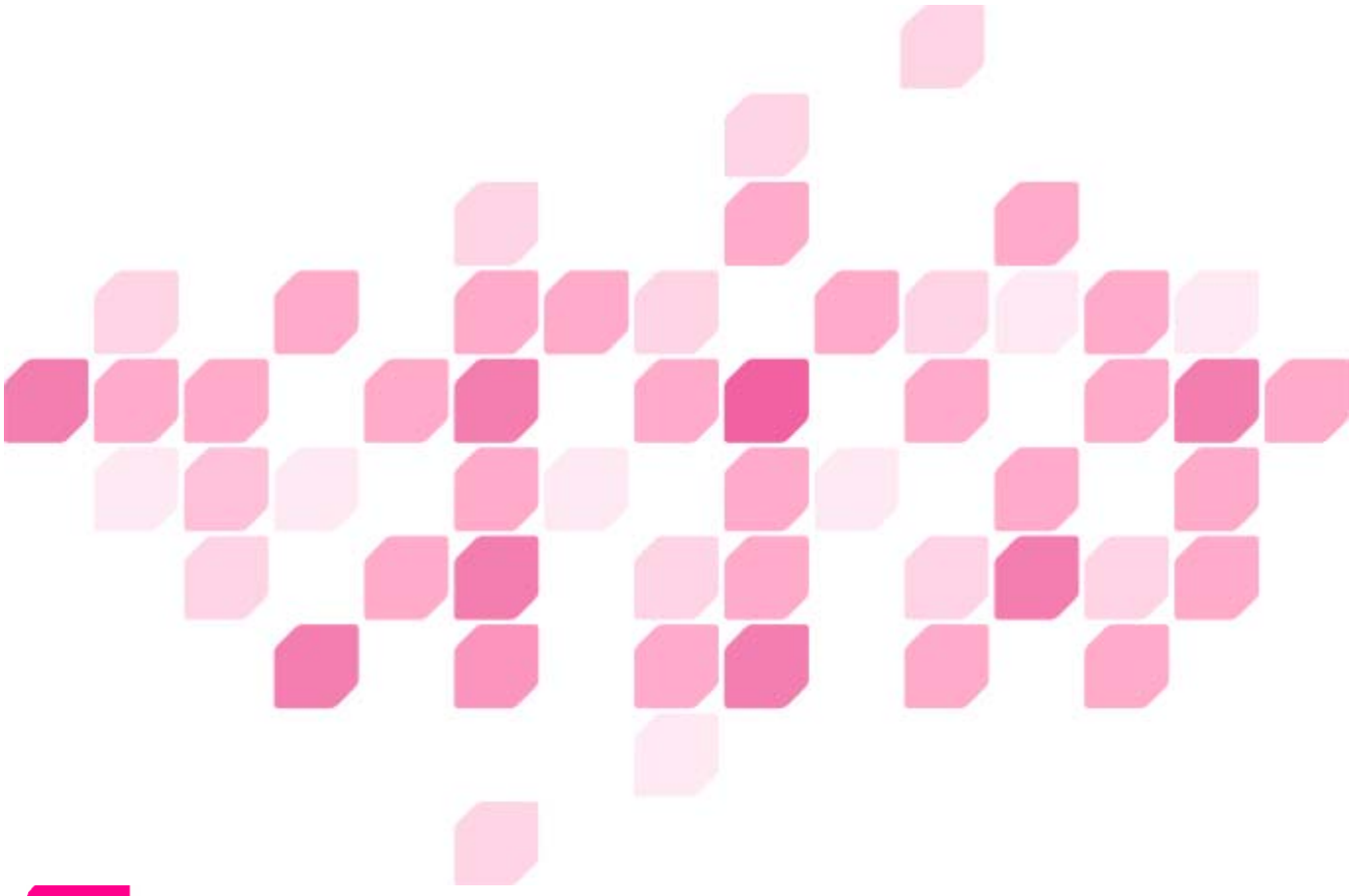
Attitudes to Mental Illness 2008 Research Report

May 2008



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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. The most recent previous surveys in the series were carried out in 2003 and 2007.

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

1,703 adults (aged 16+) were interviewed by TNS in England in January 2008.

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 personal experience of mental illness, descriptions of people with mental illness, and awareness of publicity for mental health issues.

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 2007

There were few changes since 2007:

- Agreement that 'people with mental illness have for too long been the subject of ridicule' increased from 72% to 75%.
- Agreement that 'there is something about people with mental illness that makes it easy to tell them from normal people' decreased from 21% to 17%.
- A higher proportion of respondents selected the following descriptions to indicate which they felt usually describes a person who is mentally ill:
  - Someone who has a split personality – increased from 55% to 59%

  - Someone who cannot be held responsible for his or her own actions – increased from 44% to 49%
  - Someone who is incapable of making simple decisions about his or her own life – increased from 31% to 37%.
- The proportion of respondents who said they had seen or heard any publicity about mental health or mental illness issues decreased from 56% to 45%.

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' (21% agreed) and 'Locating mental health facilities in a residential area downgrades the neighbourhood' (20% agreed).
- There was a decrease since 1994 in agreement that anyone with a history of mental health problems should be excluded from taking public office. This stood at 21% in 2008, the same proportion as in 2007, down from 29% in 1994.
- 7% agreed that people with mental illness are a burden on society, a decrease from 10% in 1994.
- Agreement that 'I would not want to live next door to someone who has been mentally ill' increased from 8% in 1994 to 12% in 2008. Over the same period the proportion disagreeing with this fell from 74% to 63%.
- Where there were differences by age group, the oldest group of respondents (aged 55+) had the most negative attitudes towards people with mental illness, being more likely than younger groups to agree that a woman would be foolish to marry a man who has suffered from mental illness, anyone with a history of mental illness should be excluded from public office, and that people with mental illness should not be given any responsibility.
- Women were less negative than men towards people with mental illness on a few of these statements.
- There were differences by social grade on several of these items, with respondents in the DE social grades (manual workers/dependent on state benefits) generally being more negative towards people with mental illness than those in the AB (professional/managerial occupations) groups. The

exception to this was on the issue of whether locating mental health facilities in a residential area downgrades the neighbourhood; AB respondents were more likely than DEs to agree with this.

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 72% agreeing that 'As far as possible, mental health facilities should be provided through community based facilities' to 89% for 'We have a responsibility to provide the best possible care for people with mental illness' and 'Virtually anyone can become mentally ill'.
- Over time, though, there were decreases in the proportion of respondents displaying understanding attitudes on several of these statements, with particular declines since 2000.
- In particular, there were decreases between 2000 and 2008 in tolerant attitudes on the following statements:
  - 'We have a responsibility to provide the best possible care for people with mental illness' - 95% agreeing in 2000, down to 89% in 2008.
  - 'Increased spending on mental health services is a waste of money' - 90% disagreeing in 2000, down to 83% in 2008.
  - 'People with mental illness don't deserve our sympathy' - 90% disagreeing in 2000, down to 85% in 2008.
  - 'We need to adopt a more tolerant attitude towards people with mental illness' - 92% agreeing in 1994, 90% in 2000, down to 83% in 2008.
- Agreement that 'People with mental illness have for too long been the subject of ridicule' decreased between 1997 (86%) and 2007 (72%). There was however an increase in agreement with this between 2007 (72%) and 2008 (75%).
- There were differences by age group for all of the statements in this section, with the youngest respondents (aged 16-34) being less likely than the 35-54 and 55+ groups to have tolerant/understanding attitudes.
- There were also differences by social grade for all of the statements in this section. Respondents in the DE group were less likely than ABs to hold tolerant/understanding attitudes.

1.5 Integrating people with mental illness into the community

- Levels of agreement with several of the statements in this section were high:
  - 74% agreed that 'No-one has the right to exclude people with mental illness from their neighbourhood' and 'Mental illness is an illness like any other'
  - 70% agreed that 'The best therapy for many people with mental illness is to be part of a normal community'
  - 66% 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' (23% agree), 'Less emphasis should be placed on protecting the public from people with mental illness' (29% agree) and 'Mental hospitals are an outdated means of treating people with mental illness' (31% agree).
- There were some changes between 1994 and 2008:
  - 'People with mental illness are far less of a danger than most people suppose' – decrease in agreement, from 62% in 1994 and 64% in 2000, to 57% in 2008.
  - 'The best therapy for people with mental illness is to be part of a normal community' - percentage agreeing decreased from 76% in 1994, to 74% in 2000 and 70% in 2008.
  - 'Mental hospitals are an outdated means of treating people with mental illness' - percentage agreeing decreased from 42% in 1994 to 31% in 2008.
  - 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' – percentage agreeing decreased from 62% in 1994 to 59% in 2008.
  - 'Mental illness is an illness like any other' – percentage agreeing increased from 71% in 1994 to 74% in 2008.
- There were significant by age group on several of the statements in this section, with the youngest age group (16-34s) being less likely than 35-54s and 55+ to be in favour of integrating people with mental illness into the community.
- Women were more likely than men to agree that mental illness is an illness like any other.

- There were differences by social grade on some of the statements in this section; where there was a difference, 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.

1.6 Causes of mental illness and the need for special services

- 20% agreed that there are sufficient existing services for people with mental illness, up from 11% in 1994.
- 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 17% in 2008. There was a decrease from 21% in 2007 to 17% in 2008.
- 14% agreed that one of the main causes of mental illness is a lack of self-discipline and will-power, not significantly different from the 1994 level.
- The youngest age group (16-34) had the most negative attitudes towards mental illness, being more likely than the 35-54 and 55+ groups to agree with these three statements.
- Men had more negative attitudes than women on these statements.
- Respondents in the AB social grade were more positive in their attitudes towards mental illness than those in the DE grade.

1.7 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' – 63% selected this in 2008.
- The next most often selected were 'someone who has a split personality' and 'someone who has to be kept in a psychiatric or mental hospital' both of which were selected by 59% of respondents in 2008.
- The descriptions least likely to be selected were 'someone who is incapable of making simple decisions about his or her own life' at 37%, and 'someone who is prone to violence' at 36%.
- There were significant increases from 2003 to 2008 in the proportions selecting several of these descriptions:

- Someone who is suffering from schizophrenia – from 56% to 63%
- Someone who has a split personality – from 53% to 59%
- Someone who has to be kept in a psychiatric or mental hospital – from 47% to 59%
- Someone who is incapable of making simple decisions about his or her own life – from 32% to 37%
- Someone prone to violence – from 29% to 36%.

1.8 Experience of mental illness

- Overall just over 1 in 10 respondents said that they had consulted a GP in the last 12 months about being anxious or depressed, or about any personal mental, nervous or emotional problem. This had not changed significantly since 1994.
- Women (13%) were more likely than men (8%) to have consulted a GP about a mental health problem.
- Around a half of respondents mentioned that someone close to them (family, friend or themselves) had experienced some kind of mental illness. This was most commonly a member of their immediate family (16%), or a friend (9%) or other family (8%).
- Respondents were asked what proportion of people in the UK they think might have a mental health problem at some point in their lives. Respondents tended to underestimate the proportion of people who would have a mental health problem at some point in their lives. 14% of respondents correctly stated 1 in 4, and 9% thought it was higher than this. A quarter of respondents thought the proportion was 1 in 10, with 35% thinking it was less than this.

1.9 Publicity about mental illness issues

- Respondents were asked in which ways they had seen or heard any publicity about mental health or mental illness issues in the last few years. This question was included in 2007 and 2008 only.
- In 2008 45% of respondents had seen some publicity in recent years, down from 56% in 2007.
- The most commonly-mentioned source of publicity was TV news, followed by national newspapers.

- For each type of publicity they had seen, respondents were asked whether the publicity from that source had influenced them to have more positive or negative views towards people with mental illness, and how important that source of publicity had been in influencing their views.
- For each source of publicity, the majority of respondents answered that it had no effect on their views about people with mental illness.
- Other TV programmes (apart from TV news and plays/soaps) were most likely to have had a positive effect. TV news, national and local newspapers were most likely to have had a negative effect on views.

