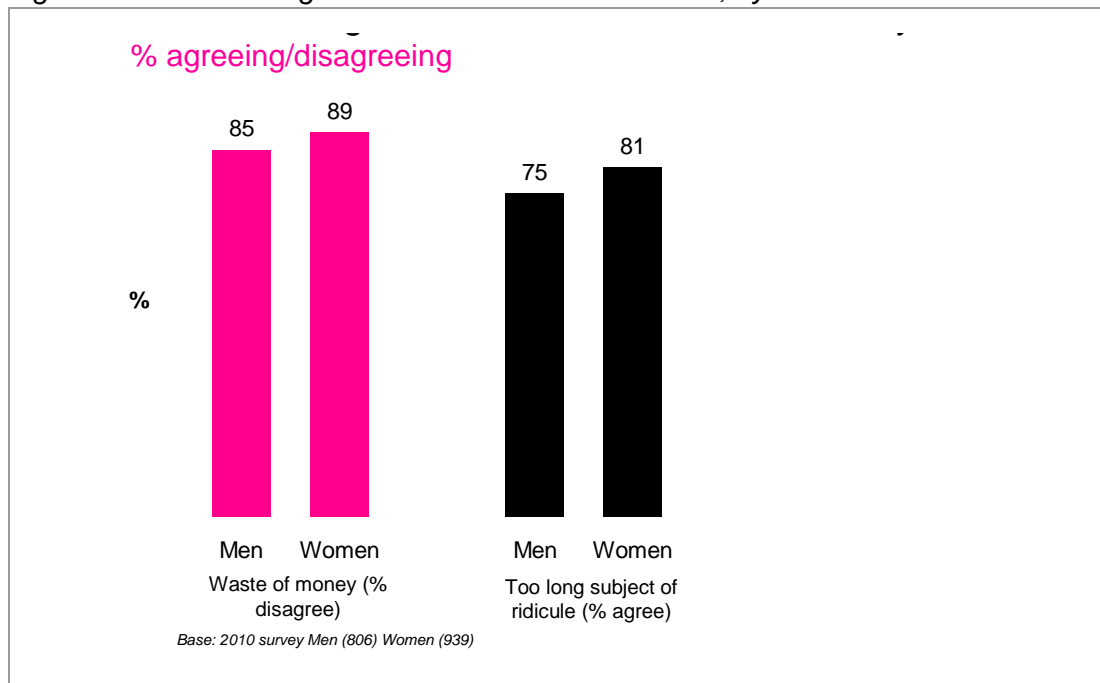
Significant differences by social grade were:

- ABs, C1s and C2s were more likely than DEs to agree that we have a responsibility to provide the best possible care. ABs and C2s were also more likely than C1s to say this

- ABs, C1s and C2s were more likely than DEs to agree that virtually anyone can become mentally ill
- ABs were more likely than C1s, C2s and DEs to disagree that increased spending on mental health services is a waste of money. C1s were also more likely than DEs to disagree with this statement
- ABs and C1s were more likely than DEs to disagree that people with mental illness don't deserve sympathy. ABs were also more likely than C2s to disagree with this
- ABs and C1s were more likely than DEs to agree that we need to adopt a more tolerant attitude towards people with mental illness
- ABs, C1s and C2s were more likely than DEs to agree that people with mental illness have for too long been the subject of ridicule
- C2s were more likely than DEs to agree that mental health services should be community based.

There were differences between men and women in their attitudes to two statements in this section, with women again displaying more tolerant attitudes (Figure 8).

Figure 8 Understanding and tolerance of mental illness, by sex



3.4 Integrating people with mental illness into the community

3.4.1 Introduction

This section includes statements which make up the third factor, which has the general theme of integrating people with mental illness into the community.

The statements included are:

- People with mental illness are far less of a danger than most people suppose
- Less emphasis should be placed on protecting the public from people with mental illness
- The best therapy for many people with mental illness is to be part of a normal community
- Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services
- People with mental health problems should have the same rights to a job as anyone else
- Most women who were once patients in a mental hospital can be trusted as babysitters
- Mental illness is an illness like any other
- No-one has the right to exclude people with mental illness from their neighbourhood
- Mental hospitals are an outdated means of treating people with mental illness.

Analysis of these statements is based on the proportions of respondents agreeing with each.

With the exception of 'People with mental health problems should have the same rights to a job as anyone else', which was first asked in 2003, the statements have been included in all years of the survey.

3.4.2 Trends over time

Figure 9 shows the proportions of respondents agreeing with these statements since 1994.

Opinions on integrating people with mental illness into the community were mixed. Levels of agreement with several of the statements in this section were high, for

example in 2010 84% agreed that 'No-one has the right to exclude people with mental illness from their neighbourhood' and 80% that 'The best therapy for many people with mental illness is to be part of a normal community'; 78% agreed that 'Mental illness is an illness like any other'; 75% agreed that 'People with mental health problems should have the same rights to a job as anyone else'.

However respondents were far less likely to agree that 'Most women who were once patients in a mental hospital can be trusted as babysitters' (26% agree), 'Less emphasis should be placed on protecting the public from people with mental illness' (34% agree) and 'Mental hospitals are an outdated means of treating people with mental illness' (33% agree).

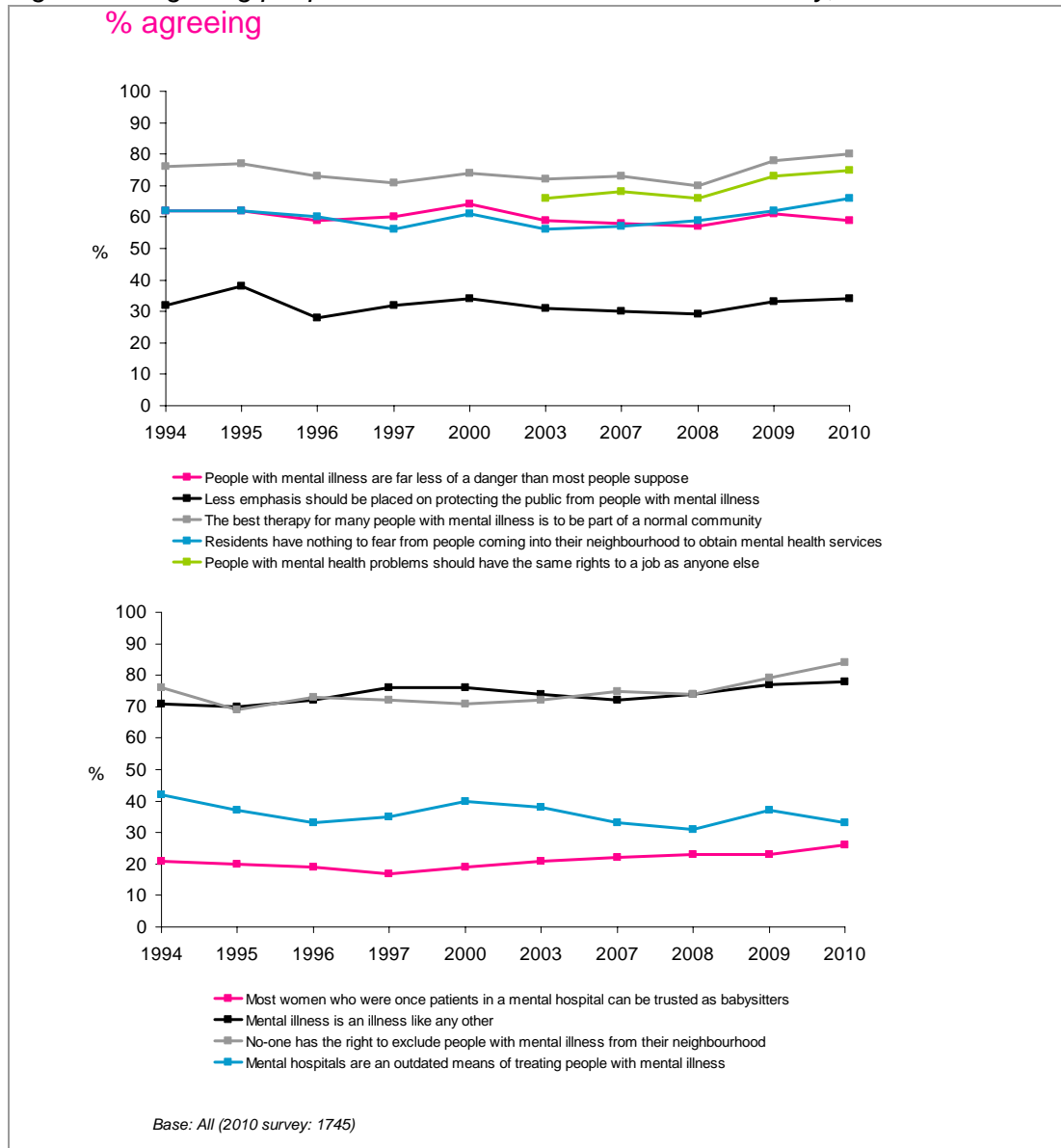
The other two statements in this section fell between these two extremes, with 66% of respondents agreeing that 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' and 59% that 'People with mental illness are far less of a danger than most people suppose'.

Attitudes towards mental illness were significantly more positive in 2010 than in 2009 for two statements in this section:

- 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' - % agreeing increased from 62% in 2009 to 66% in 2010
- 'No-one has the right to exclude people with mental illness from their neighbourhood' - % agreeing increased from 79% in 2009 to 84% in 2010.

For one statement, 'Mental hospitals are an outdated means of treating people with mental illness', agreement fell from 37% in 2009 to 33% in 2010, a return towards the 2008 level of 31%.

Figure 9 Integrating people with mental illness into the community, 1994-2010



Looking at changes since 1994, attitudes to several of the statements in this section are significantly more positive in 2010 than they were in 1994:

- 'The best therapy for many people with mental illness is to be part of a normal community' – agreement has increased from 76% in 1994 to 80% in 2010
- 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' – agreement has increased from 62% in 1994 to 66% in 2010
- 'Most women who were once patients in a mental hospital can be trusted as babysitters' – agreement has increased from 21% in 1994 to 26% in 2010

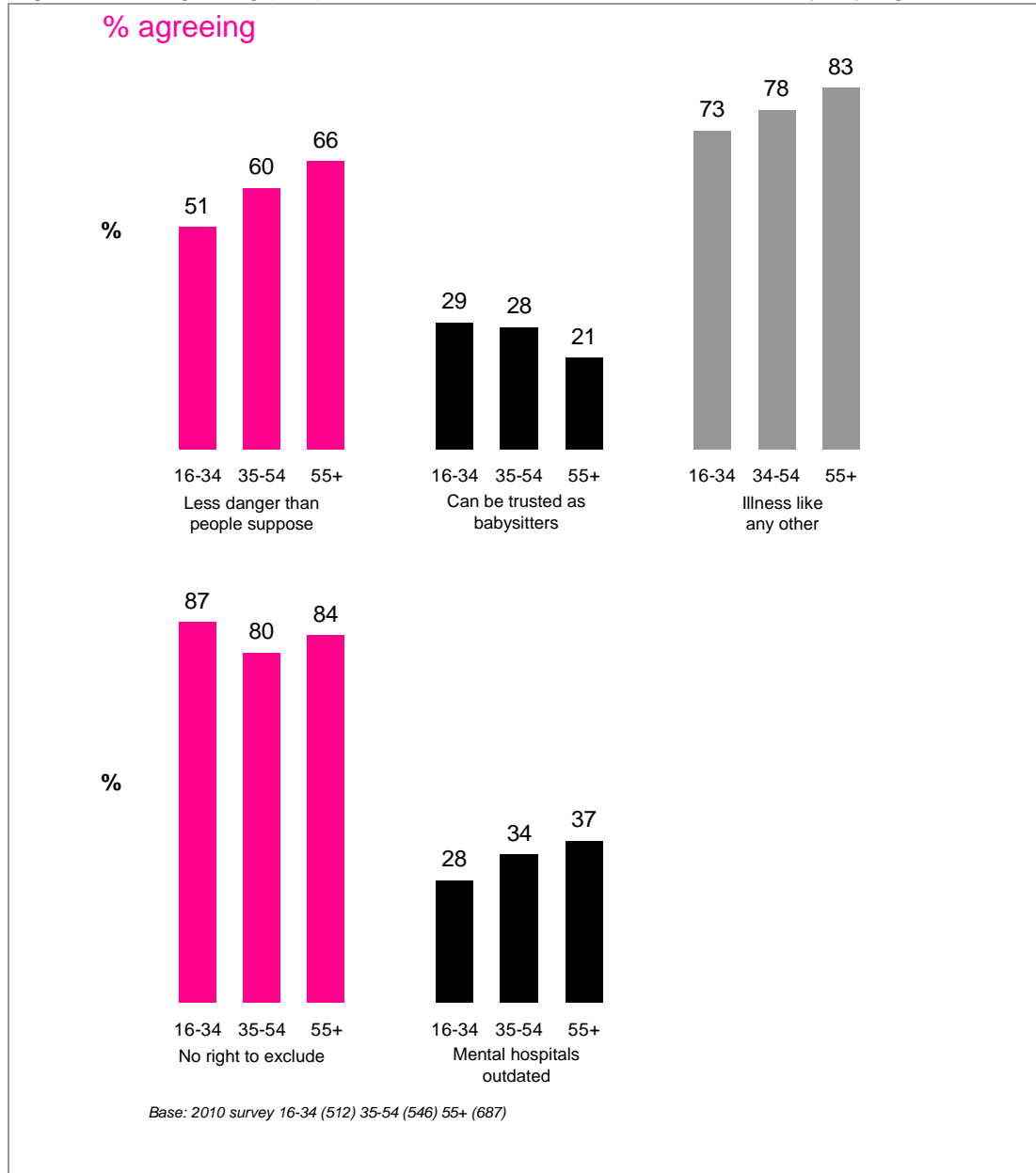
- 'Mental illness is an illness like any other' – agreement has increased from 71% in 1994 to 78% in 2010
- 'No-one has the right to exclude people with mental illness from their neighbourhood' – agreement increased from 76% in 1994 to 84% in 2010

On one statement, 'Mental hospitals are an outdated means of treating people with mental illness' – agreement decreased from 42% in 1994 to 33% in 2010.

