



Well? What Do You Think? (2008)

The Fourth National Scottish
Survey of Public Attitudes to
Mental Wellbeing and Mental
Health Problems

**WELL? WHAT DO YOU THINK? (2008)
THE FOURTH NATIONAL SCOTTISH SURVEY OF
PUBLIC ATTITUDES TO MENTAL WELLBEING AND
MENTAL HEALTH PROBLEMS**

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Glossary of Terms

Above average mental wellbeing	One of 3 classifications of mental wellbeing (the others are: average mental wellbeing and below average mental wellbeing) derived from responses to the WEMWBS section of the questionnaire. A respondent with above average mental wellbeing is one whose WEMWBS score is over one standard deviation above the mean. This three-fold classification was created solely for the purposes of analyses presented in this report and is not based on evidence that an average or below average score, while relatively lower than above average, is necessarily problematic (there is currently no marker below which mental wellbeing is classified as “poor”). Indeed, as WEMWBS is normally distributed in the population, most people <i>should</i> have average wellbeing.
Average mental wellbeing	One of three classifications of mental wellbeing (the others are: above average mental wellbeing and below average mental wellbeing) derived from responses to the WEMWBS section of the questionnaire. A respondent with average mental wellbeing is one whose WEMWBS score is within one standard deviation of the mean. This three-fold classification has been created solely for the purposes of analyses presented in this report (see “Above average mental wellbeing” above).
Below average mental wellbeing	This is one of three classifications of mental wellbeing (the others are: above average mental wellbeing and average mental wellbeing) derived from responses to WEMWBS. A respondent with below average mental wellbeing is one whose score on WEMWBS is more than one standard deviation below the mean. This three-fold classification was created solely for the purposes of analyses presented in this report (see “Above average mental wellbeing” above).
CAPI	Computer Assisted Personal Interviewing – the use of computer hardware to administer surveys rather than pen and paper questionnaires.
CASI	Computer Assisted Self Interviewing – sections of a questionnaire set out for self-completion by the respondent.
GHQ12	The 12 item version of the General Health

Questionnaire. A well-established screening instrument designed to detect possible psychiatric disorder in the general population. Respondents are asked to answer 12 questions relating to their recent experience of particular feelings (e.g. happiness, depression, anxiety, self-confidence and stress). For each of the 12 questions a score of 1 is allocated if the respondent has been experiencing the feeling more than usual, and a score of 0 is given if they have not. These scores are then summed to give an overall GHQ12 score (ranging from zero to 12) for each respondent.

High GHQ12 score

One of two classifications of mental health (the other is low GHQ12 score) derived from the GHQ12 section of the survey. Respondents with a high GHQ12 score are those who score 4 or over on the GHQ12 (on the basis of how they have 'recently' been feeling) indicating the presence of a possible psychiatric disorder.

LOT-R

Life Orientation Test-Revised. A scale of six statements designed to assess trait optimism and pessimism in individuals (three of the statements measure optimism and three measure pessimism). Respondents are asked to what extent they agree or disagree with each statement on a five point response scale ranging from 'I agree a lot' to 'I disagree a lot'. On the basis of their answers they are each allocated an optimism score and a pessimism score. For both optimism and pessimism, the minimum score possible is 3 and the maximum is 15.

Low GHQ12 score

One of two classifications of mental health (the other is high GHQ12 score) derived from the GHQ12 section of the survey. Respondents with a low GHQ12 score are those who score 0-3 on the GHQ12 (on the basis of how they have 'recently' been feeling) and who are thus defined as exhibiting no or few signs of a possible psychiatric disorder.

POMP score

Percentage Of the Maximum Possible score (POMP). Given that psychometric measures/scales are often scored differently, it can be difficult to draw comparisons across studies. As a result, the POMP method was devised as a way of standardising scores and facilitating comparisons across these (see Cohen et al., 1999).

SIMD

The Scottish Index of Multiple Deprivation (SIMD) provides a relative ranking of the data zones in Scotland from 1 (most deprived) to 6,505 (least deprived) based on a weighted combination of data in the domains of Current Income, Housing, Health, Education, Skills and Training, Employment and Geographic Access and Crime.

Standard deviation

The average amount of variation around the mean for a given set of survey findings. The most commonly used measure of the spread of scores.

Trait optimism

Trait theory is a major approach to the study of personality. Traits are thought to be habitual patterns of thoughts, emotions and behaviours which are stable over time and differ across individuals. In the present context, trait optimism (as assessed via the LOT-R) is thought to be relatively stable over time and the level of trait optimism differs from person to person.

WEMWBS

Warwick-Edinburgh Mental Well-being Scale. This has been developed as a tool for measuring mental wellbeing at a population level. The scale comprises 14 separate statements describing thoughts and feelings related to mental wellbeing. Respondents are asked to indicate how often they have had such thoughts and feelings over the last two weeks. WEMWBS is intended to complement standard scales which measure ill-health and mental health problems

EXECUTIVE SUMMARY

Policy background

The National Programme for Improving Mental Wellbeing was launched in October 2001 and ran until 2008. Its vision was to *improve the mental health and wellbeing of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems.*

To help inform the work of the National Programme, the then Scottish Executive commissioned the first National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems in 2002. The survey was designed to give a baseline set of data and to be repeatable in order that it could be used to track progress and help influence future work towards the achievement of specific outcomes and objectives, namely:

- increased public awareness and understanding of mental wellbeing, mental health problems and mental illness
- improved public mental health ‘literacy’
- positive changes in attitudes towards people who experience mental health problems and illness.

The survey was repeated in 2004 and 2006, with minor changes made to the questionnaire on each occasion to reflect progress in the National Programme’s agenda.

Since the 2006 survey was conducted, the policy context has evolved further. Spring 2009 saw the publication of *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (Scottish Government, 2009a). Building on the work of the National Programme, this document indicates a continued commitment to, and outlines the future direction for, mental health improvement in Scotland.

The fourth National Scottish Survey of Attitudes to Mental Wellbeing and Mental Health Problems was commissioned in autumn 2008, during the preparation of *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*.

Aims and objectives

The overall aims of the research were to examine the views and experiences of a representative sample of the adult Scottish population (reflecting age, gender, income, location, race and ethnic diversity) in relation to a spectrum of mental health-related issues; and to compare findings with other relevant survey data.

The specific objectives of the research were to:

- investigate people’s perceptions of their own general health and lifestyle
- explore people’s understanding of mental wellbeing and mental health problems, and their understanding of factors affecting these

- investigate people's direct experience of mental health problems and recovery from mental health problems
- investigate people's sources of information on mental health problems
- explore people's attitudes to mental health problems, including the stereotypes and myths
- explore people's attitudes to those who experience specific symptoms of mental health problems
- compare findings with the 2002, 2004 and 2006 surveys and, as far as data are comparable, with findings from similar surveys carried out in Scotland, in other parts of the UK and internationally.

The survey was conducted among a random sample of 1,177 Scottish adults (aged 16+) between 14 November 2008 and 19 March 2009. All interviews were conducted face-to-face in respondents' homes.

Survey findings

The results presented in this report are subject to sampling variability which means that observed differences between sub-groups may not always be statistically significant. Throughout this report, only differences that are statistically significant are commented upon ($p < 0.05$).

General health and lifestyle

As in the previous surveys, most respondents rated their general health as very good or good. Ratings were more positive than average among younger respondents, people with higher incomes, those living in the least deprived areas of Scotland, those with above average mental wellbeing and those displaying no or few signs of a possible psychiatric disorder.

People's immediate environment can have an important bearing on their mental health. As in the previous surveys, nine in ten respondents said they were satisfied with their local neighbourhood, with just over half saying they were *very* satisfied. Levels of satisfaction were highest among people in the least deprived areas of the country, those displaying no or few signs of a possible psychiatric disorder and those with above average mental wellbeing.

Having supportive relationships with friends and relatives is an important predictor of good mental health. Most respondents felt they had people they could rely on for support in times of difficulty, although the figure was lower than average among people exhibiting a possible psychiatric disorder and those with below average mental wellbeing.

In terms of people's wider levels of social engagement, just over one in five had given up time as a volunteer. There was a correlation between volunteering and mental wellbeing: people with above average mental wellbeing were almost twice as likely as those with below average mental wellbeing to have volunteered.

Mental health and wellbeing

The survey included the GHQ12 – a validated screening instrument designed to gauge levels of possible psychiatric disorder among the general population – and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), designed to assess mental wellbeing. It also included the Revised Life Orientation Test (LOT-R), which assesses traits towards optimism in individuals.

On the basis of their responses to the GHQ12, around four in five (79%) respondents were classified as displaying no or few signs of a possible psychiatric disorder (a low GHQ12 score) while 21% were classified as indicating the presence of a possible psychiatric disorder (a high GHQ12 score), consistent with the results for 2006.

On the WEMWBS, the higher a person's score is, the better their mental wellbeing. The minimum score possible is 14, while the maximum is 70. Respondents' mean score was 50.65 which is in line with the 2006 result. Sub-group analysis of the findings revealed that high scores were associated with having a higher than average income, living in the least deprived areas of the country, having no personal or proxy experience of a mental health problem and having a low GHQ12 score.

On the basis of their WEMWBS scores, 12% of respondents were classified as having 'above average' mental wellbeing, 75% as having 'average' mental wellbeing and 13% as having 'below average' mental wellbeing. This three-fold classification was created solely for the purposes of analyses presented in this report and is not based on evidence that an average or below average score, while relatively lower than above average, is necessarily problematic (there is currently no marker below which mental wellbeing is classified as "poor"). Indeed, as WEMWBS is normally distributed in the population, most people *should* have average wellbeing.

For the LOT-R, each respondent was allocated a separate optimism and pessimism score. The higher a person's optimism score, the more optimistic an outlook on life they demonstrated. The minimum optimism score possible is 3 and the maximum is 15. The vast majority of respondents received optimism scores of 10 or more. In terms of pessimism scores, the higher the score, the more pessimistic respondents' outlook is. Again the minimum score possible is 3 and the maximum is 15. Around 50% achieved pessimism scores between 3 and 8, while around 40% achieved scores between 9 and 15. The scores are consistent with what would be expected: the majority of the population have an optimism/pessimism score within one standard deviation of the mean optimism/pessimism score.

To afford comparison of optimism levels across nations, a POMP score (Percentage Of Maximum Possible score on the LOT-R) was calculated. The POMP score in the 'Well?' survey was 64.85. This indicates that individuals are, on average, reasonably optimistic, with scores being higher than the scale midpoint. A comparison of English and Scottish POMP optimism scores revealed that those living in Scotland are no less optimistic than their counterparts living in England.

As in 2006, when asked what sorts of things have a positive impact on their emotions or mental health and wellbeing, respondents most commonly mentioned hobbies, having a social life, spending time with friends, spending time with their children or grandchildren and the weather.

Asked what sorts of things have a negative impact on their emotions or mental health and wellbeing, respondents tended to mention not having a good income or not having enough money, the weather, physical illness, problems or bad news for family or friends, and work or having too much work. Again these results are consistent with the 2006 findings.

Just over two-thirds of respondents felt they had a good deal or complete control over the factors they identified as having an affect on their mental health and wellbeing, while 10% felt they had little or no control. These results are unchanged on 2006. Among those most likely to feel they have little or no control over factors affecting their mental health were people earning less than £5,200 per annum, those who found it difficult to manage on their income, those with a high GHQ12 score and those with below average mental wellbeing.

Experience of mental health problems

As in the 2006 survey, around three in five respondents reported that someone close to them had experienced a mental health problem, and around a quarter reported that they themselves had experienced a problem. The specific problems that respondents themselves had most commonly experienced were depression, panic attacks, anxiety disorder, severe stress and post-natal depression.

Around nine in ten of those who had personally experienced a mental health problem had told someone about it. The majority had told family or friends, while around one in five had told their boss or manager at work and a similar proportion had told someone else at work.

Around three-quarters of those who had experienced a mental health problem had not experienced any difficulties in terms of other people's attitudes, consistent with the result for 2006. However around one in ten had been discouraged from participating in social activities, and roughly half this proportion had experienced discrimination at work or been refused a job.

A quarter of those who had personal experience of a mental health problem had chosen to avoid a social event because of the way they thought people would react to their problem. This is significantly higher than the proportion who said they had *actually been* discouraged from participating in a social event, suggesting that self-stigmatisation is an issue.

Asked which factors had been important in supporting their recovery from their mental health problem, respondents most commonly mentioned support from family and friends, medication, having self-belief and developing their own coping strategies. Factors which respondents felt had most *hindered* their recovery included continuing to experience symptoms, not understanding what was going on and 'not acknowledging I had a problem'.

Around three-quarters of those who had experienced a mental health problem said they had received a positive recovery message from the professionals with whom they came into contact; a higher proportion than in 2006 (66%). A majority also said they had received a positive message of recovery from the people around them (friends, family etc.) This result is consistent with that recorded in 2006.

Attitudes towards mental health problems

For the most part, attitudes towards mental health problems are unchanged since 2006. Thus: 83% agreed that 'People with mental health problems should have the same rights as anyone else'; 40% agreed that 'People are generally caring and sympathetic to people with mental health problems', 19% agreed that 'People with mental health problems are often dangerous' and just 4% agreed that 'People with mental health problem are largely to blame for their own condition'. Significantly, the proportion agreeing with the statement, 'If I were suffering from a mental health problem, I wouldn't want people knowing about it', has also remained stable, despite decreasing gradually over previous waves of the survey.

Notwithstanding this stability, there have also been some important changes in attitudes since the last survey. Most notably, the proportion of respondents agreeing with the statement, 'The public should be better protected from people with mental health problems', has fallen by ten percentage points, to 25%, bringing it back to the level recorded in 2004. At the same time, there have been slight decreases in the proportions agreeing with the statements, 'Anyone can suffer from a mental health problem (from 97% to 93%) and 'The majority of people with mental health problems recover' (from 46% to 42%).

Attitudes tended to be more negative than average among older respondents (aged 75 and over), people with no qualifications, people living in the most deprived areas and those with no personal or proxy experience of a mental health problem.

Respondents were asked to estimate how many people in Scotland, out of 100, will have a mental health problem at some point in their lives. Although the WHO (2001) and the Mental Health Foundation (2003) report that one in four people in the world are affected by mental or neurological disorders at some point in their lives, the estimates of lifetime prevalence vary (Bourden et al., 1992; Kessler et al., 1994, 2005). A recent estimate of the lifetime prevalence of an adult suffering from a disorder is 1 in 2, with 1 in 4 adults suffering from a disorder in any one year (Kessler et al., 2005). In 'Well?' 2008, the mean estimate given by respondents was 49%, which is consistent with the results recorded in previous waves of the survey.

Attitudes towards specific symptoms of mental health problems

Each respondent in the survey was presented with a scenario describing a person with symptoms of either depression, schizophrenia or stress. There were two versions of each scenario; one describing a male (named Robert) with symptoms and the other describing a female (named Shona) with the same symptoms, giving six scenarios in total. Without being given a diagnosis of the symptoms described, respondents were asked a series of questions about the person in the scenario and his/her symptoms.

Overall, the main perceived causes of the symptoms described in the scenarios were external factors, and specifically, stressful or disturbing events in Robert's/Shona's life and the circumstances in which they live. However, many respondents, particularly those shown the depression or schizophrenia scenarios, also mentioned a chemical imbalance in the brain. Between 2006 and 2008, there was an increase in the proportion of people attributing symptoms of depression in a female to her

upbringing. The proportion attributing the symptoms of depression in a male to abuse he suffered as a child also increased.

Regardless of which scenario they were shown, a majority of respondents felt that the best place for Robert/Shona to live would be in their own, or their family's, home. However, a significant minority felt that he/she would be better living in special housing with professional support in the community – this figure rose from around one in ten of those shown the stress scenario to one in five of those shown the depression scenario and one in three of those shown the schizophrenia scenario. These findings have remained largely stable on 2006.

Across all of the scenarios, only a minority of respondents felt that Robert/Shona was likely to harm others, but the figure rose to around a third among those shown the schizophrenia scenario. Further, among those shown the female version of the schizophrenia scenario, the figure has increased since 2006.

Across all of the scenarios, majorities of respondents said they would be willing to interact with Robert/Shona under a range of circumstances, including moving next door to them, spending an evening socialising with them, making friends with them, working closely with them and doing them a favour. However, fewer than half said they would be willing to have Robert/Shona marry into their family or provide childcare for someone in their family.

Analyses were undertaken to explore the extent to which willingness to interact with Robert/Shona varied by a) survey year b) the specific scenario with which respondents were presented and c) respondents' own socio-demographic characteristics. For the purposes of analyses b) and c), aggregated data from the 2002, 2004, 2006 and 2008 surveys were used.

Between 2002 and 2006, there was no consistent pattern of variation in responding to the interaction measures; rather the picture was one of short-term fluctuation. Between 2006 and 2008 there was very little change in mean responses to the measures, suggesting that attitudes have stabilised over this period.

In terms of variation by scenario, the analysis revealed that, once again, willingness to interact with Robert/Shona was highest among those shown the stress scenario, somewhat lower among those shown the depression scenario and lower still among those shown the schizophrenia scenario. Further, respondents were consistently more willing to interact with a woman displaying symptoms of a mental health problem than with a man displaying the same symptoms.

As regards variation by respondent characteristics, women were more willing than men to spend an evening socialising with Robert/Shona, make friends with them, work closely with them and have them marry into the family. The first two of these differences were also evident when the analysis was run in 2006 but the latter two emerged for the first time in 2008.

As in 2006, the analysis found that respondents aged 54 and younger were generally more willing than people aged 55 and over to have Robert/Shona marry into their family. Similarly, people aged 25 to 54 years were more willing than older groups to have Robert/Shona provide childcare for someone in their family. Willingness to

start working closely with Robert/Shona was higher among people aged 35 to 54 years than among those aged 75 and over.

As in previous 'Well?' surveys, around three quarters of respondents shown the depression scenario were able to correctly identify the symptoms described. However, fewer than half of those shown the schizophrenia scenario were able to give a correct diagnosis, and for the stress scenario the figure was lower still – indeed, around half of those shown the stress scenario attributed the symptoms to depression, and around one in five attributed them to an anxiety disorder. To some extent this is unsurprising as stress is often closely linked to depression and anxiety.

Key messages

Much work has been done in Scotland over recent years to promote good mental health and wellbeing. While some of this work has sought to target high risk groups, other work has been targeted at the general population as it is recognised that effective mental health improvement necessitates the integration of both targeted and universal public health strategies. However, one of the most consistent messages emerging from the survey is that significant inequalities remain in the distribution of mental health problems. Specifically, there were strong correlations between 1) having a high GHQ12 scores or personal or proxy experience of mental health problems, and 2) having a low income, finding it difficult to manage financially and living in a deprived areas of the country. Further, disadvantaged groups were more likely than other groups to have below average mental wellbeing and less likely to have an optimistic outlook on life - which in turn may have implications for their levels of resilience in times of difficulty. The Scottish Government's plan to implement the *Equally Well* recommendations aimed at tackling mental health problems in deprived communities (Scottish Government 2008a) is thus a crucial development and it will be important to monitor the effects of this work in the future.

Once again, the survey findings also point towards a link between social isolation and poor mental health (as measured in the GHQ12) and below average mental wellbeing (as measured in WEMWBS). Such findings underpin the importance of the Government's third priority described in *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*, to promote Mentally Healthy Communities which value social cohesion and social inclusion. As noted in the previous report, however, it is not possible for a study such as this to identify causation and a different, longitudinal design would be required to investigate the direction of the relationship between social isolation and mental health and wellbeing.

Still, it was clear that respondents themselves felt that spending time with close family and friends had a positive influence on their mental health, along with leisure activities and hobbies, good weather and financial security. Conversely, among the factors they commonly identified as having a negative influence on mental health and wellbeing were family problems, not having enough money, bad weather and pressures at work. The prominence of money, as both a positive and a negative influence, is worthy of particular attention. Given the current economic climate, it may be that money worries will become increasingly prominent in some people's minds, with possible implications for their mental health and wellbeing. While the survey results indicate that mental health problems are currently no more prevalent

than was the case two years ago, it is notable that there has been a decrease in the proportion of people saying they feel optimistic about the future. While it remains to be seen how the economic situation will evolve in the future, it does appear to have the potential to affect people on a number of levels and it will be important that health service providers and policymakers keep this under review.

With regard to public attitudes to mental health problems, the findings indicate that positive trends identified over previous waves of the survey may have at best plateaued for the time being. Certainly, the observed stability in agreement with the statement, 'If I were suffering from a mental health problem I wouldn't want people knowing about it', would suggest that efforts to reduce stigma might need to be considered in order to identify how further progress can be made. In *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*, the Government has outlined a commitment to support 'see me' in delivering a social marketing campaign to improve public attitudes and behaviour towards those experiencing mental health problems and their carers. There is also a related commitment to deliver specific social marketing campaigns that address inequality and multiple discrimination and stigma. Again, it will be important that the impact of these initiatives is monitored in the long term to identify both progress and areas requiring further attention.

Notwithstanding the apparent stability in attitudes, there are signs that, in some quarters at least, perceptions of and behaviour towards people with mental health problems may be changing for the better. Between 2006 and 2008, there was a significant increase in the proportion of people with experience of a mental health problem who said they had received a positive message of recovery from professionals with whom they came into contact. It will be interesting to see whether there is further improvement on this measure in the future following implementation of 'see me's' planned strategy for tackling stigma within public services. However, any future evaluation of changes in attitudes must take due cognisance of the ever changing economic climate and, indeed of wider, cultural shifts.

In terms of recovery from mental health problems, the findings once again underscore the fact that there are a broad range of influences which assist personal recovery and no two individuals' journey of recovery will be the same. Whatever a person's needs and preferred coping strategies, however, it is important that appropriate support services are available to all who may benefit from them. The new Scottish Recovery Indicator will be a crucial development in this respect, helping to ensure that recovery principles are realised in practice.

Overall, the results of the fourth National Scottish Survey of Attitudes Towards Mental Wellbeing and Mental Health Problems, provide a timely indication of the status of public opinion on mental health-related issues and will provide an important benchmark against which the impact of future policies and initiatives can be measured.

1 INTRODUCTION

Policy background

- 1.1 The World Health Organisation (WHO) has defined mental health as: “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community” (WHO, as cited in Scottish Government 2007a).
- 1.2 It is estimated that one in four adults in Britain experiences at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time (ONS, 2001: p26 table 2.11 & figure 2.5). According to WHO, 450 million people worldwide are affected by mental, neurological or behavioural problems at any time.
- 1.3 In Scotland mental health problems are no less common. Indeed, official psychiatric morbidity statistics indicate that at any one time, one in six Scots reports mental health problems, one in 200 has a psychotic disorder, whilst one in 25 has a personality disorder. Three per cent have a learning disability (ONS 2001). Poor mental wellbeing and mental health problems are a burden to the Scottish economy and society. In February 2006, 4.3% of the working age population in Scotland were claiming incapacity benefit in respect of a mental disorder. In some more deprived areas of Scotland, this figure reached 7.9% (Scottish Government 2007b).
- 1.4 Mental health policy in Europe, including Scotland, focuses on the promotion of mental wellbeing as well as the prevention of mental health problems. Indeed, the World Health Organisation has recently highlighted mental wellbeing as one of its key priorities (WHO Regional Office for Europe 2005). Such approaches are consistent with the dual factor model of mental health (e.g., Greenspoon & Saklofske, 2001) which assesses indicators of wellbeing as well as the more traditional indicators of mental health problems. Indicators of wellbeing include subjective wellbeing, optimism and positive mental health.
- 1.5 Mental health improvement is an essential part of the Scottish Government’s wider commitment to addressing health and social inequalities. By concentrating on mental health improvement, the Government aims to make considerable progress in addressing the growing range of problems that are manifest where poor mental wellbeing or mental health problems exist. For example in excessive drinking, substance misuse, violent and abusive behaviour, self-harm and suicide, obesity and poor sexual health.
- 1.6 The National Programme for Improving Mental Wellbeing was launched in October 2001 and ran until 2008. Its vision was to *improve the mental health and wellbeing of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems*. The first phase of the National Programme (2003-2006) set out to establish delivery agencies for, and a body of work in, the areas of reducing

stigma, preventing suicide and supporting recovery (nationally and locally). The second phase (2006-2008) focused on promoting mental wellbeing and ensuring that mental health and wellbeing work is sustained beyond the life of the National Programme.