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 was then repeated in 2007 and 2008, under management of the Care Services Improvement Partnership (CSIP). 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. 2000 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. 6000 adults in each. In 2007 the sample base was changed to be England rather than Great Britain, with c. 1700 adults interviewed. The 2008 survey again included adults in England, with 1703 interviewed in total. 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 156 fully trained interviewers using Computer-Assisted Personal Interviewing (CAPI), and were carried out in respondents' homes. Interviewing took place between January 23rd-27th 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, descriptions of people with mental illness, and awareness of publicity for mental health issues.

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 CSIP – Robert.westhead@csip.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. All the findings 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

The 2008 survey included 27 attitude statements, with which respondents were asked to state their level of agreement on a five point scale from 'Agree strongly' to 'Disagree strongly'.

In order to group these for analysis purposes, a factor analysis was carried out. 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 Appendix I. The factor loading is a measure of the correlation between the statement and the factor – which shows how important the statement is to that factor. Each statement was allocated to the factor on which it had the highest loading.

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

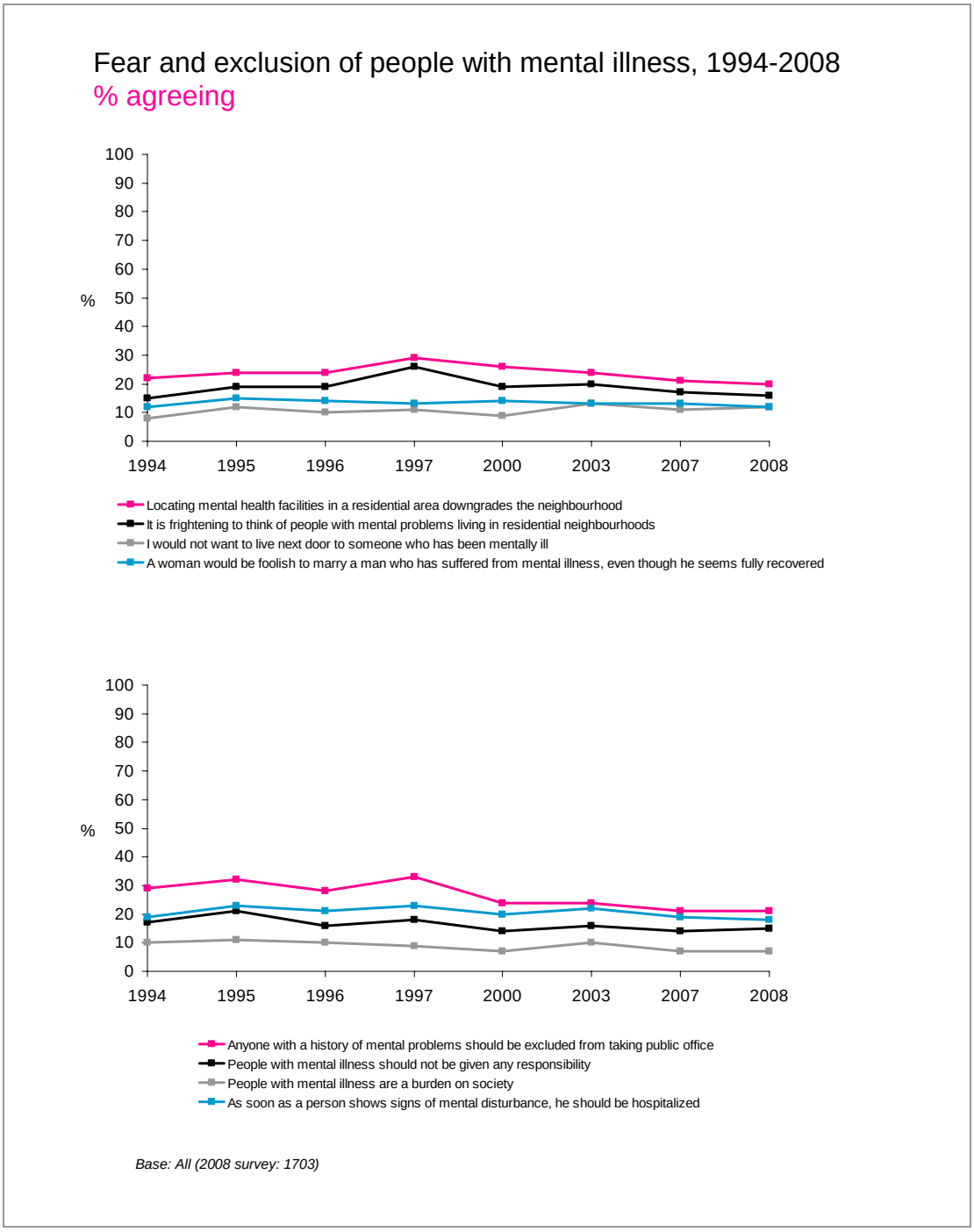
- It is frightening to think of people with mental problems living in residential neighbourhoods
- I would not want to live next door to someone who has been mentally ill
- A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered
- Anyone with 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 2008. Overall, the levels of agreement with these negative statements about people with mental illness were low, ranging in 2008 from 7% to 21%. The highest levels of agreement in 2008 were with the statements 'Anyone with a history of mental illness should be excluded from taking public office' (21%) and 'Locating mental health facilities in a residential area downgrades the neighbourhood' (20%) (Figure 1).

Figure 1



In general, agreement with these negative statements towards people with mental illness changed little between 1994 and 2008. There were some increases in agreement with individual statements in the intervening years, particularly between 1994 and 2007, but levels of agreement in 2008 had generally fallen back to the lower levels seen at the start of the survey series.

Overall there was no significant change between 1994 and 2008 in the proportion agreeing that locating mental health facilities in a residential area downgrades the neighbourhood. However agreement with this statement increased between 1994 (22%) and 1997 (29%), and decreased since 1997 to 20% in 2008.

Similarly, agreement that 'it is frightening to think of people with mental health problems living in residential neighbourhoods' increased from 15% in 1994 to 26% in 1997, before decreasing to 16% in 2008 (no overall significant change since 1994).

Agreement that 'I would not want to live next door to someone who has been mentally ill' fluctuated between 8% and 13% since 1994, and stood at 12% in 2008, a significant increase from the 1994 level (8%). At the same time, the proportion disagreeing with this statement fell significantly – from 74% in 1994 to 63% in 2008.

Agreement that a woman would be foolish to marry someone who has suffered from mental illness was 12% in 2008, the same figure as in 1994. Agreement with this statement reached a maximum of 15% in 1995.

There was a significant decrease since 1994 in agreement that anyone with a history of mental problems should be excluded from taking public office - this stood at 21% in 2008, the same proportion as in 2007, down from 29% in 1994. Agreement with this statement increased between 1994 and 1997 (33%), gradually falling back since then.

The proportion of respondents agreeing that people with mental illness should not be given any responsibility was 15% in 2008, not significantly different from the 1994 figure of 17%.

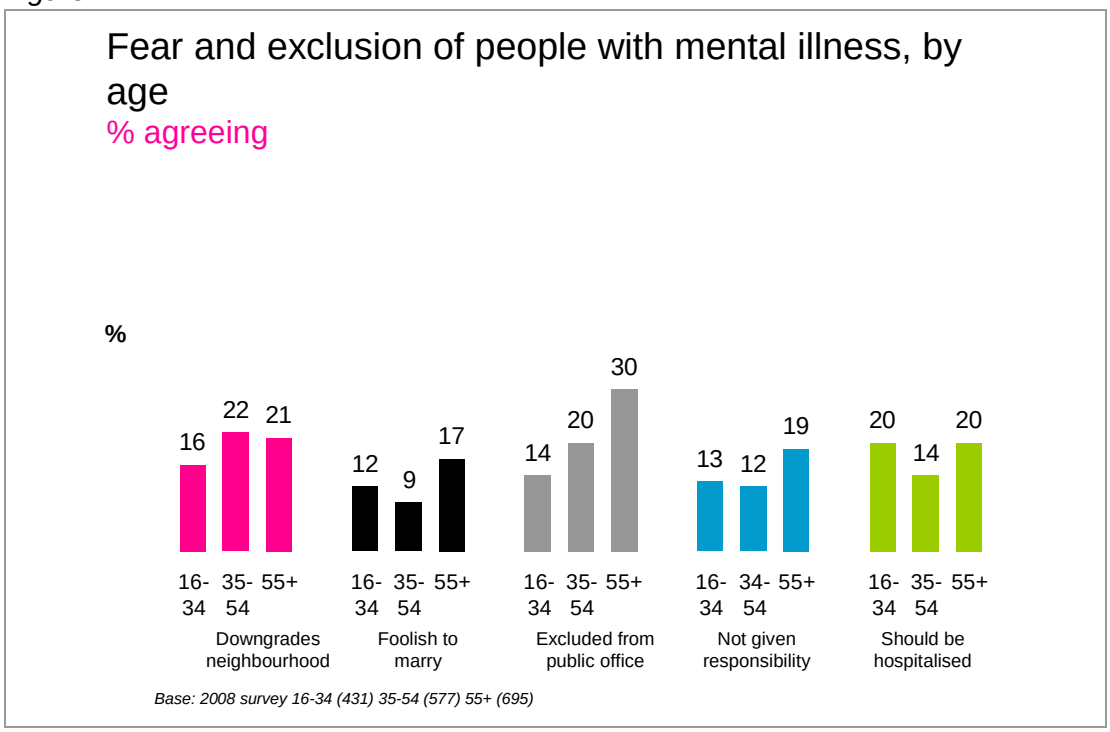
Agreement that people with mental illness are a burden on society stood at 7% in 2008, a decrease from 10% in 1994.

The proportion agreeing that as soon as a person shows signs of mental disturbance, he should be hospitalised, was 18% in 2008, not significantly different from the figure in 1994 (19%). However agreement with this statement did increase significantly between 1994 and 1997 (23%), falling back since then to the lower level.

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 2008 (Figure 2). Statements from this section where there were no significant differences by age are not shown on the chart.

Figure 2



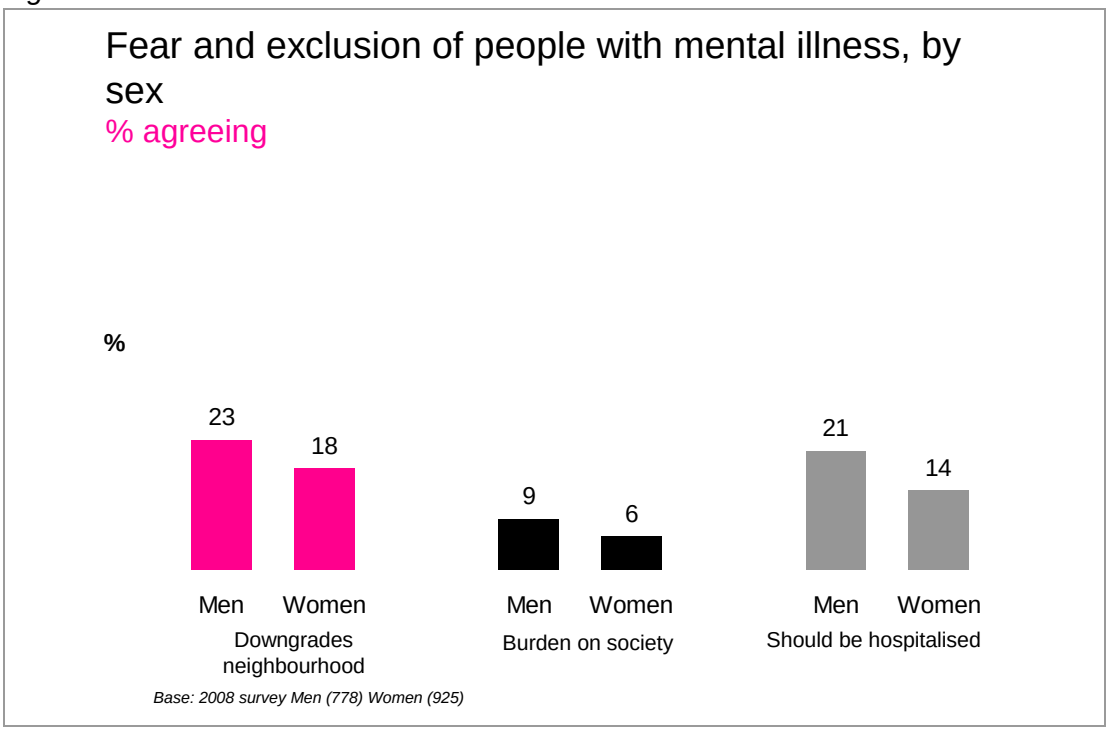
In general the oldest group had the most negative attitudes towards people with mental illness, being significantly more likely than younger groups to agree that a woman would be foolish to marry a man who has suffered from mental illness, anyone with a history of mental illness should be excluded from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

Those aged 16-34 were least likely to agree that locating mental health facilities in a residential area downgrades the neighbourhood, and that anyone with a history of mental illness should be excluded from public office.