3.4.3 Differences by age, sex and social grade

The statements in this section for which there were significant differences by age group in 2010 are shown in Figure 10.

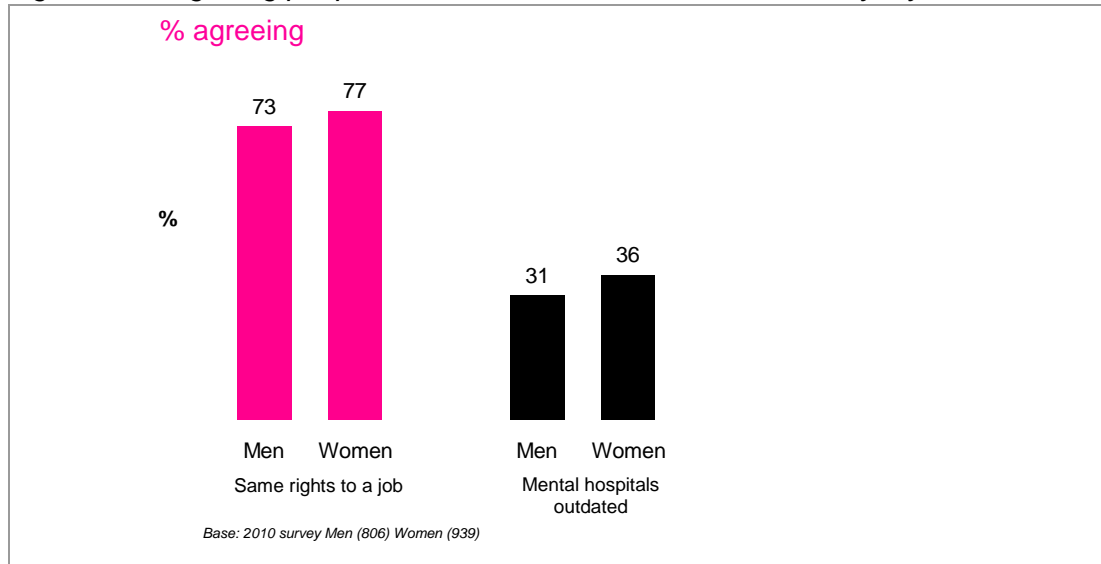
Figure 10 Integrating people with mental illness into the community, by age



The youngest age group (16-34s) were least likely, and the oldest group (age 55+) most likely to agree that people with mental illness are less of a danger than most people suppose; that mental illness is an illness like any other, and that mental hospitals are an outdated means of treating people with mental illness. In contrast, respondents aged 55+ were less likely than the younger groups to say that most women who were once patients in a mental hospital can be trusted as babysitters. The youngest group (16-34s) were more likely than older groups to agree that no-one has the right to exclude people with mental illness from their neighbourhood.

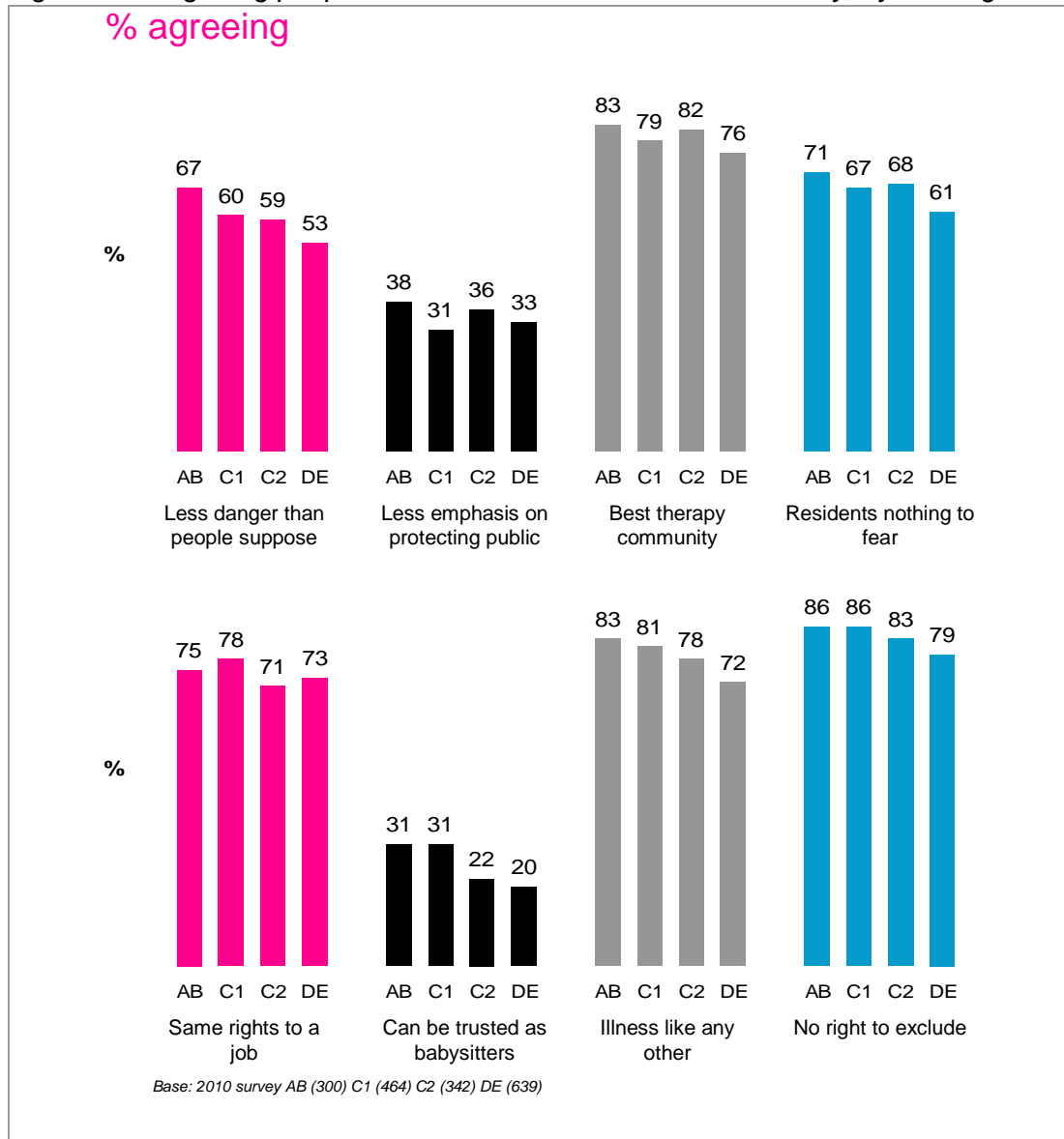
Looking at differences by gender, women were more likely than men to agree that people with mental illness have the same rights to a job as anyone else, and that mental hospitals are an outdated means of treating people with mental illness (Figure 11).

Figure 11 Integrating people with mental illness into the community, by sex



The statements on which there were significant differences by social grade in 2010 are shown in Figure 12.

Figure 12 Integrating people with mental illness into the community, by social grade



In general, where there was a difference by social grade, respondents in the AB group were most in favour of integrating people with mental illness into the community, and those in the DE group least in favour.

3.5 Causes of mental illness and the need for special services

3.5.1 Introduction

This section reports on statements which make up the fourth factor, which has been labelled causes of mental illness and the need for special services.

The statements reported here are:

- There are sufficient existing services for people with mental illness

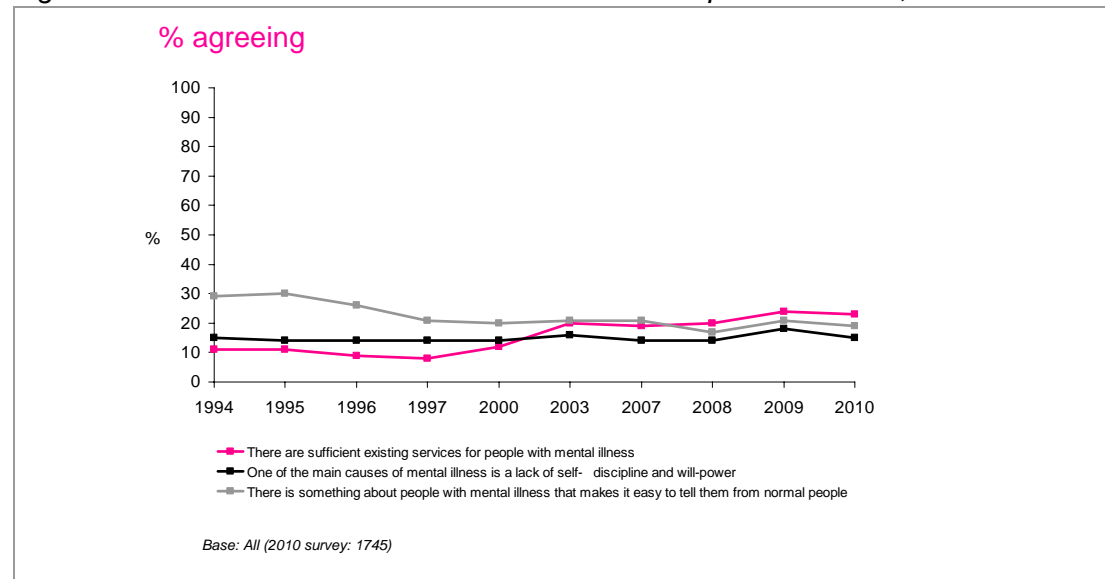
- One of the main causes of mental illness is a lack of self-discipline and will-power
- There is something about people with mental illness that makes it easy to tell them from normal people.

Analysis is based on the level of agreement with these statements, which have been included in all surveys since 1994.

3.5.2 Trends over time

Figure 13 shows levels of agreement with these statements since 1994.

Figure 13 Causes of mental illness and the need for special services, 1994-2010



Since 1994, the proportion agreeing that there are sufficient existing services for people with mental illness has increased steadily, from 11% in 1994 to 23% in 2010, although there was no significant change between 2009 and 2010.