1.7 To help inform the work of the National Programme, the then Scottish Executive commissioned *'Well: What do you think?'*: the first National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems in 2002. The survey was designed to give a baseline set of data at the beginning of the National Programme's work and to be repeatable in order that it could be used to track progress and help influence future work towards the achievement of specific outcomes and objectives, namely:

- increased public awareness and understanding of mental health, mental wellbeing, mental health problems and mental illness
- improved public mental health 'literacy'
- positive changes in attitudes towards people who experience mental health problems and illness.

1.8 The survey was repeated in 2004 and 2006, with minor changes made to the questionnaire on each occasion to reflect progress in the National Programme's agenda.

1.9 Taken together, the findings from the three surveys suggest that significant progress has been made towards the National Programme objectives. Attitudes towards mental health appear to have improved – for example, the proportion of people agreeing with the statement, *'If I were suffering from mental health problems, I wouldn't want people knowing about it'*, has declined steadily over time. Further, between 2004 and 2006 the proportion of people with experience of a mental health problem who said they had not faced any difficulties in terms of other people's attitudes to their problems rose by almost 10 percentage points.

1.10 However, a number of important challenges remain. Firstly, there is still work to be done to foster more public understanding of, and tolerance towards, mental health problems, especially schizophrenia. Secondly, self-stigmatisation and fear of rejection remain important issues that need to be addressed – it was clear from the survey that people limit their own behaviour because of the way they think others will react to their mental health problem. Thirdly, the results also point towards significant health inequalities, with mental health problems and below average mental wellbeing being more common in areas of greater socio-economic deprivation (Scottish Government, 2007c).

1.11 Since the 2006 survey was conducted, the policy context has evolved. October 2007 saw the publication of a major consultation document entitled *Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-11* (Scottish Government, 2007a). Building on the work of the National Programme, this paper outlined the potential

future direction for mental health improvement and population mental health for 2008-11. Three main themes were identified for action:

- *Promotion* and improvement in mental health through a focus on increasing key protective factors and reducing key risk factors
- *Prevention of* mental health problems, mental illness, co-morbidity and suicide, with a focus on key risk and protective factors
- *Support improvements* in the quality of life, social inclusion, health, equality and recovery of people who experience mental illness.

1.12 Following the publication of the paper, a wide ranging consultation was launched across Scotland. This culminated in the release of *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (Scottish Government, 2009a). This document sets out six strategic priorities, namely:

- mentally healthy infants, children and young people
- mentally healthy later life
- mentally healthy communities
- mentally healthy employment and working life
- reducing the prevalence of suicide, self-harm and common mental health problems
- improving the quality of life of those experiencing mental health problems and mental illness.

1.13 These priorities not only reflect the Government's ambitions for a healthier Scotland but also add to and complement a range of policies aimed at achieving the Government's other strategic objectives – to make Scotland wealthier and fairer, smarter and stronger, safer, and greener.

Aims and objectives

1.14 The fourth National Scottish Survey of Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems was commissioned in autumn 2008. The overall aims of the research were to examine the views and experiences of a representative sample of the adult Scottish population (aged 16+) (reflecting age, gender, income, location, race and ethnic diversity) in relation to a spectrum of mental health-related issues; and to compare findings with other relevant survey data.

1.15 The specific objectives of the research were to:

- investigate people's perceptions of their own general health and lifestyle
- explore people's understanding of mental wellbeing and mental health problems, and their understanding of factors affecting these

- investigate people's direct experience of mental health problems and recovery from mental health problems
- investigate people's sources of information on mental health issues
- explore people's attitudes to mental health problems, including the stereotypes and myths surrounding these problems
- explore people's attitudes to those who experience specific symptoms of mental health problems
- compare findings with the 2002, 2004 and 2006 surveys and, as far as data are comparable, with findings from similar surveys (and from other relevant components of broader surveys) carried out in Scotland, in other parts of the UK and internationally.

1.16 The next chapter describes the methodology adopted for the research and Chapter 3 describes the profile of the survey sample. Chapters 4 to 8 present the main findings from the survey, drawing comparisons with the 2002, 2004 and 2006 surveys, as well as other similar surveys conducted elsewhere in the UK and overseas. Chapter 9 presents the conclusions of the research and makes recommendations for future research.

2 RESEARCH METHODOLOGY AND ANALYSIS

Questionnaire design

2.1 The questionnaire used in the first (2002) 'Well?' survey was developed by a multidisciplinary advisory group representing interests across the spectrum of mental health improvement issues and including relevant National Programme delivery agencies. When the survey was run in 2004 and 2006, minor adjustments were made to the questionnaire, to reflect progress in the National Programme's agenda. For the 2008 survey, further changes were made following discussion between Ipsos MORI, Professor Rory O'Connor and the 'Well?' Research Advisory Group, which comprised representatives from across the Scottish Government, NHS Health Scotland, Edinburgh University and representatives from the 'Choose Life' initiative, the 'see me...' campaign, Breathing Space and the Scottish Recovery Network. Specific topics covered in the 2008 questionnaire included:

- general health
- length of residency in, and satisfaction with, local neighbourhood
- social engagement and informal support networks
- perceived positive and negative influences on mental health
- control over factors affecting mental health
- a measure of mental wellbeing
- a measure of possible psychiatric disorder
- a measure of optimism/pessimism
- experience of mental health problems
- telling others about mental health problems
- the social impact of mental health problems
- recovery from mental health problems
- sources of information about mental health problems
- the perceived prevalence of mental health problems
- attitudes to mental health problems
- attitudes towards specific symptoms of mental health problems

2.2 Given that the survey is used to track progress towards specific outcomes, it was important that the questionnaire was comparable with that used in the previous waves. Therefore, the main changes made in 2008 were relatively minor. Specifically:

- in the section on sources of information about mental health problems, two questions regarding awareness of mental health campaigns, initiatives and promotional activity were removed from the questionnaire on the ground that

all national campaigns now have their own evaluation mechanisms and there would be no value in duplicating this research

- the Life Orientation Test-Revised (LOT-R) (Scheier, *et al.*, 1994) was added to the end of the questionnaire. The rationale for including the measure was five-fold:
 - it is a widely used scale (with good psychometric properties) which allows for comparison with studies from other countries
 - optimism/pessimism is a personality dimension that has been shown to be associated with predicting future outcomes (Rasmussen *et al.*, 2006), including how people cope with stressful situations (O'Connor *et al.*, 2009). Optimism/pessimism affects psychological well-being (Scheier, Carver & Bridges, 2002).
 - there was interest in assessing how optimism and pessimism relate to other measures included in the survey, particularly the measures of mental wellbeing and possible psychiatric disorder
 - consistent with the dual-factor model of mental health, the LOT-R yields separate optimism and pessimism subscales
 - the scale has been shown to facilitate an understanding of mental wellbeing from a self-regulation perspective (Carver & Scheier, 1989)
- several of the demographic questions were replaced with the new Scottish Government harmonised equivalents – specifically, those focusing on age of respondent; ethnicity of respondent; educational qualifications; and housing tenure
- the response categories for the question on household income were slightly amended in order to reflect changes in earnings
- the question at the end of the survey in which respondents are asked if they would be willing to be recontacted to take part in future Scottish Government research was reworded to meet new data protection guidelines.

2.3 A copy of the final questionnaire is provided in Annex E.

Methodology

2.4 The survey was undertaken among a random sample of the Scottish adult (aged 16 and over) population. All interviews were conducted face-to-face in respondents' homes between 14 November 2008 and 19 March 2009.

2.5 As in the previous waves of the survey, an advance letter was sent to all sampled households. The letter was printed on Ipsos MORI headed paper, with the Scottish Government logo, and signed by the Managing Director of Ipsos MORI. The letter was designed to be easy to read and provide basic information about the survey while also avoiding giving prominence to the issue of mental health.

2.6 A copy of the advance letter is provided in Annex A.

- 2.7 The sample was drawn from the small user file of the Postcode Address File (PAF). Being the only complete source of all known UK Postcodes, the PAF is the best available sample frame for Scotland's household population.
- 2.8 Addresses were sorted into five geographic groups by amalgamating NHS Health Board areas. These were:
- Central belt/West (Greater Glasgow, Lanarkshire and Forth Valley)
 - Lothian and Fife
 - Borders and South (Borders, Ayrshire & Arran, Dumfries & Galloway)
 - Highlands and Islands (Highland, Western Isles, Orkney & Shetland)
 - North East (Tayside & Grampian)
- 2.9 A target number of interviews was allocated to each area in proportion to the adult population of the area. Within each area, Output Areas (OAs)¹ were selected with probability proportionate to the population. A total of 90 OAs were selected.
- 2.10 In order to maximise the chance of making initial contact at sampled addresses, interviewers made at least six calls at each address. These calls were made at different times of the day and on different days of the week.
- 2.11 Within each household, an individual was randomly selected to be interviewed using a Kish grid. For each sampled address interviewers were issued with a contact sheet which included a Kish grid and detailed instructions on the selection process (See Annex C for contact sheet).
- 2.12 All fieldwork was conducted using Computer Assisted Personal Interviewing (CAPI), where data is collected on laptop computers. The General Health Questionnaire 12 (GHQ12), the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and the Revised Life Orientation Test (LOT-R) components of the survey were administered using CASI (Computer Assisted Self Interviewing) whereby respondents are invited to enter their responses directly into the CAPI machine. Ninety seven per cent of respondents agreed to complete the CASI modules. Interviewers provided assistance to those for whom computer literacy was an issue. Further information on survey administration and achieved interviews is provided in Annex B.
- 2.13 The target number of interviews for the survey was 1,200 and the total number of addresses allocated was 2,038. In the event, a total of 1,177 interviews were achieved, giving a response rate of 63% (allowing for invalid addresses).

¹ OAs are the smallest unit of census geography for which data is provided. Each OA contains around 50 households.

2.14 There were differential levels of refusals among different sub-groups of the population with the effect that the survey over-represented older age groups and women (whilst under-representing younger groups and men). Furthermore, since the interview was undertaken with only one person in each household, adults in single person households had a higher chance of participation in the survey than those in multi-adult households.

2.15 Accordingly, the data was weighted by household composition, NHS Board area, age and gender². Table 2.1 shows the weighted and the non-weighted profile of the achieved sample. The weighted sample is in line with the weighted profiles of other large scale national surveys conducted by Ipsos MORI, including the 2007 Scottish Household Survey, and also with mid-2007 population estimates.

Table 2.1: Sample Profile

	Mid-2007 population estimates	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	4,227,249 %	1,177 %	1,177 %
Male	48	43	48
Female	52	57	52
16 to 24	14	9	14
25 to 34	15	13	13
35 to 44	18	18	20
45 to 54	17	17	18
55 to 59	8	7	6
60 to 64	7	8	7
65 to 74	11	15	12
75+	9	12	8

Analysis

2.16 To facilitate analysis of the survey data, computer tables were prepared to a specification agreed with the Scottish Government. In the tables, responses to each survey question were analysed against a number of key variables, namely:

- sex
- age (8 groups – 16 to 24 years through to 75 years and over)
- age interlocked with sex (6 groups – males aged 16 to 34 years, 35 to 54 years and 55 years and over; and females aged 16 to 34 years, 35 to 54 years and 55 years and over)

² For NHS Board area, age and gender weighting, mid-2007 population estimates published by the General Register for Scotland were used as the most accurate and up-to-date source of this information.

- ethnicity (2 groups – White and non-White)
- working status (3 groups – full time, part time, not working)
- household income (5 groups – less than £5,200 per annum, between £5,200 and £15,599 p.a., between £15,600 and £25,999 p.a., between £26,000 and £36,399 p.a., and £36,400 or more p.a.)
- ease of managing on income (3 groups – easy, manageable, difficult)
- affluence of area (5 bands – most to least deprived based on the Scottish Index of Multiple Deprivation (SIMD) quintiles)³
- qualifications (5 groups – no qualifications, Standard Grade or equivalent, Higher level or equivalent, HNC/HND or equivalent and degree/professional qualifications)
- urbanity/rurality (6 groups – large urban areas, other urban areas, accessible small towns, remote small towns, accessible rural and remote rural⁴)
- NHS Board Areas (5 groups – Borders and South, Central Belt West, Highlands and Islands, Lothian and Fife, North East)
- long-standing illness/disability/infirmity (3 groups – limiting condition, non-limiting condition, none)
- experienced a mental health problem (3 groups – a problem of their own, someone close with a problem, no contact at all)
- general health (2 groups – good and bad)
- psychiatric disorder (2 groups – low and high GHQ12 scores)⁵
- mental wellbeing (3 groups – below average, average, and above average mental wellbeing)⁶

3 The Scottish Index of Multiple Deprivation (SIMD) 2006 is based on 37 indicators in the seven individual domains of Current Income, Employment, Education, Skills and Training, Geographic Access to Services, Housing, and Crime.

4 For the purposes of the survey, the Scottish Government's six-fold urban/rural classification has been adopted. This is based on settlement size and remoteness (measured by drive times). The classification being used in this report is the latest version.

5 The GHQ12 is a measure of possible psychiatric disorder. Each item in the GHQ12 asks whether the respondent has experienced a particular symptom or feeling on a scale ranging from 'less than usual' to 'more than usual'. In the present study responses were scored in accordance with the bimodal scoring method outlined in *A User's Guide to the General Health Questionnaire* (Goldberg et al 1991). Specifically, respondents were divided into two groups: those with an overall score of 4 or more, which is considered to indicate the presence of a possible psychiatric disorder (hereafter referred to as a high GHQ12 score), and those with scores of under 4 who are considered to exhibit no or few signs of a possible psychiatric disorder (hereafter referred to as a low GHQ12 score).

6 Mental wellbeing was measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). WEMWBS is a relatively new scale and respondents are not, as a rule, classified on the basis of their scores as a diagnostic tool. However, for the purposes of analyses presented in this report, the sample was divided into three groups, on the basis of their combined scores for the constituent items of WEMWBS. The three groups are those with 'above average' mental wellbeing (a WEMWBS score of over one standard deviation above the mean score), those with 'average' mental wellbeing (a WEMWBS score within one standard deviation of the mean) and those with 'below average' mental wellbeing.

- 2.17 In addition to these tabulations, multivariate analyses were undertaken to explore the strength of relationships between variables. The main types of analysis undertaken were correlation analysis, segmentation analysis, regression analysis, and the aggregation of responses across different variables.
- 2.18 A full description of each technique is presented in Annex F.
- 2.19 Several questions in the survey were asked of only a subset of respondents. For example, the questions about recovery from mental health problems were asked only of those who said they had experienced such a problem (359 people). Similarly, each of the six vignettes was presented to only one sixth of the total sample (around 200 respondents). There is a limit to the amount of reliable sub-group analysis that can be undertaken on such small samples. To address this issue and maximise the explanatory potential of the survey, data from the 2002, 2004, 2006 and 2008 surveys were aggregated, thus substantially increasing the effective sample sizes for questions which have run in all four waves of the survey.

Interpretation of the data

- 2.20 Because the survey respondents are only a sample of the total population, results are subject to sampling variability. This means that observed differences between sub-groups may have occurred by chance. Throughout the report, only differences that are statistically significant are commented upon in the text – i.e. where the difference is unlikely to have occurred by chance ($p < 0.05$). Any other differences calculated from tables presented in the report may not be significant and should be checked using the formula for calculating significant differences which is provided in Annex G.
- 2.21 It is important to note that cross-sectional data generated in this survey can be used to establish correlations between variables but not definitively identify causation.
- 2.22 All findings given are based on the weighted data. All sample sizes reported are based on unweighted data. Where percentages do not sum to 100%, this may be due to computer rounding, the exclusion of 'don't know' categories, or multiple answers. Throughout the report, an asterisk (*) denotes any value less than half a per cent, while a dash (-) denotes zero.
- 2.23 It is important to note that the findings presented throughout this report are based on what people say about their attitudes towards, and experiences of, mental health problems and related issues. It may be that some

wellbeing (a WEMWBS score of more than one standard deviation below the mean). This three-fold classification was created solely for the purposes of analyses presented in this report and is not based on evidence that an average or below average score, while relatively lower than above average, is necessarily problematic (there is currently no marker below which mental wellbeing is classified as "poor"). Indeed, as WEMWBS is normally distributed in the population, most people *should* have average wellbeing

respondents have chosen not to reveal particular information, for example, that they have experienced a specific condition or that they hold, or have faced, negative attitudes towards mental health problems. This point should be borne in mind when interpreting the data.

3 DEMOGRAPHIC PROFILE OF RESPONDENTS

- 3.1 This chapter describes the demographic profile of the 1,177 respondents to the survey. For comparison purposes, and where possible, data from the previous waves of the survey are also provided.
- 3.2 Respondents were aged between 16 and 96 years, with an average age of 47 years. Table 3.1 shows the demographic sex/age profile of the respondents and compares it to that achieved in the 2002, 2004 and 2006 surveys. As in those previous surveys, the 2008 survey over-represented older people and under-represented young people.

Table 3.1: Age and sex

	Mid-2007 population estimates	'Well?' 2002 (weighted)	'Well?' 2004 (weighted)	'Well?' 2006 (weighted)	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	4,227,249 %	1,381 %	1,401 %	1,216 %	1,177 %	1,177 %
Male						
16 to 24	7.4	7.5	6.8	7.3	4.4	7.4
25 to 34	7.4	8.5	8.4	8.0	4.7	6.3
35 to 44	8.9	8.7	9.3	8.7	8.0	10.0
45 to 54	8.4	7.7	7.9	7.6	7.4	8.8
55 to 59	3.8	3.0	3.9	3.5	3.3	3.3
60 to 64	3.5	3.1	3.2	4.3	3.2	3.6
65 to 74	5.0	4.4	4.9	5.7	7.0	4.9
75+	3.4	3.3	3.0	2.5	5.1	3.5
Total	47.7	46.2	47.4	47.6	43.1	47.8
Female						
16 to 24	7.1	6.1	6.8	7.0	4.9	7.0
25 to 34	7.5	9.2	7.6	6.7	8.6	6.8
35 to 44	9.6	9.1	11.3	10.8	10.4	10.4
45 to 54	8.8	8.2	8.6	8.1	9.8	9.8
55 to 59	4.0	3.9	3.7	4.4	3.3	2.7
60 to 64	3.7	4.5	3.4	3.7	5.2	3.8
65 to 74	5.9	8.3	6.4	6.7	7.7	6.8
75+	5.8	4.6	4.9	5.0	7.0	4.9
Total	52.3	53.9	52.7	52.4	56.9	52.2

- 3.3 Sixty-seven per cent of the respondents had no children (under 16) in their household. Fifteen per cent had one child (under 16), 13% had two and 5% had three or more. Again, these figures are in line with those from the previous 'Well?' surveys.
- 3.4 The majority of respondents described themselves as White, Scottish (83%) and 15% assigned themselves to another White category. The remainder of the sample assigned themselves to non-white categories, as illustrated in

table 3.2. Data for previous waves of the survey are not provided as the question wording and response options were slightly altered for the 2008 survey in line with the new Scottish Census ethnicity question.

Table 3.2: Ethnicity

	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	1,177 %	1,177 %
White	98	98
Scottish	83	83
English	5	5
Welsh	*	*
Northern Irish	1	1
British	5	6
Irish	1	1
Gypsy/traveller	-	1
Polish	1	1
Any other White background	1	*
Mixed or Multiple ethnic groups	*	2
Any mixed or multiple ethnic groups	*	1
Asian, Asian Scottish or Asian British	1	1
Pakistani, Pakistani Scottish or Pakistani British	*	*
Indian, Indian Scottish or Indian British	1	*
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	*	*
Chinese, Chinese Scottish or Chinese British	*	*
Other Asian, Asian Scottish or Asian British background	*	*
African, Caribbean or Black	*	*
African, African Scottish, African British	*	*
Caribbean, Caribbean Scottish, Caribbean British	*	*
Black, Black Scottish, Black British	*	*
Other African, Caribbean or Black background	*	*
Other ethnic group	*	*
Arab	*	*
Other ethnic group	*	*

3.5 Four per cent of respondents said that their annual gross household income was less than £5,200 per annum. Twenty per cent said it was between £5,200 and £15,599 per annum while a similar proportion said £15,600 to £25,999 (23%) or £36,400 or more per annum (21%). Thirty per cent of respondents did not provide this information – 13% said they did not know their household income and 17% refused to disclose this information (table 3.3).

3.6 Average gross household income for the sample was £25,700 per annum⁷, which is higher than the figure from 'Well?' 2006 (£22,192). However, in large part, this difference reflects the fact that the banded response

⁷ Income estimation was derived by taking the mid-point of the respondent's income band as their estimated income.

categories were amended for the 2008 survey to reflect changes in earnings.

Table 3.3: Annual household income

	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	1,177 %	1,177 %
Less than £5,200 per year	6	4
£5,200 to £10,399 per year	15	11
£10,400 to £15,599 per year	11	9
£15,600 to £25,999 per year	13	13
£26,000 to £36,399 per year	10	10
£36,400 to £49,399 per year	8	10
£49,400 to £62,399 per year	4	5
£62,400 to £77,999	3	3
£78,000 or more per year	3	3
Don't know	11	13
Refused	16	17

3.7 When asked how easy or difficult they found it to manage on their household's income, 45% of respondents said they found it easy, while 35% said they found it manageable, and 16% said they found it difficult (table 3.4). Thus, whereas between 2002 and 2006 there was a move towards people finding it easier to manage on their household income, the trend has since reversed. This is likely to reflect the fact that the survey fieldwork was conducted during a period of economic slowdown characterised by a falling housing market and rising food and fuel prices.

Table 3.4: Ease of managing on household income

	'Well?' 2002 (weighted)	'Well?' 2004 (weighted)	'Well?' 2006 (weighted)	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	1,381 %	1,401 %	1,216 %	1,177 %	1,177 %
Very easy	13	14	18	15	14
Fairly easy	30	33	34	29	31
Manageable	40	36	31	36	35
Fairly difficult	11	10	8	11	11
Very difficult	6	4	3	6	5
Don't know	-	3	6	3	5

3.8 Around half (54%) of respondents were in paid work while around a quarter (23%) were retired. Seven per cent were in full time education, 6% were long term sick or disabled, 4% were registered unemployed or signing on for Job Seekers Allowance (JSA), and 4% were at home or not seeking work. These findings are consistent with those from previous waves of the survey (table 3.5).

Table 3.5: Working status

	'Well?' 2002 (weighted)	'Well?' 2004 (weighted)	'Well?' 2006 (weighted)	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	1,381 %	1,401 %	1,216 %	1,177 %	1,177 %
In paid work	53	56	54	48	54
Local or government training scheme (GTS)	*	*	1	*	*
Modern Apprenticeship	*	*	*	*	*
Registered unemployed/signing on for Job Seekers Allowance	3	2	3	3	4
Not registered but seeking work	1	1	1	2	2
At home/not seeking work	6	5	4	5	4
Long term sick or disabled	7	6	6	7	6
Retired	25	22	24	31	23
Full time education	3	5	8	4	7
Carer	N/A	N/A	2	2	2
Other	1	2	4	*	*

3.9 Twenty-eight per cent of respondents said that they had a degree or professional qualification. Twelve per cent said they had an HNC, HND or equivalent, while 34% said they had achieved a Higher, A level or equivalent and 55% had achieved an O Grade, Standard Grade or equivalent. Around a quarter (23%) said that they had no qualifications. Data for previous waves is not provided as the question wording and response options were changed for the 2008 survey to reflect the Scottish Government's new harmonised qualifications question (table 3.6).

Table 3.6: Qualifications

	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	1,177 %	1,177 %
Degree or Professional qualification	33	28
HNC/HND or equivalent	11	12
Higher, A Level or equivalent	37	34
O Grade, Standard Grade or equivalent	55	55
None	26	23
Other qualification	8	7
Don't know/refused	1	*

3.10 While the sample was once again distributed proportionate to the population among NHS Board areas, its urban/rural profile differed somewhat to that of

both the 2007 Scottish Household Survey (SHS) and previous waves of the 'Well?' survey. Specifically, a lower proportion in the present sample lived in 'other urban areas' (band 2), while a higher proportion lived in accessible rural areas (band 5) (table 3.7).