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 2008 between men and women in the proportion agreeing are shown in Figure 3.

Figure 3



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 people with mental illness are a burden on society, and that as soon as a person shows signs of disturbance, he should be hospitalised.

Figure 4 shows differences by social grade in 2008 for those statements in this section for which there were any significant differences.

Figure 4

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

Respondents in the 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 as soon as a person shows signs of mental disturbance, he should be hospitalised.

DE respondents were also significantly more likely than ABs to agree that they would not want to live next door to someone who has been mentally ill, that a woman would be foolish to marry someone who has suffered from mental illness, and that people with mental illness should not be given any responsibility.

In contrast, AB respondents were more likely than DEs 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:

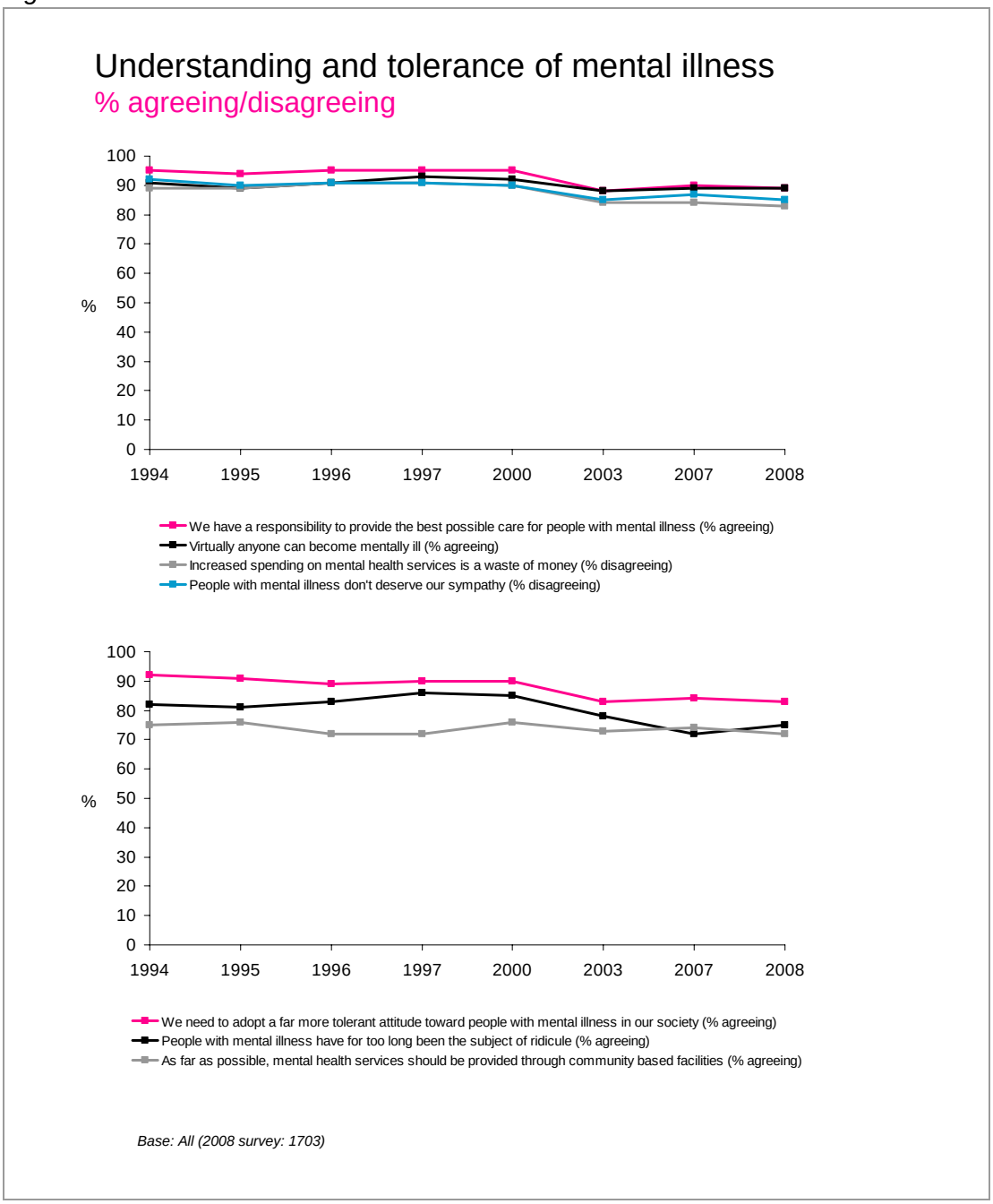
- We have a responsibility to provide the best possible care for people with mental illness *(% agreeing)*
- Virtually anyone can become mentally ill *(% agreeing)*
- Increased spending on mental health services is a waste of money *(% disagreeing)*
- People with mental illness don't deserve our sympathy *(% 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 2008 from 72% for ‘As far as possible, mental health facilities should be provided

through community based facilities' to 89% for 'We have a responsibility to provide the best possible care' and 'Virtually anyone can become mentally ill' (Figure 5).

Figure 5



Looking at trends over time, there were significant decreases since 1994 in the proportion of respondents displaying understanding attitudes on several of these statements, with particular declines since 2000.

The proportion agreeing that 'We have a responsibility to provide the best possible care for people with mental illness' did not change significantly between 1994 and 2000 (95%), but decreased significantly since 2000 to 89% in 2008. Similarly, the proportion disagreeing that 'increased spending on mental health services is a waste of money' did not change significantly between 1994 (89%) and 2000 (90%), but decreased significantly since 2000, to 83% in 2008. The proportion disagreeing that 'people with mental illness don't deserve our sympathy' followed a similar pattern, being 92% in 1994, 90% in 2000, and falling significantly to 85% in 2008.

Agreement that 'we need to adopt a more tolerant attitude towards people with mental illness' also decreased significantly between 1994 (92%) and 2008 (83%), although most of the decrease happened since 2000 (90%).

The proportion agreeing that 'virtually anyone can become mentally ill' initially increased significantly between 1994 and 1997, from 91% to 93%, decreased significantly to 88% by 2003, and stood at 89% in 2008.

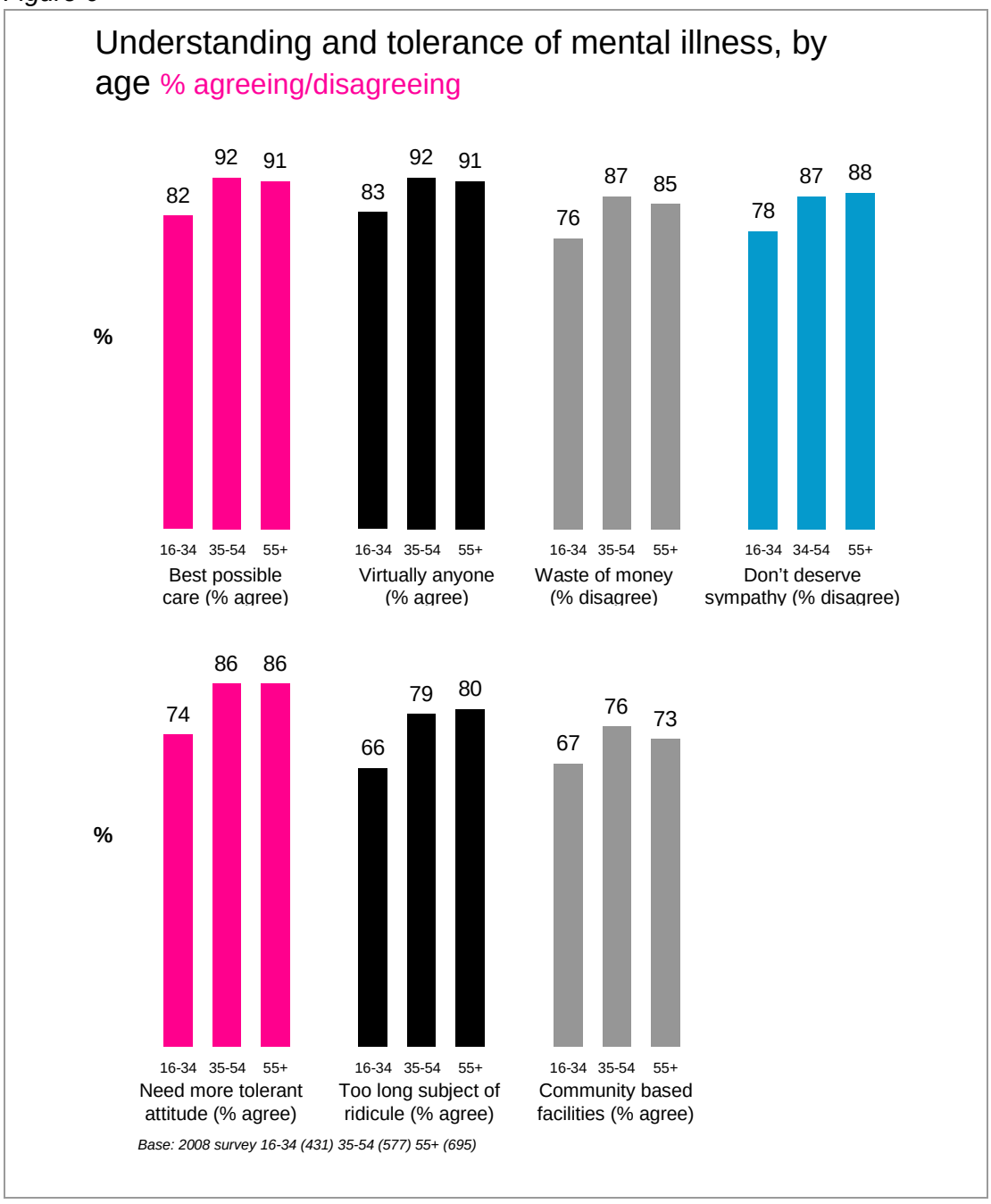
Agreement that 'People with mental illness have for too long been the subject of ridicule' initially increased between 1994 (82%) and 1997 (86%), and decreased between 1997 and 2007 (72%). There was however a significant increase in agreement with this between 2007 (72%) and 2008 (75%).

The proportion agreeing that mental health services should be provided through community based facilities has fluctuated since 1994, but overall there was no significant change between 1994 (75%) and 2008 (72%).

3.3.3 Differences by age, sex and social grade

There were significant differences by age group in 2008 for all of the statements in this section (Figure 6).