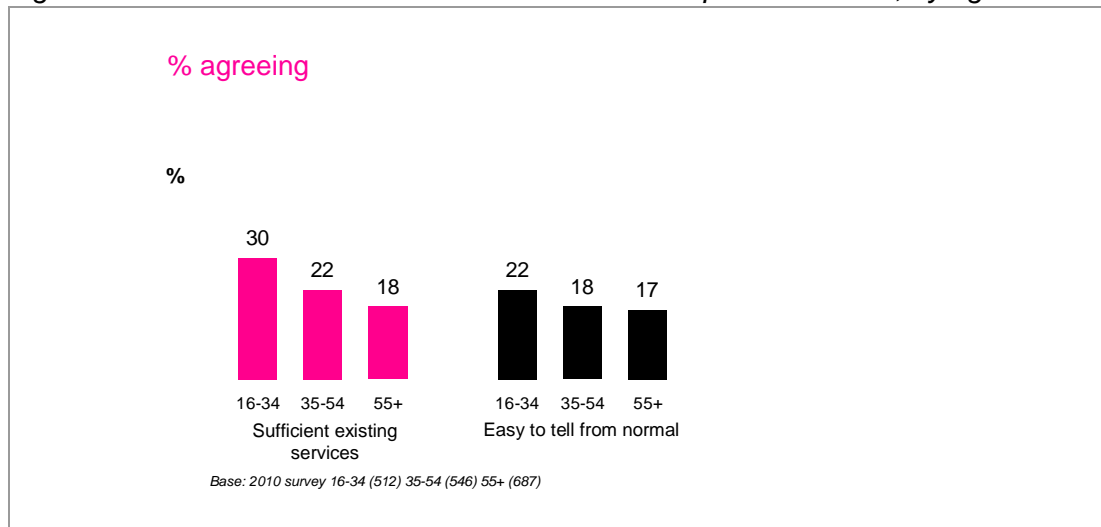
The proportion agreeing that 'there is something about people with mental illness that makes it easy to tell them from normal people' decreased fairly steadily from 29% in 1994 to 19% in 2010, although the decrease from 21% in 2009 to 19% in 2010 was not statistically significant.

Agreement that one of the main causes of mental illness is a lack of self-discipline and will-power stands at 15% in 2010, the same as the 1994 figure, although there was a significant decrease from 18% in 2009 to 15% in 2010.

3.5.3 Differences by age, sex and social grade

Differences in agreement by age group are shown in Figure 14.

Figure 14 Causes of mental illness and the need for special services, by age

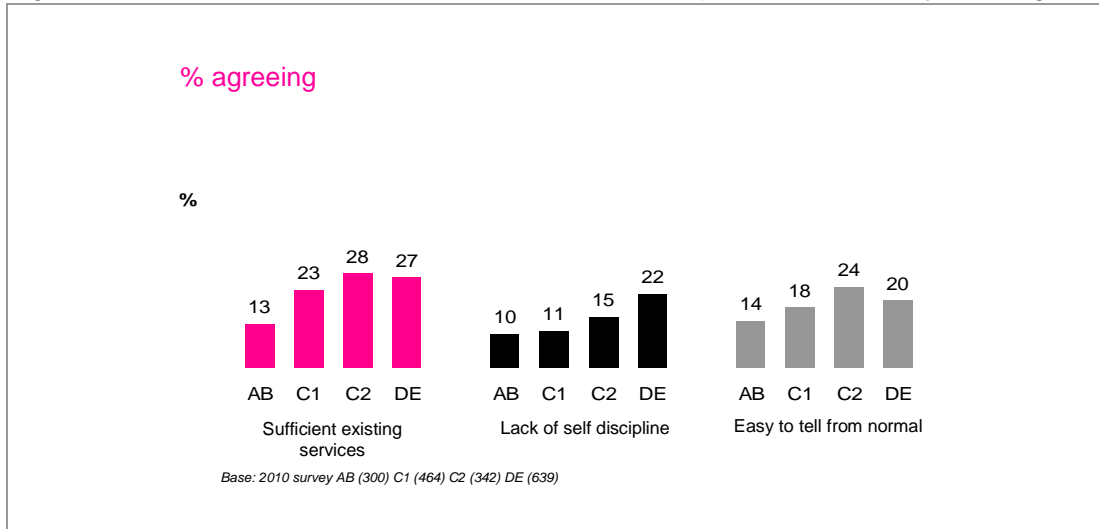


The youngest age group (16-34s) had the most negative attitudes towards mental illness, being more likely than the 35-54 and 55+ groups to agree that there are sufficient existing services, and that there is something about people with mental illness that makes it easy to tell them from normal people.

There were no significant differences between men and women in responses to these statements.

Differences by social grade are shown in Figure 15.

Figure 15 Causes of mental illness and the need for special services, by social grade



The pattern in this section was similar to that reported in earlier sections, namely that respondents in the AB social grade were significantly more positive in their attitudes towards mental illness than those in the C2 and DE grades, being less likely to agree with all three of these statements.

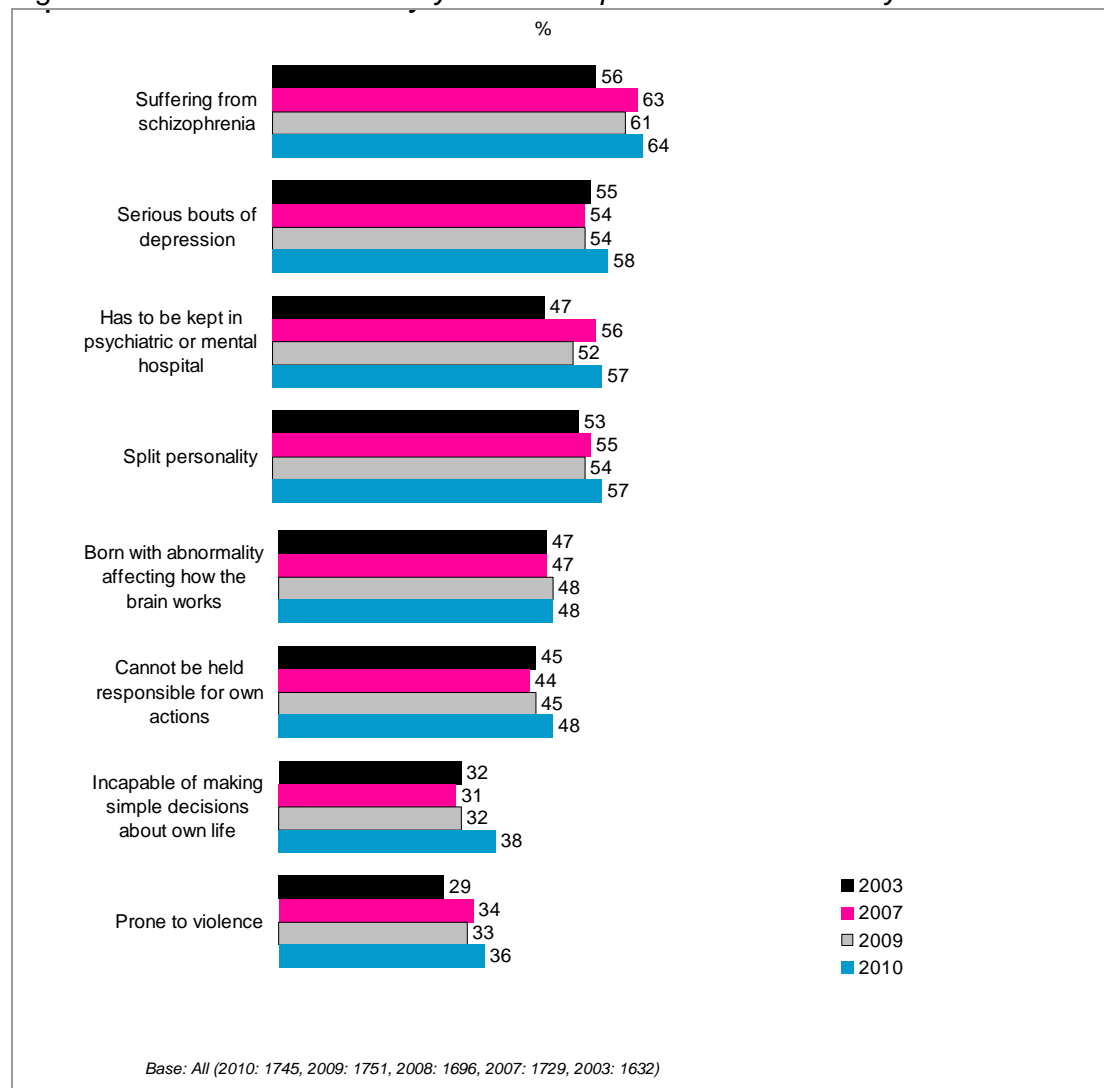
4. Ways of describing someone who is mentally ill and types of mental illness

4.1 Ways of describing someone who is mentally ill

Respondents were presented with a list of descriptions and were asked to indicate which they felt usually describes a person who is mentally ill.

The format of this question has changed since it was first asked in 1997, so comparisons are only possible from the 2003 survey onwards (see Figure 16) (data for 2008 is not shown to improve clarity).

Figure 16 Statements that usually describe a person who is mentally ill



The description most likely to be selected was 'someone who is suffering from schizophrenia' – 64% in 2010.

The next most often selected were 'someone who has serious bouts of depression' (selected by 58%) and 'someone who has a split personality' (57%).

The descriptions least likely to be selected were 'someone who is prone to violence' at 33% and 'someone who is incapable of making simple decisions about his or her own life' at 38%.

Overall there were significant increases from 2003 to 2010 in the proportions selecting several of these descriptions:

- Someone who is suffering from schizophrenia – from 56% to 64%
- Someone who has to be kept in a psychiatric or mental hospital – from 47% to 57%
- Someone who has a split personality – from 53% to 57%
- Someone who is incapable of making simple decisions – from 32% to 38%
- Someone prone to violence – from 29% to 36%.

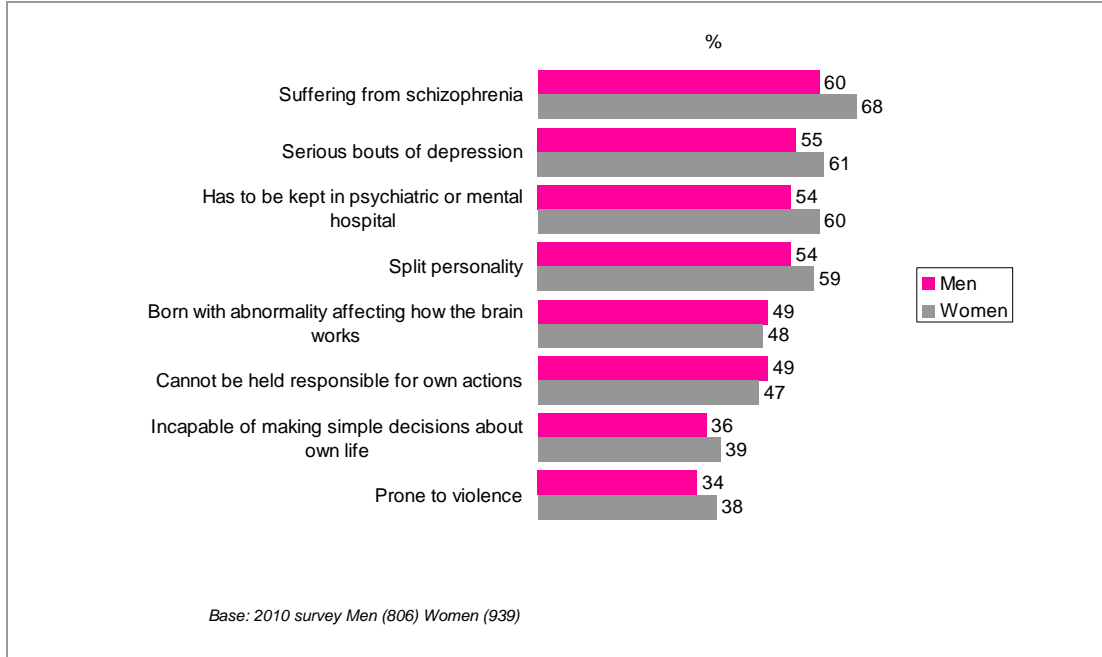
The proportion selecting several of these descriptions increased significantly from 2009 to 2010, reversing decreases seen between 2008 and 2009:

- Someone who has serious bouts of depression – from 54% to 58%
- Someone who has to be kept in a psychiatric or mental hospital – from 52% to 57%
- Someone who is incapable of making simple decisions about his or her own life – from 32% to 38%.

In total, respondents selected 4.1 of these descriptions on average in 2010, slightly higher than the average of 3.8 in 2009. This compares with 3.7 on average at the start of the series in 2003. This may explain the general increase in 2010 in the proportion of respondents choosing each of the statements to describe a person who is mentally ill.