Table 3.7: Urban/rural composition

	SHS 2007	'Well?' 2004 (weighted)	'Well?' 2006 (weighted)	'Well?' 2008 (unweighted)	'Well?' 2008 (weighted)
<i>Base: All</i>	13,414	1,401	1,216	1,177	1,177
	%	%	%	%	%
Large urban areas (band 1)	40	36	42	42	42
Other urban areas (band 2)	30	29	22	26	25
Accessible small towns (band 3)	9	12	7	9	9
Remote small towns (band 4)	4	4	3	3	3
Accessible rural (band 5)	11	12	21	14	15
Remote rural (band 6)	6	8	5	6	6

4 GENERAL HEALTH AND LIFESTYLE

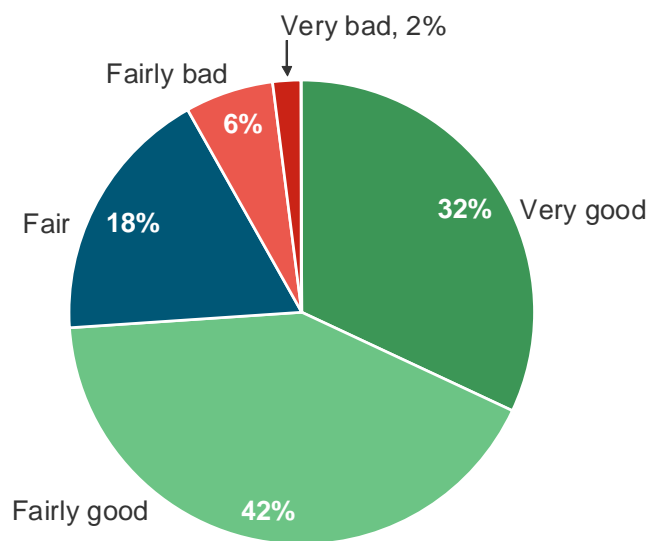
4.1 This section considers respondents' perceptions of their general health and lifestyle. It also looks at their views of their local area, their level of social engagement and their informal support networks.

Self-assessed general health ratings

4.2 Respondents were asked to rate their general health on a five point scale ranging from 'very good' to 'very bad'. Around three-quarters (74%) rated their health as very good (32%) or good (42%), while 18% said their health was fair and 8% said it was bad (6%) or very bad (2%). These results are very much in line with the comparable findings from the 2006 survey, in which 76% rated their general health as good or very good, 18% rated it as fair and 6% as bad or very bad (figure 4.1).

Figure 4.1: Self-assessed general health ratings

Q. I'd like to start by asking you some questions about your general health and lifestyle. First of all, how is your health in general?



Base: All respondents (1,177)

Source: Ipsos MORI

4.3 Consistent with previous years, the proportion rating their general health as good or very good decreases with age, from 87% among people aged 16 to 24 years, to 72% among those aged 45 to 54 years and 55% among those aged 75 and over (table 4.1).

4.4 There is also a clear socio-economic dimension to the findings: people with an annual income of £15,600 or higher were more likely than lower earners to rate their general health as good or very good, and people who found it easy to manage on their income were more likely to be positive about their general health than those who found it difficult to manage financially.

Reflecting this, ratings were more positive among people living in the least deprived areas of the country than among those in the most deprived areas.

- 4.5 Consistent with the burgeoning literature highlighting links between physical and mental health, people displaying no or few signs of a possible psychiatric disorder (as reflected in their scores on the GHQ12) rated their general health more positively than those with a possible psychiatric disorder. Similarly people with above average mental wellbeing (according to their WEMWBS score) gave more positive ratings than those with below average mental wellbeing.

Table 4.1: Self-assessed general health ratings by sub-group

	Very good	Good	Fair	Bad	Very bad	Don't know	<i>Base</i>
	%	%	%	%	%	%	
All	32	42	18	6	2	-	1,177
16-24	42	45	11	3	-	-	190
25-34	38	48	10	2	1	-	159
35-44	39	42	13	4	1	-	215
45-54	29	43	19	6	3	-	200
55-59	27	41	19	7	5	-	76
60-64	25	34	23	17	1	-	98
65-74	29	33	24	12	3	-	172
75+	15	40	33	8	3	-	142
Household income: < £5,200 per yr	13	43	29	12	3	-	70
Household income: £36,400 + per yr	45	43	11	1	*	-	201
Easy to manage on income	39	42	14	3	1	-	520
Difficult to manage on income	20	35	27	15	4	-	197
Least deprived areas (band 5)	44	42	11	3	*	-	288
Most deprived areas (band 1)	16	40	26	15	3	-	218
Low GHQ12 score	36	43	16	5	1	-	907
High GHQ12 score	17	39	26	13	5	-	236
Above average mental wellbeing	49	37	13	1	*	-	140
Below average mental wellbeing	10	30	32	19	8	-	178

Long-standing limiting conditions

- 4.6 Just less than a third (32%) of respondents said they had a long-standing illness disability or infirmity. Of this group, around seven in ten (69%) said that their condition limited their activities in some way. Again, these results are consistent with findings from the previous 'Well?' surveys.

- 4.7 Reflecting results reported in table 4.1, respondents aged 45 years and over were more likely than younger groups to have a long-standing limiting condition, and people in the most deprived areas were more likely to than those in the least deprived areas (table 4.2).
- 4.8 Experience of long-standing conditions was also associated with having personal experience of a mental health problem, exhibiting a possible psychiatric disorder and having below average mental wellbeing.

Table 4.2: Experience of long-standing illness, disability or infirmity by sub-groups

	% with an illness, disability or infirmity	<i>Base</i>
	%	
All	32	1,177
16-24	13	109
25-34	14	156
35-44	22	215
45-54	35	200
55-59	44	76
60-64	55	98
65-74	51	172
75+	55	142
Least deprived areas (band 5)	24	288
Most deprived areas (band 1)	41	218
Personal experience of a mental health problem	51	344
No experience of a mental health problem	30	750
Low GHQ12 score	28	907
High GHQ12 score	45	236
Above average mental wellbeing	27	140
Below average mental wellbeing	57	178

Satisfaction with local neighbourhood

- 4.9 There is a growing emphasis on the link between the physical environment and mental and physical wellbeing. Indeed, a key national outcome associated with the Scottish Government's 'Healthier' strategic objective is, '*we live in well-designed sustainable places where we are able to access the amenities and services we need*' (Scottish Government, 2008b). Similarly, in *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* it is noted that: "the quality of the physical environment

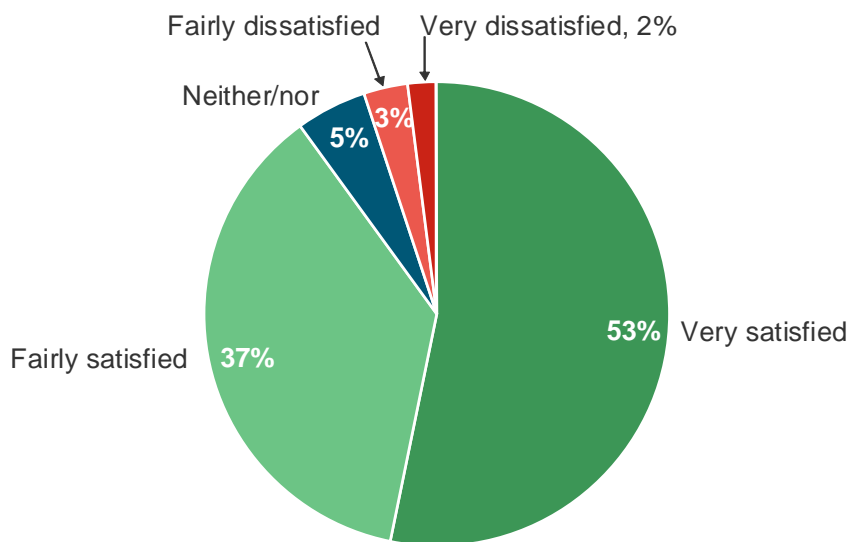
(noise and light levels; the layout of buildings; access to ‘escape’ facilities such as green space and community facilities; the design of buildings, including good, secure housing; and transport systems) has an important role to play in mental health improvement” (Scottish Government, 2009a). Consistent with this focus, the ‘Well?’ survey includes questions to identify the extent of any relationship between respondents’ level of satisfaction with their immediate neighbourhood and their mental health and wellbeing.

4.10 Most respondents (58%) had lived in their current neighbourhood for 10 years or more while 16% had done so for between five and 10 years, and 12% for between two and five years. Seven percent had lived in their neighbourhood for between one and two years, and an equal proportion had done so for less than a year. There were few sub-group differences but, as would be expected, mobility was higher among younger people and those living in large urban areas.

4.11 As figure 4.2 shows, nine in ten respondents said they were satisfied with their neighbourhood, with 53% saying they were *very* satisfied. Just 5% in total expressed any dissatisfaction with their neighbourhood. These results are virtually the same as those recorded in the previous survey, despite a slight increase in satisfaction between 2004 and 2006 (from 87% to 90%).

Figure 4.2: Satisfaction with neighbourhood

Q. How satisfied or dissatisfied are you with this area as a place to live?



Base: All respondents (1,177)

Source: Ipsos MORI

4.12 There was a correlation between neighbourhood satisfaction and area deprivation: 98% of those in the least deprived areas were satisfied with

their neighbourhood compared with 77% in the most deprived areas. No other geographical-based variation was found.

- 4.13 There were links between neighbourhood satisfaction and mental health and wellbeing: people displaying no or few signs of a possible psychiatric disorder tended to be more positive about their neighbourhood than those with a possible disorder (92% versus 82% respectively were satisfied), and those with above average mental wellbeing tended to be more positive than those with below average mental wellbeing (91% versus 80%). However, there were no correlations between proxy or personal experience of a mental health problem and neighbourhood satisfaction.

Social engagement

- 4.14 Having few close friends or relatives has been associated with a greater likelihood of experiencing symptoms of mental health problems across the lifespan (see, for example, Marjo *et al.*, 2009; Cattan *et al.*, 2005; Miller, 1979; Ueno, 2005; Putnam 2000). In order to explore these linkages, the survey included a number of questions focusing on respondents' levels of social engagement and their informal support networks.
- 4.15 Asked how often they see friends or relatives who are not living with them, two in five (41%) respondents said on most days and a similar proportion said once or twice a week (44%). Nine per cent said once or twice a month and 5% said less often than once a month. One per cent said they never see friends or relatives who are not living with them. These figures have remained static on 2006.
- 4.16 Seeing friends and relatives almost daily was associated with being female (45% versus 36% of men) and belonging to the 16 to 24 age group (59% versus, for example, 50% of people aged 45 to 54 years and 32% of people aged 75 and over). The latter finding is to some extent intuitive: people aged 16 to 24 years will spend large proportions of their time either at school or college where they will come into regular contact with peers. They are also among the groups least likely to have caring responsibilities and therefore they may have more free time to spend with family and friends.
- 4.17 There was also a correlation between seeing friends and relatives almost daily and living in one of the most deprived areas of the country (51% of people in these areas saw friends or relatives almost daily, compared with 38% of those in the least deprived areas). Reasons for this link are unclear, although it may be significant that people in deprived areas are less likely to be in employment and therefore may have more time to see friends and relatives. Small base sizes preclude a robust analysis of the results by the Scottish Government's urban rural classification, but the data indicates that people living in remote rural areas were more likely than average to see friends and relatives less than once a month (12% versus 5% overall).
- 4.18 There was no variation by self-reported experience of mental health problems, by levels of psychiatric disorder or by mental wellbeing. This is of

note, as it suggests that social engagement *per se* is not straightforwardly associated with the experience of mental health problems.

- 4.19 To gauge respondents' wider levels of social engagement, they were asked whether they gave up any time as a volunteer or organiser for charities, clubs or organisations. Just over one in five (22%) said that they did so. This figure is consistent with the 2006 result (20%) and with findings from other, UK-wide studies conducted in recent years – for example, the Hansard Society's 2008 *Audit of Political Engagement* in which 23% of respondents said that they have done voluntary work in the last two or three years (Hansard Society, 2008).
- 4.20 Volunteering was found to be associated with living in the least deprived areas of Scotland (25% of people in these areas had volunteered compared with 12% in the most deprived areas), finding it easy to manage financially (26% versus 14% of those who found it difficult to manage) and living in accessible rural areas (31% compared with 19% in large urban areas).
- 4.21 There were no associations between volunteering and self-reported experience of mental health problems or GHQ12 scores, but more people with above average mental wellbeing than with below average mental wellbeing had volunteered (24% versus 14%). Of course it is not possible for a study such as this to identify causation and a different longitudinal design would be required to investigate whether volunteering itself contributes to mental wellbeing being or whether people with above average mental wellbeing are, for whatever reason, more likely to volunteer.

Informal support networks

- 4.22 Reflecting their regular contact with friends and family, most respondents felt that they had people they could rely on for support in times of difficulty. Just over nine in ten (92%) said they had someone they could turn to if they were ill in bed, and 83% said that they had someone from whom they could borrow money if they were in financial difficulty. Both figures are in line with the 2006 results.
- 4.23 Having people to rely on for support was correlated with age and area deprivation: people aged 45 and younger were more likely than older groups to say they had people they could rely on for financial support (93% of people aged 16 to 24 years compared to 72% of people aged 75 and over) and people in the least deprived area were more likely to do so than those in the most deprived areas (89% versus 74%).
- 4.24 There were no associations between having people to rely on and self-reported experience of mental health problems but people exhibiting no or few signs of a possible psychiatric disorder were more likely than those with a possible psychiatric disorder to say they had people they could rely on if they were ill in bed (94% versus 89%) or in financial difficulty (86% versus 75%). Similarly, people with above average mental wellbeing were more likely to say they had people they could rely on in these situations than those with below average mental wellbeing (ill in bed: 97% versus 83%; in

financial difficulty: 89% versus 64%). Again, however, it is not possible to comment on causation and the direction of the association between having informal support networks and mental health and wellbeing.

4.25 As in the previous surveys, the mean number of people respondents said they would be able to turn to in a personal crisis was six. There were no notable sub-group differences on this measure.

4.26 An analysis was undertaken to explore the links between people's level of social engagement and the strength of their informal support networks. To facilitate the analysis, a single social engagement variable was derived by combining responses to four of the survey questions discussed above, namely, those focusing on:

- the frequency with which respondents see friends or relatives who are not living with them
- whether they volunteer
- whether they have someone they could turn to if they were ill in bed
- whether they have someone they could turn to if they were in financial difficulty.

4.27 Respondents were classified as 'more socially engaged' if they gave a positive response on at least three⁸ of these measures and 'less socially engaged' if they gave a positive response on fewer than three⁹.

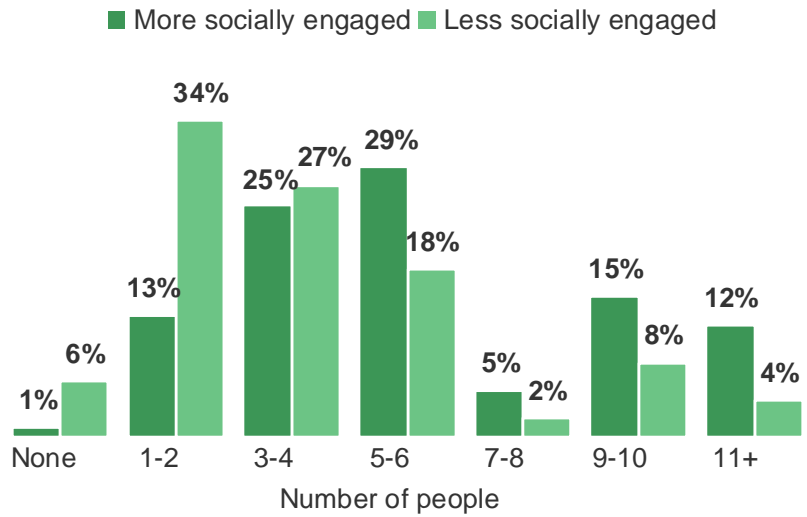
4.28 As in 2006, the analysis confirmed that respondents who were more socially engaged had significantly more people they could turn to in the event of a personal crisis than those who were less so. Indeed, and as figure 4.3 illustrates, they were twice as likely to have five or more people they could turn to (62% in total versus 32%). Although this finding is intuitive, it is nonetheless important as it illustrates that social engagement may have psychosocial benefits when one encounters stressful life events.

8 Three was chosen as the cut off point as it represented a majority of positive responses.

9 In respect to the measure focusing on the frequency with which respondents saw friends or relatives, a positive response was defined as: 'on most days' or 'once or twice a week'.

Figure 4.3: strength of support networks by level of social engagement

Q. If you had a personal crisis, how many people, if any, do you feel you could turn to for comfort and support?



Base: All respondents (1,177)

Source: Ipsos MORI

5 MENTAL HEALTH PROBLEMS AND WELLBEING

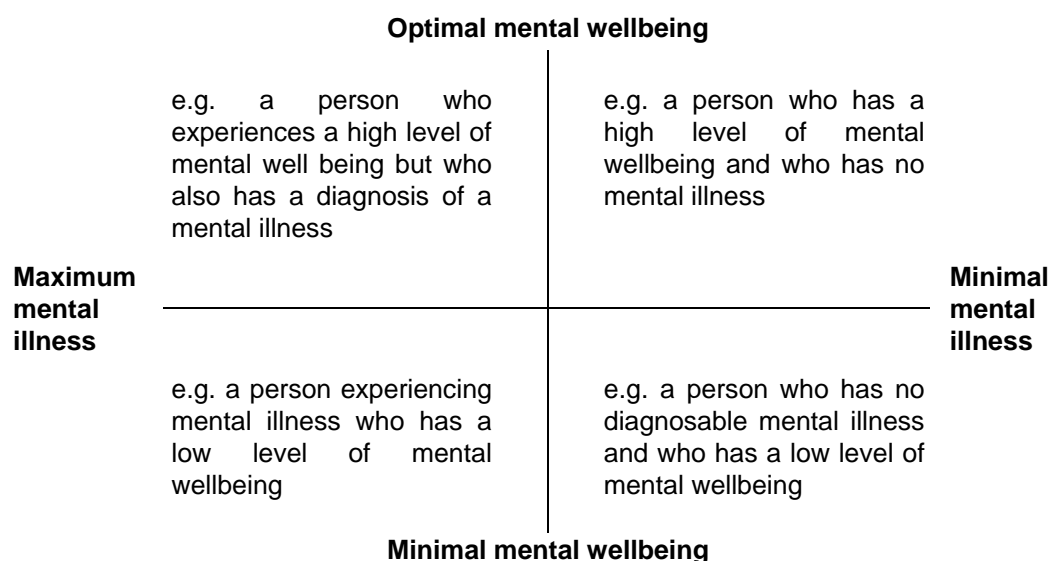
5.1 This chapter examines findings from the GHQ12 component of the survey, which was used to gauge levels of possible psychiatric disorder among the population, and from the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), designed to assess mental wellbeing. It also considers the results from the Revised Life Orientation Test (LOT-R), which assesses trait optimism and was included in the 'Well?' survey for the first time in 2008. The latter part of the chapter looks at factors respondents thought had a positive or negative effect on their mental health, and how much control they felt they have over these factors.

The dual factor model of mental health

5.2 Mental health policy in Europe, including Scotland, is increasingly focused on mental health improvement (Scottish Government, 2009a). Mental health improvement refers to focusing activity on both enhancing mental wellbeing *and* preventing mental health problems. Such approaches are consistent with the dual factor model of mental health (e.g., Greenspoon & Saklofske, 2001), which assesses indicators of wellbeing, as well as the more traditional indicators of mental health problems.

5.3 In such an approach, mental wellbeing and mental health are identified as being two distinct dimensions. Therefore, it is possible for someone to experience mental health problems while at the same time having good mental wellbeing and a good quality of life, just as someone who does not experience mental health problems may nonetheless experience poor mental wellbeing and a poor quality of life. This is illustrated in figure 5.1.

Figure 5.1: The dual factor model of mental health



- 5.4 Consistent with this model, the survey included both the General Health Questionnaire 12 (GHQ12) – a screening instrument designed to detect possible psychiatric disorder – and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), designed to measure mental wellbeing.

General Health Questionnaire (GHQ12)

- 5.5 The GHQ12 has been included in the ‘Well?’ survey since 2004. Each of the twelve items in GHQ12 consists of a question asking whether the respondent has recently experienced a symptom or feeling (e.g. happiness, depression, anxiety, self-confidence, stress) on a four-point scale ranging from ‘less than usual’ to ‘more than usual’.¹⁰
- 5.6 The completed GHQ12 sections were scored according to the bimodal scoring method in *A User’s Guide to the General Health Questionnaire* (Goldberg and Williams, 1991). A score of 1 was allocated to an item if the respondent had been experiencing the symptom or behaviour described more than usual, and a score of 0 was given if they had not done so. These scores were then summed to give an overall GHQ12 score (ranging from zero to 12) for each respondent. The composite scores were then recoded to derive a binary analysis variable indicating whether or not a respondent exhibited a possible psychiatric disorder: scores of 0-3 were classified as ‘low GHQ12 scores’ (no or few signs of a possible psychiatric disorder) while scores of 4+ were classified as ‘high GHQ12 scores’ (possible presence of a psychiatric disorder).
- 5.7 Table 5.1 presents the results of the analysis together with comparable data from the 2004 and 2006 surveys (GHQ12 was not included in the 2002 survey). Throughout this report, the GHQ12 binary variable is used as a key analysis variable.
- 5.8 There are no differences between the results for the 2004, 2006 and 2008 surveys, with around four in five respondents in each case classified as having a ‘low GHQ12 score’ and around one in five as having a ‘high GHQ12 score’. However, the 2008 results differ from comparable figures recorded in the 2003 Scottish Health Survey, in which 85% of adult respondents were classified as having a low score and 15% a high score (Scottish Executive 2005b). In other words, more respondents in ‘Well?’ 2008 than in the Scottish Health Survey were classified as having a possible psychiatric disorder. To some extent this is unsurprising: as the ‘Well?’ survey focuses predominantly on mental health related issues, respondents may be more likely to focus on negative aspects of their own mental health, whereas in the Scottish Health Survey, the GHQ12 appears among a much wider range of questions and respondents may not see it as being specifically about mental health.

10 The GHQ12 is traditionally administered through a pen and paper self-completion approach. However, because this survey is conducted using CAPI, in order to maintain privacy and emulate the traditional mode of data collection, respondents were invited to enter their responses directly into the interviewer’s computer. Interviewers provided assistance to those for whom computer literacy was an issue.

5.9 GHQ12 scores for the UK and comparative scores for England, Northern Ireland, Scotland and Wales were published recently (Murphy & Lloyd, 2007). Using data from the Northern Ireland Household Panel Survey (NIHPS) and the British Household Panel Survey (BHPS), Murphy and Lloyd (2007) found that one in five (19.5%) respondents in the UK was classified as having a high GHQ12 score. With the exception of Wales, which had the highest GHQ12 scores in the UK (23.0%), there was little difference in the prevalence of high GHQ12 scores across England (19.5%), Northern Ireland (19.7%) and Scotland (19.2%). The prevalence of high GHQ12 scores in the 'Well?' samples is consistent with Murphy and Lloyd's (2007) findings.

Table 5.1: GHQ12 scores

	'Well?' 2004	'Well?' 2006	'Well?' 2008
<i>Base: All answering GHQ12</i>	1,300	460 ¹¹	1,143
Total points scored on GHQ12	%	%	%
0	50	52	48
1	16	18	17
2	10	7	8
3	6	7	6
4	3	4	4
5	3	3	3
6	3	2	3
7	2	2	2
8	2	2	2
9	1	2	2
10	1	*	1
11	1	*	2
12	2	2	2
GHQ12 score grouped			
0-3 (low GHQ12 score)	82	83	79
4+ (high GHQ12 score)	18	17	21
TOTAL	100	100	100

5.10 As can be seen in table 5.2, high GHQ12 scores were correlated with:

- having 'bad' or 'very bad' (self-assessed) general health
- having a long standing illness, infirmity or disability
- having personal or proxy experience of a mental health problem
- having little or no feeling of control over factors affecting personal mental health
- having difficulty managing financially
- not having anyone to turn to in the event of being ill in bed or in financial difficulty
- being out of work
- being dissatisfied with neighbourhood.

11 Although 973 respondents agreed to complete the self-completion module in 2006, only 460 respondents were presented with the full GHQ12 section with the remainder completing only the first two items. This was due to an administrative error in the scripting of the survey (full details on this omission are included in the 'Well?' 2006 report).