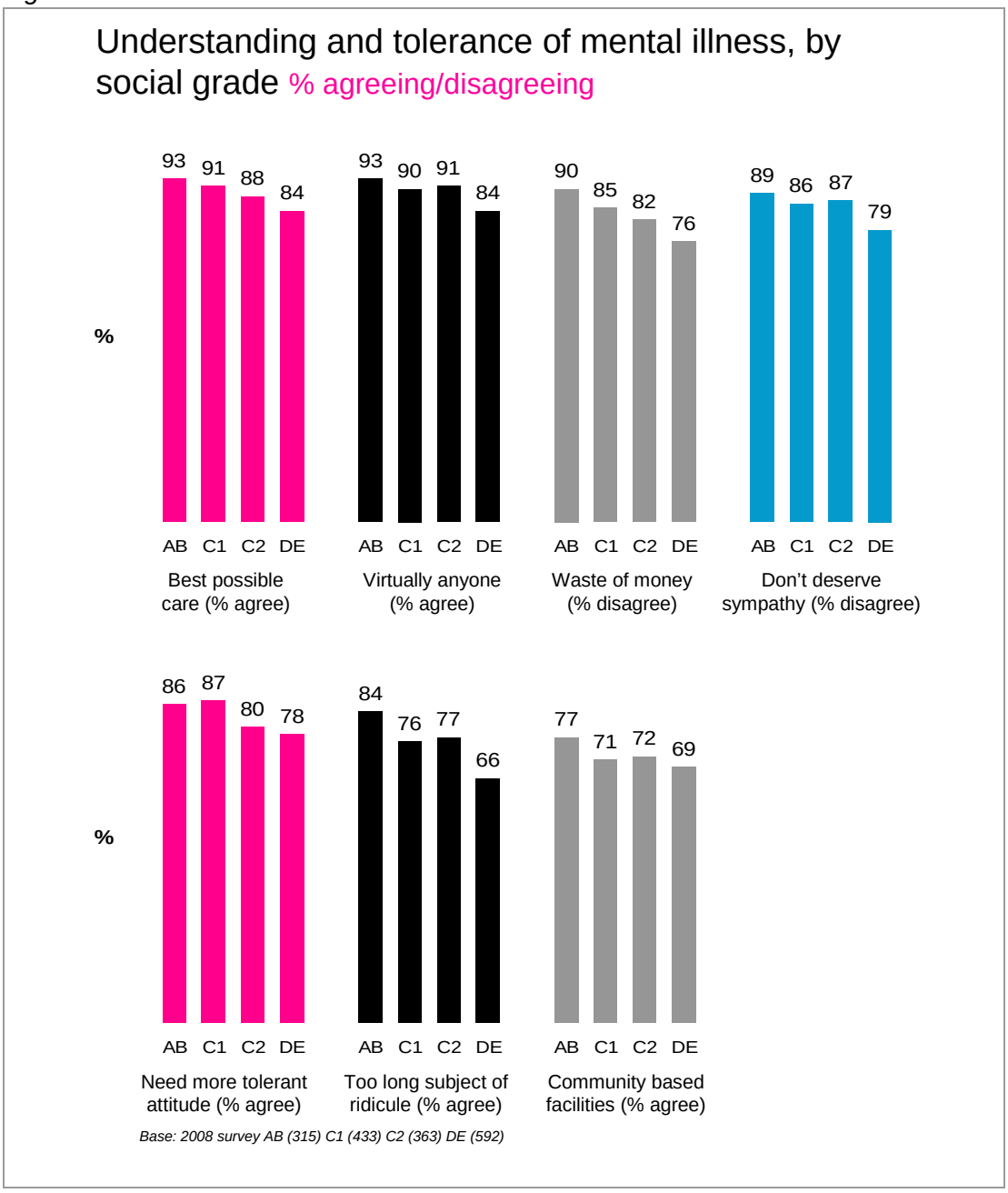
Figure 6



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 all of these 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 2008 for all of the statements in this section (Figure 7).

Figure 7



Respondents in the DE group were significantly less likely than ABs to adopt understanding/tolerant attitudes towards mental illness for all of these statements.

Other significant differences by social grade were:

- C2s were less likely than ABs to agree that we have a responsibility to provide the best possible care

- C1s and C2s were less likely than ABs to disagree that increased spending on mental health services is a waste of money; DEs were significantly less likely to disagree with this than both C1s and C2s (as well as ABs)
- C2s were less likely than ABs and C1s to agree that we need to adopt a more tolerant attitude toward people with mental illness
- C1s and C2s were less likely than ABs to agree that people with mental illness have for too long been the subject of ridicule; the decrease between C1/C2s and DEs on this statement was also significant.

There were no significant differences between men and women in their attitudes to the statements in this section.

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 8 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 2008 74% agreed that 'No-one has the right to exclude people with mental illness from their neighbourhood' and 'Mental illness is an illness like any other'; 70% agreed that 'The best therapy for many people with mental illness is to be part of a normal community'; 66% 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' (23% agree), 'Less emphasis should be placed on protecting the public from people with mental illness' (29% agree) and 'Mental hospitals are an outdated means of treating people with mental illness' (31% agree).

The other two statements in this section fell between these two extremes, with 59% of respondents agreeing that 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' and 57% that 'People with mental illness are far less of a danger than most people suppose'.

In general there was little change between 1994 and 2008 in the overall levels of agreement with most of the statements in this section.

Figure 8

The proportion of respondents agreeing that 'people with mental illness are far less of a danger than most people suppose' decreased significantly, from 62% in 1994 and 64% in 2000, to 57% in 2008. Similarly, the proportion agreeing that 'the best therapy for people with mental illness is to be part of a normal community' decreased over the course of the surveys, from 76% in 1994, to 74% in 2000 and 70% in 2008.

Agreement that 'Less emphasis should be placed on protecting the public from people with mental illness' stood at 29% in 2008. The level of agreement with this

statement fluctuated over the years, but in 2008 was not significantly different from the 1994 level (32%).

The proportion agreeing that 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services', at 59% in 2008, was significantly lower than the 1994 level (62%), although agreement was lowest in 1997 and 2003 (56%).

The proportion agreeing that people with mental health problems should have the same rights to a job as anyone else, at 66% in 2008, had not changed significantly since this question was introduced into the survey in 2003.

The proportion of respondents agreeing that 'most women who were once patients in a mental hospital can be trusted as babysitters' decreased significantly between 1994 and 1997, from 21% to 17%. After 1997, agreement increased steadily to 23% by 2008; overall not significantly different from the 1994 figure.

In 2008, 74% of respondents agreed that 'mental illness is an illness like any other', significantly higher than the 1994 level of 71%, although agreement with this was highest in 1997 and 2000 (76%).

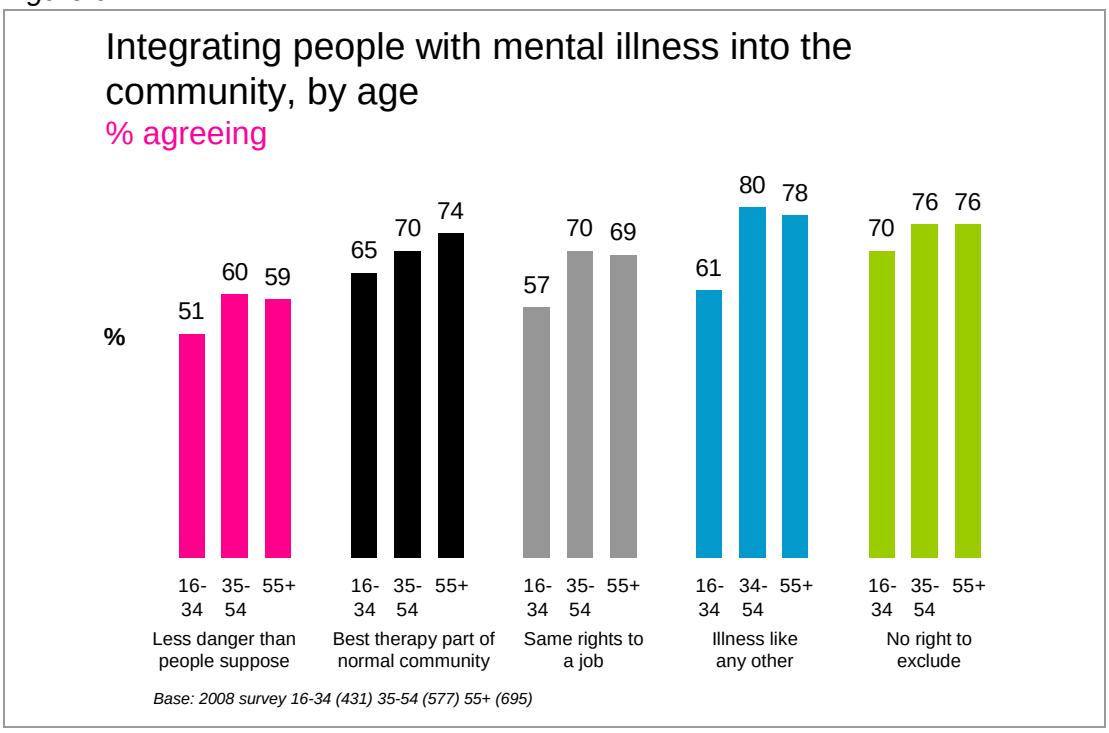
74% in 2008 agreed that 'no-one has the right to exclude people with mental illness from their neighbourhood', not significantly different from the 1994 level (76%).

The biggest change over time in the statements in this section was in the level of agreement that 'mental hospitals are an outdated means of treating people with mental illness'. Agreement with this fell from 42% in 1994 to 31% in 2008. Although there was some fluctuation in the level of agreement in the earlier years of the survey, since 2000, when agreement stood at 40%, there has been a steady decline.

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 2008 are shown in Figure 9.

Figure 9

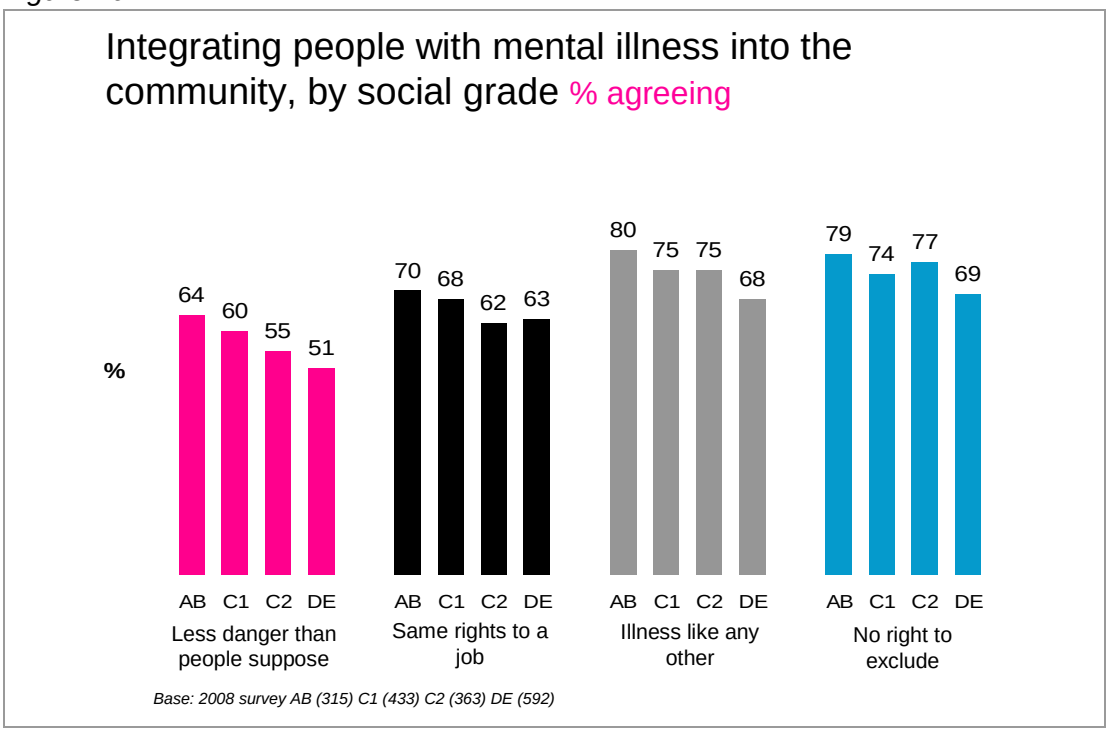


The youngest age group (16-34s) were less likely than the older groups (35-54 and 55+) to be in favour of integrating people with mental illness into the community, being less likely to agree with several of the statements in this section, namely that people with mental illness are less of a danger than most people suppose; the best therapy for people with mental illness is to be part of a normal community; people with mental illness have the same rights to a job as anyone else; mental illness is an illness like any other; and no-one has the right to exclude people with mental illness from their neighbourhood. There were no significant differences between the 35-54 and 55+ groups in their levels of agreement with these statements.

Looking at differences by gender, the only statement in this section for which there was a significant difference between men and women in 2008 was 'Mental illness is an illness like any other' – 76% of women agreed with this, compared with 71% of men.