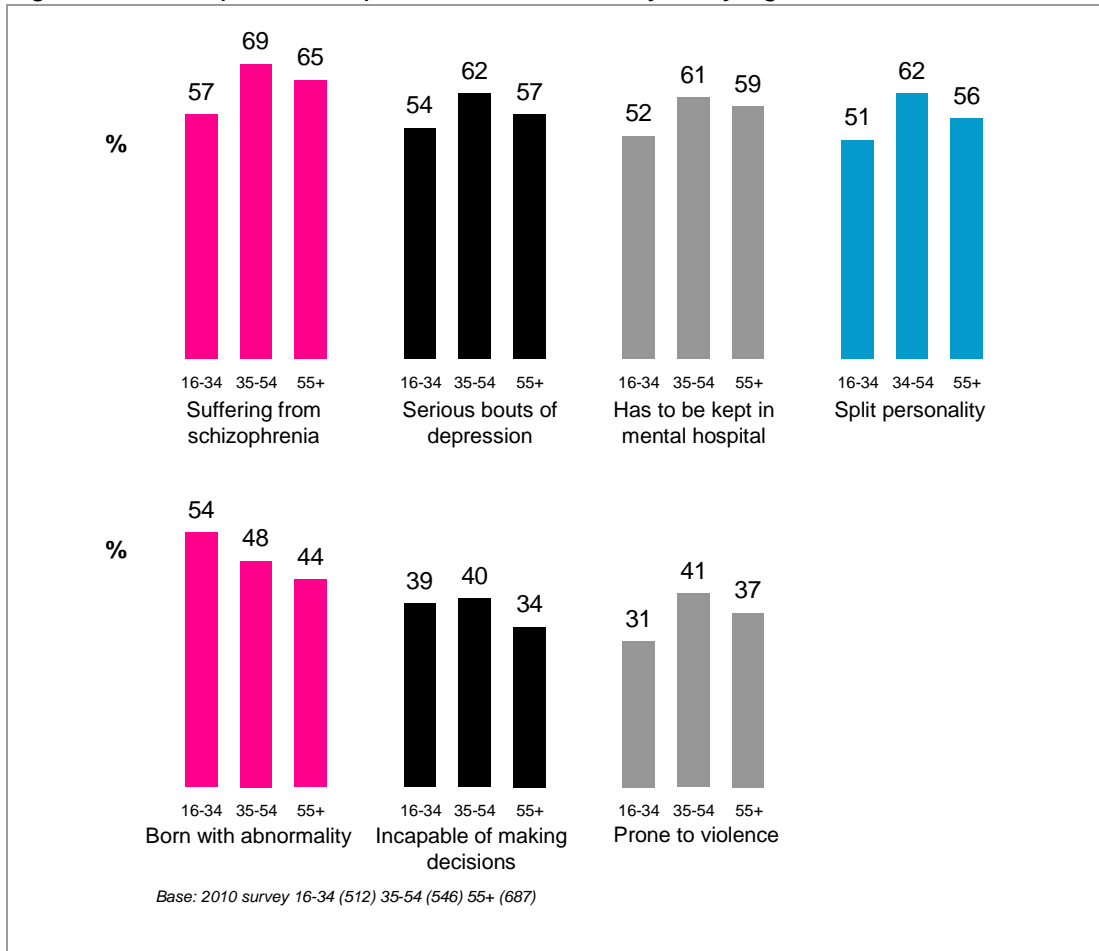
Looking at differences by gender, in the 2010 survey, women were more likely than men to select 'someone suffering from schizophrenia', 'someone who is incapable of making simple decisions' and 'someone who has serious bouts of depression' (Figure 17).

Figure 17 Statements that usually describe a person who is mentally ill, by gender



There were differences in the proportions selecting some of these descriptions by age group in 2010, shown in Figure 18.

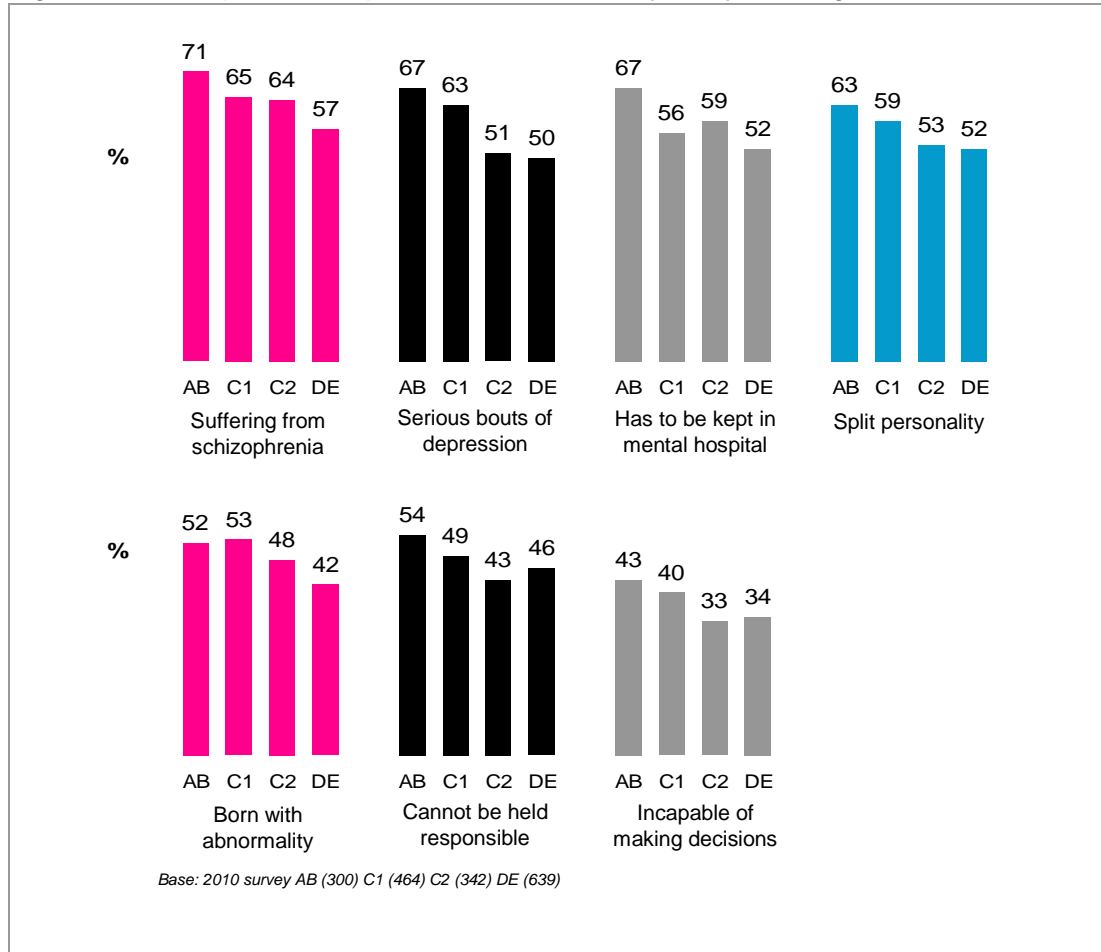
Figure 18 Descriptions of a person who is mentally ill, by age



Respondents aged 16-34 were less likely than the older groups to select most of these statements, apart from ‘someone who is born with an abnormality affecting how the brain works’ which the youngest group were most likely to select. Those aged 55+ were less likely than the younger groups to select ‘someone who is incapable of making simple decisions’.

There were some differences by social grade in responses to this question, shown in Figure 19.

Figure 19 Descriptions of a person who is mentally ill, by social grade



Respondents in social grades AB tended to be most likely to select each description, and those in groups DE least likely.

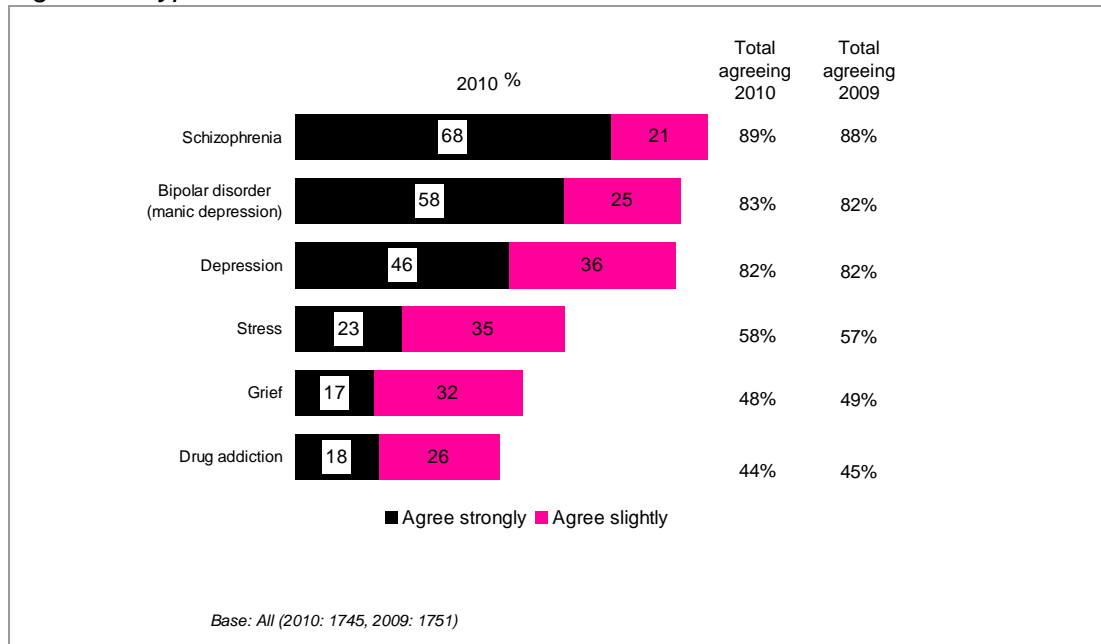
4.2 Types of mental illness

Respondents were asked to say to what extent they agreed or disagreed that each of the following conditions is a type of mental illness:

- Depression
- Stress
- Schizophrenia
- Bipolar disorder (manic depression)
- Drug addiction
- Grief

These questions, which form part of the Mental Health Knowledge Schedule (MAKS), were asked for the first time in 2009.

Figure 20 Types of mental illness



Respondents were most likely to agree that schizophrenia was a type of mental illness – 68% agreed strongly, with nearly nine out of ten agreeing in total. The pattern was similar for bipolar disorder, with 58% agreeing strongly and 82% agreeing overall (Figure 20).

The proportion agreeing that depression was a type of mental illness was also 82%, however the proportion strongly agreeing was lower (46%) and slightly agree higher (36%) than for bipolar disorder.

The lowest proportion was for drug addiction, although nearly a half of respondents (44%) agreed that this was a type of mental illness.

There were no significant differences between 2009 and 2010 in responses to these questions.

5. Attitudes to people with mental health problems

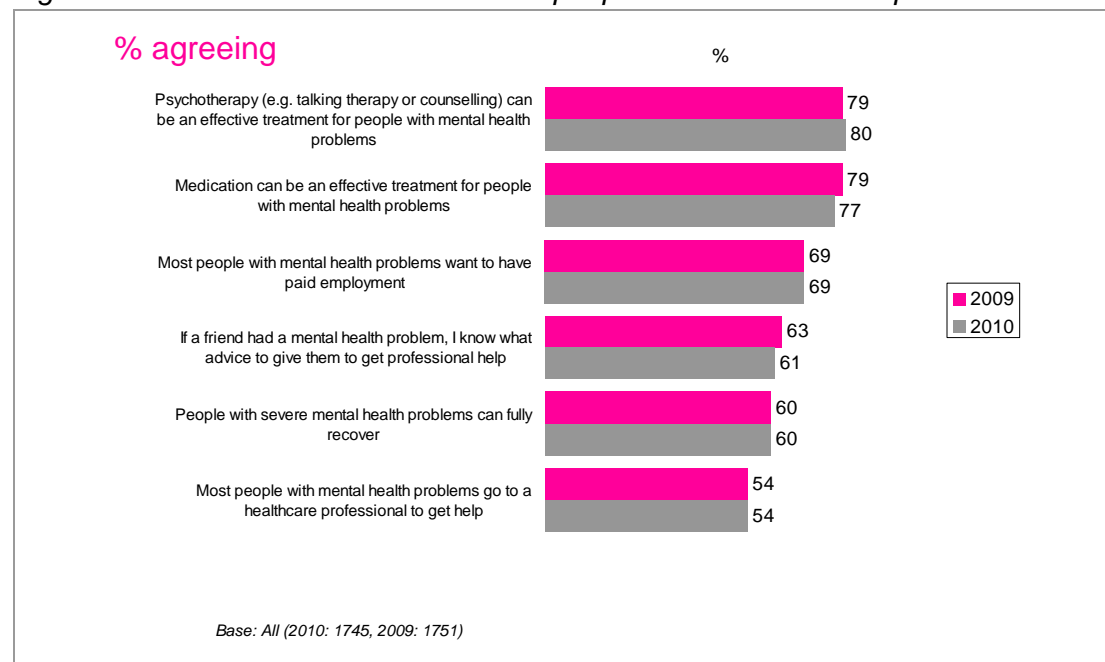
5.1 Introduction

A new set of questions in 2009 covered attitudes towards people with mental health problems – ‘that is, conditions for which an individual would be seen by healthcare staff’. The questions covered employment, getting professional help, medication, treatment and recovery, and were repeated in 2010. These items form part of the Mental Health Knowledge Schedule (MAKS).