Table 5.2: Correlates of high GHQ12 scores

	% of those with a high GHQ12 score	% of those with a low GHQ12 score
Good or very good general health	56	79
Bad or very bad general health	18	6
Long standing illness, disability etc.	45	28
No long standing illness, disability etc.	55	72
Personal experience of a mental health problem	49	22
Proxy experience of a mental health problem	80	67
Complete/good deal of control over factors affecting your mental health	39	71
Little/no control of factors affecting mental health	22	7
Easy to manage on income	33	48
Difficult to manage on income	34	11
Someone to turn to if ill in bed	89	94
No-one to turn to if ill in bed	10	6
Someone to turn to in financial crisis	75	86
No-one to turn to in financial crisis	22	11
In paid work	45	58
Not in paid work	55	42
Satisfied with neighbourhood	82	92
Dissatisfied with neighbourhood	11	4

WEMWBS

5.11 The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)¹², provides a psychometrically sound tool for measuring mental wellbeing at a population level. The measure, intended to complement standard scales that measure

¹² The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Executive National Programme for improving mental health and well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.

mental health problems (see Tennant *et al*, 2007), has been included in the 'Well?' series of surveys since 2006.

- 5.12 WEMWBS comprises 14 positively worded statements describing thoughts and feelings relating to aspects of mental wellbeing. For each statement, respondents are asked to indicate, using a five-point scale (from 'none of the time' to 'all of the time'), how often they have experienced these over the last two weeks. Table 5.3 presents the responses to the individual WEMWBS statements together with comparable data from the 2006 survey.

Table 5.3: Frequencies of responses to individual WEMWBS statements

	'Well?' 2006	'Well?' 2008
<i>Base: All respondents who answered WEMWBS</i>	973	1,143
	%	%
I've been feeling optimistic about the future		
None of the time	3	4
Rarely	9	12
Some of the time	37	41
Often	38	34
All of the time	13	8
I've been feeling useful		
None of the time	2	3
Rarely	6	7
Some of the time	31	29
Often	47	47
All of the time	14	14
I've been feeling relaxed		
None of the time	2	3
Rarely	12	15
Some of the time	39	38
Often	38	34
All of the time	9	10
I've been feeling interested in other people		
None of the time	2	2
Rarely	6	7
Some of the time	30	30
Often	45	43
All of the time	17	18
I've had enough energy to spare		
None of the time	4	8
Rarely	24	24
Some of the time	40	38
Often	25	21
All of the time	7	9
I've been dealing with problems well		
None of the time	2	2
Rarely	4	6
Some of the time	33	31

Often	48	45
All of the time	14	15
I've been thinking clearly		
None of the time	1	1
Rarely	3	4
Some of the time	26	24
Often	49	50
All of the time	20	22
I've been feeling good about myself		
None of the time	1	3
Rarely	6	7
Some of the time	39	36
Often	42	42
All of the time	12	13
I've been feeling close to other people		
None of the time	2	1
Rarely	6	7
Some of the time	25	27
Often	50	45
All of the time	16	20
I've been feeling confident		
None of the time	2	2
Rarely	6	8
Some of the time	35	32
Often	43	42
All of the time	14	15
I've been able to make up my own mind about things		
None of the time	*	1
Rarely	4	3
Some of the time	20	18
Often	47	48
All of the time	28	30
I've been feeling loved		
None of the time	1	1
Rarely	4	5
Some of the time	18	18
Often	42	48
All of the time	35	30
I've been interested in new things		

None of the time	2	3
Rarely	10	13
Some of the time	27	28
Often	42	39
All of the time	20	17
I've been feeling cheerful		
None of the time	1	2
Rarely	4	6
Some of the time	33	27
Often	48	49
All of the time	15	16

5.13 The 2008 results are broadly consistent with those from 2006. However, there has been a decrease in the proportion of respondents saying that they felt optimistic about the future 'all of the time' (from 13% in 2006 to 8% in 2008). This may reflect the fact that the survey fieldwork was conducted during a period of economic slowdown characterised by a falling housing market and rising food and fuel prices. The associated 'credit crunch' has received extensive coverage in the media and dominated political debate during the survey fieldwork.

5.14 For each of the individual WEMWBS questions, respondents were allocated a score from 1 (for none of the time) to 5 (for all of the time). These scores were then summed to provide an overall WEMWBS score. The minimum score possible from the scale is 14 while the maximum is 70. The higher a person's score is, the better their mental wellbeing. Consistent with findings from 2006, respondents' mean score on WEMWBS was 50.65 and the standard deviation was 8.82¹³. Additionally, WEMWBS was found to be normally distributed among the general population and to have a single underlying factor.

5.15 Looking beyond the aggregate-level findings, the full range of mental wellbeing scores were evident among all sub-groups of respondents but the *distribution* of the scores varied significantly. More specifically, and as in 2006, high WEMWBS scores were associated with:

- being in paid work
- having a high income
- finding it easy to manage financially
- living in the least deprived areas of the country
- having someone to turn to in the event of being ill in bed or in financial difficulty
- feeling in control of factors affecting mental health
- having good or very good (self-assessed) general health
- having no personal or proxy experience of a mental health problem

¹³ Respondents' mean score on WEMWBS in 'Well?' 2006 was 51.05 and the standard deviation was 8.54

- having a low GHQ12 score (table 5.4)

Table 5.4: Descriptive Statistics of WEMWBS scores: Mean, Standard Deviation, Median, Range

	Mean	Standard Deviation	Median	Minimum	Maximum	Base
	50.65	8.82	52	14	70	1,143
Male	51.12	8.83	52	14	70	494
Female	50.22	8.80	52	14	70	649
16-24	52.64	7.56	53	26	69	108
25-34	50.77	8.97	51	14	70	153
35-44	50.04	8.78	51	14	70	211
45-54	48.74	9.82	50	14	70	197
55-59	49.54	9.27	51	24	70	73
60-64	51.80	8.09	52.95	25	70	95
65-74	51.93	8.66	53	14	70	167
75+	50.96	7.99	51.15	28	69	119
Easy to manage on income	52.85	7.89	53	14	70	508
Difficult to manage on income	44.97	10.94	46	14	70	191
Household income of < £5,200 per year	45.08	12.77	48.37	14	69	67
Household income of £36,400+ per year	51.69	7.32	52	31	70	199
Someone to turn to if ill in bed	51.03	8.50	52	14	70	1,066
No-one to turn to if ill in bed	45.72	11.01	48	14	70	81
Someone to turn to in financial crisis	46.92	10.90	49.92	14	70	155
No-one to turn to in financial crisis	51.33	8.28	52	14	70	966
In paid work	51.58	7.74	52	14	70	633
Not in paid work	49.52	9.88	51	14	70	518
Complete/good deal of control over factors affection your mental health	52.98	7.73	53	14	70	745
Little/no control of factors affecting mental health	44.01	11.58	45	14	70	118

Personal experience of a mental health problem	46.69	10.59	47.12	14	70	332
No experience of a mental health problem	50.80	8.90	52	14	70	727
Low GHQ12 score	52.82	7.04	53	14	70	907
High GHQ12 score	41.82	9.76	42	14	70	236
Good or very good general health	52.39	7.44	53	14	70	813
Bad or very bad general health	41.51	11.19	42	14	70	110

5.16 WEMWBS is a relatively new scale and respondents are not, as a rule, classified on the basis of their scores as a diagnostic tool. However, for the purposes of analyses presented in this report, the following three-fold statistical classification has been used:

- those with ‘above average mental wellbeing’ (a WEMWBS score of over one standard deviation above the mean)
- those with ‘average mental wellbeing’ (a WEMWBS score of within one standard deviation of the mean)
- those with ‘below average mental wellbeing’ (a WEMWBS score of more than one standard deviation below the mean).¹⁴

5.17 As WEMWBS is a discrete scale comprising only whole numbers, the cut-off scores were 42 and 59. Thus, a score of 41 or below was considered below average mental wellbeing and a score of 60 or above as above average mental wellbeing, for this survey. The vast majority of respondents (75%) fell into the ‘average mental wellbeing’ category, 12% were classified as having ‘above average mental wellbeing’, and 13% as having ‘below average mental wellbeing’. These scores are in line with those reported in ‘Well?’ 2006 where 73% of respondents were classed as having ‘average mental wellbeing’, 14% as having ‘above average mental wellbeing’, and 14% as having ‘below average mental wellbeing’. It is important to note that the three-fold classification was created solely for the purposes of analyses presented in this and the 2006 ‘Well?’ report. It is not based on any evidence that an average or below average score is problematic. Indeed, as WEMWBS is normally distributed in the population, most people *should* have average wellbeing.

5.18 Analyses were also undertaken to test the dual factor model of mental health. To do this, respondents’ raw scores on the GHQ12 and WEMWBS were dichotomised via a median split into high and low GHQ12 and WEMWBS, thereby yielding the following categories:

14 The three categories are in line with those used in ‘Well?’ 2006. They were initially arrived at through analysis of respondents’ WEMWBS results which revealed that their scores were either in line with or at least one standard deviation above or below the mean.

1. Individuals below the median on GHQ12 and below the median on the WEMWBS
 2. Individuals below the median on GHQ12 and equal to or above the median on the WEMWBS
 3. Individuals equal to or above the median on the GHQ12 and below the median on the WEMWBS
 4. Individuals equal to or above the median on the GHQ12 and equal to or above the median on the WEMWBS
- 5.19 As expected, the majority of respondents (71.4%) were classified as either (2) or (3). However, in support of the dual factor model, all four quadrants were populated with almost 30% of respondents being also either (1) below the median on the GHQ12 and below the median on the WEMWBS (13.0%) or (4) equal to/or above the median on the GHQ and equal to/or above the median on the WEMWBS (15.6%).

Life Orientation Test – Revised (LOT – R)

- 5.20 In addition to GHQ12 and WEMWBS, the 2008 survey included a version of the Revised Life Orientation Test (LOT-R) – a widely used self-report measure of trait optimism. Optimism is an individual difference/personality measure which is thought to be relatively stable over time (Carver *et al.*, 2005; Scheier *et al.*, 1992).
- 5.21 Optimism and pessimism can be described as psychological dimensions in which optimism represents a bias in perceptions and expectations in favour of positive features in life and pessimism represents a negative bias (Peterson & Bossio, 1991). In short, optimists have greater confidence in their own abilities and expect good experiences in the future whereas pessimists expect bad experiences (Scheier & Carver, 2003) and these expectancies predict psychological wellbeing (Carver & Scheier, 1998; O'Connor & Cassidy, 2007).
- 5.22 Optimism and pessimism have been extensively explored within clinical and health psychology (Lewis *et al.*, 1995). Indeed, optimism has been found to be positively associated with adaptive coping skills (Natail-Aleman, 1991), while pessimism has been associated with less effective coping strategies (Weintrub *et al.*, 1986). The two traits have also been shown to correlate with different patterns of preferred defence mechanisms (Dember *et al.*, 1989).
- 5.23 However, people may not be exclusively either optimistic or pessimistic. Depending on the situation, many people possess optimistic and pessimistic characteristics (Peterson & Bossio, 1991). For example, someone may be optimistic regarding certain aspects of their life while being pessimistic towards other aspects.

- 5.24 There are thus two contrasting views concerning the measurement of optimism and pessimism. The bipolar view regards optimism and pessimism as being at different ends of a single bipolar continuum, while the separate dimensional view advises that both optimism and pessimism can exist within a person.
- 5.25 LOT-R is designed to assess individual differences in generalised optimism versus generalised pessimism by exploring people’s expectations for the future. Generalised optimism is the tendency to expect positive events to happen in the future, i.e., view the glass as half full versus half empty (generalised pessimism), whereas pessimism reflects an expectation that bad things will happen. A version of LOT-R comprising six statements was used (Scheier *et al.*, 1994) in ‘*Well?*’ 2008. Three of the six items are framed in an optimistic manner while three are phrased in a pessimistic manner. Respondents were asked to indicate, on a five point scale (ranging from ‘I agree a lot’ to ‘I disagree a lot’), the extent to which they agreed or disagreed with each statement. The three optimistically worded items are summed to yield an optimism score and the three pessimistically worded items are summed to yield a pessimism score.
- 5.26 Table 5.5 shows the frequencies of responses to the individual LOT-R statements. Agreement with each of the optimistic statements lay between 64% and 74% while agreement with the pessimistic statements varied from 24% to 35%.

Table 5.5: Frequencies of responses to individual LOT-R statements

	I agree a lot	I agree a little	I neither agree nor disagree	I disagree a little	I disagree a lot
<i>Base: All respondents answering LOT-R (1,138)</i>					
	%	%	%	%	%
In uncertain times I usually expect the best	23	41	19	14	4
If something can go wrong for me, it will	10	25	18	26	20
I’m always optimistic about my future	33	38	15	11	3
I hardly ever expect things to go my way	5	19	21	31	23
I rarely count on good things happening to me	7	20	18	32	23
Overall, I expect more good things to happen to me than bad	36	38	15	8	4

5.27 Reflecting the distribution of high WEMWBS scores in the population, subgroup analysis of the LOT-R findings found optimism to be correlated with:

- having good or very good (self-assessed) general health (the only exception to this was in respect to the statement ‘In uncertain times I usually expect the best’ where no correlation with general health was evident)

- having a high GHQ12 score
- having above average mental wellbeing
- having no personal or proxy experience of a mental health problem
- living in the least deprived areas of the country
- having a higher income
- finding it easy to manage financially

5.28 An analysis was undertaken which allocated each respondent a separate optimism and pessimism score. Table 5.6 presents the results of this analysis.

5.29 The optimism score was calculated by summing the scores for each of the items phrased in an optimistic manner¹⁵: 'In uncertain times, I usually expect the best', 'I'm always optimistic about my future', and, 'Overall, I expect more good things to happen to me than bad'. The minimum score possible on the scale is 3 while the maximum is 15. The higher a person's optimism score is, the more optimistic an outlook on life they demonstrate. As table 5.6 shows, the vast majority of respondents received optimism scores of 10 or more.

5.30 The pessimism score summed the three items framed in a pessimistic manner¹⁶: 'If something can go wrong for me, it will', 'I hardly ever expect things to go my way', and, 'I rarely count on good things happening to me'. Again, the minimum score possible on the scale is 3 and the maximum is 15. Higher pessimism scores demonstrate a more pessimistic outlook. As shown in table 5.6, pessimism scores were more widely dispersed than the optimism scores; around 60% achieved pessimism scores between 3 and 8 and around 40% achieved scores between 9 and 15. The scores are consistent with what would be expected: the majority of the population have an optimism/pessimism score within one standard deviation of the mean optimism/pessimism score.

15 The scale represents a score for each item from 1 to 5 respectively. Responses least consistent with an optimistic disposition were coded with a score of one and those most consistent with an optimistic disposition were coded with a score of five.

16 To calculate pessimism scores, the responses were flipped, so "I agree a lot" received a value of 5 while "I disagree a lot" took the value of 1.

Table 5.6: LOT-R Optimism and Pessimism scores

	Optimism	Pessimism
<i>Base: All answering LOT-R (1,138)</i>		
Total points scored	%	%
3	1	10
4	*	7
5	1	7
6	3	13
7	3	9
8	4	12
9	7	10
10	12	9
11	15	6
12	20	8
13	11	4
14	12	1
15	12	3

5.31 A *net* optimism score was also calculated for each respondent by subtracting their pessimism score from their optimism score. Net optimism is used as an analysis variable throughout the report.

5.32 To provide a means of comparing respondents' LOT-R scores with those of other survey populations, a POMP (Percent Of Maximum Possible scores) score was calculated using a method outlined in Cohen, Aiken & West (1999). The POMP score was 64.85, with a 95% confidence interval ranging from 63.74 to 65.96. This indicates that individuals are, on average, reasonably optimistic, with scores being higher than the scale midpoint.

5.33 Fischer & Chalmers (2008) recently conducted a meta-analytic investigation of optimism levels in different countries. Their review reported the mean POMP optimism score for the UK (which comprised 9 studies in which optimism levels were measured among respondents living in England¹⁷). A comparison of the English mean POMP optimism scores (reported in Fischer & Chalmers, 2008) and the Scottish POMP optimism (reported herein) revealed no differences: the Scottish POMP optimism score reported herein (64.85) is similar to the comparable mean POMP score for those residing in England (64.36). In other words, those living in Scotland are no more or less optimistic than their counterparts living in England. It is worth noting, however, that none of the English samples reported in Fischer & Chalmers (2008) was nationally representative; student samples were

¹⁷ As the UK sample (k=9) reported by Fischer & Chalmers (2008) only included respondents living in England, it is referred to as the English sample hereafter.

predominant. Indeed, as student samples have a skewed age range and the respondents are disproportionately drawn from less deprived backgrounds, it would be reasonable to expect the average levels of optimism in student samples to be, if anything, higher than those derived from nationally representative samples (i.e., like the present sample).

5.34 This is the first time that trait optimism levels in England and Scotland have been directly compared in such a way. With the caveat that the English and Scottish samples differed in composition, the data suggest that there are no differences in levels of trait optimism between those living in the two nations. To confirm that inhabitants of both nations have similar levels of trait optimism, future studies should endeavour to compare LOT-R scores in nationally representative samples drawn from England and Scotland.

Correlations between WEMWBS, GHQ12 and LOT-R

5.35 Analyses were undertaken to identify the extent to which the WEMWBS, GHQ12 and LOT-R scales correlate with each other, and to determine the strength and direction of relationships between the three measurements. Overall, as expected, the three scales showed strong inter-correlations. In particular:

- there was a very strong negative correlation between WEMWBS and GHQ12¹⁸. In other words, respondents with below average mental wellbeing tended to have high GHQ12 scores while those with above average mental wellbeing tended to have low GHQ12 scores.
- there was a reasonably strong negative correlation between GHQ12 and the LOT-R net optimism score¹⁹, a slightly weaker, but still significant, positive correlation between GHQ12 and the LOT-R pessimism score²⁰, and a negative correlation between GHQ12 and the LOT-R optimism score²¹. In short, respondents with a low GHQ12 score tended to display a more optimistic than pessimistic outlook on life.
- there was a strong positive correlation between WEMWBS and the LOT-R net optimism score²² and slightly weaker, but still significant, positive correlation between WEMWBS and the LOT-R optimism score²³ and a negative correlation with the LOT-R pessimism score²⁴. In other words, respondents with above average mental wellbeing tended to display higher levels of optimism on LOT-R, while those with below average mental wellbeing tended to demonstrate a more pessimistic outlook.

18 correlation coefficient = -0.626

19 correlation coefficient = -0.379

20 correlation coefficient = 0.284

21 correlation coefficient = -0.330

22 correlation coefficient = 0.503

23 correlation coefficient = 0.461

24 correlation coefficient = -0.359

- the relationship between the LOT-R net optimism score was stronger with WEMWBS²⁵ than it was with GHQ12²⁶.
- there was a strongly significant negative correlation between the LOT-R optimism scale and the LOT-R pessimism scale²⁷. Thus, respondents displaying a more optimistic outlook on life tended to display fewer pessimistic traits

Positive effects on mental health and wellbeing

- 5.36 As in previous waves of the 'Well?' survey, respondents were asked what sorts of things they consider to have a positive impact on their emotions or mental health and wellbeing, and what things they consider to have a negative impact.²⁸ The questions were unprompted.
- 5.37 Figure 5.2 shows the most commonly mentioned influences, alongside the comparable results for 2006. As illustrated, the top responses related to leisure activities, hobbies and having a social life (31%), spending time with family (27%), and spending time with friends (22%), followed by spending time with children and grandchildren (13%), and the weather (12%).
- 5.38 Findings from 2008 are very similar to those recorded in 2006. They are also broadly comparable with results from other recent studies such as the 2008 Scottish Environmental Attitudes and Behaviours Survey (Scottish Government, 2009b), in which having enough money, improved health, spending time with family, and exercise or physical activity were identified by respondents as factors that would most improve their wellbeing²⁹.

25 correlation coefficient = 0.503

26 correlation coefficient = -0.379

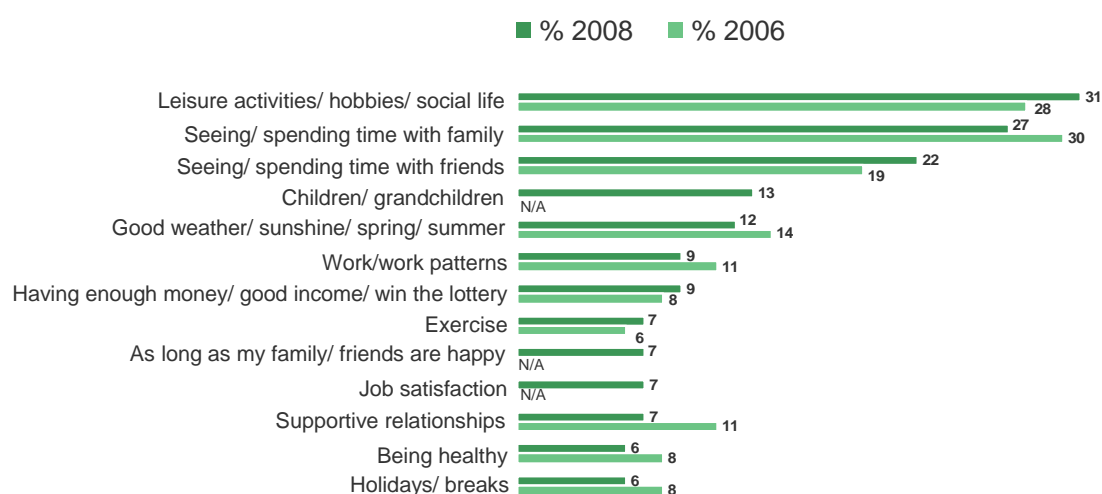
27 correlation coefficient = -0.285

28 As a result of the structure and wording of the question being changed in 2006, the 2002 and 2004 results are not directly comparable and therefore not presented.

29 It should be noted that the question asked about wellbeing in general, not mental wellbeing

Figure 5.2: Positive effects on mental health and wellbeing

Q. What sorts of things, if any, have a positive or good effect on your own emotions or mental health, mental well-being and mental health problems?



Base: All respondents 2006 (1,216); 2008 (1,177)

Source: Ipsos MORI

5.39 Perceived positive influences were correlated with gender, age, household income and ease of managing on income. In particular:

- men were more likely than women to cite leisure activities, hobbies and a social life as positive influences (37% versus 27%)
- women were more likely than men to mention seeing friends (28% versus 15%) and family (32% versus 21%)
- those aged 16 to 24 years were more likely than any other age group to cite seeing friends (43% versus 21% of those aged 75 years or over)
- those aged 35 years or over were more likely than those aged 16 to 24 years to mention the weather (for example, 18% of those aged 45 to 54 years versus 4% of those aged 16 to 24 years)
- people who found it easy to manage on their income were more likely than those who found it difficult to manage to mention family (30% versus 17%) and weather (14% versus 5%)
- those who found it difficult to manage on their income (20% versus 10% of those who found it easy to manage) and those who lived in the most deprived areas (19% versus 12% of those living in the least deprived areas) were more likely to mention children or grandchildren
- those living in the least deprived areas were more likely than people living in the most deprived areas to mention seeing friends (25% versus 16%) and weather (15% versus 7%).

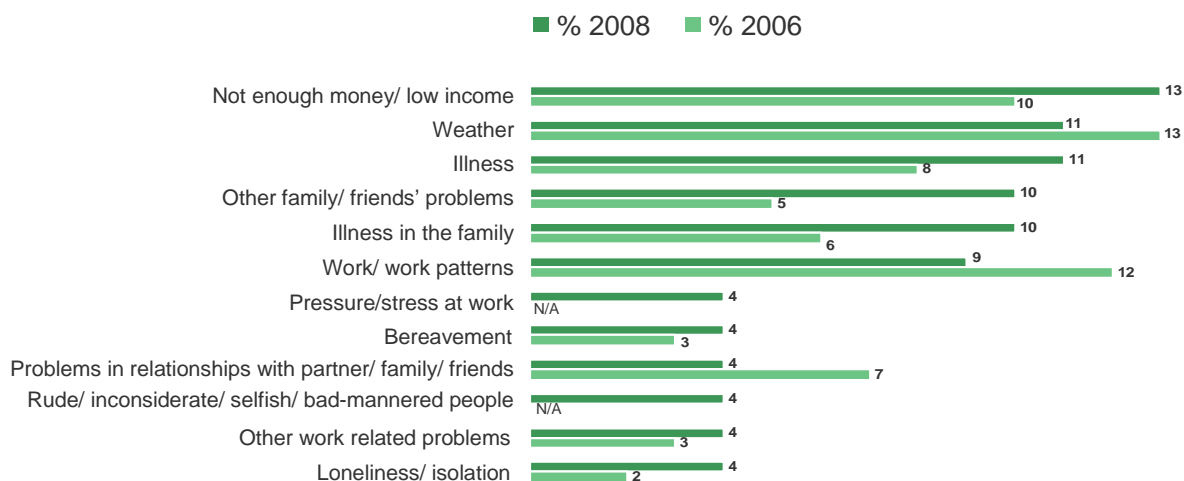
5.40 Where comparable, these correlations are broadly consistent with those from 'Well?' 2006.