The statements on which there were significant differences by social grade in 2008 are shown in Figure 10.

Figure 10



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:

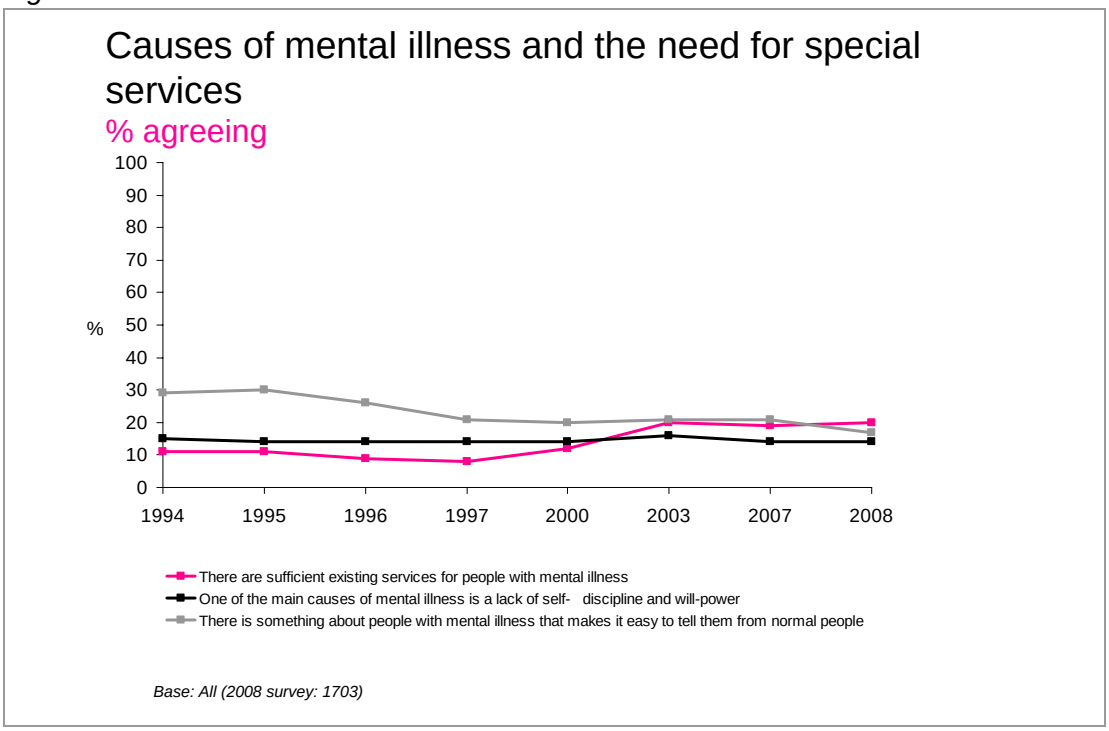
- There are sufficient existing services for people with mental illness
- One of the main causes of mental illness is a lack of self-discipline and will-power
- There is something about people with mental illness that makes it easy to tell them from normal people.

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 11 shows levels of agreement with these statements since 1994.

Figure 11



Agreement that there are sufficient existing services for people with mental illness decreased significantly between 1994 and 1997, from 11% to 8%. Agreement then increased significantly to 20% by 2003, and since then has remained at the higher level (20% in 2008).

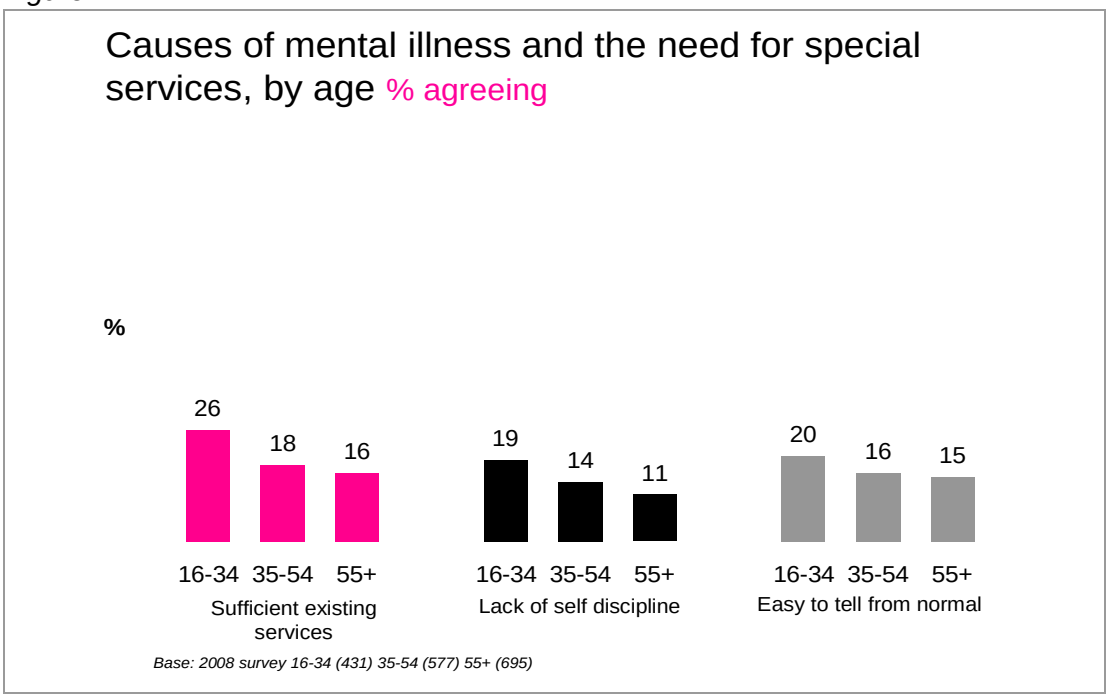
The proportion agreeing that 'there is something about people with mental illness that makes it easy to tell them from normal people' decreased fairly steadily from 29% in 1994 to 17% in 2008. There was a significant decrease from 21% in 2007 to 17% in 2008.

There was no significant change since 1994 in agreement that one of the main causes of mental illness is a lack of self-discipline and will-power (14% in 2008).

3.5.3 Differences by age, sex and social grade

Differences in agreement by age group are shown in Figure 12.

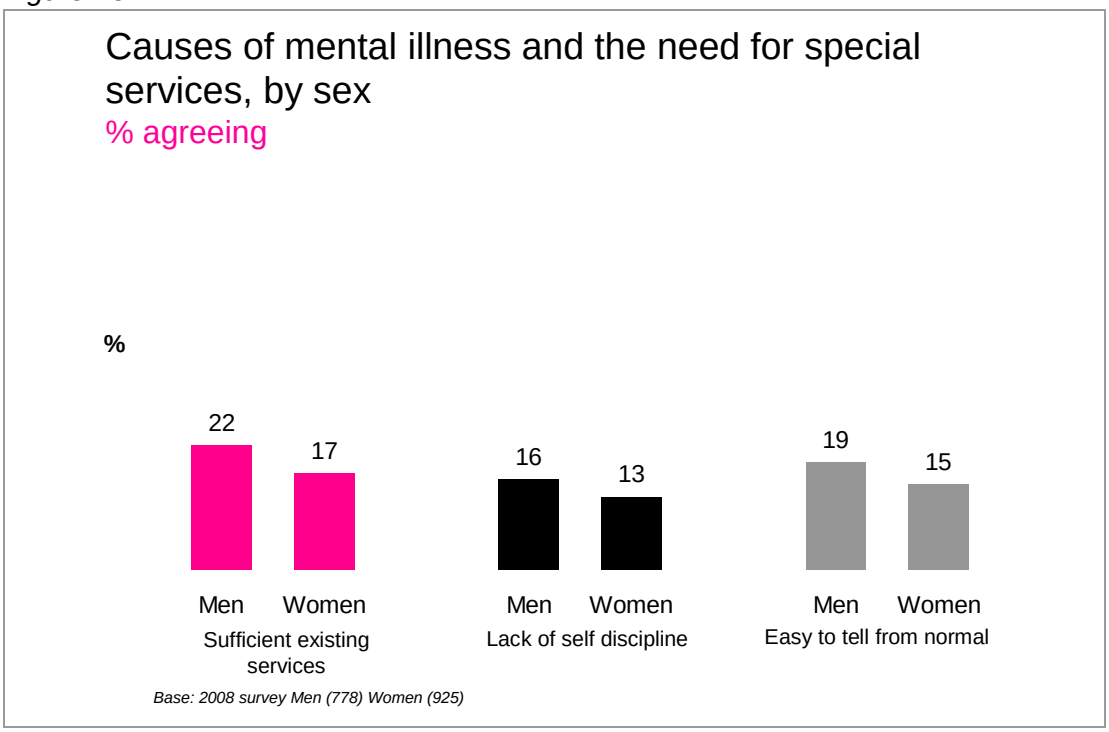
Figure 12



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 with these three statements.

Figure 13 shows the differences between men and women in levels of agreement with these statements.

Figure 13



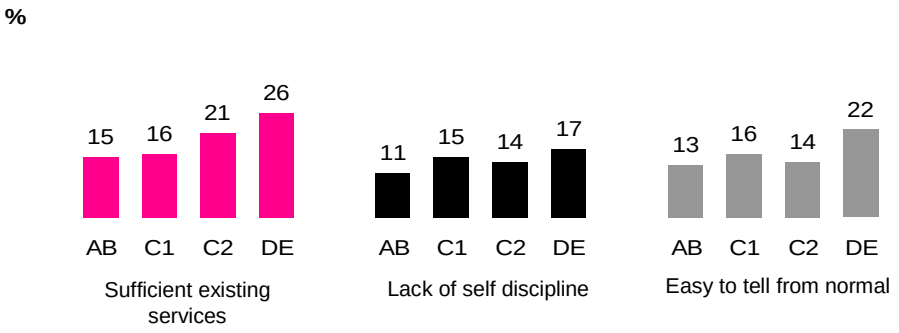
Men had the more negative attitudes towards mental illness, being significantly more likely than women to agree will all three of these statements.

Differences by social grade are shown in Figure 14.

Figure 14

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

% agreeing



Base: 2008 survey AB (315) C1 (433) C2 (363) DE (592)

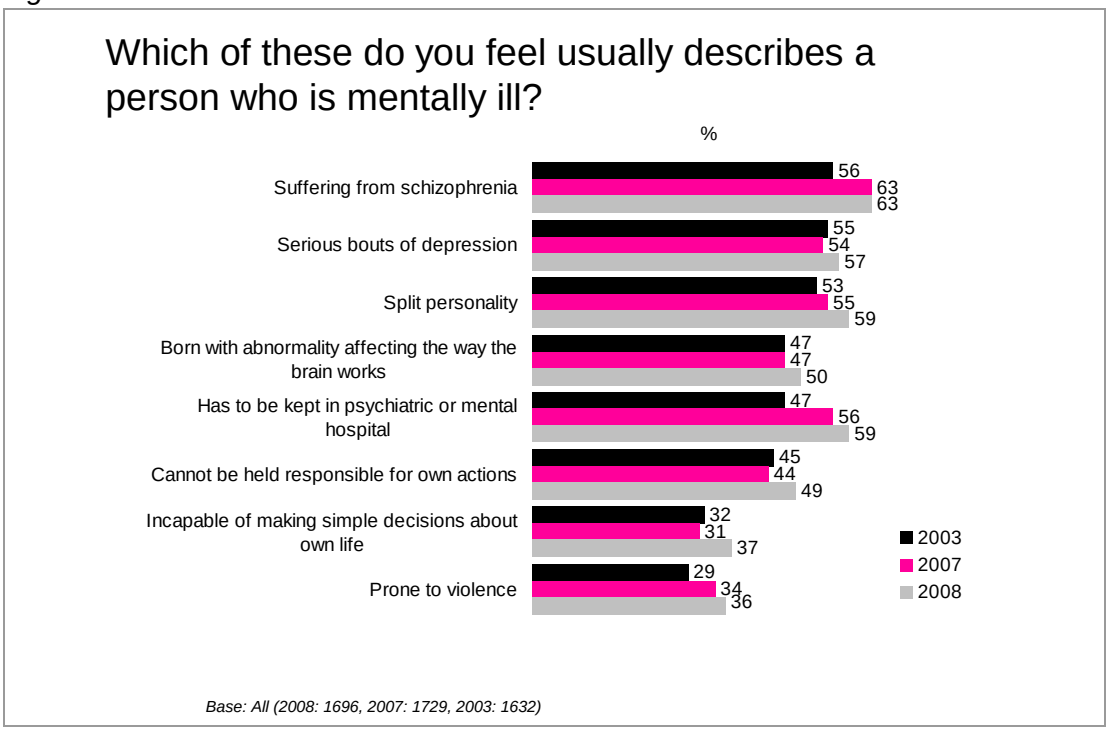
The pattern in this section was similar to that reported in earlier sections, namely that respondents in the AB social grade were significantly more positive in their attitudes towards mental illness than those in the DE grade, being less likely to agree with all three of these statements.