5.2 Trends over time

Figure 21 shows agreement with statements relating to treatment for mental health problems.

Figure 21 Attitudes towards treatment for people with mental health problems



There was a high level of agreement that mental health problems can be treated, with nearly eight out of ten respondents agreeing that psychotherapy and medication can be effective treatments for people with mental health problems. Nearly seven out of ten respondents agreed that most people with mental health problems want to have paid employment. Three out of five respondents agreed that they would know what advice to give a friend to get professional help, and that people with severe mental health problems can fully recover.

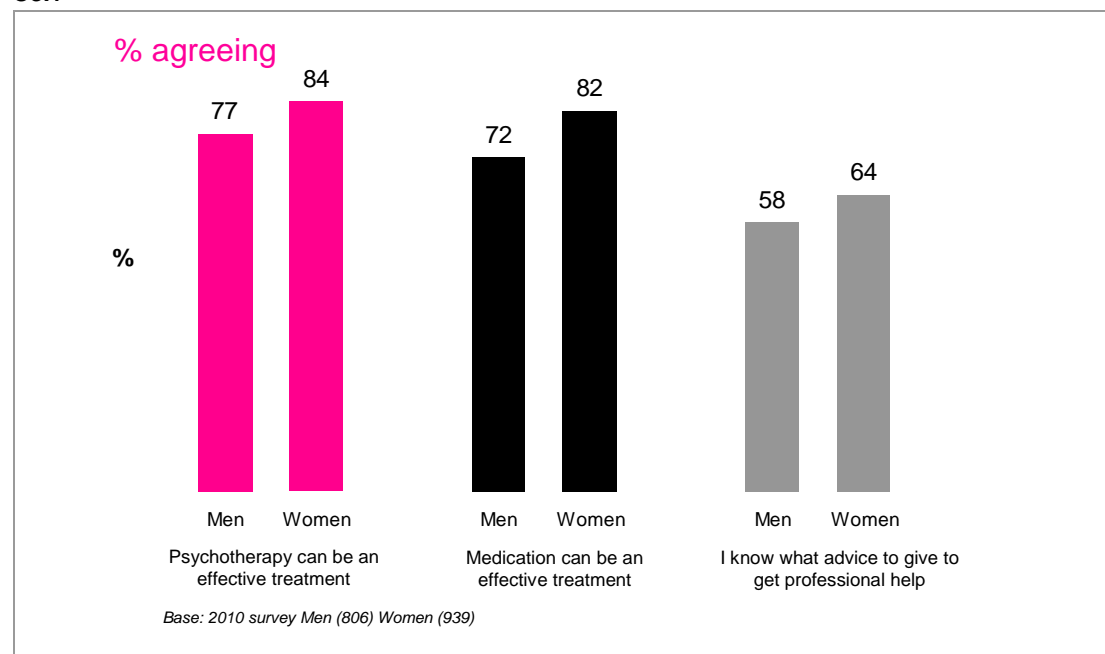
Opinion on whether most people with mental health problems go to a healthcare professional to get help was more mixed, with 54% agreeing (17% said they neither agreed nor disagreed, 22% disagreed and 7% did not know).

There were no significant differences between 2009 and 2010 in responses to these statements.

5.3 Differences by age, sex and social grade

There were differences between men and women in responses to some of these items. Significant differences are shown in Figure 22.

Figure 22 Attitudes towards treatment for people with mental health problems, by sex



Women were more likely than men to agree that both psychotherapy and medication can be effective treatments for people with mental health problems. Women were also more likely than men to say that, if a friend had a mental health problem, they would know what advice to give to get professional help.

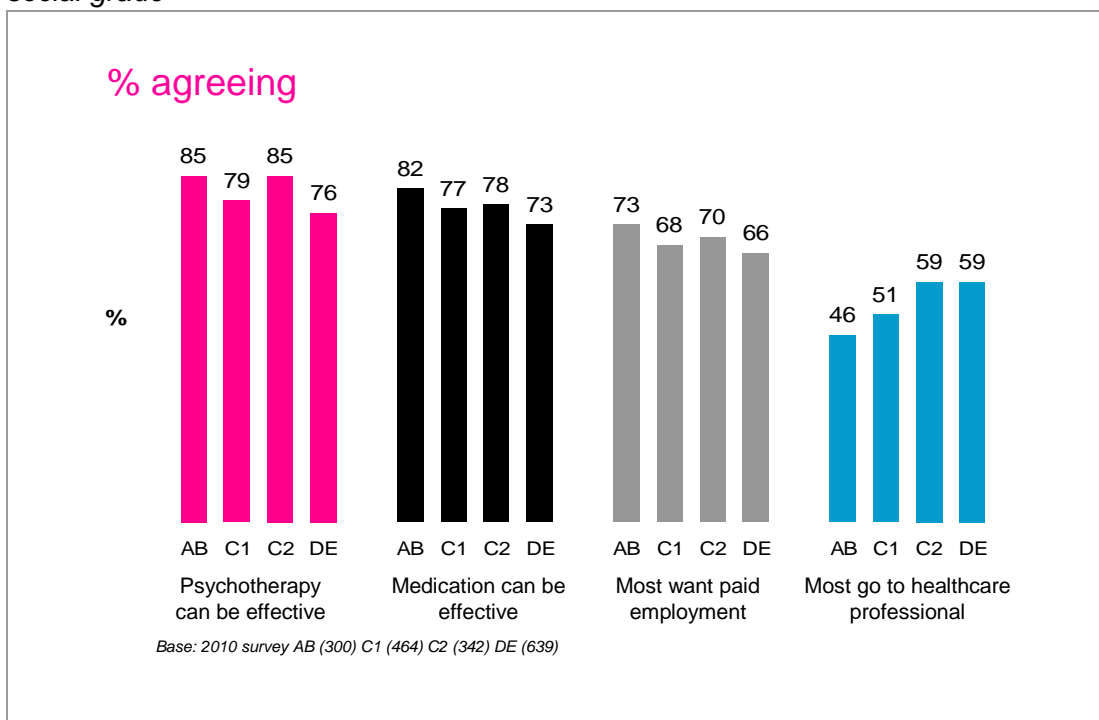
There were few differences by age group:

- Respondents aged 55+ (78%) were less likely than those aged 35-54 (84%) to agree that psychotherapy can be an effective treatment for people with mental health problems

- Respondents aged 35-54 (65%) were more likely than those aged 16-34 (59%) and 55+ (58%) to agree that if a friend had a mental health problem, they would know what advice to give them to get professional help
- Respondents aged 16-34 (65%) were more likely than those aged 55+ (56%) to agree that people with severe mental health problems can fully recover.

There were differences by social grade in agreement with some of the items. Items with significant differences are shown in Figure 23.

Figure 23 Attitudes towards treatment for people with mental health problems, by social grade



Respondents in the AB and C2 social grades were more likely than C1s and DEs to agree that psychotherapy can be an effective treatment for people with mental health problems.

ABs were also more likely than DEs to agree that medication can be an effective treatment, and that most people with mental health problems want to have paid employment.

ABs and C1s were, however, less likely than C2s and DEs to agree that most people with mental health problems go to a healthcare professional to get help.

6. Personal experience of mental illness

6.1 Relationships with people with mental health problems

Respondents were asked about their experiences of people who have mental health problems, that is, 'people who have been seen by healthcare staff for a mental health problem'. Respondents were asked whether they currently, or ever had:

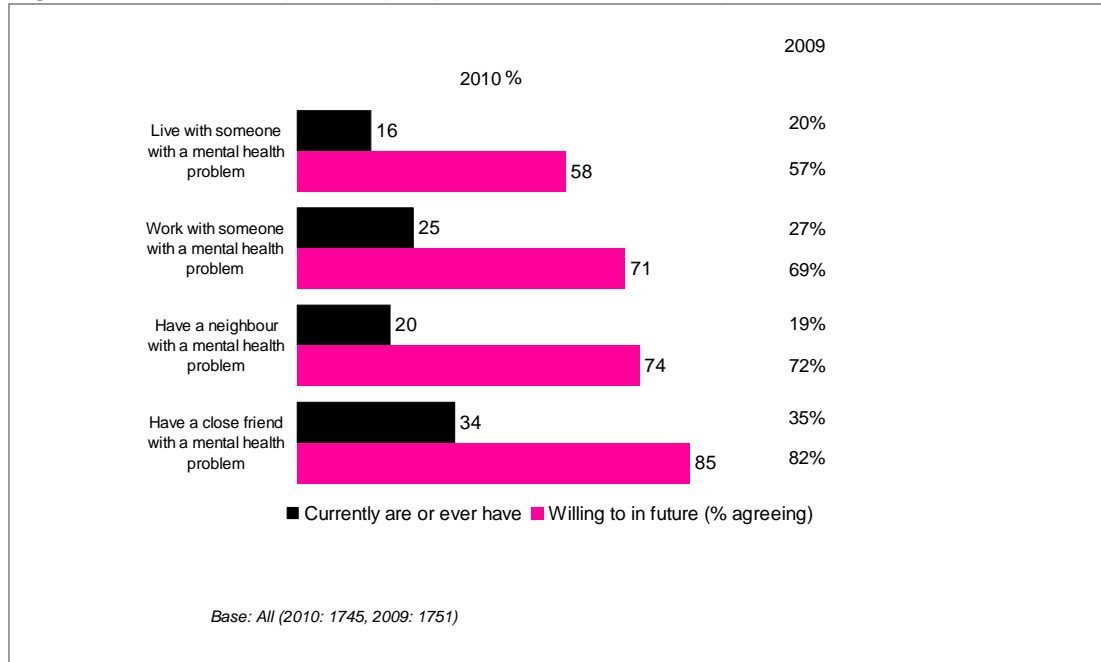
- lived with someone with a mental health problem;
- worked with someone with a mental health problem;
- had a neighbour with a mental health problem;
- or had a close friend with a mental health problem.

They were then asked to agree or disagree (on a 5-point scale) with the following statements – 'In the future, I would be willing to...'

- ... live with someone with a mental health problem
- ... work with someone with a mental health problem
- ... live nearby to someone with a mental health problem
- ... continue a relationship with a friend who developed a mental health problem

These questions, which form the Reported and Intended Behaviour Scale (RIBS), were asked for the first time in 2009 and repeated in 2010. Results are shown in Figure 24.

Figure 24 Relationships with people with mental health problems



The most common experience of someone with a mental health problem was with a close friend – 34% of respondents said they currently or ever had a close friend with a mental health problem.

16% said that they currently or had ever lived with someone with a mental health problem.

Over four-fifths of respondents (85%) agreed that in future they would be willing to continue a relationship with a friend who developed a mental health problem. Around seven out of ten would be willing either to live nearby to (74%) or work with (71%) someone with a mental health problem. Future willingness to live with someone with a mental health problem was lower at 58%.

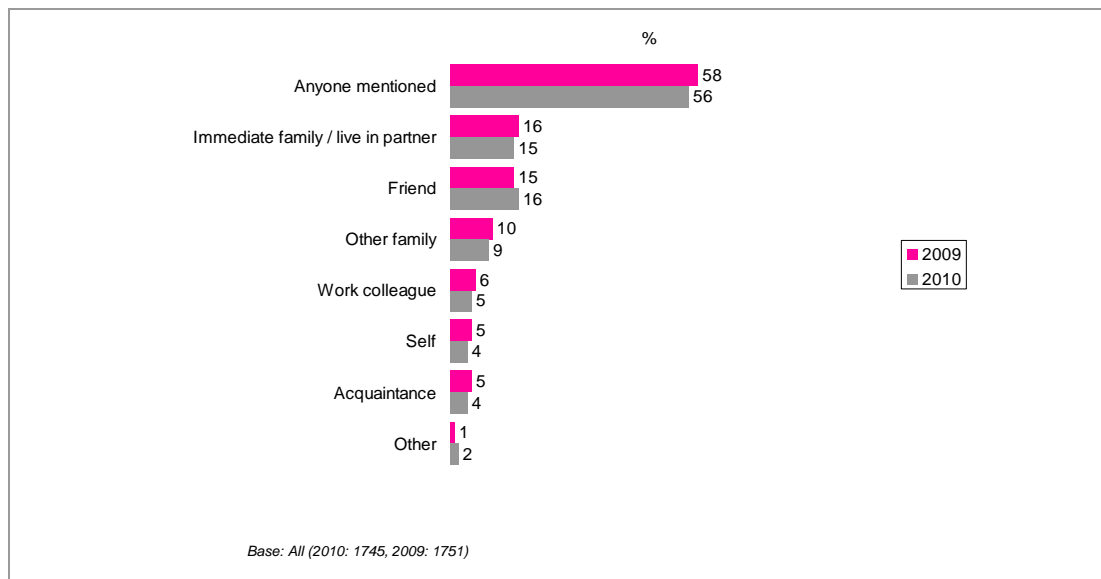
There were some changes between 2009 and 2010 – the proportion who said they had ever lived with someone with a mental health problem fell slightly from 20% in 2009 to 16% in 2010; and the proportion who said they would be willing to continue a relationship with a friend who developed a mental health problem increased from 82% in 2009 to 85% in 2010.