Negative effects on mental health and wellbeing

5.41 When asked what sorts of things have a *negative* effect on their emotions or mental health and wellbeing, respondents most commonly mentioned not having a good income or not having enough money (13%), weather (11%), physical illness (11%), illness in the family (10%), problems, or bad news, for family or friends (10%) and work or having too much work (9%) (Figure 5.3). *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* recognises the influence of the workplace on mental wellbeing and contains a commitment to *develop a comprehensive programme of work to promote mentally healthy workplaces* (Scottish Government, 2009a). Moreover, the Government's mental health improvement approach is based on the social model of health which recognises the concomitant influences of social, economic and environmental factors on mental health and wellbeing.

Figure 5.3: Negative effects on mental health and wellbeing

Q. What sorts of things, if any, have a negative or bad effect on your own emotions or mental health, mental well-being and mental health problems?



Base: All respondents 2006 (1,216); 2008 (1,177)

Source: Ipsos MORI

5.42 Again, findings from 2008 are broadly similar to those recorded in 2006 and there were again correlations between perceived negative influences and both age and gender. In particular:

- women were more likely than men to mention the health of family or friends (12% versus 7%) and family or friends' problems (13% versus 6%)

- younger age groups were more likely than older age groups to mention having a low income, or not having enough money (25% of those aged 25 to 34 years versus 7% of those aged 55 to 59 years)
- older age groups were more likely than younger age groups to mention physical illness (17% of those aged 60 to 64 years versus 5% of those aged 16 to 24 years).

5.43 Previous research suggests that the absence of positive influences on mental wellbeing, as opposed to the presence of negative influences, is crucial in predicting suicidal behaviour (see O'Connor *et al*, 2007). Accordingly, and as in 'Well?' 2006, an analysis was undertaken to explore whether there was a relationship between the number of positive and negative influences respondents mentioned and their mental health and wellbeing (as measured by their responses to GHQ12, WEMWBS, and their personal or proxy experience of mental health problems). In the event, no such relationship was identified. This may be a result of the questions on positive and negative influences being unprompted, allowing for respondents to provide open responses as opposed to closed responses. A fuller discussion of the analysis is provided in Annex G.

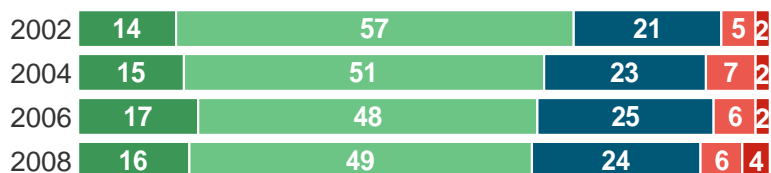
Self assessed control over factors affecting mental health

5.44 Respondents were asked how much control they felt they had over the factors they considered to affect their mental health and wellbeing. As can be seen from figure 5.4, 65% felt that they had either a good deal (49%) or complete control (16%) over these factors, compared to 10% who felt they had little (6%) or no control (4%). These results are very similar to those for 2006.

Figure 5.4: Trend in levels of control over mental health

Q. Thinking about all those things that might affect your own emotions or mental health and well-being, how much control, if any, do you feel you have over them?

■ % Complete ■ % Good deal ■ % Some ■ % Little ■ % No control



Base: All respondents 2002 (1,381); 2004 (1,401); 2006 (1,216); 2008 (1,177)

Source: Ipsos MORI

5.45 As table 5.7 shows, feelings of control were associated with gender: men were more likely than women to say that they felt in complete control (19% versus 13%).

- 5.46 There were no associations between feelings of control and age, despite the fact that in 'Well?' 2004 and 'Well?' 2006, people aged 16 to 24 years were more likely than the other age groups to feel in control. In 2008 the proportion of 16 to 24 year olds who said they felt in complete control decreased from one in four to one in six (from 24% in 2006 to 19% in 2008).
- 5.47 Respondents who had no experience of a mental health problem (either personal or proxy) were more likely to feel in control than those who reported personal experience of a problem (at 66% versus 50%, the figure has reverted back to the level recorded in 'Well?' 2004). Similarly, people with above average mental wellbeing were more likely to feel in control than were those with below average mental wellbeing (89% versus 32%), and people with a low GHQ12 score were more likely do so than those with a high score (71% versus 39%).
- 5.48 There were also highly significant positive correlations between perceptions of control and LOT-R net optimism³⁰ and LOT-R optimism³¹, and a highly significant negative correlation with LOT-R pessimism³². In other words, people who had a high optimism score were more likely to feel in control than those who had a low score, and those who had a high pessimism score were less likely to feel in control than those who had a low pessimism score.
- 5.49 There were also links between perceptions of control and physical health. People who rated their general health as good or very good tended to feel more in control than those who rated it as bad or very bad (70% versus 43%). Similarly, those without any limiting illness, infirmity or disability were more likely to feel in control than people reporting a limiting condition (65% versus 46%).
- 5.50 In terms of other correlations, people with higher household incomes were more likely than those with lower incomes to feel in control of factors affecting their mental health (66% of those earning £36,400 or more versus 54% of those earning between £5,200 and £15,999), and those who found it easy to manage on their income were more likely to feel in control than those who found it difficult to manage (72% versus 49%). This is reflected in the SIMD analysis – respondents in the least deprived areas were more likely to feel in control than those in the most deprived areas (66% versus 57%). Potentially also related to these differences, respondents with qualifications tended to feel more in control than those without qualifications (70% of those obtaining an HNC, HND or equivalent versus 59% of those without any qualification).

30 Correlation coefficient = 0.265

31 Correlation coefficient = 0.262

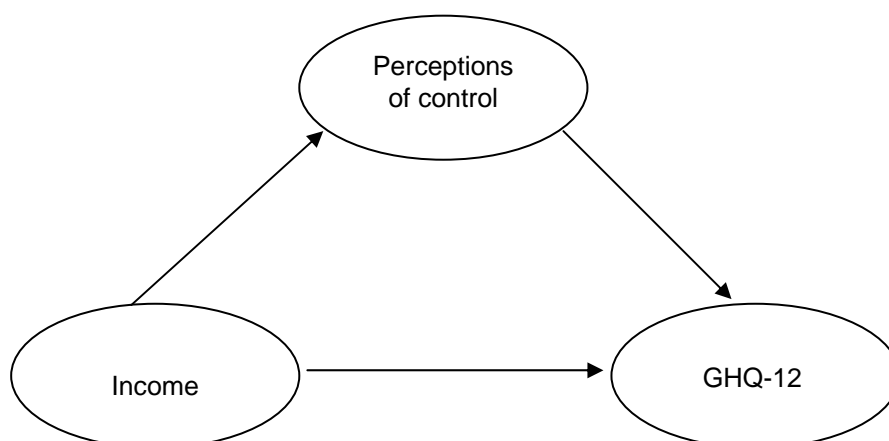
32 Correlation coefficient = -0.175

Table 5.7: Perceived levels of control over factors affecting mental health

	Complete control	A good degree of control	Some control	A little control	No control at all	Don't know	Base
	%	%	%	%	%	%	
All	16	49	24	6	4	1	1,177
Male	19	48	23	6	3	1	508
Female	13	49	25	7	4	1	669
16-24	19	56	19	5	1	-	109
25-34	12	56	23	7	2	-	156
35-44	16	48	25	4	6	1	215
45-54	14	44	29	10	3	1	200
55-59	12	50	22	8	7	-	76
60-64	16	37	32	4	6	5	98
65-74	18	57	15	6	3	*	172
75+	20	41	26	8	3	3	142
In paid work	15	53	25	4	3	1	570
Not in paid work	17	44	23	9	5	2	607
Easy to manage on income	18	54	20	4	2	1	520
Difficult to manage on income	9	40	28	13	10	*	197
Household income < £5,200 per year	25	31	21	14	10	-	70
Household income £36,400+ per year	12	54	27	4	3	*	201
Personal experience of a mental health problem	7	43	33	10	6	1	344
No experience of a mental health problem	19	47	25	5	3	1	750
Low GHQ12 score	19	52	21	4	3	1	907
High GHQ12 score	4	36	38	16	7	*	236
Above average mental wellbeing	37	52	6	4	1	1	178
Below average mental wellbeing	6	26	38	19	11	-	140

5.51 As in 2006, further analysis was undertaken to explore whether, and to what extent, the relationships between a) socio-economic status and GHQ12 scores, and b) socio-economic status and mental wellbeing (as measured through WEMWBS), highlighted elsewhere in this report, are mediated by perceptions of 'control'. Mediation analysis is helpful in this context as it allows us to examine what factors, if any, link socio-economic status to GHQ12 scores and mental wellbeing, and whether any of these factors are more important in explaining relationships in the data. So, for example, having a low income may be associated with having a high GHQ12 score but part or all of this association may be explained by a third (mediating) variable; in this case perceptions of control – in other words, and as figure 5.5 illustrates, being on a low income may partly or only be associated with having a high GHQ12 score because people with a low income are less likely to feel in control of factors affecting their mental health (and therefore more likely to have a high GHQ12 score). In short, mediation analysis helps us to understand the contribution of each variable in the relationship (see Annex H for a fuller explanation of mediation analysis).

Figure 5.5: Example of mediation analysis: do perceptions of control mediate the relationship between income and GHQ12 scores



5.52 Although mediation analysis describes potential mechanisms or pathways that may link, for example, indices of socio-economic status and mental wellbeing, as 'Well?' 2008 is a cross-sectional survey and does not involve experimental manipulation, conclusions about causality cannot be drawn.

5.53 The analysis drew on four individual measures of socio-economic status (SES) namely:

- area deprivation (as measured by SIMD and derived from postcode)
- annual income
- employment status
- highest professional qualification

- 5.54 A composite SES measure, incorporating all four of the individual variables was also calculated for the analysis.
- 5.55 When this analysis was undertaken in 2006, the only significant finding to emerge was that perceptions of control had a substantial mediating effect on the relationship between employment status and mental wellbeing, (but not the relationship between employment status and GHQ12 scores). More specifically, people in paid employment reported higher levels of control, which in turn were associated with better mental wellbeing. In the present analysis there was considerably more evidence of mediation. Indeed, perceptions of control were found to mediate the relationship between GHQ12 scores, mental wellbeing and *all* of the SES measures, apart from highest professional qualification. Thus people who were in employment, those who lived in the least deprived areas of the country, those with a higher income and those classified as being of higher economic status on the composite SES measure felt more in control and this in turn was associated with both lower GHQ12 scores and better mental wellbeing (as assessed via WEMWBS).
- 5.56 Additional mediation analysis was undertaken on the 2008 data to explore whether the relationship between SES and GHQ12 scores and mental wellbeing (as measured through WEMWBS) was mediated by trait optimism (as measured by the LOT-R). The same four measures of SES listed above were used in the analysis, together with three measures from the LOT-R: optimism, pessimism and net optimism.
- 5.57 These analyses found that optimism/pessimism mediated the relationship between SES and both GHQ12 scores and mental wellbeing. These effects can be summarised as follows:
- optimism was a moderately strong mediator of the relationship between income and both GHQ12 scores and mental wellbeing. In other words, although income had a direct³³ relationship with GHQ12 scores and wellbeing, it was also associated with optimism which in turn was associated with GHQ12 scores and mental wellbeing. This indirect³⁴ effect made up one quarter of the total effect that income had on GHQ12 scores and wellbeing. None of the other SES measures were found to be associated with optimism.
 - pessimism had a strong mediating effect on the relationship between all of the SES measures and both GHQ12 scores and mental wellbeing; that is, the effect of employment, of area deprivation, of income and of qualification level on GHQ12 scores and mental wellbeing was exerted both directly and also indirectly through the mediating variable of pessimism. In the case of both income and area deprivation, the indirect effect accounted for approximately half of the total effect of these variables on GHQ12 scores and mental

33 The relationship is direct in the context of the model – that is, on the basis of the analysis conducted, income was found to be directly associated with GHQ12 scores and wellbeing and these relationships did not simply reflect the influence of another variable i.e. optimism

34 The effect is indirect in the sense that income is associated with GHQ12 scores and wellbeing through the effect of optimism – i.e. income affects optimism which in turn affects GHQ12 scores and wellbeing.

wellbeing. In the case of working status, the indirect affect accounted for one-third of the total effect. In respect of the relationship between qualification level and mental wellbeing full mediation was observed; that is, qualification level had no effect on mental wellbeing *per se*, but qualification level affected pessimism and pessimism affected mental wellbeing.

- net optimism was a very strong mediator of the relationship between all of the SES measures and both GHQ12 scores and mental wellbeing. Eighty-eight per cent of the total effect of qualifications on mental wellbeing was due to qualifications being associated with net optimism which in turn accounted for mental wellbeing. Similarly, around two-thirds of the total effect that income and area deprivation had on mental wellbeing was due to the mediating influence of net optimism. For working status a lesser but still significant effect was observed.
- for the relationship between SES measures and GHQ12 scores, similar patterns emerged. Three quarters of the effect that income had on GHQ12 scores was accounted for by net optimism. For area deprivation the figure was just over half and for working status, just over one third.

6 EXPERIENCE OF MENTAL HEALTH PROBLEMS

- 6.1 This chapter focuses on respondents' personal experience of mental health problems, both through having experienced a mental health problem themselves and through the experiences of people close to them (experience by proxy). The chapter also considers the social consequences of mental health problems from the perspective of those with direct personal experience of problems and explores issues relating to recovery, including, what recovery means to people, factors that are seen to promote and hinder recovery, and recovery messages that people receive from professionals and those close to them.

Experience of mental health problems in someone close

- 6.2 Sixty-one per cent of respondents reported that someone close to them had *'ever experienced a mental health problem'*. This figure, which has remained static since 2004, is lower than the 68% of respondents who, in a 2005 survey of public attitudes to mental health in Ireland (Mental Health Ireland, 2005), said that someone close to them *'has or has had some kind of mental illness'*. Care should be taken when comparing these results given that the surveys were conducted three years apart and used different question wording (italicised) and different methodologies (the *'Well?'* series of surveys are conducted face to face among a random sample of adults aged 16 and over, while the Irish study was conducted by telephone among a quota sample of adults aged 15 and over).
- 6.3 There was an association between proxy experience of a mental health problem and age: respondents aged 25 to 64 years were more likely than those aged 16 to 24 years, or 65 years and over to say that someone close to them had experienced a mental health problem. As in 2006, respondents aged 75 years and over were less likely than all other age groups to say that someone close to them had experienced a problem.
- 6.4 In the 2006 *'Well?'* survey, correlations were observed between proxy experience of a problem and finding it difficult to manage financially (71% of those who found it difficult to manage said someone close to them have experienced a problem compared with 58% of those who found it easy to manage). This difference was not apparent in 2008 (the corresponding figures were 62% and 63% respectively).
- 6.5 However, there were associations between proxy experience and *income*: respondents with a household income of £26,000 or more were more likely than average to have proxy experience of a mental health problem (for example, 75% of those earning between £26,000 and £36,399 compared to 52% of those earning less than £5,200 per year). These differences stand in contrast to the finding, reported below, that lower income groups were more likely than higher income groups to report *personal* experience of a mental health problem. Reasons for this paradox are unclear but it may be that

higher income groups are more likely to discuss their mental health problems with people close to them.

- 6.6 Proxy experience of problems was also associated with having a high GHQ12 score (76% of those with a high score reported proxy experience compared with 59% of those with a low score) and below average mental wellbeing (73% versus 49% of those with above average mental wellbeing). This presents another paradox: if lower income groups, who have higher GHQ12 scores, have less proxy experience, but at the same time people with higher GHQ12 are more likely to report proxy experience, why are those with a lower income (who tend to have higher GHQ12 scores) claiming *less* proxy experience? Again, it may be that lower income groups are more reticent about revealing their mental health problem to those close to them but there may be other reasons too: while we can observe correlations between views expressed and other factors, it is not possible to draw firm conclusions about causality.
- 6.7 There were further associations between proxy experience of a mental health problem and educational qualifications: 76% of respondents with degree-level qualifications said someone they knew had experienced a mental health problem, compared with 51% of those without any qualifications.
- 6.8 Respondents were presented with a list of specific mental health problems and asked if anyone close to them had ever experienced any of these. The conditions that respondents most commonly said someone close to them had experienced were depression (45%), panic attacks (26%) and Alzheimer's disease or dementia (22%), followed by post-natal depression (16%), severe stress (14%), nervous breakdown (14%), and anxiety disorder (13%). Panic attacks, anxiety disorder and severe stress, along with excessive compulsive disorders and phobias (mentioned by 8% and 6% respectively) can be combined under the heading of anxiety and stress-related disorders. A total of 38% of respondents reported proxy experience of such disorders. These results are broadly consistent with the 2006 findings.
- 6.9 Proxy experience of particular problems was correlated with socio-economic measures. Most notably people who found it difficult to manage on their income were more likely than those who found it easy to manage to report proxy experience of manic depression (16% versus 10%), a nervous disorder (17% versus 11%), panic attacks (35% versus 22%), and self-harm (17% versus 8%). Meanwhile, people living in the least deprived areas of the country were more likely than those in the most deprived areas to report proxy experience of Alzheimer's disease or dementia (27% versus 16%).
- 6.10 There were also associations between proxy experience of specific problems and mental health and wellbeing: respondents with a high GHQ12 score were more likely than those with a low score to report proxy experience of all the listed conditions apart from Alzheimer's disease or dementia, personality disorder, schizophrenia and self-harm. Meanwhile,

those with below average mental wellbeing were more likely than those with above average mental wellbeing to report proxy experience of:

- depression (52% versus 37% of those with above average mental wellbeing)
- manic depression (19% versus 7%)
- nervous breakdown (20% versus 8%)
- self-harm (14% versus 6%)
- post traumatic stress disorder (9% versus 4%).

Personal experience of mental health problems

6.11 As in the previous 'Well?' surveys, around a quarter (26%) of respondents said they had *'personally experienced a mental health problem'*. This is considerably higher than the 5% of respondents to a 2009 Department of Health Survey of Attitudes to Mental Illness who said that they had personally experienced *'some kind of mental illness'* (TNS, 2009). It is also higher than the 14% of respondents in the 2008 Health Promotion Agency (HPA) Northern Ireland survey who said *'I have experienced mental health issues myself'* and the 9% in the 2005 Mental Health Ireland Survey who said they *'have personally suffered from mental illness'*. As in the case of proxy experience, however, these differences are in part likely to reflect the different question wording used in the surveys (italicised) and the fact that each survey was conducted in different years using different methodologies (like the 'Well?' surveys the DoH study and the HPA study were conducted face to face but households were selected for participation using quota rather than random pre-selected sampling. The Mental Health Ireland study was conducted by telephone and also among a quota sample).

6.12 In 'Well?' 2008, personal experience of mental health problems was correlated with:

- gender – 31% of women had experienced a problem compared with 20% of men
- age – 37% of respondents aged 35 to 44 years had experienced a problem compared to 12% of those aged 16 to 24 years and 12% of those aged over 75 years
- having a low income – 37% of those earning less than £5,200 per year compared to 23% of those earning £36,400 or more
- finding it difficult to manage financially – 42% versus 22% of those who found it easy to manage
- living in the most deprived areas of the country – 40% versus 19% of those in the least deprived areas
- having bad or very bad (self-assessed) general health – 48% versus 22% of those with good general health)
- having a high GHQ12 score – 47% versus 21% of those with a low score

- having below average mental wellbeing – 53% versus 13% of those with above average mental wellbeing
- 6.13 Where comparable, these differences are in line with findings from the 2009 DoH survey.
- 6.14 The specific mental health problems most commonly experienced by respondents were depression (17%), panic attacks (6%), anxiety disorder (4%), severe stress and post-natal depression (each 3%). If all of the anxiety and stress-related disorders are grouped together, as in the case of proxy experience, a total of 11% had personal experience of such a disorder. Again, these findings are broadly consistent with the 2006 results.
- 6.15 Experience of depression and panic attacks was most common among respondents with no qualifications (22% compared to 15% of respondents with degree level qualifications), those living in the most deprived areas (24% compared to 11% of those living in the least deprived areas) and those who said they found it difficult to manage on their income (33% compared to 13% of those who said they found it easy to manage). The later group of respondents were also among those most likely to have experienced severe stress (7% compared to 3% of those who found it easy to manage).
- 6.16 *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* acknowledges the higher prevalence of mental health problems among economically disadvantaged groups and indeed outlines action to undertake work focused specifically on addressing depression, stress and anxiety among deprived communities.

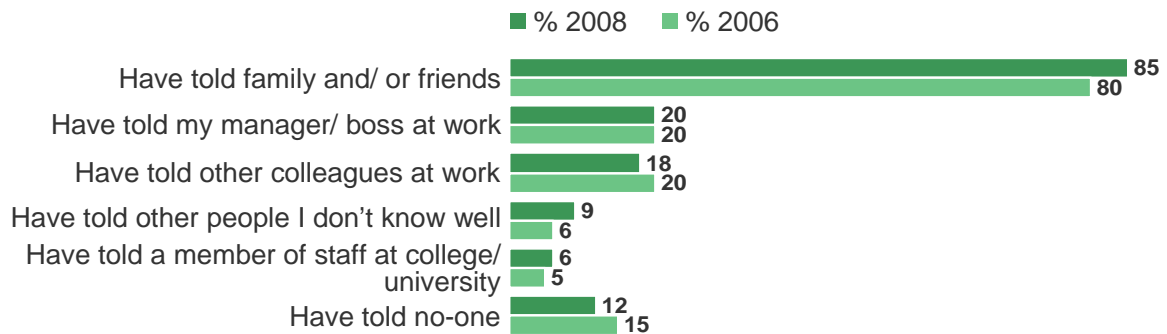
Telling others about mental health problems

- 6.17 In the 2006 and 2008 surveys, respondents who said they had personally experienced a mental health problem were asked if they had told anyone (other than their doctor or other health professionals) about it. In 2008, 88% said that they had done so. The majority (85%) said they had told family or friends while around one in five said they had told their boss or manager at work or other colleagues (20% and 18% respectively). Smaller proportions had told people they don't know well (9%) or a tutor or member of staff at college or university (6%). Twelve per cent said they had not told anyone about their mental health problem. As illustrated in figure 6.1, the findings are very much in line with the 'Well?' 2006 results.
- 6.18 That most respondents had chosen not to disclose their mental health problems at work is consistent with findings from surveys conducted elsewhere in the UK. For example, a survey conducted on behalf of DoH and The Mental Health Foundation found that 52% of respondents concealed their mental health problems for fear of losing their job (DoH, 2001). Similarly, in a 2005 survey exploring mental health and employment in Ireland, two-thirds of respondents said they would feel unable to disclose their mental health problems at a job interview and four in ten said they had

not disclosed their mental health problems to anyone in their workplace (Workway, 2005).

Figure 6.1 Disclosure of mental health problems

Q. Have you told anyone about your mental health problem, apart from your doctor or any other health professionals?



Base: All who have personally experienced a mental health problem: 2006 (384); 2008 (359)

Source: Ipsos MORI

6.19 While small base sizes preclude full sub-group analysis of the findings, a correlation was evident between disclosure of mental health problems and gender: women were more likely than men to say they had told family or friends about their mental health problem (91% versus 75%) while men were more likely than women to say they had not told anyone (22% versus 7%).

The social impact of mental health problems

6.20 Respondents who said they had experienced a mental health problem were asked about the social impact of their condition and specifically, about any difficulties they had experienced in terms of other people's attitudes towards their problem. As shown in table 6.1, 77% of respondents said they had not experienced any such difficulties. This figure has remained stable since 2006, despite an increase of over 10 percentage points between 2004 and 2006 (from 64% to 75%).