4. 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 15).

Figure 15



The description most likely to be selected was 'someone who is suffering from schizophrenia' – 63% in 2008.

The next most often selected were 'someone who has a split personality' and 'someone who has to be kept in a psychiatric or mental hospital', both of which were selected by 59% of respondents in 2008.

The descriptions least likely to be selected were 'someone who is incapable of making simple decisions about his or her own life' at 37%, and 'someone who is prone to violence' at 36%.

There were significant increases from 2003 to 2008 in the proportions selecting several of these descriptions:

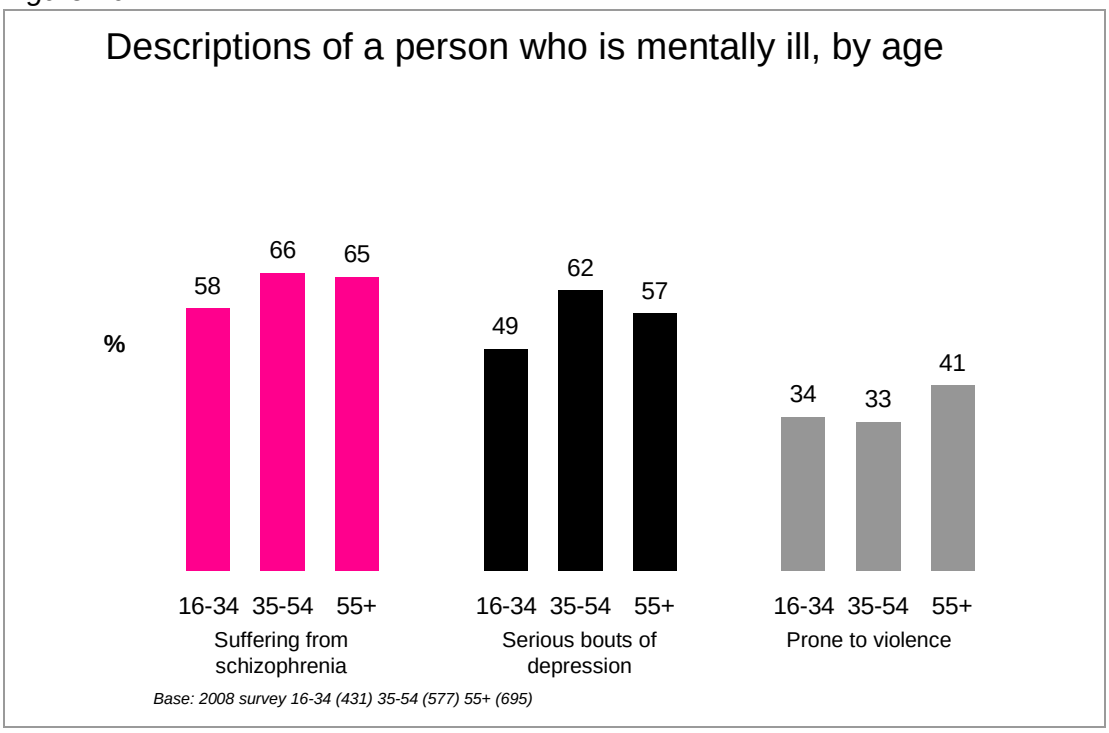
- Someone who is suffering from schizophrenia – from 56% to 63%
- Someone who has a split personality – from 53% to 59% (this increased significantly between 2007 (55%) and 2008)
- Someone who has to be kept in a psychiatric or mental hospital – from 47% to 59%
- Someone who cannot be held responsible for his or her own actions – from 45% to 49% (this increased significantly between 2007 (44%) and 2008)
- Someone who is incapable of making simple decisions about his or her own life – from 32% to 37% (this increased significantly between 2007 (31%) and 2008)
- Someone prone to violence – from 29% to 36%.

In 2008, 1% of respondents named other descriptions, 3% selected none of these, and 6% didn't know.

Looking at differences by gender, in the 2008 survey, men were more likely than women to select 'someone who is born with some abnormality affecting how the brain works' (53% compared with 48%) and 'someone who cannot be held responsible for his or her own actions' (52% compared with 47%).

There were differences in the proportions selecting some of these descriptions by age group in 2008, shown in Figure 16.

Figure 16

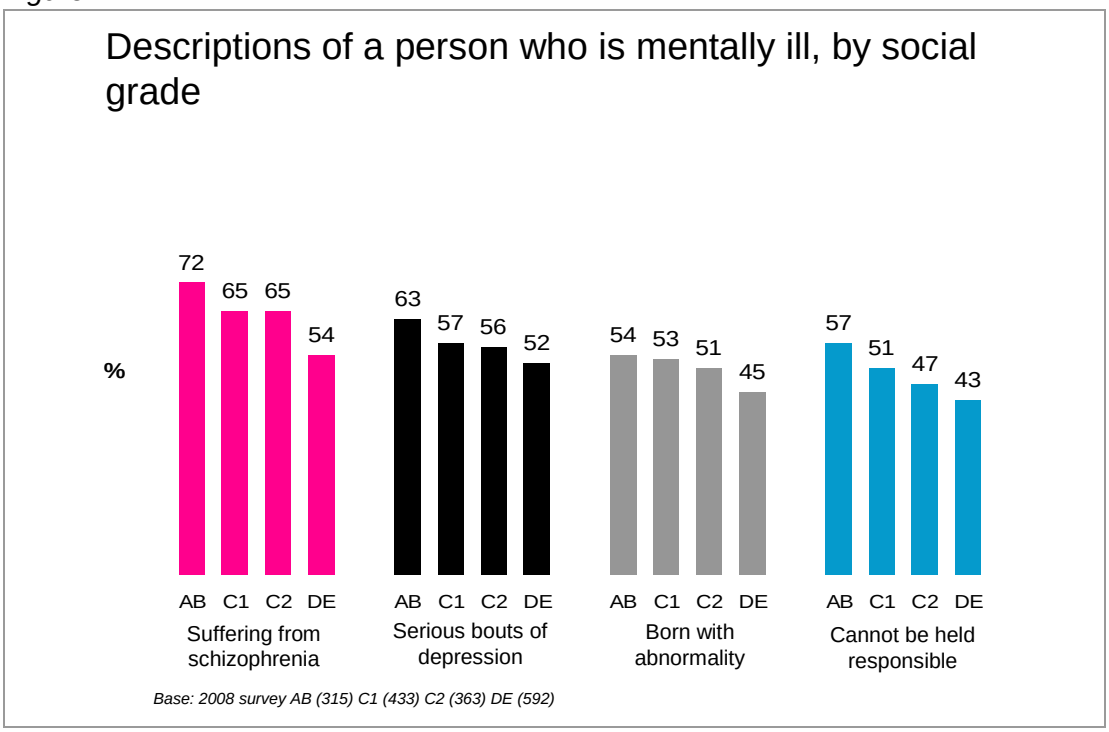


Respondents aged 16-34 were less likely than the older groups to select 'suffering from schizophrenia' or 'someone who has serious bouts of depression'. Those aged 55+ were more likely than the younger groups to select 'someone who is prone to violence'.

In general the youngest group was least likely to select any of these descriptions – 4% of 16-34s answered 'none of these' and 8% didn't know.

There were some differences by social grade in responses to this question, shown in Figure 17.

Figure 17



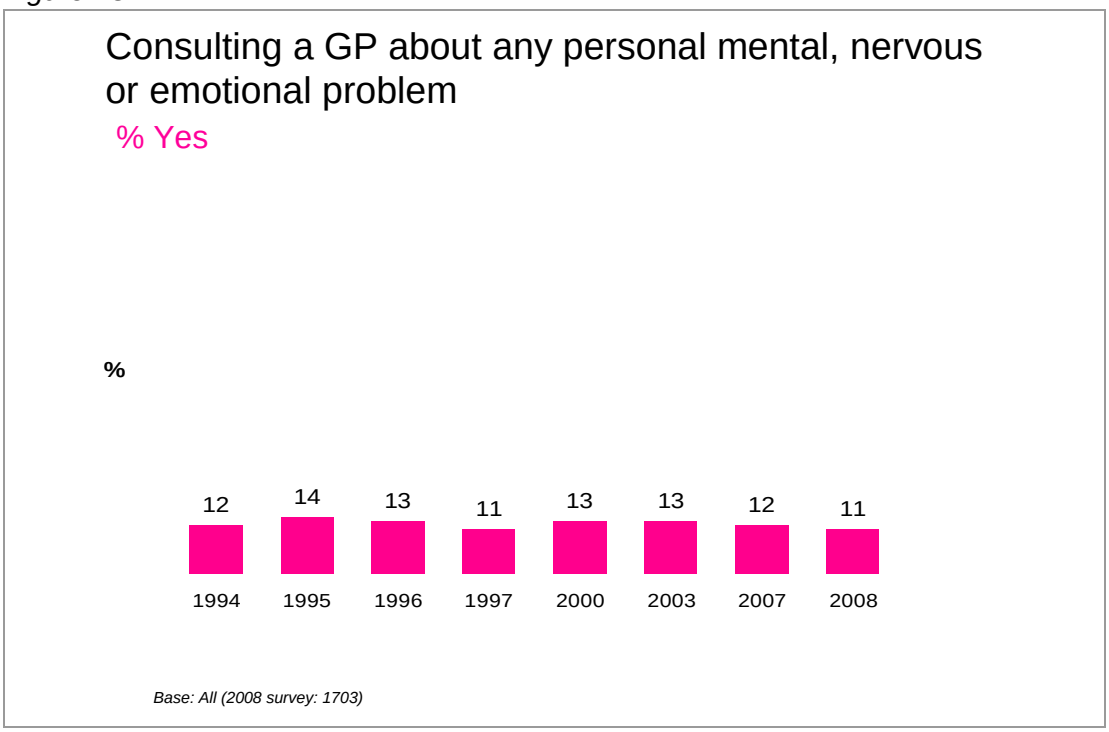
Respondents in social grades DE were less likely than ABs to select each of these descriptions.

5. Experience of mental illness

5.1 Consulting a doctor about a mental, nervous or emotional problem

Respondents have been asked in all surveys since 1994, whether they have spoken with their GP or family doctor in the past 12 months, about 'being anxious or depressed' or about 'any personal mental, nervous or emotional problem'. The proportions in each survey who had consulted a doctor about these problems are shown in Figure 18.