6.2 Friends and family who have had mental illness

Respondents were asked who, if anyone, close to them has had some kind of mental illness. Although these questions have been included in earlier surveys, in 2009 the

new questions on relationships with people with mental health problems (reported in Section 6.1) were asked before these questions. This may have affected comparability with earlier surveys, by prompting respondents to think of different categories of friends, relations and other contacts who may have had mental illness, and by provide a definition of mental health problems. For this reason, findings from earlier years are not reported here (Figure 25).

Figure 25 Person closest to respondent who has had some kind of mental illness, 2009-2010



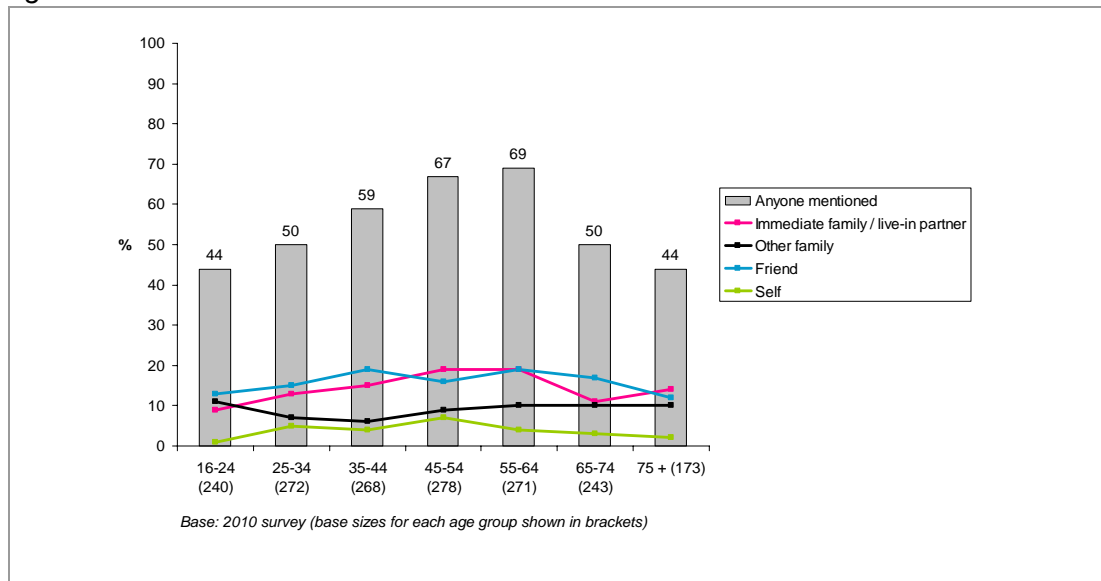
The majority of respondents reported that someone close to them had some kind of mental illness (56%).

The most commonly selected answer was a friend, with 16% of respondents selecting this. Next most common was immediate family/live-in partner (15%). 9% of respondents mentioned other family. 4% of respondents said that they themselves had experienced some kind of mental illness.

There were no significant differences in responses to this question between 2009 and 2010.

There were some differences by age group (Figure 26).

Figure 26 Person closest to respondent who has had some kind of mental illness, by age



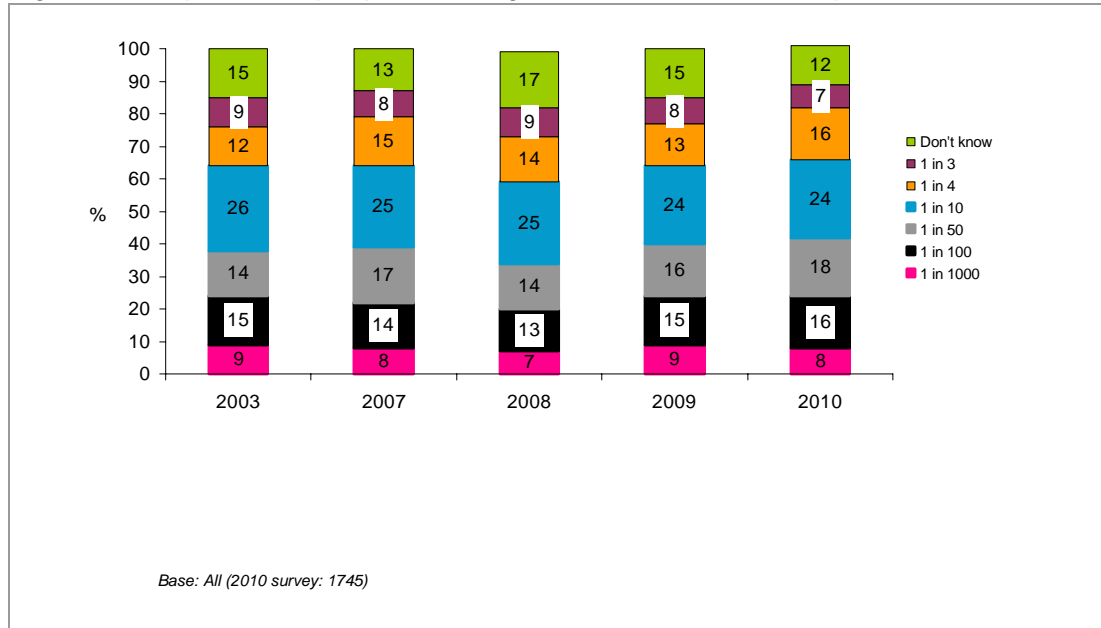
Respondents in the age groups 45-44 and 55-64 were most likely to say that they knew someone who had experienced mental illness, and the oldest and youngest groups were least likely. Those aged 16-24 were least likely to say that they had experienced mental illness themselves.

6.3 Proportion of people who may have a mental health problem

Respondents were asked what proportion of people in the UK they think might have a mental health problem at some point in their lives, and were given a list of options to choose from, ranging from 1 in 3 to 1 in 1000. The actual lifetime incidence of mental health problems is estimated to be around 1 in 4. This question has been included in the survey since 2003.

Respondents tended to underestimate the proportion of people who would have a mental health problem at some point in their lives. The proportion of respondents correctly stating 1 in 4 increased from 13% in 2009 to 16% in 2010. The largest group of respondents (24%) thought the proportion was 1 in 10, with 42% of respondents thinking it was less than this. 7% thought it was 1 in 3. It is worth noting that 12% of respondents said that they did not know (Figure 27).

Figure 27 Proportion of people who might have a mental health problem, 2003-2010

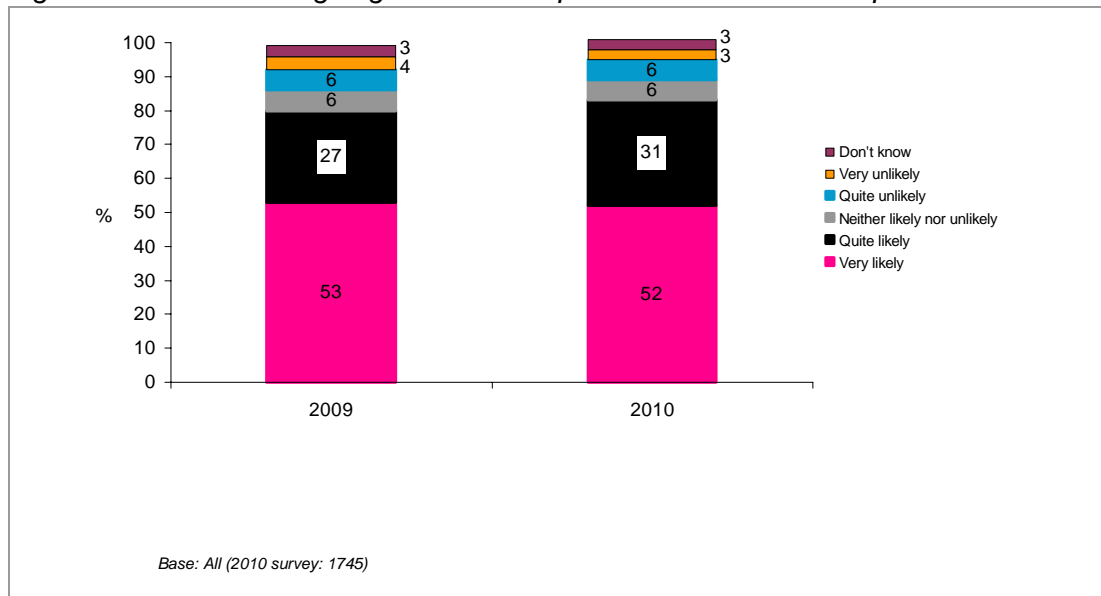


6.4 Consulting a GP about a mental health problem

Respondents were asked how likely they would be to go to their GP for help, if they felt that they had a mental health problem. This question was asked for the first time in 2009, and repeated in 2010.

The vast majority of respondents (83%) said they would be likely to go to their GP for help (Figure 28).

Figure 28 Likelihood of going to GP for help about a mental health problem



Respondents aged 16-34 were less likely than the older groups to say they would be likely to go to their GP. These figures have not changed significantly since 2009.

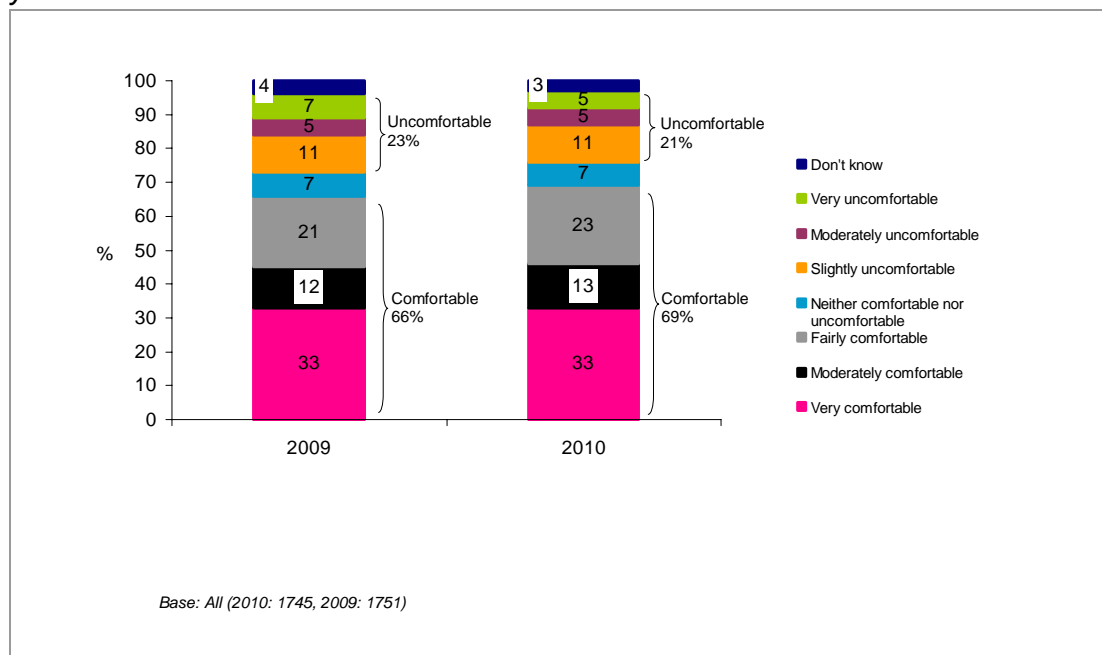
6.5 Talking to friends and family about mental health

Respondents were asked in general how comfortable they would feel talking to a friend or family member about their mental health, for example, telling them they had a mental health diagnosis and how it affects them. This question was first asked in 2009, and repeated in 2010.

Responses in 2009 and 2010 are shown in Figure 29.