6.21 Among the minority who *had* experienced difficulties in terms of other people's attitudes, 10% reported being discouraged from participating in social events, 5% said they have been discouraged from taking part in local community life and 4% said they had refused a job or been discriminated against at work.

6.22 While these figures have remained fairly static since 2006, the proportion of respondents who said they have been physically abused in public (3%) has returned to the level recorded in 2004, suggesting that the 2006 result (less than half a per cent) reflected natural, short term fluctuation in the findings.

Table 6.1: Social impact of mental health problems, 2002-2008

	% who have experienced each			
	2002	2004	2006	2008
<i>Base: All who have personally experienced a mental health problem</i>	440	377	384	359
	%	%	%	%
Discouraged from participating in social events	12	15	11	10
Experienced discrimination at work	7	6	5	4
Been refused a job	6	4	5	4
Verbally abused within the family	7	6	4	3
Discouraged from taking part in community life	4	6	4	5
Discouraged from going on holiday	3	4	4	2
Been overlooked/refused for promotion	4	5	3	3
Physically abused within the family	4	4	2	3
Verbally abused in public	8	5	2	3
Discouraged from participating in children's school based activities	1	2	2	2
Physically abused in public	3	2	*	3
Graffiti or rubbish targeted at the home	1	1	1	1
Other	2	2	2	*
None of these	68	64	75	77
Don't know	1	*	*	1

6.23 Data from the 2006 and 2008 surveys was combined to allow sub-group analysis of the findings. The analysis found that experience of stigma was correlated with gender, socio-demographic characteristics and mental health. Specifically:

- men were more likely than women to say they had not experienced any difficulties (80% versus 70%). However, they were also more likely to say they had been discouraged from participating in social events (15% versus 8% of females).
- respondents living in the most deprived areas were among those most likely to say they had been discouraged from participating in social events (17% versus 6% of those living in the least deprived areas) and community life (9% versus 1%)
- respondents who found it difficult to manage on their income were more likely than those who found it easy to manage to say they had been discouraged from participating in social events (17% versus 7%), children's school based activities (4% versus 1%), and community life (11% versus 2%). They were also more likely to say they had been refused a job (8% versus 3%) and been physically abused within their family (5% versus 1%).

- respondents with a high GHQ12 score were also particularly likely to say they had been discouraged from participating in social events (15% versus 8% of those with a low score) and community life (8% versus 3%). They were also among those most likely to report experience of verbal abuse in public (6% versus 2%), physical abuse within their family (4% versus 1%), and discrimination within their workplace (8% versus 3%).
- 6.24 Respondents who said they had experienced a mental health problem were also asked if they had ever chosen to avoid a social event because of the way they thought people would react to their mental health problem. As in 2006, around a quarter of respondents (24%) said they had done so. This figure is significantly higher than the proportion who said they had *actually been* discouraged from participating in a social event (10%) which suggests that self-stigmatisation is a major issue in this respect: it is the anticipation of failure or rejection which limits, in part, an individual's behaviour.

Recovery from mental health problems

- 6.25 During the first phase of the National Programme for Improving Mental Health and Wellbeing (2003-2006), there was a focus on establishing national and local delivery agencies to support the recovery of people experiencing mental health problems. The Scottish Recovery Network (SRN) was launched in late 2004 with a remit to raise awareness that people can and do recover from long term and serious mental health problems, identify what recovery might mean for people, and build understanding of what helps people recover and stay well.
- 6.26 The Scottish Government has announced its intention to continue funding the SRN to promote recovery-based service delivery and self-directed approaches to recovery until 2011 (Scottish Government 2009a). An evaluation is planned to commence in 2009-10. To inform work in this area, and to help measure progress to date, respondents to the 2004, 2006 and 2008 'Well?' surveys who had experienced a mental health problem, were asked a suite of questions about their own recovery. In 2006 and 2008, the focus of the questions was on identifying factors that support and hinder recovery, establishing what recovery means to people, and identifying the recovery messages that people receive from those around them and from health professionals.

Factors that promote and hinder recovery

- 6.27 In terms of factors that respondents felt had supported their recovery, the top responses were 'support from family or friends' (62%), 'medication' (39%), 'having belief in myself' (31%) and 'developing my own coping strategies' (24%), respectively. The next most common answers were 'other forms of treatment and therapy' (19%), 'support from people with a similar experience' (13%), 'having something worthwhile to do during the day' (13%) and 'having others believe in me' (12%). The only statistically significant difference between these results and those from 2006 is a

decrease in the proportion of people mentioning 'other' forms of treatment or therapy (table 6.2).

Table 6.2: Factors important in supporting recovery

	2004	2006	2008
<i>Base: All who have personally experienced a mental health problem</i>	377 %	384 %	359 %
Support from family or friends	76	56	62
Medication	38	35	39
Having belief in myself	n/a	27	31
Developing my own coping strategies	n/a	30	24
Other forms of treatment/therapy (e.g. psychology, counselling, alternative treatments, support groups)	29	30	19
Support from people with a similar experience	14	11	13
Having something worthwhile to do during the day (e.g. work, volunteering, education, hobbies, etc.)	21	11	13
Having others believe in me	n/a	12	12
Support from colleagues/work	18	8	12
Finding out more about mental health (e.g. through support groups, leaflets, web information etc.)	6	8	8
Having a chance to contribute and be valued	n/a	2	5
Other	3	6	-
I don't believe myself to be in recovery	2	*	2
None of these	4	3	3
Don't know	*	*	*

6.28 Sub-group analysis of the combined data for the 2006 and 2008 surveys³⁵ revealed that women, (41% versus 31% of men), people with no qualifications (58% versus 26% of those with a degree or professional qualification), and those earning £5,200 or less (53% versus 24% of those earning £36,400 or more) were particularly likely to cite medication as an important influence on their recovery.

6.29 Respondents aged 35 to 44 years were more likely than average to cite other forms of treatment or therapy (28% versus 20% overall), as were respondents with a degree or professional qualification (26% versus 12% overall).

6.30 Respondents living in the most deprived areas were more likely than respondents in the least deprived areas to cite support from people with a similar experience (18% versus 8% of those in the least deprived areas) and finding out more about mental health (13% versus 5% of those in the

³⁵ The survey questions concerning recovery were slightly refined between the 2004 and 2006 'Well?' surveys. As such, only combined data for the 2006 and 2008 surveys was used to explore sub-group differences.

least deprived areas). Respondents living in the least deprived areas, on the other hand, were more likely to cite development of their own coping strategies (40% versus 25% of those in the most deprived areas) and other forms of treatment or therapy (25% versus 14% of those in the most deprived areas).

- 6.31 Factor analysis was conducted to identify related influences on recovery. The analysis revealed that 'external' factors such as support from family or friends, had a more important bearing on recovery than 'internal' factors such as having self-belief (taking into account the fact that there are more external than internal factors listed in the question). On the whole, however, the factors did not group together in any strong or meaningful way. This would suggest that recovery is typically influenced by a range of different factors and that these will vary unpredictably from person to person.
- 6.32 Turning to factors that have *hindered* people's recovery from mental health problems, the most common responses were 'continuing to experience symptoms' (19%), 'not understanding what was going on' (19%) and 'not acknowledging I had a problem' (17%) (table 6.3). Reinforcing findings reported above, stigma was also clearly an issue for some people, with 15% mentioning 'not being able to tell people about my mental health problem' and 11% mentioning 'negative attitudes of people around me'. Just over a third (34%) said that *none* of the factors listed in the question had hindered their recovery (table 6.3). Given that this figure is relatively high, it may be that there are factors, other than those listed in the question, which hinder recovery. Or, it may simply be the case that significant proportions of people cannot 'pin down' what, if anything, has prevented them from getting better. All of the results for this question are consistent with those for 2006.

Table 6.3: Factors hindering recovery

	2006	2008
<i>Base: All who have personally experienced a mental health problem</i>	384	359
	%	%
Continuing to experience symptoms	17	19
Not understanding what was going on	17	19
Not acknowledging I had a problem	19	17
Not feeling able to tell people about my mental health problem	12	15
Not getting the right medication	6	12
Negative attitudes of people around me	13	11
Not being able to access appropriate services or treatment	4	7
Lack of support or understanding from family or friends	9	6
Lack of support or understanding from colleagues/work	5	6
Lack of access to employment, education or training opportunities	4	5
Other	6	*
None of these	34	34
Don't know	2	4

6.33 Again, there were a number of sub-group differences in the findings. Not getting the right medication was particularly likely to be cited by respondents who:

- found it difficult to manage on their income (14% versus 5% of those who found it easy to manage)
- earned less than £5,200 a year (25% versus 7% of those earning between £26,000 and £36,399)
- rated their health as bad or very bad (16% versus 8% of those rating their health as good or very good)
- had a high GHQ12 score (14% versus 7% of those with a low score).

6.34 Continuation of symptoms was particularly likely to be cited by respondents:

- living in the most deprived areas (23% versus 12% of respondents living in the least deprived areas)
- with a high GHQ12 score (28% versus 13% of those with a low score)

6.35 Negative attitudes were most commonly cited by respondents:

- with a high GHQ12 score (15% versus 8% of those with a low score)
- living in the most deprived areas (16% versus 7% of those living in the least deprived areas)
- earning less than £5,200 a year (30% versus 12% overall).

6.36 Finally, lack of support from family or friends was particularly an issue for respondents earning less than £5,200 per annum (18% versus 4% of those earning £36,400 or more).

Conceptions of recovery

6.37 The survey found that, for the majority of people who have had a mental health problem, recovery means simply 'getting back to normal'. However, for around a quarter, it also means 'feeling able to cope in general' and 'taking charge of my life again'. Comparatively few respondents equated recovery with having fewer symptoms or no longer needing treatment. This is consistent with the conception of recovery promoted by the SRN, which, among other things, emphasises that people can live satisfying and fulfilling lives in the presence or absence of ongoing symptoms³⁶.

6.38 For the most part, and as table 6.4 illustrates, the results are in line with those for 2006, but there had been a decrease in the proportion of respondents equating recovery with taking charge of their life again.

Table 6.4: Conceptions of recovery

	2006	2008
<i>Base: All who have personally experienced a mental health problem</i>	384	359
	%	%
Getting back to normal	49	53
Feeling able to cope in general	32	27
Taking charge of my life again	38	24
Having a satisfying and fulfilling life	20	18
Getting back to work	6	10
Fewer symptoms	9	8
Getting involved in activities I enjoy	8	6
Feeling more able to socialise	7	6
No longer needing treatment or services (including medication)	5	6
To feel positive/happy/confident again	-	1
Getting more sleep	6	1
Don't know	2	3

6.39 Sub-group analysis of the combined data for the 2006 and 2008 surveys found that:

- respondents aged 75 or over were more likely than average to cite getting involved in activities they enjoy (20% versus 7% overall)

36 Scottish Recovery Network, <http://www.scottishrecovery.net/content/default.asp?page=s4>

- respondents aged 60 to 64 years old were more likely than average to cite feeling positive/happy/confident again (11% versus 4% overall)
- respondents with a high GHQ12 score were more likely than those with a low score to cite feeling able to cope in general (33% versus 23%)
- respondents with above average mental wellbeing were more likely than average to cite fewer symptoms (16% versus 9% overall)
- respondents who found it difficult to manage on their income and those without any qualifications were particularly likely to cite getting back to work (12% versus 5% of those who found it easy to manage and 15% versus 8% of those with qualifications, respectively)
- respondents living in the most deprived areas were more likely than those living in the least deprived areas to cite getting back to normal (63% versus 45%).

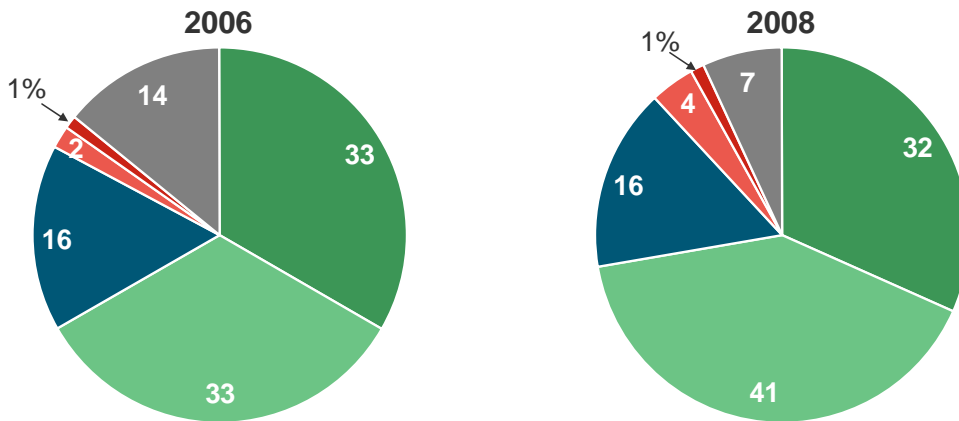
Messages of recovery from family, friends and professionals

6.40 *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* includes a strategy to tackle stigma within Scotland's public services (Scottish Government, 2009a). Findings from the survey suggest some progress may already be underway in this area. As figure 6.5 shows, around three-quarters of those who had had a mental health problem said that they had received a positive message of recovery from the professionals with whom they came into contact; a higher proportion than in 2006 (66%).

Figure 6.5: Message of recovery from professionals

Q. To what extent have the professionals you have come into contact with (nurses, doctors, support workers, etc.) given you a positive or negative message about your recovery?

■ % Completely positive ■ % Mainly positive ■ % Mixed
■ % Mainly negative ■ % Completely negative ■ % Don't know



Base: All who have personally experienced a mental health problem: 2006 (384); 2008 (359)

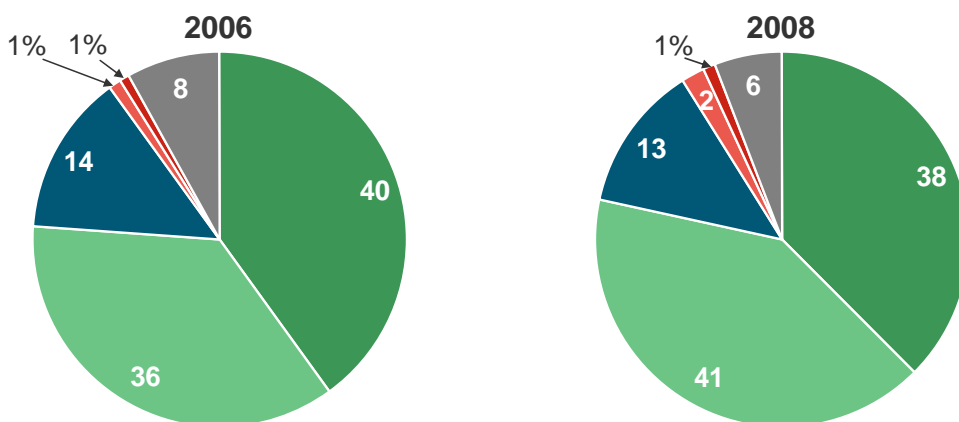
Source: Ipsos MORI

6.41 As figure 6.6 illustrates, a majority (79%) had also received a positive message of recovery from the people around them (friends, family, colleagues, carers etc.), while 15% had received a negative message. These results are unchanged on 2006.

Figure 6.6: Message of recovery from friends, family, colleagues, carers etc.

Q. To what extent have the people around you (family, friends, colleagues, carers, etc.) given you a positive or negative message about your recovery?

■ % Completely positive ■ % Mainly positive ■ % Mixed
■ % Mainly negative ■ % Completely negative ■ % Don't know



Base: All who have personally experienced a mental health problem: 2006 (384); 2008 (359)

Source: Ipsos MORI

- 6.42 Sub-group analysis of the combined data for the 2006 and 2008 surveys revealed that women were more likely than men to say that they had received a positive recovery message from professionals (75% versus 61%), and from people around them (80% versus 72%).
- 6.43 There was also some variation by mental health; respondents with a low GHQ12 score were more likely than those with a high score to say they had received a positive message from professionals (74% versus 62%) and from people around them (83% versus 72%).
- 6.44 As in 2006, analyses were undertaken to identify whether there was a relationship between the recovery messages people had received and their mental health and wellbeing (as measured using the GHQ12 and WEMWBS). Once again, the results show that people who had received a positive message from professionals were more likely than those who had not to have above average mental wellbeing – although they were no more likely to have a low GHQ12 score. Meanwhile, people who had received a positive message of recovery from family and friends were more likely than those who had not to have above average mental wellbeing and a low GHQ12 score.
- 6.45 These results are consistent with findings from narrative research carried out by SRN which indicate that being given optimistic messages of recovery potential (from friends and family, professionals, carers, peers) had a positive impact on individuals and “gave them the emotional strength to fuel their own recovery journeys” (Brown & Kandirikirira 2008).

7 ATTITUDES TOWARDS MENTAL HEALTH PROBLEMS

7.1 As noted in chapter 1, one of the main aims of the National Programme was to promote positive changes in attitudes towards people who experience mental health problems and illness. *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* similarly outlines measures to address discrimination and stigma, including a strategy aimed specifically at tackling stigma within public services (Scottish Government 2009a). This chapter looks in detail at public perceptions of mental health problems and considers how these perceptions have evolved over the lifetime of the National Programme.

Attitudes towards mental health problems

7.2 As in the previous 'Well?' surveys, respondents were presented with a number of statements relating to mental health problems and asked to what extent they agreed or disagreed with each.

7.3 In many respects, the findings are encouraging. A large majority of respondents agreed that 'Anyone can suffer from a mental health problem' (93%) and that 'People with mental health problems should have the same rights as anyone else' (86%). Similarly, a majority *disagreed* with several of the more negatively worded statements namely: 'People with mental health problems are largely to blame for their own condition' (86%); 'I would find it hard to talk to someone with a mental health problem' (70%); and 'People with mental health problems are often dangerous' (57%).

7.4 On the other hand, roughly as many respondents agreed as disagreed that if they were suffering from a mental health problem, they wouldn't want people knowing about it (44% and 38% respectively), and whereas 41% of people disagreed that 'The public should be better protected from people with mental health problems', a significant minority (25%) agreed with this statement.

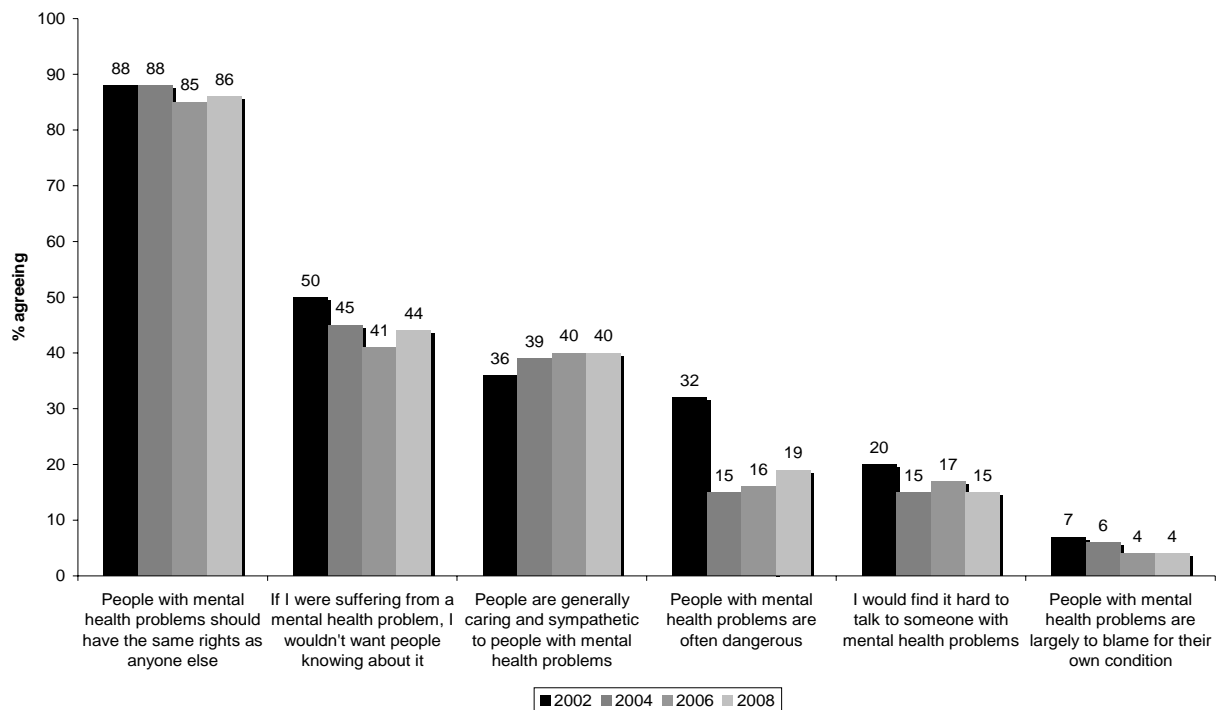
7.5 Views were similarly divided in respect of the statement, 'People are generally caring and sympathetic to people with mental health problems'. However, it is worth considering that what it means to agree or disagree with this statement is ambiguous and open to interpretation. On the one hand, agreement could be seen as a measure of society's general level of tolerance of people with mental health problems. This being the case, an increase in agreement with the statement over time would be a positive finding. On the other hand, agreement could also point towards a lack of awareness of society's stigmatising attitudes towards people with mental health problems. From this viewpoint, an increase in agreement over time would be a negative trend. In other words, there is a discussion to be had regarding the desirable direction of change for this measure.

7.6 There are few statistically significant differences between the 2008 results and those recorded in 2006. Specifically, and as figure 7.1 illustrates, there has been no change in the proportions of respondents agreeing and

disagreeing with the statements: 'I would find it hard to talk to someone with a mental health problem'; 'People are generally caring and sympathetic to those with mental health problems'; 'People with mental health problems are often dangerous'; 'People with mental health problems should have the same rights as anyone else'; and 'People with mental health problems are largely to blame for their own condition'.

7.7 Responses to the statement, 'If I were suffering from a mental health problem, I wouldn't want people knowing about it', have also remained stable since 2006, despite a gradual downward trend in agreement between 2002 and 2006 (from 50% to 41%). This may suggest that the Scottish Government's work on tackling the stigma and discrimination associated with mental health problems might need to be considered in order to identify how further progress can be made.

Figure 7.1: Attitudes to mental health problems 2002-2008 (% agreeing)

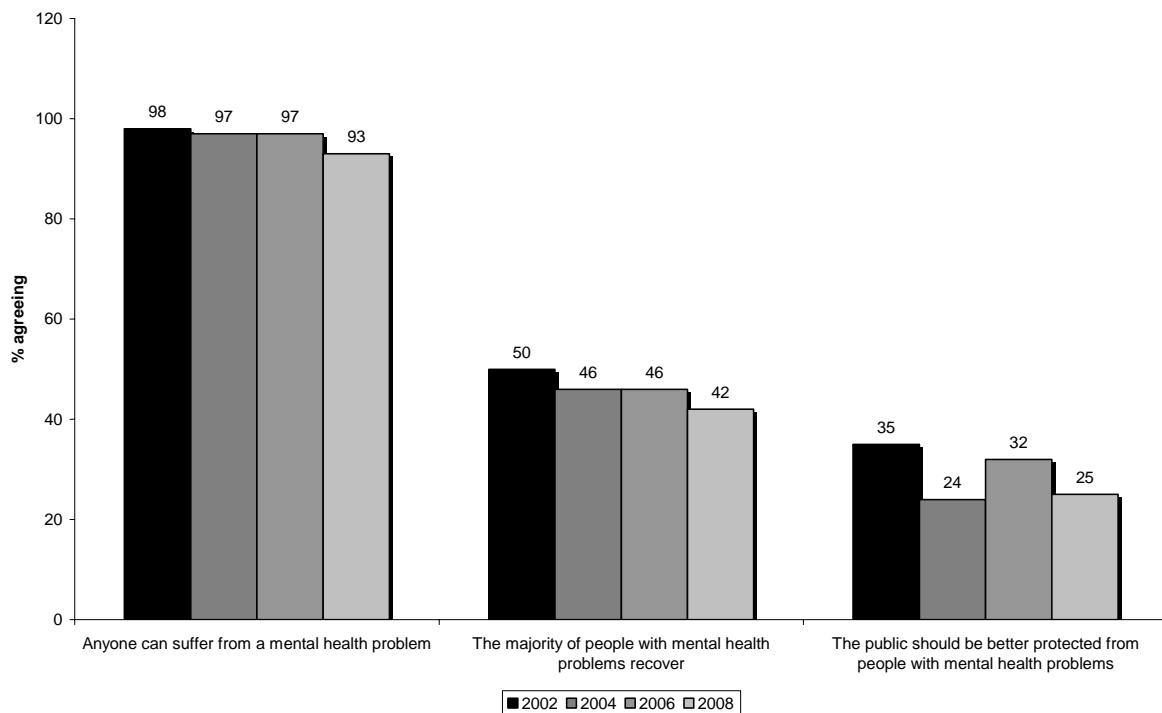


7.8 Notwithstanding the trends in figure 7.1, there are a few differences between the 2008 and 2006 results. Most notably, the proportion of respondents agreeing with the statement, 'The public should be better protected from people with mental health problems', has fallen by 10 percentage points, to 25%, bringing it back to the level recorded in 2004. This fluctuation reinforces the view put forward in the previous 'Well?' report that the 2006 result may have been influenced by events which took place around the time of the survey and specifically the fact that there was considerable media interest in the issues of secure care violence and system failures (Figure 7.2).