Figure 18

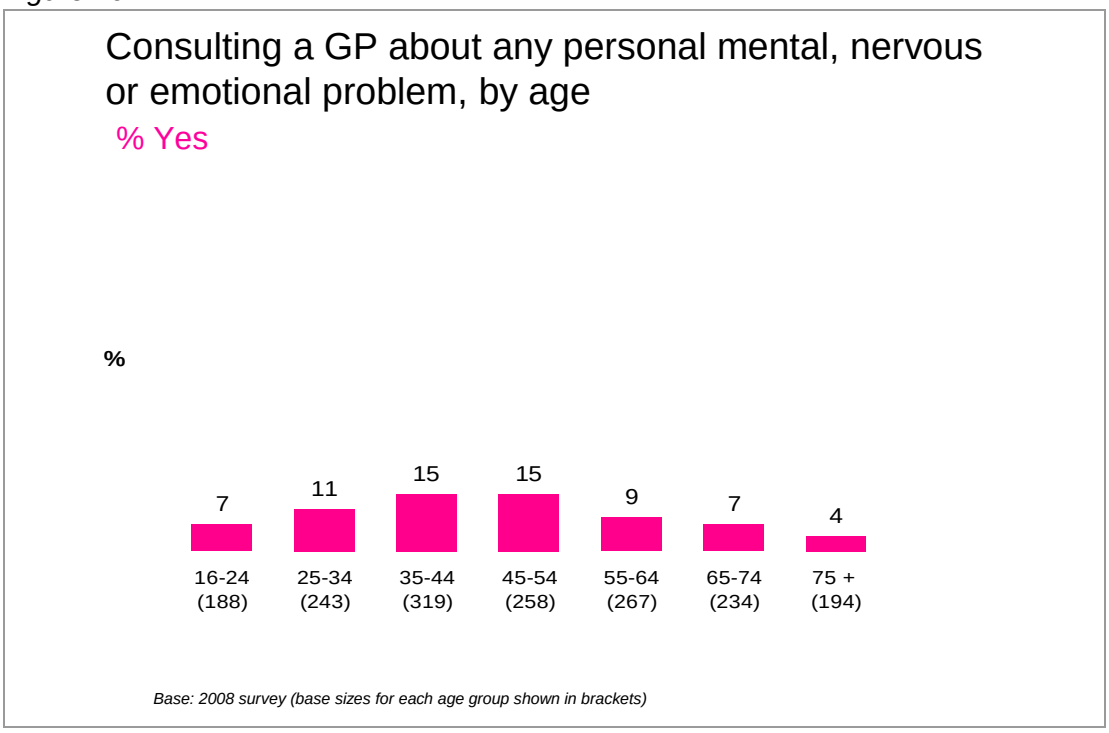


Overall just over 1 in 10 respondents had consulted a GP about these problems, with no significant changes since 1994.

In 2008 women (13%) were more likely than men (8%) to have consulted a GP about a mental, nervous or emotional problem.

The proportion of respondents who had consulted a doctor about these problems in the last 12 months was highest in the middle age groups (15% of those aged 35-44 and 45-54), and lower among the younger and older age groups (Figure 19).

Figure 19

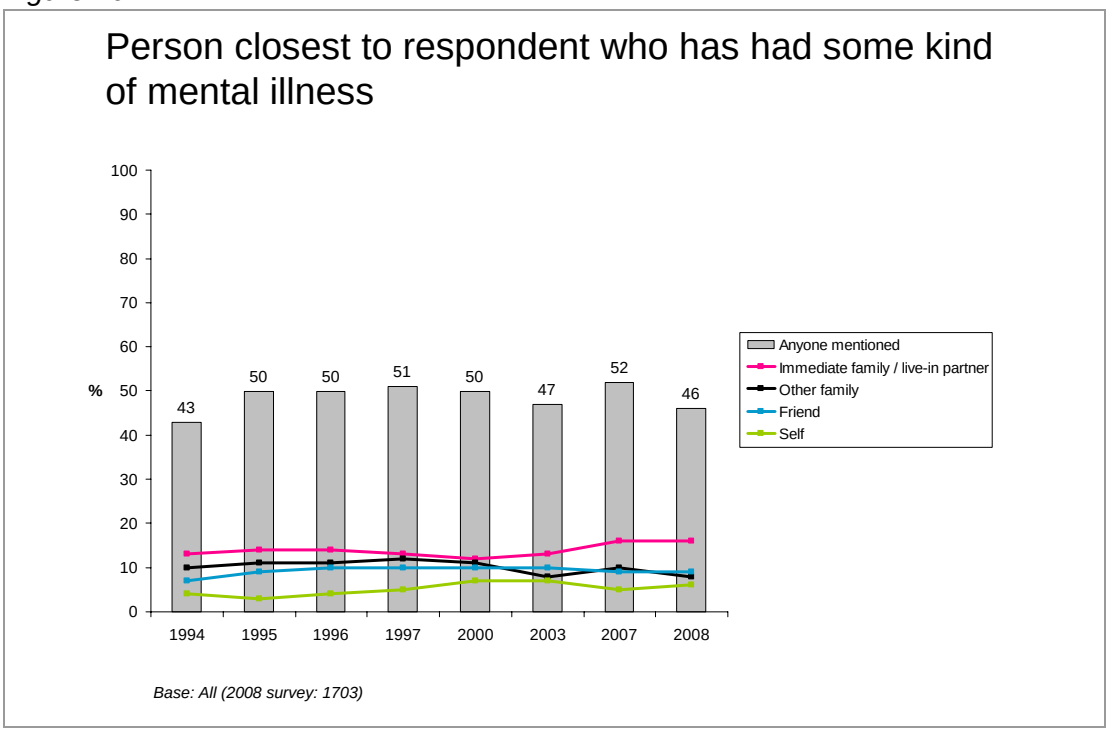


Looking at differences by social grade, respondents in social grades DE were more likely than the other groups to have consulted a doctor about a mental, nervous or emotional problem – 16% of them had, compared with 10% of C2s, 9% of C1s and 6% of ABs.

5.2 Friends and family who have had mental illness

Respondents have been asked since 1994 who, if anyone, close to them has had some kind of mental illness (Figure 20).

Figure 20



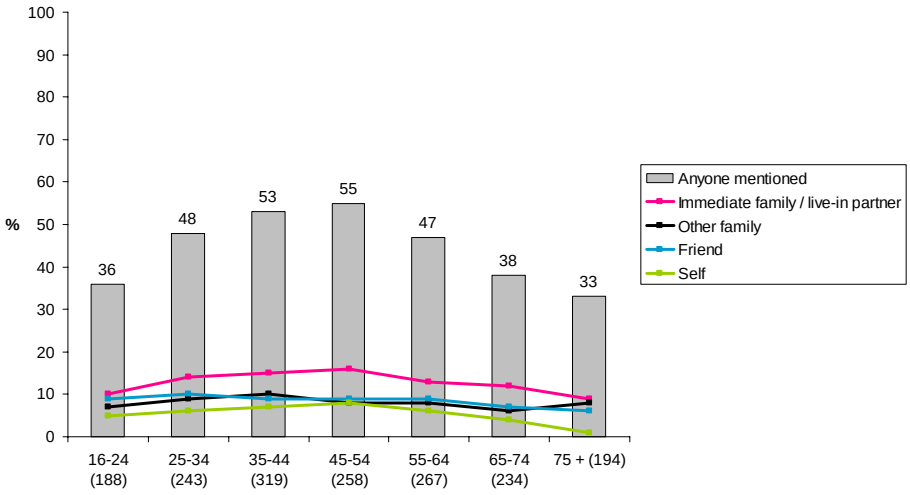
Around a half of respondents in each year mentioned that someone close to them had some kind of mental illness. At 46% in 2008, this proportion was significantly lower than the 52% in 2007, reversing the increase seen between 2003 and 2007. The 2008 proportion was not significantly different to the 43% reporting this in 1994.

As with previous surveys, the most commonly mentioned answer was immediate family/live-in partner, with 16% of respondents selecting this. 9% of respondents mentioned a friend, and 8% other family. Other people also mentioned were acquaintances (3%), work colleagues (3%) and 'others' (1%). 6% of respondents said that they themselves had experienced some kind of mental illness.

There were some differences by age group (Figure 21).

Figure 21

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



Base: 2008 survey (base sizes for each age group shown in brackets)

Respondents in the middle age groups (35-44 and 45-54) 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 75+ were least likely to say that they had experienced mental illness themselves.

5.3 Proportion of people who may have a mental health problem

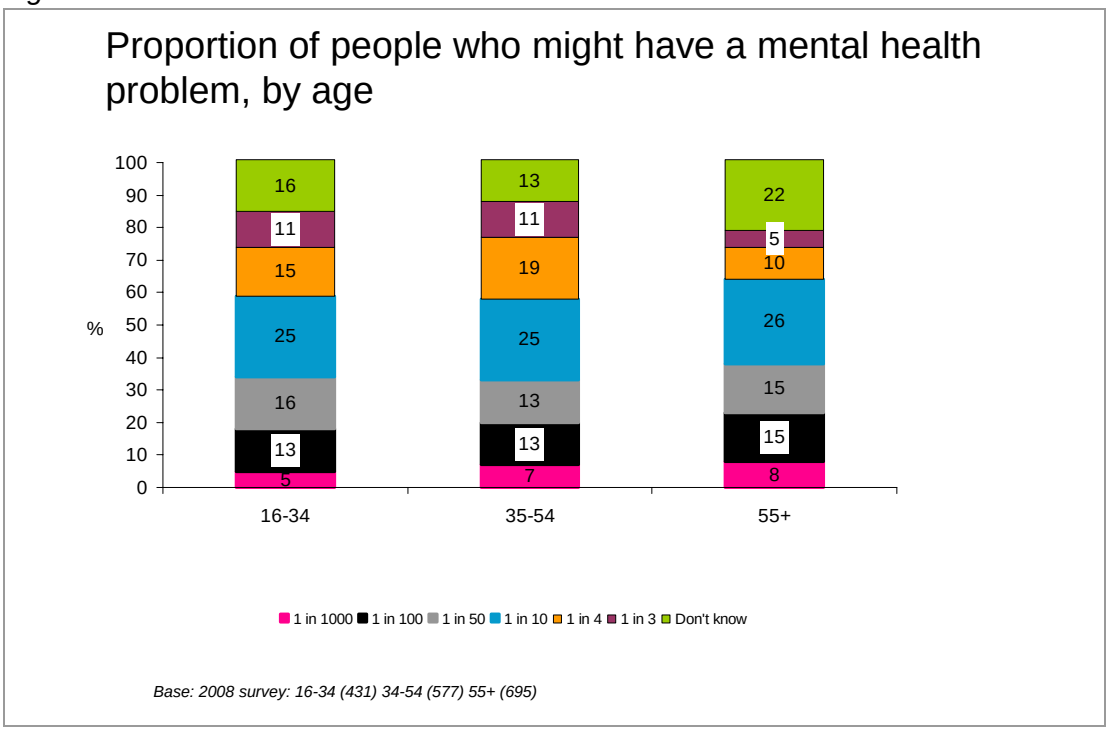
Respondents were asked what proportion of people in the UK they think might have a mental health problem at some point in their lives, and were given a list of options to choose from, ranging from 1 in 3 to 1 in 1000. The actual lifetime incidence of mental health problems is estimated to be around 1 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. A quarter of respondents (25%) thought the proportion was 1 in 10, with 35% of respondents thinking it was less than this (7% saying 1 in 1000, 13% 1 in 100 and 14% 1 in 50). 14% of respondents correctly stated the overall proportion was 1 in 4, and 9% thought it was higher than this (1 in 3). It is worth noting that 17% of respondents said that they did not know.

There have been no significant changes in responses to this question over time.

The breakdown by age group in 2008 is shown in Figure 22.