The majority of respondents would be comfortable with this, with over two-thirds of respondents (69%) saying they would be comfortable, and around a fifth (21%) uncomfortable, with the rest saying ‘neither’ or ‘don’t know’ (Figure 29). The small increase in the proportion who would feel comfortable between 2009 and 2010 was not statistically significant.

Figure 29 How comfortable would you feel talking to a friend or family member about your mental health?



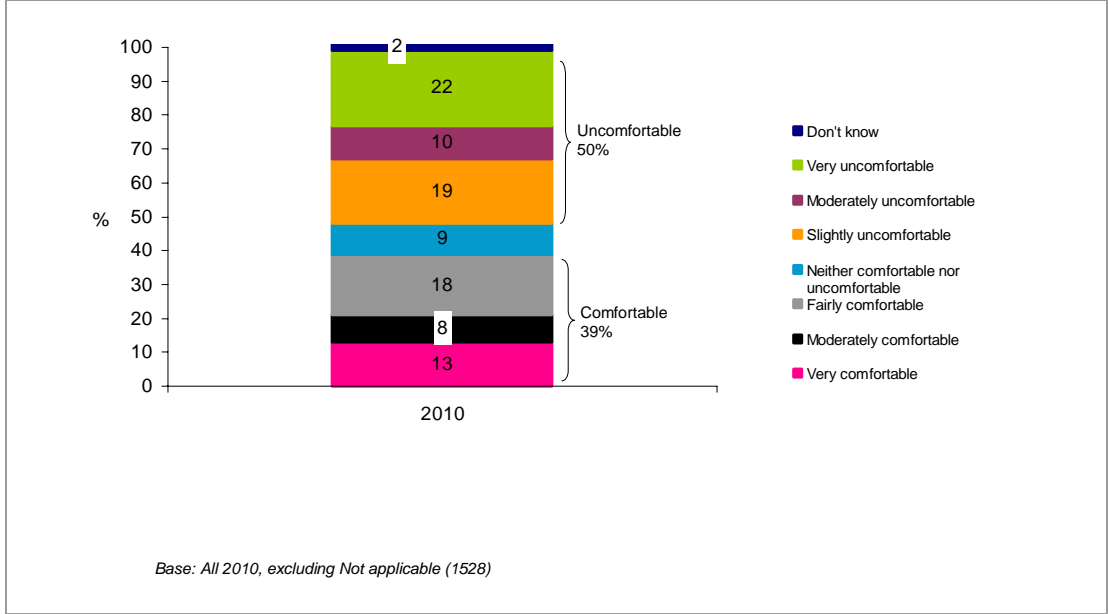
Women (72%) were more likely than men (66%) to say that they would feel comfortable discussing their mental health with friends and family.

6.6 Talking to an employer about mental health

A new question in 2010 asked respondents how comfortable they would feel talking to a current or prospective employer about their mental health, for example telling

them they have a mental health diagnosis and how it affects them. Responses are shown in Figure 30, percentages are calculated excluding the 13% of respondents who said this was not applicable to them.

Figure 30

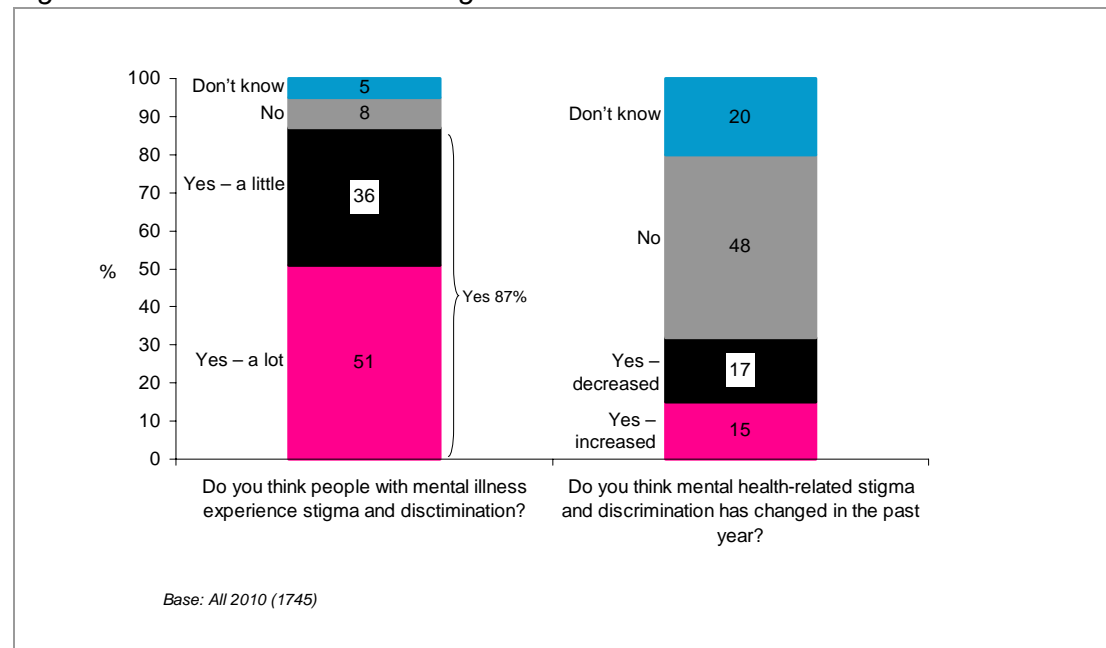


Respondents were far less likely to say they would feel comfortable talking to an employer than to friends and family – 39% would feel comfortable talking to an employer, compared with 69% who would feel comfortable talking to friends and family.

7. Mental health-related stigma and discrimination

Two new questions around stigma and discrimination were asked in 2010: whether people with mental illness experience stigma and discrimination nowadays, because of their mental health problems; and whether mental health-related stigma and discrimination has changed in the past year. Responses are shown in Figure 31.

Figure 31 Mental health-related stigma and discrimination



Overall, nearly nine out of ten respondents said that people with mental illness experience stigma and discrimination. Around a half (51%) said they experience a lot of discrimination, and a further 36% that they experience a little discrimination.

Respondents aged 35-54 (91%) were more likely than those aged 16-34 (85%) or 55+ (86%) to say that people with mental illness experience stigma and discrimination.

Looking at social grade, AB respondents (94%) were most likely, and DE respondents (81%) least likely to say this.

Around a half of respondents (48%) said that mental health-related stigma and discrimination has not changed in the past year.

Among the 32% who thought that discrimination had changed, opinion was fairly evenly divided on whether it had gone up or gone down, with 15% saying discrimination has increased, and 17% that it has decreased. A significant proportion, 20%, said that they did not know.

The youngest group of respondents, those aged 16-34, were most likely to say that discrimination has decreased – 21% said this, compared with 17% of 35-54s and 14% of those aged 55+.

Appendix I Survey methodology

I.1 Population

The Attitudes to Mental Illness surveys have been carried out in England as part of TNS's Omnibus survey. The Omnibus survey aims to cover adults aged 16+, living in private households. This report relates to the 2010 survey, although the methodology followed was the same for the earlier surveys.

I.2 Interview mode

Interviews were carried out by face-to-face interviewing in-home, using Computer Assisted Personal Interviewing (CAPI).

I.3 Sample selection

I.3.1 Sample frame

The TNS Omnibus is carried out using a quota sample, with sample points selected by a random location methodology.

The sample points were selected from those determined by TNS's own sampling system. 2001 Census small area statistics and the Postcode Address File (PAF) were used to define sample points. The sample points are areas of similar population sizes formed by the combination of electoral Wards, with the constraint that each sample point must be contained within a single Government Office Region (GOR). Geographic systems were used to minimise the travelling time that would be needed by an interviewer to cover each area.

TNS have defined 600 points south of the Caledonian Canal in Great Britain.

I.3.2 Selection of sampling points

278 TNS sample points were selected south of the Caledonian Canal for use by the Omnibus, after stratification by GOR and Social Grade. Sample points were checked to ensure that they are representative by an urban and rural classification. These points were divided into two replicates, and each set of points is used in alternative weeks of Omnibus fieldwork. Sequential waves of fieldwork are issued systematically across the sampling frame to provide maximum geographical dispersion. For this survey, 139 sampling points were selected in England.

I.3.3 Selection of clusters within sampling points

All the sample points in the sampling frame have been divided into two geographically distinct segments each containing, as far as possible, equal populations. The segments comprise aggregations of complete wards. For the Omnibus, alternate A and B halves are worked each wave of fieldwork. Each week different wards are selected in the required half and Census Output Areas selected within those wards. Then, blocks containing an average of 150 addresses are sampled from PAF in the selected Output Areas, and are issued to interviewers.

I.3.4 Interviewing and quota controls

Assignments are conducted over two days of fieldwork and are carried out on weekdays from 2pm-8pm and at the weekend. Quotas are set by sex (male, female housewife, female non-housewife, where a 'housewife' is the person (male or female) responsible for carrying out more than half of the weekly shopping); within female housewife, presence of children and working status, and within men, working status, to ensure a balanced sample of adults within contacted addresses. Interviewers are instructed to leave 3 doors between each successful interview.

I.3.5 Response rates

As this is a quota sample it is not possible to quote response rates for achieved interviews. Approximately 13 interviews were achieved on average per sample point.

I.4 Fieldwork

Interviews were carried out by 149 fully trained interviewers from TNS Field. Interviewing took place between January 20th-24th 2010, inclusive.

I.5 The questionnaire

The Attitudes to Mental Illness questionnaire was developed for the 1993 survey. The statements used originated in local studies based in Toronto and the West Midlands. There have been minor changes to the questionnaire over the course of the surveys, but the core has remained the same. Some new questions were added in 2009 and 2010 to tie in with the evaluation of the 'Time to Change' anti-discrimination campaign, by the Institute of Psychiatry. The 2010 questionnaire consisted of:

- 27 attitude statements using a five-point Likert scale (Agree strongly/Agree slightly/Neither agree nor disagree/Disagree slightly/Disagree strongly), covering a wide range of issues including attitudes towards people with

mental illness, to opinions on services provided for people with mental health problems.

- Descriptions of people with mental illness.
- Relationships with people with mental health problems.
- Attitudes towards people with mental health problems.
- Types of mental illness.
- Personal experience of mental illness.
- Proportions of people who may have a mental health problem.
- Likelihood of going to a GP with a mental health problem.
- Talking to friends and family about a mental health problem.
- Talking to employers about a mental health problem.
- Perceptions of mental health-related stigma and discrimination.

In addition a range of demographic measures are included on the Omnibus:

- Sex
- Age
- Social Grade, using the Market Research Society's classification system (AB/C1/C2/DE), based on the occupation of the Highest Income Householder (chief income earner). A description of the social grades is as follows:
 - AB – professional/managerial occupations
 - C1 – other non-manual occupations
 - C2 – skilled manual occupations
 - DE – semi-/unskilled manual occupations and people dependent on state benefits
- Marital status
- Presence of children aged under 16 in the household
- Ethnicity of respondent (White British, White Irish, Any other white background, Mixed white & Black Caribbean, Mixed white & Black African, Mixed white & Asian, Other mixed background, Indian, Pakistani, Bangladeshi, Other Asian background, Black Caribbean, Black African, Other Black background, Chinese, Other)
- Government Office Region (North East, North West, Yorkshire and Humberside, East Midlands, West Midlands, East of England, London, South East, South West).

A copy of the 2010 survey questionnaire is included in Appendix II.

I.6 Validation, editing and imputation

As the interviews are carried out using CAPI, validation is carried out at the point of interview. The CAPI program ensures that the correct questionnaire routing is followed, and checks for valid ranges on numerical variables such as age. Range and consistency checks are then validated in the post-interview editing process.

Following the fieldwork, data were converted from CAPI into the Quantum data processing package. A set of tabulations of questions by demographic variables was created. A dataset in SPSS format was exported from Quantum. The tabulations and dataset were checked against the source data by the research staff.

A problem inherent in all surveys is item non-response, where respondents agree to given an interview but either does not know the answer to certain questions or refuses to answer them. In the 2010 Attitudes to Mental Illness survey, the level of item non-response was generally around 2% to 3% of respondents, but on a couple of the attitude statements was 10% or higher (10% and 16%). These 'don't know' responses have been counted as valid responses in the data analysis, so that the base for analysis for each question is the whole sample who were asked the question, *not* those who gave a substantive response. There has been no attempt made to impute missing data.