7.9 However, there have also been slight decreases in the proportions of respondents agreeing with the statements 'Anyone can suffer from a mental

health problem' (from 97% to 93%) and 'The majority of people with mental health problems recover' (from 46% to 42%). There are several possible reasons for these differences. First, it may be that the public has reached saturation point in terms of absorbing anti-stigma messages or that these messages are failing to reach some segments of the population. Second, the differences may reflect a decrease in advertising by "see me". Third, the changes may simply reflect natural, short term fluctuation in trends over time. Only when the survey has been repeated a number of times will it be possible to identify whether this latter hypothesis holds true.

Figure 7.2: Changing attitudes to mental health problems 2002-2008 (% agreeing)



7.10 It is worth noting that there has been no change in the *intensity* of agreement and disagreement with any of the attitude statements since 2006; that is, the proportions who *strongly* agree/disagree *vis a vis* the proportions who *tend to* agree/disagree have for the most part remained constant. While it is encouraging that there has been no hardening of negative attitudes, the lack of any shift towards strong agreement with the positively worded statements further reinforces the case for consideration of approaches to tackling stigma and discrimination.

7.11 Nonetheless, available evidence suggests that attitudes towards mental health problems in Scotland remain more positive than elsewhere in the UK. In the 2008 Health Promotion Agency Northern Ireland study, respondents were more likely than those in 'Well?' 2008 to agree that if they 'were experiencing a mental health problem, they wouldn't want other people knowing about it' (56% versus 44%), that 'The public should be better protected from people with mental health problems' (34% versus 25%), that

'People with mental health problems are often dangerous' (29% versus 19%) and that they 'would find it hard to talk to someone with mental health problems. Further they were *less* likely to agree that 'People with mental health problems should have the same right as anyone else' (77% versus 86%) (Health Promotion Agency 2008).

- 7.12 As was noted in the previous 'Well?' report, these differences may reflect the fact that, until 2006 there had not been a mental health anti-stigma and discrimination campaign in Northern Ireland equivalent to those that have run in Scotland since 2002 as part of the National Programme.
- 7.13 The 2009 Department of Health (DoH) Survey of Attitudes to Mental Illness also included a number of attitudinal statements, but none of these were the same as those included in the 'Well?' surveys so direct comparisons cannot be drawn. However, it is worth noting that 91% of respondents in the DoH study agreed that 'virtually anyone can become mentally ill', which is consistent with the 93% in 'Well?' 2008 agreeing that 'anyone can suffer from a mental health problem' (TNS, 2009).
- 7.14 As in 2006, age emerged as one of the main correlates of attitudes towards mental health problems in 'Well?' 2008, with older people typically holding more negative views than younger groups. As table 7.1 shows, people aged 75 and over were more likely than younger groups to agree that: 'The public should be better protected from people with mental health problems'; 'People with mental health problems are often dangerous'; 'People with a mental health problem are largely to blame for their own condition'; and they would find it hard to talk to someone with mental health problems. These differences are likely to be a cohort effect.
- 7.15 Together with the *youngest* group of respondents (aged 16 to 24 years), people aged 75 and over were also among those most likely to agree that 'People are generally caring and sympathetic towards people with mental health problems' and to disagree that 'anyone can suffer from a mental health problem'.

Table 7.1: Attitudes towards mental health problems by age

	% agreeing with each statement							
	16-24	25-34	35-44	45-54	55-59	60-64	65-74	75+
<i>Base:</i>	109	156	215	200	76	98	172	142
If I were suffering from a mental health problem, I wouldn't want people knowing about it	42	48	40	50	58	39	39	37
The public should be better protected from people with mental health problems	16	20	23	25	27	21	32	43
Anyone can suffer from a mental health problem	83	94	95	96	99	96	95	86
I would find it hard to talk to someone with mental health problems	16	14	10	11	17	12	22	22
People are generally caring and sympathetic to people with mental health problems	52	41	30	33	36	35	51	49
People with mental health problems are often dangerous	16	17	16	15	18	25	26	26
The majority of people with mental health problems recover	31	45	51	47	41	30	38	32
People with mental health problems should have the same rights as anyone else	87	84	87	86	86	90	84	83
People with mental health problems are largely to blame for their own condition	3	4	2	2	7	8	5	11

7.16 Attitudes were also closely associated with educational attainment. People with no qualifications were among those most likely to agree that:

- 'The public should be better protected from people with mental health problems' (30% versus 20% of people with a degree or professional qualification)
- 'People are generally caring and sympathetic towards people with mental health problems' (48% versus 30%)

- they would ‘find it hard to talk to someone with a mental health problem’ (20% versus 13%)
- ‘People with mental health problem are often dangerous’ (27% versus 12%)
- ‘People with mental health problems are largely to blame for their own condition’ (9% versus 2%).

7.17 People with no qualifications were also *less* likely to agree that ‘anyone can suffer from a mental health problem’ (90% versus 97%).

7.18 However, it was people with the *highest* qualifications who were most likely to say that if they had a mental health problem, they wouldn’t want people knowing about it (46% versus 37% of those with no qualifications). As was suggested in the 2006 report, this may be because those with higher qualifications might feel their higher professional status would be threatened if it was revealed that they were experiencing a problem, or that they are less believing that society is supportive to those who experience such problems.

7.19 To some extent, differences by educational attainment are reflected in correlations between attitudes and area deprivation. People living in the most deprived areas (where educational attainment tends to be lower) were less likely than those in the least deprived areas to agree that ‘Anyone can suffer from a mental health problem’ (87% versus 95%), and *more* likely to agree that ‘People are generally caring and sympathetic to people with mental health problems (45% versus 38%). Meanwhile, people in the *least* deprived areas were among those most likely to agree that if they were suffering from a mental health problem, they would not want people knowing about it (49% versus 36%).

7.20 There was further variation depending on whether or not respondents had any experience of a mental health problem. Compared to those with no experience of mental health problems, more people with personal or proxy experience of a problem *disagreed* that:

- they would ‘find it hard to talk to someone with mental health problems’ (76% and 74% versus 68%)
- ‘People with mental health problems are largely to blame for their own condition’ (91% and 89% versus 84%)
- ‘People are generally caring and sympathetic to people with mental health problems’ (47% and 48% versus 40%)
- and that ‘People with mental health problems are often dangerous’ (66% and 61% versus 55%).

7.21 People with personal (but not proxy) experience of a problem were also more likely than those with no experience to agree that ‘The majority of people with mental health problems recover’ (51% versus 40%) and that ‘People with mental health problems should have the same rights as anyone else’ (90% versus 84%). At the same time, they were *less* likely to

agree that 'The public should be better protected from people with mental health problems' (19% versus 26%).

- 7.22 In other words, it appears that experience of a problem, whether personal or proxy, tends to lead to increased awareness and tolerance of mental health problems but also a more negative view of the way society treats people with problems.
- 7.23 To some extent, these findings are reinforced by correlations between attitudes and mental health and wellbeing. People with a high GHQ12 score and those with below average mental wellbeing were more likely than average to agree that if they had a mental health problem, they wouldn't want people knowing about it (53% and 51%), and to disagree that 'People are generally caring and sympathetic to people with mental health problems' (41% and 53%).
- 7.24 In terms of other sub-group differences, there were associations between attitudes and gender: more men than women agreed that 'People are generally caring and sympathetic to people with mental health problems' (44% versus 36%), whereas more women agree that 'The majority of people with mental health problems recover' (45% versus 37%). In the 2006 survey, women were more likely than men to disagree with the statement, 'I would find it hard to talk to someone with a mental health problem', but no such difference was apparent in 2008.
- 7.25 All of the other correlations reported in this section are consistent with those observed over the previous surveys.
- 7.26 As in 2006, segmentation analysis was undertaken on the attitudinal data to further explore the links between attitudes and other variables. The resulting data served to reinforce the bivariate correlations discussed above (see Annex G for a fuller discussion of the analysis).

Perceived prevalence of mental health problems

- 7.27 In addition to promoting positive change in attitudes to mental health problems, a key aim of the National Programme was to improve the public's mental health literacy. To assess progress towards this aim, respondents in all four 'Well?' surveys have been asked to estimate how many people in Scotland, out of 100, will have a mental health problem at some point in their lives. Although the WHO (2001) and the Mental Health Foundation (2003) report that one in four people in the world are affected by mental or neurological disorders at some point in their lives, the estimates of lifetime prevalence vary (Bourden et al., 1992; Kessler et al., 1994, 2005). A recent estimate of the lifetime prevalence of an adult suffering from a disorder is 1 in 2, with 1 in 4 adults suffering from a disorder in any one year (Kessler et al., 2005).
- 7.28 In 'Well?' 2008, the mean estimate given was 49%, which is consistent with the results recorded in previous waves of the survey. Only 29% of

respondents thought that the prevalence rate was below 30%; indeed, just under a quarter (22%) estimated it to be 70% or higher.

7.29 The mean estimate was higher than that recorded in other, similar surveys conducted elsewhere in the UK. For example, in the 2009 Department of Health Survey of Attitudes to Mental Illness a quarter of respondents estimated the prevalence rate at one in ten, with 41% thinking it was less than this. Thirteen per cent estimated the proportion was one in four and 8% thought it was higher than this (TNS, 2009). The same question was included in the 2008 HPA Northern Ireland study and the figures recorded were similar: 29% estimated that one in ten people would experience a mental health problem at some point in their lives, 31% gave a lower figure than this, 6% estimated the figure at one in four and 7% gave a higher figure.

7.30 As was noted in the previous 'Well?' reports, it may be that the higher estimates in Scotland are a function of the various campaigns, initiatives and promotional activity that has taken place here, of which there have been few equivalents elsewhere in the UK. Equally, however, the estimates given in all three surveys are consistent with what would be expected if most respondents were simply *guessing* the prevalence rates and giving a 'middle-ground' answer as a safe option in the absence of greater knowledge. As already noted the mean estimate in the 'Well?' survey was 49%. Similarly, in the DoH and the Northern Irish studies, majorities of respondents gravitated around the mid-point of the list of possible response options.

7.31 In 'Well?' 2008, Mean estimates of the prevalence of mental health problems were higher than average among:

- women (54% compared with 45% among men)
- people aged 35 to 44 years (55% compared with 46% among people aged 16 to 24 years and 40% of those aged 75 and over),
- those with personal or proxy experience of mental health problems (60%, and 53% compared with 48% of those with no such experience)
- people with a high GHQ12 score (56% compared with 48% of those with a low score)
- people with below average mental wellbeing (56% compared with 46% of those with above average mental wellbeing)

7.32 As in the 2006 survey, regression analysis was undertaken to explore further the relationship between respondents' estimates of the prevalence of mental health problems and their wider perceptions and experience of such problems. Specifically, the analysis sought to explore the *relative influence* of the following factors on respondents' prevalence estimates:

- willingness to interact with someone displaying symptoms of a mental health problem³⁷
- proxy experience of a mental health problem
- proxy experience of any of 15 specific mental health problems³⁸
- personal experience of a mental health problem
- personal experience of any of 15 specific mental health problems

7.33 As figure 7.3 shows, six factors were found to correlate most strongly with respondents' estimates of the prevalence of mental health problems. These were: personal experience of a mental health problem; experience of panic attacks in someone close; willingness to interact with someone with symptoms of a mental health problem; experience of depression in someone close; experience of a mental health problem in someone close; and experience of stress in someone close. All of the correlations were positive – that is, they were associated with higher prevalence estimates. The percentages in figure 7.3 indicate the *relative* strength of each of the factors in terms of their relationship with prevalence estimates. So, for example, personal experience of a mental health problem was found to have twice the effect of any of the others factors in influencing prevalence estimates.

7.34 Each driver within the model has an unstandardised coefficient associated with it. The unstandardised coefficient represents the change in the predicted outcome (estimate of prevalence in percentage points) for every unit change in the driver. As most of the drivers are binary variables, a unit change is a change from zero to one and represents a change from absence to presence of the driver (or vice versa). Personal experience has the biggest effect of all the binary drivers. All other things being equal, someone who has had personal experience of mental ill-health will have a predicted outcome that is 12.19 percentage points higher than someone who has not. Applying the same logic, the following percentage point increases in predicted outcome can be found for the remaining drivers:

- Experience of panic attacks in someone close (5.77)
- Experience of depression in someone close (4.96)
- Experience of a mental health problem in someone close (4.72)
- Experience of panic attacks in someone close (5.57)

7.35 The willingness to interact measure is a composite score ranging from a minimum of 7 (very unwilling to interact for all seven QE5 components) to a maximum of 35 (very willing to interact for all seven QE5 components). For

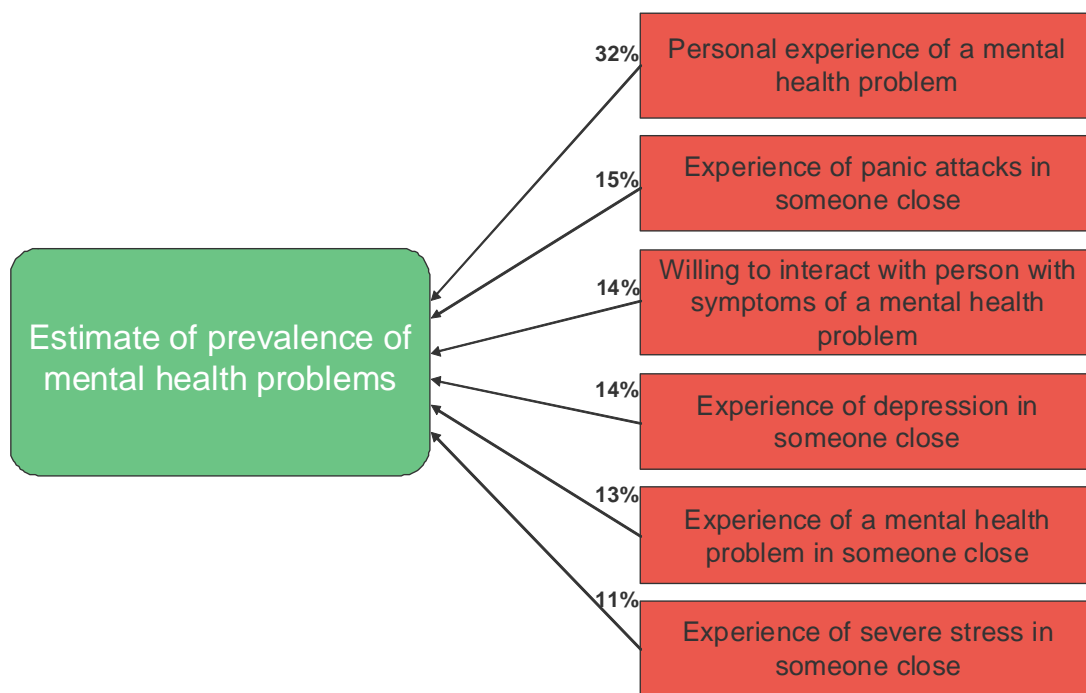
37 This measure was derived from a battery of questions which are discussed in detail in the next chapter

38 The problems are listed in chapter 6

every single-point increase in this score, the predicted outcome increases by 0.46 percentage points.

7.36 While, the results in figure 7.3 are broadly similar to those obtained in 2006, the rank ordering of the factors is slightly different. The strongest three factors in 2006 were willingness to interact with someone with symptoms of a mental health problem, personal experience of a mental health problem and experience of a mental health problem in someone close, respectively. Further, these three factors were more equal in strength than was the case in 2008.

Figure 7.3: Perceived prevalence of mental health problems – regression analysis



Sources of information on mental health problems

7.37 To identify factors shaping the attitudes and perceptions described in this chapter, respondents were asked what sources of information have been most important in forming their impressions of mental health problems. As in the 2006 survey, the most common responses were personal contact or experience and television news or current affairs programmes, mentioned by 56% and 45% respectively. The next most common were word of mouth (30%), health professionals (29%), national newspapers (26%), and work (28%). While this ranking is consistent with that recorded in 2006, the proportions of respondents mentioning word of mouth and health professions is slightly higher than in the previous survey (table 7.2)

7.38 Asked which *single* source of information had been most influential in forming their impressions of mental health problems, the majority of respondents mentioned either personal contact or experience, or television news and current affairs programmes, while around one in ten mentioned health professionals (9%). Again, these results are in line with those for 2006, notwithstanding a slight decrease in the proportion mentioning personal contact or experience (table 7.2).

Table 7.2: Sources influencing people's impressions of mental health problems

	All sources				Single most important source			
	2002	2004	2006	2008	2002	2004	2006	2008
<i>Base:</i>	1,381	1,401	1,216	1,177	1,381	1,401	1,216	1,177
	%	%	%	%	%	%	%	%
Personal contact/experience	38	57	59	57	21	39	41	37
TV news/current affairs programmes	51	44	45	45	18	15	16	15
National newspapers	34	26	29	26	8	4	4	4
Work	20	24	26	28	7	8	10	10
Word of mouth	29	32	25	30	5	7	5	5
Health professionals	33	27	25	29	17	8	7	9
Books/leaflets/magazines	28	24	21	24	5	3	3	2
Television soaps	14	15	16	15	2	2	3	3
Schools colleges	17	13	10	14	3	4	3	4
Local newspapers	16	13	10	12	2	1	1	1
Radio	10	10	9	10	1	1	1	1
Other TV	6	12	9	10	1	2	1	1
Internet	1	5	8	11	*	*	1	1
Other	1	1	3	*	1	*	1	1
None of these	6	3	2	2	6	4	3	2
Don't know	1	1	2	3	2	2	3	4

7.39 Mention of some of the sources in table 7.2 was correlated with age: people aged 25 to 54 years and 60 to 64 years were more likely than younger or older groups to mention personal contact or experience (67% of people aged 35 to 44 years and 66% of those aged 60 to 64 years, compared with 34% of those aged 16 to 24 years 48% of those aged 75 and over).

7.40 There were also correlations between sources mentioned and gender: men were more likely than women to mention national newspapers (30% versus 23%), while women – and particularly young women – were more likely to mention television soaps (22% of women aged 16 to 24 years compared with 15% of men). In 2006 women were also more likely than men to mention books, leaflets and magazines but this gender gap closed in 2008.

7.41 Further variation was apparent along socio-economic lines. Most notably, people in the least deprived areas were more likely than those in the most deprived areas to say they had formed their impressions about mental health problems from national newspapers (35% versus 14%), books, leaflets and magazines (30% versus 23%) and work (34% versus 18%). The latter difference in part reflects the fact that levels of employment are higher in less deprived areas.

8 ATTITUDES TOWARDS SPECIFIC SYMPTOMS OF MENTAL HEALTH PROBLEMS

8.1 The previous chapter considered attitudes towards mental health problems, focusing, in particular, on the extent to which the public stigmatise mental health problems and people who suffer from them. The chapter also began to look at the public's mental health literacy, as indicated by both their responses to the attitude statements and their perceptions concerning the prevalence of mental health problems. This chapter builds on these discussions by exploring the public's attitudes towards, and ability to correctly identify, specific symptoms of mental health problems; in particular, symptoms of depression, stress and schizophrenia.

Mental health 'scenarios'

8.2 Each respondent in the survey was presented with a scenario describing a person with symptoms of either depression, schizophrenia or stress. There were two versions of each scenario, one describing a male (named Robert) with symptoms and the other describing a female (named Shona) with the same symptoms, giving six scenarios in total. The full text of the six scenarios is provided in Annex I. Without being given a diagnosis of the symptoms described, respondents were asked a series of questions about the person in the scenario and his/her symptoms (scenarios were randomly assigned to respondents). The questions focused on:

- the likely cause(s) of the symptoms described
- possible sources of help for Robert/Shona
- the likelihood of Robert/Shona harming themselves or others
- the extent to which respondents would be willing to interact with Robert/Shona
- the condition that is most likely to have caused the symptoms described

8.3 Given that there were six scenarios, each was considered by a relatively small sub-sample of respondents. This point should be borne in mind when considering the findings.

8.4 The following section provides an overview of the findings for all six versions of the scenario, before focusing specifically on respondents' willingness to interact with Robert/Shona under a range of circumstances. A detailed question by question analysis of all findings pertaining to the scenarios can be found in Annex I.

Overview of attitudes towards symptoms of depression, schizophrenia and stress

Perceived causes of the symptoms described in the scenarios

- 8.5 Overall, the main perceived causes of the symptoms described in the scenarios were external factors, and specifically, stressful or disturbing events in Robert's/Shona's life and the circumstances in which they live. However, many respondents, particularly those shown the depression or schizophrenia scenarios, also mentioned a chemical imbalance in the brain. Further, respondents shown the stress scenario were more likely than average to attribute these symptoms to Robert's/Shona's own character or personality.
- 8.6 The high mention of stressful or disturbing events in the 2008 and earlier 'Well?' surveys is consistent with findings from a recent study of depression literacy in Alberta, Canada (Wang *et al.*, 2007), in which 90% of respondents attributed depressive symptoms to 'traumatic' experiences. In other respects, however, the results of the two studies are quite different, with higher proportions of the Canadian respondents attributing depression to childhood abuse or a genetic or inherited problem. To some extent these differences may reflect the fact that the methodology for the two surveys differed, as did the scenario and question wording used.
- 8.7 Whereas in the 2006 'Well?' survey, the perceived causes of symptoms varied depending on the gender of the person in the scenarios, this was less apparent in 2008. Indeed, the only difference that did emerge was that respondents shown the male version of the schizophrenia scenario were more likely than those shown the female version to attribute the symptoms to a character or personality trait.
- 8.8 Between 2006 and 2008, there was an increase in the proportion of people attributing symptoms of depression in a female to her upbringing. The proportion attributing the symptoms of depression in a male to abuse he suffered as a child also increased.

Most appropriate sources of support for the person in the scenarios

- 8.9 Across all of the scenarios, family doctors, family members and qualified counsellors were felt to be the most appropriate sources of support for Robert/Shona. However, among respondents who were shown the schizophrenia scenario, psychiatrists were also commonly mentioned.
- 8.10 There was some variation depending on the gender of the person in the scenario. In particular, respondents shown the male version of the stress scenario were more likely than those shown the female version to mention a psychiatrist or a psychologist, while those shown the female version were more likely to mention a friend or neighbour. Mention of family members was higher among those shown the male version of the schizophrenia scenario than among those shown the female version.

- 8.11 Comparing the results with those from 2006, the proportions of respondents shown the male version of the depression scenario who said Robert would best be supported by a family member, someone with the same problem, or a friend or neighbour has decreased. At the same time the proportion shown the female version of the scenario who felt that Shona would best be supported by a psychiatrist increased. With regard to the stress scenario, there has been an increase in the proportion who felt that the best person to help a male showing these symptoms would be a psychiatrist or psychologist. Meanwhile, the proportion who felt that a female with the same symptoms would be best helped by a psychologist has decreased.

Most appropriate place for the person in the scenarios to live

- 8.12 Regardless of the scenario they were shown, a majority of respondents felt that the best place for Robert/Shona to live would be in their own, or their family's, home. However, a significant minority felt that he/she would be better living in special housing with professional support in the community – this figure rose from around one in ten of those shown the stress scenario to one in five of those shown the depression scenario and one in three of those shown the schizophrenia scenario. These findings have remained largely stable on 2006.