Figure 22



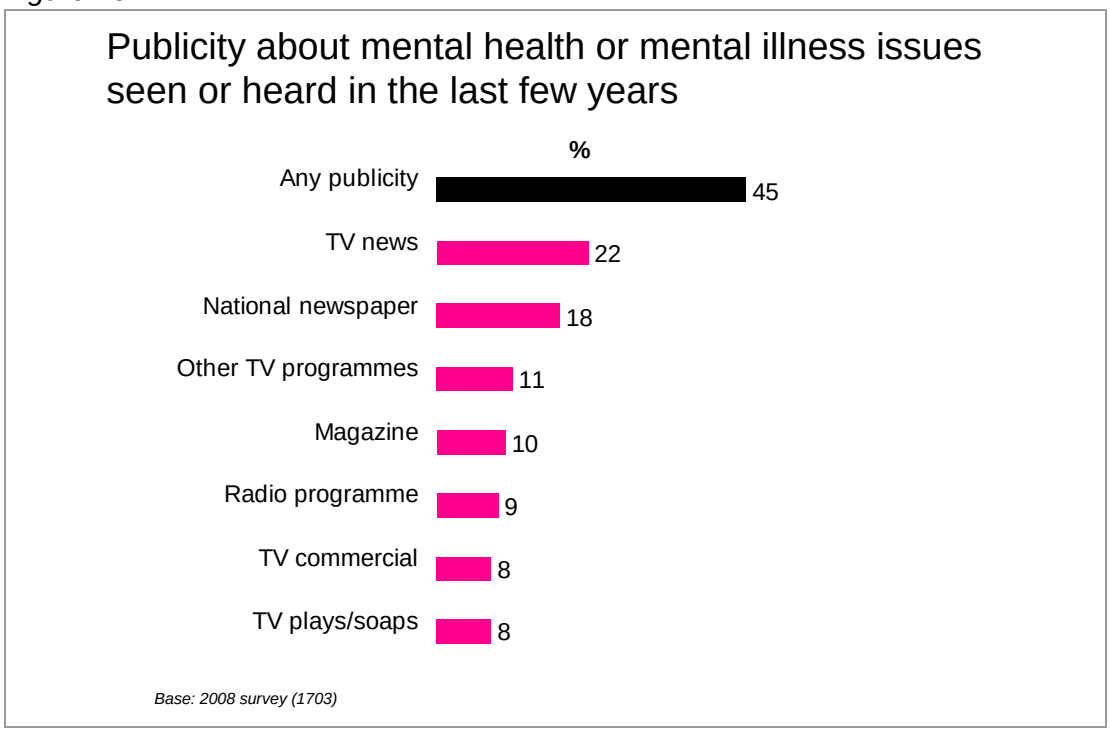
Respondents aged 55 and over were most likely to under-estimate the proportion of people who would have mental health problems – 64% of this age group answered less than 1 in 4, compared with 58% of those aged 35-54 and 59% of those aged 16-34. Respondents aged 55+ were also most likely to say that they didn't know (22%). Respondents aged 35-54 were most likely to give the 'right' answer of 1 in 4 (19%).

6. Publicity about mental illness issues

In 2007 and 2008, respondents were asked to indicate in which ways they had seen or heard any publicity about mental health or mental illness issues in the last few years. Respondents were shown a list of possible places and were asked to indicate which applied to them. A similar question had been asked in earlier surveys, but concentrated on whether publicity had been seen *recently*, and so results are not comparable with earlier years.

Results for 2008 are shown in Figure 23.

Figure 23



Overall, 45% of respondents had seen some publicity in recent years, a reduction from the 2007 figure of 56%. The most commonly-mentioned source of publicity was TV news, followed by national newspapers.

For each type of publicity that they had seen, respondents were asked whether the publicity from that source had influenced them to have more positive or negative views towards people with mental illness, and how important that source of publicity had been in influencing their views about people with mental illness. Results for 2008 are shown in Figures 24 and 25.

Figure 24 Influence of publicity on views about people with mental illness

		More positive views	No effect	More negative views	Don't know	*Unweighted base*
TV news	%	24	61	13	2	*359*
National newspaper	%	23	64	12	1	*302*
Other TV programmes	%	41	54	5	-	*192*
Magazine	%	32	63	4	1	*170*
Local newspaper	%	25	63	11	1	*151*
Radio programme	%	30	62	5	3	*142*
TV commercial	%	31	65	3	1	*137*
TV plays/soaps	%	32	64	4	-	*138*
In a film/at the movies	%	36	61	1	1	*107*

NB Sources selected by fewer than 100 respondents are not included here; these include Posters, Leaflets, Internet, Radio commercials, Through the post, and Others

For each source of publicity, the majority of respondents answered that it had had no effect on their views about people with mental illness.

Other TV programmes were most likely to have had a positive effect, followed by publicity seen in a film/at the movies. TV news, national and local newspapers were most likely to have had a negative effect on views (Figure 25).

Figure 25 Importance of publicity in influencing views about people with mental illness

		Important	Not important	Don't know	*Unweighted base*
TV news	%	49	50	2	*359*
National newspaper	%	38	59	2	*302*
Other TV programmes	%	54	45	1	*192*
Magazine	%	49	50	1	*170*
Local newspaper	%	36	63	1	*151*
Radio programme	%	40	55	5	*142*
TV commercial	%	43	54	3	*137*
TV plays/soaps	%	35	63	2	*138*
In a film/at the movies	%	43	53	5	*107*

NB Sources selected by fewer than 100 respondents are not included here; these include Posters, Leaflets, Internet, Radio commercials, Through the post, and Others

The sources most likely to be rated as having an important effect on views about people with mental illness were Other TV programmes (54%), TV news (49%) and magazines (49%). The least important source of publicity was TV plays/soaps (35%). (Figure 25).

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 2008 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) wre 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, 141 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 14 interviews were achieved on average per sample point.

I.4 Fieldwork

Interviews were carried out by 156 fully trained interviewers from TNS Field. Interviewing took place between January 23rd-27th 2008, 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. The 2008 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.
- Personal experience of mental illness.
- Proportions of people who may have a mental health problem.
- Awareness of publicity about mental health or mental illness issues.

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 2008 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 2008 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 higher than 10% (11% and 15%). 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 below:

Figure 26 Weighting matrix - weights

	Total	North	Midlands	South
Total	1	1	0.99	1
Men ABC1 : 16-24	1.36	1.24	1.24	1.55
Men ABC1 : 25-44	1.28	1.21	1.27	1.31
Men ABC1 : 45-64	1.33	1.35	1.16	1.47
Men ABC1 : 65+	0.7	0.65	0.6	0.82
Men C2 : 16-24	1.06	1.55	1.01	0.8
Men C2 : 25-44	1.03	1.33	1.98	0.71
Men C2 : 45-64	1.04	1.33	1.21	0.72
Men C2 : 65+	0.84	0.74	1.03	0.83
Men DE : 16-24	1.04	0.91	0.91	1.32
Men DE : 25-44	1.1	1.12	0.81	1.54
Men DE : 45-64	0.91	0.86	1.03	0.87
Men DE : 65+	0.74	0.73	0.89	0.67
Female ABC1 : 16-24	1.46	1.64	1.29	1.4
Female ABC1 : 25-44	1.22	1.21	1.29	1.18
Female ABC1 : 45-64	1.1	1.19	1.01	1.12
Female ABC1 : 65+	0.91	0.86	0.75	1.07
Female C2 : 16-24	1.04	0.99	1.85	0.78
Female C2 : 25-44	0.96	1.17	0.91	0.89
Female C2 : 45-64	1	0.75	1.57	0.99
Female C2 : 65+	0.88	0.66	1	1.05
Female DE : 16-24	1	0.91	0.92	1.14
Female DE : 25-44	0.75	0.92	0.72	0.68
Female DE : 45-64	0.77	0.99	0.75	0.65
Female DE : 65+	0.62	0.61	0.6	0.66

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

Figure 27 Weighted and unweighted sample profiles

	Weighted		Unweighted	
	N	%	N	%
Sex				
Male	820	48%	778	46%
Female	876	52%	925	54%
Age				
16-24	224	13%	188	11%
25-34	266	16%	243	14%
35-44	345	20%	319	19%
45-54	267	16%	258	15%
55+	594	35%	695	41%
Social Grade				
AB	357	21%	315	18%
C1	503	30%	433	25%
C2	358	21%	363	21%
DE	479	28%	592	35%
Working status				
Full time	690	41%	615	36%
Part time (8-29 hrs)	221	13%	209	12%
Part time (under 8 hrs)	18	1%	18	1%
Retired	391	23%	490	29%
Total	1696	100%	1703	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 27 above) indicates that the achieved sample contained fewer men, young people, and full-time workers; and correspondingly more women and retired people, than would be expected if it were fully representative of the population. This discrepancy has 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, 1994-2008

The table below shows the sample sizes for all surveys in this series since 1994.

Figure 28

	Sample size (unweighted)
	n
1994	1682
1995	1554
1996	5071
1997	4900
2000	1707
2003	1632
2007	1729
2008	1703

I.12 Factor analysis

A factor analysis was carried out on the 27 attitude statements, in order to identify a smaller set of themes to describe the key features of the data, which could be used to group statements for analysis.

A principal components factor analysis with varimax rotation was carried out using SPSS. Four factors with an eigenvalue of greater than 1 were identified. Overall 45% of the variance was explained by these four factors. All the statements loaded with a level of at least 0.43 on a factor. Statements were allocated to the factor on which they had the highest loading.

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.

Figures 29-32 show the statements comprising each factor, together with their factor loadings, which indicate the relative importance of each statement within the factor.

Negative factor loadings relate to disagreement rather than agreement with a statement.

Figure 29 **Factor 1 Fear and exclusion of people with mental illness**

Statements	Factor loading
Locating mental health facilities in a residential area downgrades the neighbourhood	0.66
It is frightening to think of people with mental problems living in residential neighbourhoods	0.64
I would not want to live next door to someone who has been mentally ill	0.63
A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	0.61
Anyone with a history of mental problems should be excluded from taking public office	0.60
People with mental illness should not be given any responsibility	0.54
People with mental illness are a burden on society	0.53
As soon as a person shows signs of mental disturbance, he should be hospitalized	0.44

Figure 30 **Factor 2 Understanding and tolerance of mental illness**

Statements	Factor loading
We have a responsibility to provide the best possible care for people with mental illness	0.70
Virtually anyone can become mentally ill	0.67
People with mental illness don't deserve our sympathy	-0.65
Increased spending on mental health services is a waste of money	-0.65
We need to adopt a far more tolerant attitude toward people with mental illness in our society	0.59
People with mental illness have for too long been the subject of ridicule	0.49
As far as possible, mental health services should be provided through community based facilities	0.43

Figure 31 **Factor 3 Integrating people with mental illness into the community**

Statements	Factor loading
People with mental illness are far less of a danger than most people suppose	0.62
Less emphasis should be placed on protecting the public from people with mental illness	0.55
The best therapy for many people with mental illness is to be part of a normal community	0.53
Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	0.50
People with mental health problems should have the same rights to a job as anyone else	0.49
Most women who were once patients in a mental hospital can be trusted as babysitters	0.49
Mental illness is an illness like any other	0.46
No-one has the right to exclude people with mental illness from their neighbourhood	0.45
Mental hospitals are an outdated means of treating people with mental illness	0.43

Figure 32 **Factor 4 Causes of mental illness and the need for special services**

Statements	Factor loading
There are sufficient existing services for people with mental illness	0.69
One of the main causes of mental illness is a lack of self-discipline and will-power	0.59
There is something about people with mental illness that makes it easy to tell them from normal people	0.52

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...

(Rotate order of statement)

...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.3a 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

DO NOT SHOW SCREEN FOR NEXT QUESTION

Q.4 In the past 12 months, have you spoken with your G.P. or family doctor, either in person or by telephone, about being anxious or depressed or about any personal mental, nervous or emotional problem?

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

SHOW SCREEN
Q.5 Who is the person closest to you who has or has had some kind of mental illness ?

Please take your answer from this screen.

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.6 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 MULTICHOICE

Q.8 Can I just check, have you seen or heard any publicity about mental health or mental illness issues in the last few years in any of these ways?

01: National newspaper
02: Local newspaper
03: TV commercial
04: TV plays\soaps
05: TV news
06: Other TV programmes
07: Radio commercial
08: Radio programme
09: Magazine
10: Poster
11: Through the internet\a website
12: Leaflet\booklet picked up
13: In the post\through the letterbox
15: In a film\at the movies

16: 1st other (type-in)
17: 2nd other (type-in)
18: 3rd other (type-in)
(N)
(DK)

(route: ask Q.9 and Q.10 in turn for each answer 01-18 coded at Q.8, others close)

(scripter: if code 11 coded at Q.8, amend text at Q.9/Q.10 to read "internet/websites", If code 12 coded at Q.8, amend text to read "information received in the post/through the letter box"

Now, thinking about where you have said you have seen or heard any publicity about mental health or mental illness issues in the last few years.
SHOW SCREEN

Q.9 Please tell me whether (insert answer from Q.8) have influenced you to have more positive or negative views towards people with mental illness during the last few years?

01: More positive views
02: Has not affected my views at all
03: More negative views
(DK)

SHOW SCREEN

Q.10 And how important have (insert answer from Q.8) been in the last few years in influencing your views about people with mental illness?

01: Very important
02: Quite important
03: Not very important
04: Not important at all
(DK)