I.7 Weighting

Data were weighted to match the population profile by region. The weighting matrix used is shown in Figure 32:

Figure 32 Weighting matrix - weights

	Total	North	Midlands	South
Total	0.98	0.95	0.98	1.01
Men ABC1 : 16-24	0.97	1.31	1.24	0.73
Men ABC1 : 25-44	1.37	1.45	1.11	1.54
Men ABC1 : 45-64	1.18	0.94	1.16	1.37
Men ABC1 : 65+	0.89	0.91	0.78	0.96
Men C2 : 16-24	1.37	0.99	2.02	1.37
Men C2 : 25-44	1.03	1.01	1.17	0.96
Men C2 : 45-64	1.04	0.95	1.59	0.83
Men C2 : 65+	0.66	0.84	0.82	0.50
Men DE : 16-24	0.95	0.96	0.98	0.91
Men DE : 25-44	0.97	1.16	0.86	0.92
Men DE : 45-64	0.87	0.75	0.95	0.94
Men DE : 65+	0.80	0.69	0.89	0.86
Female ABC1 : 16-24	1.24	1.33	1.31	1.16
Female ABC1 : 25-44	1.44	1.53	1.28	1.51
Female ABC1 : 45-64	1.13	1.09	1.10	1.18
Female ABC1 : 65+	0.87	1.00	0.65	1.01
Female C2 : 16-24	1.28	1.24	1.16	1.44
Female C2 : 25-44	1.13	1.06	0.95	1.36
Female C2 : 45-64	0.84	0.68	1.47	0.71
Female C2 : 65+	0.78	0.70	0.72	0.94
Female DE : 16-24	0.68	0.91	0.68	0.54
Female DE : 25-44	0.64	0.84	0.48	0.66
Female DE : 45-64	0.73	0.64	0.75	0.84
Female DE : 65+	0.75	0.66	1.02	0.66

The profile of the samples before and after application of the weighting is shown below:

Figure 33 Weighted and unweighted sample profiles

	Weighted		Unweighted	
	N	%	N	%
Sex				
Male	829	48	806	46
Female	888	52	939	54
Age				
16-24	241	14	240	14
25-34	293	17	272	16
35-44	310	18	268	14
45-54	279	16	278	16
55+	594	35	687	39
Social Grade				
AB	348	20	300	17
C1	545	32	464	27
C2	330	19	342	20
DE	494	29	639	37
Working status				
Full time	690	40	612	35
Part time (8-29 hrs)	234	14	223	13
Part time (under 8 hrs)	8	*	8	*
Retired	418	24	506	29
Total	1717	100	1745	100

I.8 Reliability of estimates

All survey estimates have a sampling error attached to them, calculated from the variability of the observations in the sample. From this, a margin of error (confidence interval) is derived. It is this confidence interval, rather than the estimate itself, that is used to make statements about the likely 'true' value in the population; specifically, to state the probability that the true value will be found between the upper and lower limits of the confidence interval. In general, a confidence interval of twice the standard error is used to state, with 95 per cent confidence, that the true value falls within that interval. A small margin of error will result in a narrow interval, and hence a more precise estimate of where the true value lies.

The technical calculation of sampling errors (and thus confidence intervals) is based on an assumption of a simple random sampling method. This survey did not use a

simple random sample, however it is common practice in such surveys to use the formulae applicable to simple random samples to estimate confidence intervals.

In addition to sampling errors, consideration should also be given to non-sampling errors. Sampling errors generally arise through the process of sampling and the influence of chance. Non-sampling errors arise from the introduction of some systematic bias in the sample as compared to the population it is supposed to represent. Perhaps the most important of these is non-response bias.

As this survey used a quota sample there is no measure available of the level of unit non-response to the survey. However, comparison of the achieved sample with the population profile (see Figure 33 above) indicates that the achieved sample contained fewer men, professionals, and full-time workers; and correspondingly more women and non-working people, than would be expected if it were fully representative of the population. These discrepancies have been corrected by weighting, to remove this potential source of bias from survey estimates.

There are many other potential sources of error in surveys, including misleading questions, data input errors or data handling problems. There is no simple control or measurement for such non-sampling errors, although the risk can be minimised through careful application of the appropriate survey techniques from questionnaire and sample design through to analysis of results.

I.9 Statistical disclosure control

Respondents were assured that any information they provided would be confidential and that personal details would not be disclosed at an identifiable level. Respondents' contact details were collected for quality control purposes but this information was detached from the survey responses and the records anonymised during the processing stage. Data are published in aggregated tabulations only so as to minimise the risk that a combination of responses will lead to a respondent being identifiable. Data processing was carried out in accordance with the Data Protection Act and the Market Research Society Code of Conduct.

I.10 Statistical significance

Where findings are reported as 'significant' in this report this always means that the findings are statistically significant at the 95% confidence level or higher. If a finding

is statistically significant we can be 95% confident that differences reported are real rather than occurring just by chance. Significance of differences has been tested using the two-tailed t-test for independent samples.

I.11 Sample numbers, 1994-2010

Figure 34 shows the sample sizes for all surveys in this series since 1994.

<i>Figure 34</i>	
	Sample size (unweighted)
	n
1994	1682
1995	1554
1996	5071
1997	4900
2000	1707
2003	1632
2007	1729
2008	1703
2009	1751
2010	1745

Appendix II Questionnaire

SHOW SCREEN

Q.1 We have been asked by the Department of Health to find out peoples opinions on mental illness. I am going to read out some opinions which other people hold about mental illness and would like you to tell me how much you agree or disagree with each one...

(Order of statements rotated)

...One of the main causes of mental illness is a lack of self-discipline and will-power

...There is something about people with mental illness that makes it easy to tell them from normal people

...As soon as a person shows signs of mental disturbance, he should be hospitalized

...Mental illness is an illness like any other

...Less emphasis should be placed on protecting the public from people with mental illness

...Mental hospitals are an outdated means of treating people with mental illness

...Virtually anyone can become mentally ill

...People with mental illness have for too long been the subject of ridicule

...We need to adopt a far more tolerant attitude toward people with mental illness in our society

...We have a responsibility to provide the best possible care for people with mental illness

...People with mental illness don't deserve our sympathy

...People with mental illness are a burden on society

...Increased spending on mental health services is a waste of money

...There are sufficient existing services for people with mental illness

...People with mental illness should not be given any responsibility

...A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered

...I would not want to live next door to someone who has been mentally ill

...Anyone with a history of mental problems should be excluded from taking public office

...No-one has the right to exclude people with mental illness from their neighbourhood

...People with mental illness are far less of a danger than most people suppose

...Most women who were once patients in a mental hospital can be trusted as babysitters

...The best therapy for many people with mental illness is to be part of a normal community

...As far as possible, mental health services should be provided through community based facilities

...Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services
...It is frightening to think of people with mental problems living in residential neighbourhoods
...Locating mental health facilities in a residential area downgrades the neighbourhood
...People with mental health problems should have the same rights to a job as anyone else

- 01: Agree strongly
- 02: Agree slightly
- 03: Neither agree nor disagree
- 04: Disagree slightly
- 05: Disagree strongly
- (DK)

SHOW SCREEN - MULTI CHOICE

Q.2 And which of these do you feel usually describes a person who is mentally ill?

- 01: Someone who has serious bouts of depression
- 03: Someone who is incapable of making simple decisions about his or her own life
- 05: Someone who has a split personality
- 06: Someone who is born with some abnormality affecting the way the brain works
- 07: Someone who cannot be held responsible for his or her own actions
- 09: Someone prone to violence
- 10: Someone who is suffering from schizophrenia
- 11: Someone who has to be kept in a psychiatric or mental hospital
- 12: Other (specify)
- None\dk

SHOW SCREEN

The following questions ask about your experiences and views in relation to people who have mental health problems. By this I mean people who have been seen by healthcare staff for a mental health problem.

Q.3 Are you currently living with, or have you ever lived with, someone with a mental health problem?

- 01: Yes
- 02: No
- (DK)
- (R)

Q.4 Are you currently working, or have you ever worked, with someone with a mental health problem?

- 01: Yes
- 02: No
- (DK)
- (R)

Q.5 Do you currently, or have you ever, had a neighbour with a mental health problem?

- 01: Yes
- 02: No
- (DK)
- (R)

Q.6 Do you currently have, or have you ever had, a close friend with a mental health problem?

- 01: Yes
- 02: No
- (DK)
- (R)

Q.7 The following statements ask about any future relationships you may experience with people with mental health problems. Please tell me how much you agree or disagree with each one, taking your answer from the screen.

SHOW SCREEN

(Order of statements rotated)

...In the future, I would be willing to live with someone with a mental health problem

...In the future, I would be willing to work with someone with a mental health problem

...In the future, I would be willing to live nearby to someone with a mental health problem

...In the future, I would be willing to continue a relationship with a friend who developed a mental health problem

(Answer categories inverted on alternate interviews)

- 01: Agree strongly
- 02: Agree slightly
- 03: Neither agree nor disagree
- 04: Disagree slightly
- 05: Disagree strongly
- (DK)

Q.8 I am now going to read out some more statements about mental health problems, again that is conditions for which an individual would be seen by healthcare staff. Please tell me how much you agree or disagree with each one.

SHOW SCREEN

(Order of statements rotated)

...Most people with mental health problems want to have paid employment
...If a friend had a mental health problem, I know what advice to give them to get professional help
...Medication can be an effective treatment for people with mental health problems
...Psychotherapy (e.g., talking therapy or counselling) can be an effective treatment for people with mental health problems
...People with severe mental health problems can fully recover
...Most people with mental health problems go to a healthcare professional to get help

(Answer categories inverted on alternate interviews)

01: Agree strongly
02: Agree slightly
03: Neither agree nor disagree
04: Disagree slightly
05: Disagree strongly
(DK)

Q.9 Please say to what extent you agree or disagree that each of the following conditions is a type of mental illness...

SHOW SCREEN

(Order of items rotated)

- ...Depression
- ...Stress
- ...Schizophrenia
- ...Bipolar disorder (manic-depression)
- ...Drug addiction
- ...Grief

(Answer categories inverted on alternate interviews)

- 01: Agree strongly
- 02: Agree slightly
- 03: Neither agree nor disagree
- 04: Disagree slightly
- 05: Disagree strongly
- (DK)

SHOW SCREEN

Q.10 Who is the person closest to you who has or has had some kind of mental illness ?

Please take your answer from this screen.

(Answer categories inverted on alternate interviews, 'Other' / 'No-one' fixed at bottom of list)

- 01: Immediate family (spouse\child\sister\brother\parent etc)
- 02: Partner (living with you)
- 03: Partner (not living with you)
- 04: Other family (uncle\aunt\cousin\grand parent etc)
- 05: Friend
- 06: Acquaintance
- 07: Work colleague
- 08: Self
- 09: Other (please specify)
- 10: No-one known
- (R)

SHOW SCREEN

Q.11 What proportion of people in the UK do you think might have a mental health problem at some point in their lives?

- 01: 1 in 1000
- 02: 1 in 100
- 03: 1 in 50
- 04: 1 in 10
- 05: 1 in 4
- 06: 1 in 3
- (DK)

SHOW SCREEN

Q.12 If you felt that you had a mental health problem, how likely would you be to go to your GP for help?

(Answer categories inverted on alternate interviews)

- 01: Very likely
- 02: Quite likely
- 03: Neither likely nor unlikely
- 04: Quite unlikely
- 05: Very unlikely
- (DK)

SHOW SCREEN

Q.13 In general, how comfortable would you feel talking to a friend or family member about your mental health, for example telling them you have a mental health diagnosis and how it affects you?

(Answer categories inverted on alternate interviews)

- 01: Very uncomfortable
- 02: Moderately uncomfortable
- 03: Slightly uncomfortable
- 04: Neither comfortable nor uncomfortable
- 05: Fairly comfortable
- 06: Moderately comfortable
- 07: Very comfortable
- (DK)

SHOW SCREEN

Q.14 In general, how comfortable would you feel talking to a current or prospective employer about your mental health, for example telling them you have a mental health diagnosis and how it affects you?

(Answer categories inverted on alternate interviews)

- 01: Very uncomfortable
- 02: Moderately uncomfortable
- 03: Slightly uncomfortable
- 04: Neither comfortable nor uncomfortable
- 05: Fairly comfortable
- 06: Moderately comfortable
- 07: Very comfortable
- (Not applicable)
- (DK)

SHOW SCREEN

Q.15 Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?

(Answer categories inverted on alternate interviews)

- 01: Yes- a lot of stigma and discrimination
- 02: Yes- a little stigma and discrimination
- 03: No
- (DK)

SHOW SCREEN

Q.16 Do you think mental health-related stigma and discrimination has changed in the past year?

(Answer categories inverted on alternate interviews)

- 01: Yes - increased
- 02: Yes – decreased
- 03: No
- (DK)