Likelihood of the person in the scenario doing harm to themselves or others

- 8.13 A majority of those shown the schizophrenia scenario and around half of those shown the depression scenario thought that Robert/Shona was likely to self-harm. Among those shown the stress scenario, the figure was appreciably lower. There were no differences depending on the gender of the person in the scenario and again, the results have remained stable on 2006.
- 8.14 Across all of the scenarios, only a minority of respondents felt that Robert/Shona was likely to harm others, but the figure rises to around a third among those shown the schizophrenia scenario. Further, among those shown the female version of the schizophrenia scenario, the figure has increased since 2006.

Willingness to interact with the people in the scenarios

- 8.15 Across all of the scenarios, majorities of respondents said they would be willing to interact with Robert/Shona under a range of circumstances, including moving next door to them, spending an evening socialising with them, making friends with them, working closely with them and doing them a favour. However, fewer than half said they would be willing to have Robert/Shona marry into their family or provide childcare for someone in their family.

- 8.16 Willingness to interact with Robert/Shona was consistently higher among those shown the stress scenario than among those shown the depression or schizophrenia scenarios.

Freedoms and rights of the person in the scenario

- 8.17 Two in five respondents who were shown the depression scenario and three in five of those who were shown the schizophrenia scenario felt that Robert's/Shona's freedoms and rights might have to be limited because of their condition. Among those shown the stress scenario the figure was considerably lower, though still not insignificant.
- 8.18 Among respondents shown the female version of the schizophrenia scenario and the male version of the stress scenario, the proportions who felt that Robert's/Shona's freedoms and rights might have to be limited have increased since 2006. In all other respects the results have remained stable.

Ability to identify the symptoms displayed by the person in the scenario

- 8.19 Around three quarters of respondents shown the depression scenario were able to correctly identify the symptoms described, which is consistent with the figure recorded in previous 'Well?' surveys and in the Canadian study, cited above (76%). Fewer than half of respondents shown the schizophrenia scenario correctly identified the symptoms, and for the stress scenario the figure was lower still. Indeed, around half of those shown the stress scenario attributed the symptoms to depression, and around one in five attributed them to an anxiety disorder.
- 8.20 Respondents who correctly identified the symptoms in the depression and schizophrenia scenarios were less likely than those who did not to agree that people with mental health problems are often dangerous and that the public should be better protected from people with mental health problems. They were also somewhat more willing than average to interact with the person in the scenarios. More specifically, those who correctly identified depression were more willing to move next door to Robert/Shona, spend an evening socialising with them, make friends with them, start working closely with them and have them marry into the family. Those who correctly identified schizophrenia were more willing than average to do Robert/Shona a favour or have them provide childcare for someone in the family.

Inter-survey analysis of willingness to interact with the person in the scenarios

- 8.21 Of the findings reported above, the key measures in terms of establishing public attitudes towards specific symptoms of mental health problems are those focusing on willingness to interact with Robert/Shona. As in 2006, analyses were undertaken to explore to what extent responses on the seven interaction measures varied by a) survey wave b) scenario (both in

terms of the gender of the person in the scenario and his/her symptoms) and c) socio-demographic characteristics of the respondent.

Variation by survey wave

8.22 Table 8.1 shows the mean responses for each of the seven social interaction measures by survey wave. As for all tables presented in this chapter, the mean ranges from 1 to 5, with 1 indicating a response of 'very unwilling' and 5 a response of 'very willing'.

8.23 Between 2004 and 2006 there was no consistent pattern of variation or trend in responding; rather the picture was one of short term fluctuation. More specifically, between 2002 and 2004 willingness to make friends with Robert/Shona, start working closely with him/her and have him/her marry into the family increased. For the remaining interaction measures there were no differences between the two waves. Between 2004 and 2006, willingness to interact with Robert/Shona decreased for all seven measures, with most of the change significant at the 1% level. These decreases largely cancelled out the increases observed between 2002 and 2004.

8.24 Between 2006 and 2008 there was very little change in mean responses to the seven measures; in other words, attitudes appear to have stabilised over this period.

Table 8.1: Willingness to interact with person in scenarios by survey wave – mean responses

	2002	2004	2006	2008
<i>Base:</i>	1,366	1,373	1,182	1,153
Move next door to Robert/Shona	3.87	3.93	3.77	3.67
Spend an evening socialising with Robert/Shona	3.85	3.91	3.79	3.74
Make friends with Robert/Shona	3.97	4.08	3.90	3.89
Start working closely with Robert/Shona	3.75	3.87	3.67	3.68
Have Robert/Shona marry into the family	3.15	3.29	3.09	3.13
Do Robert/Shona a favour if they asked you to	4.35	4.35	4.26	4.24
Have Robert/Shona provide childcare for someone in your family	n/a	2.42	2.28	2.34
<i>Aggregate score for all means</i>	<i>23.04</i>	<i>23.55</i>	<i>22.60</i>	<i>22.48</i>

Variation by scenario

- 8.25 A similar analysis was undertaken to explore the extent to which willingness to interact with the person in the scenario varied depending on the nature of his/her symptoms.
- 8.26 As in 2006, the analysis indicates that respondents were consistently more willing to interact with a woman displaying symptoms of a mental health problem than with a man displaying the same symptoms (table 8.2). This variation was significant at the 1% level for each of the seven interaction measures. These results are consistent with findings highlighted elsewhere in this report that men who have had a mental health problem were more likely than their female counterparts to have experienced some form of stigma as a result. It may be that men suffering from a mental health problem are felt to pose more of a threat than women with the same symptoms. Alternatively, the findings may simply be a reflection of people's willingness to interact with strangers of the two sexes, irrespective of whether or not those strangers have a mental health problem.

Table 8.2: Willingness to interact with person in scenarios by gender of subject – mean responses

	Female subject	Male subject
<i>Base:</i>	2,500	2,460
Move next door to Robert/Shona	3.87	3.75
Spend an evening socialising with Robert/Shona	3.92	3.73
Make friends with Robert/Shona	4.03	3.90
Start working closely with Robert/Shona	3.83	3.66
Have Robert/Shona marry into the family	3.32	3.01
Do Robert/Shona a favour if they asked you to	4.35	4.26
Have Robert/Shona provide childcare for someone in your family	2.49	2.22
<i>Aggregate scores for all measures</i>	23.42	22.43

- 8.27 Turning to variation by the *symptoms* described in the scenario, again the findings are unchanged since 2006. As table 8.3 shows, willingness to interact with Robert/Shona was highest among those shown the stress scenario, lower among those shown the depression scenarios and lower still among those shown the schizophrenia scenarios.

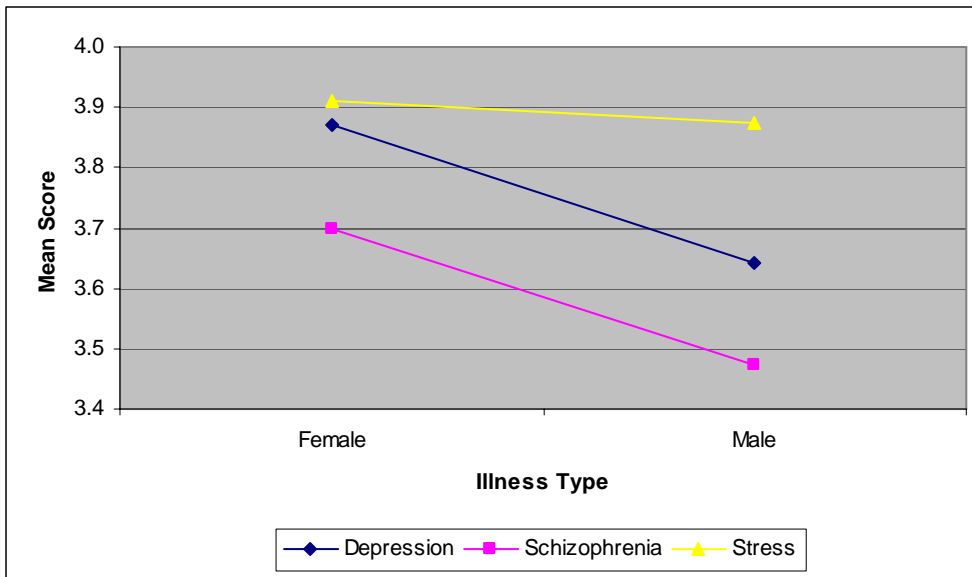
Table 8.3: Willingness to interact with person in scenarios by symptoms described – mean responses

	Depression	Schizophrenia	Stress
<i>Base:</i>	1,664	1,662	1,634
Move next door to Robert/Shona	3.85	3.60	3.99
Spend an evening socialising with Robert/Shona	3.82	3.65	4.01
Make friends with Robert/Shona	3.96	3.81	4.12
Start working closely with Robert/Shona	3.76	3.59	3.89
Have Robert/Shona marry into the family	3.15	2.89	3.47
Do Robert/Shona a favour if they asked you to	4.33	4.21	4.37
Have Robert/Shona provide childcare for someone in your family	2.35	1.98	2.76
<i>Aggregate scores for all measures</i>	<i>22.94</i>	<i>21.91</i>	<i>23.94</i>

8.28 Further analysis was undertaken to identify whether there was an interaction between the gender of the person in the scenarios and the symptoms described – in other words whether the observed differences in mean responses for the male and female versions of the scenarios differed depending on the symptoms described and *vice versa*.

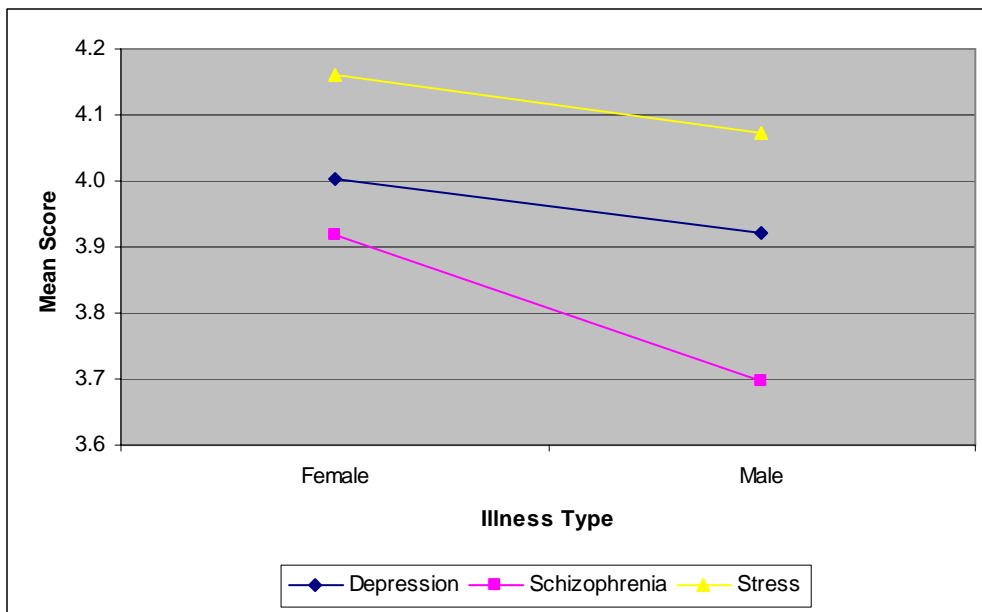
8.29 For the most part, the differences between mean responses for the male and female versions of the scenarios were constant, regardless of the symptoms described. As in 2006, however, an interaction was observed for the “start working closely with Robert/Shona” measure. Specifically, and as figure 8.1 shows, respondents were more willing to work with a female showing symptoms of schizophrenia or depression than with a male showing the same symptoms. In the case of stress, no such difference was observed; in other words, people were equally willing to work with a male displaying symptoms of stress as with a female displaying the same symptoms.

Figure 8.1: Willingness to start working closely with Robert/Shona, interaction between gender and symptoms of person in scenario – mean responses



8.30 A similar interaction was observed for the “make friends with Robert/Shona” measure – respondents were much more willing to make friends with a female showing signs of schizophrenia, depression or stress than with a male showing the same symptoms. The differences were greatest for schizophrenia than for either depression or stress (figure 8.2).

Figure 8.2: Willingness to make friends with Robert/Shona, interaction between gender and symptoms of person in scenario – mean responses



Variation by respondents' socio-demographic characteristics

8.31 Analyses were undertaken to explore the extent to which willingness to interact with the person in the scenarios varied depending on respondents' gender, age and income.

Gender

8.32 In 2006, gender was found to correlate strongly with responses on two of the interaction measures, namely, willingness to spend an evening socialising with Robert/Shona and willingness to make friends with him/her. In both cases, mean responses were higher among women than men. When the analysis was run in 2008, these differences were again apparent. Further, gender was found to correlate with two additional measures: willingness to start working closely with Robert/Shona and willingness to have him/her marry into the family. Again, mean responses were higher among women than men (table 8.4).

Table 8.4: Willingness to interact with person in scenarios by gender of respondents – mean responses

	Men	Women
<i>Base:</i>	1,589	2,119
Move next door to Robert/Shona	3.77	3.81
Spend an evening socialising with Robert/Shona	3.74	3.88
Make friends with Robert/Shona	3.87	4.03
Start working closely with Robert/Shona	3.67	3.80
Have Robert/Shona marry into the family	3.09	3.24
Do Robert/Shona a favour if they asked you to	4.27	4.30
Have Robert/Shona provide childcare for someone in your family	2.36	2.24
<i>Aggregate scores for all measures</i>	24.84	25.55

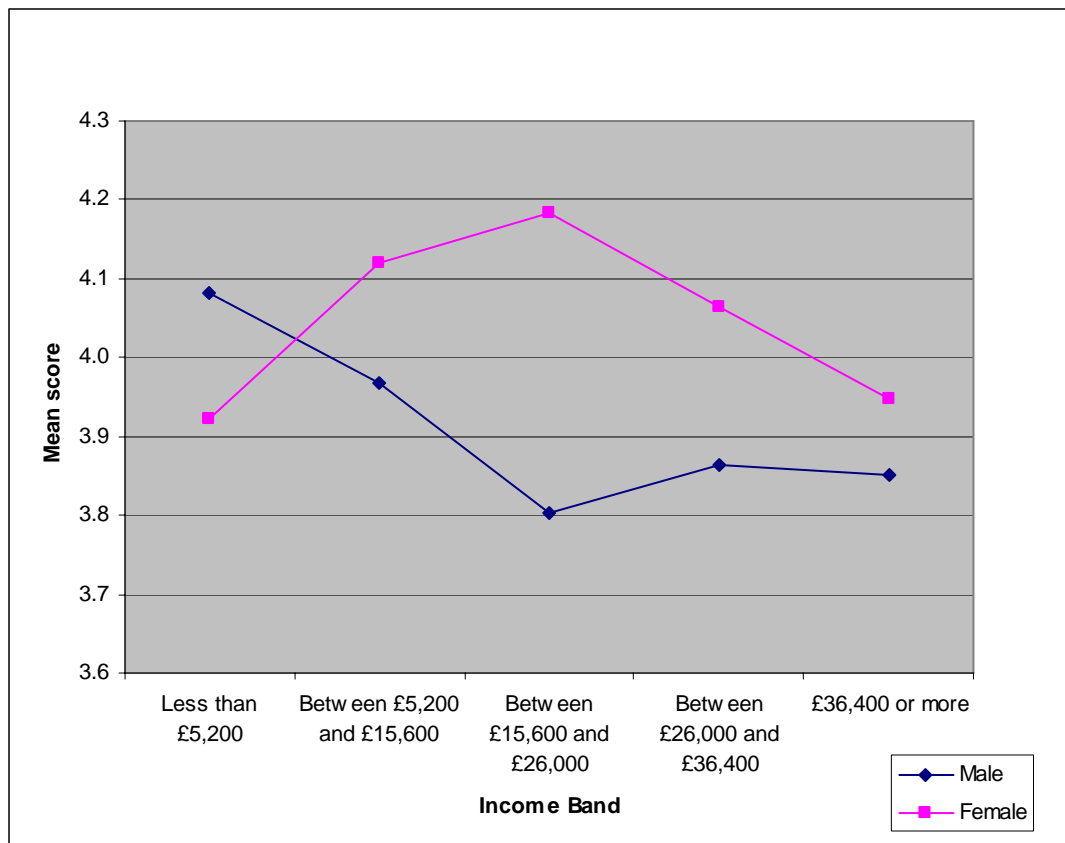
8.33 In addition to these findings, there were also significant interactions between gender and income – that is, observed differences in mean responses between men and women at times varied according to their income. These interactions were evident for four of the measures namely, willingness to: make friends with Robert/Shona; have them marry into the family; do them a favour; and have them provide childcare for someone in the family³⁹. For each of these measures the nature of the interaction differed, as described below.

Willingness to make friends with Robert/Shona

8.34 Among men, willingness to make friends with Robert/Shona decreased as income rose; in other words, men on a lower income were the most willing to make friends with Robert/Shona than those on a higher income. Among women, a different pattern emerged: the lowest and highest income groups were more willing than those on middle-level incomes to make friends with Robert/Shona (figure 8.3).

³⁹ It is not possible to compare these finding with the results for 2006 due to the fact that different income measures were used in the two surveys.

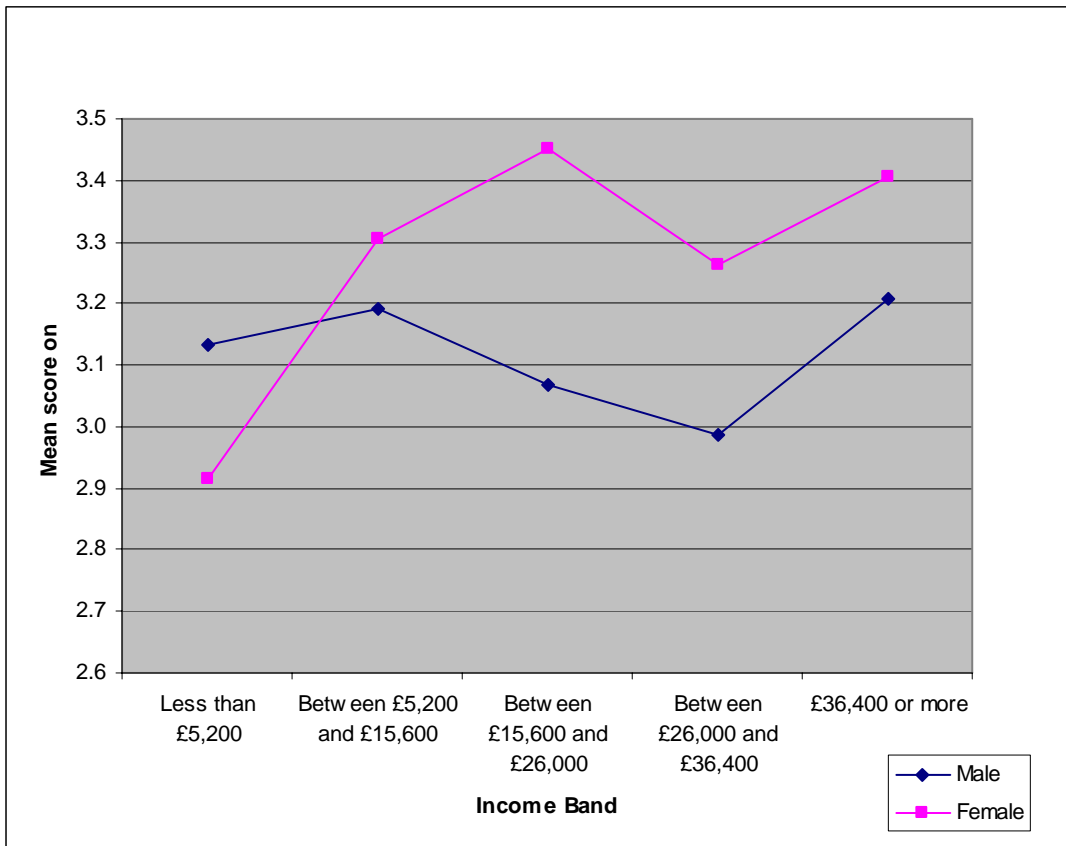
Figure 8.3: Willingness to make friends with Robert/Shona - interaction between gender and income (mean responses)



Willingness to have Robert/Shona marry into the family

8.35 Among women, willingness to have Robert/Shona marry into the family increased with income - although there was a slight dip among women earning between £26,000 and £36,000 per annum. Among men, less fluctuation by income was observed: men on middle and upper-middle incomes were the least willing to have Robert/Shona marry into the family, while those on the lowest and highest incomes were the most willing to do so (figure 8.4).

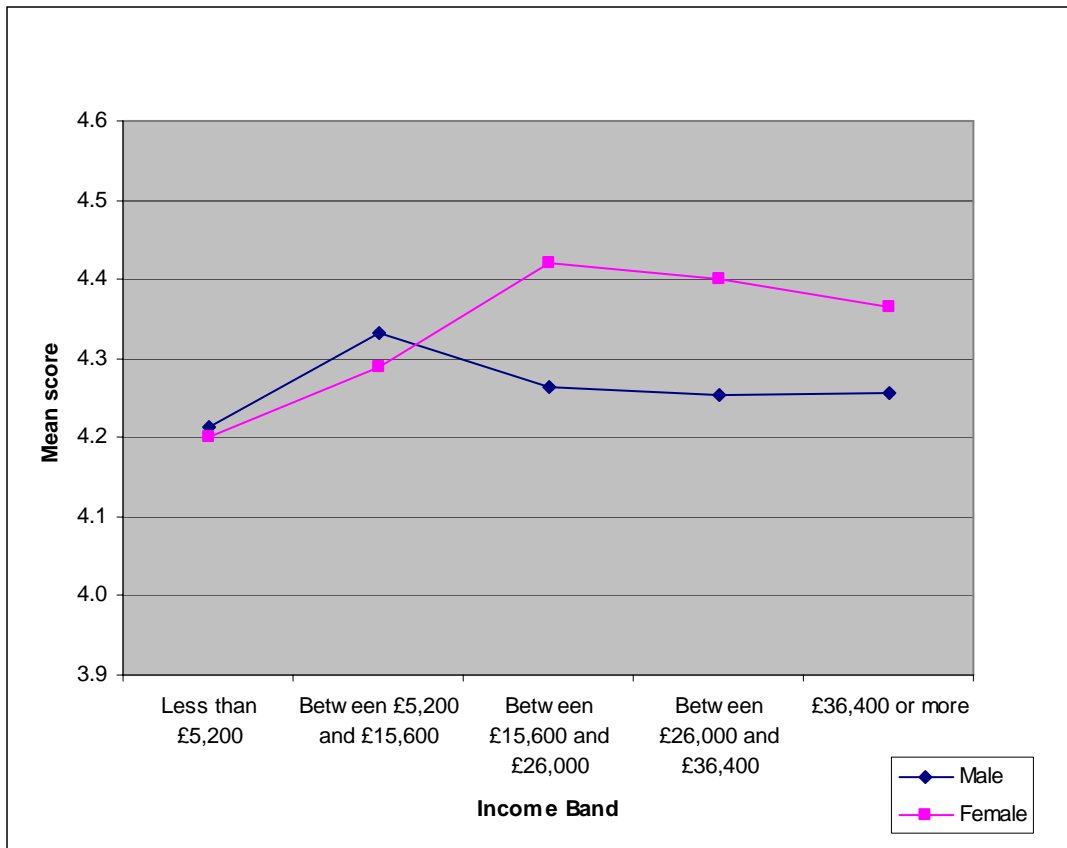
Figure 8.4: Willingness to have Robert/Shona marry into the family – interaction between gender and income (mean responses)



Willingness to do Robert/Shona a favour

8.36 Among women, willingness to do Robert/Shona a favour increased gradually across the lower to middle-income groups before levelling off thereafter. A similar pattern was observed among men. However, whereas there was a significant rise in willingness to do Robert/Shona a favour among women on a middle income, a significant dip was observed for men (figure 8.5).

Figure 8.5: Willingness to do Robert/Shona a favour – interaction between gender and income (mean responses)



Willingness to have Robert/Shona provide childcare for someone in the family.

8.37 As for the previous measure, women’s willingness to have Robert/Shona provide childcare for someone in their family increased gradually across the lower to middle income groups but dropped sharply among those earning between £26,000 and £36,000 per annum. Men’s willingness to have Robert/Shona provide childcare *decreased* as income rose but, again, it was among those earning between £26,000 and £36,000 per annum (the second highest income category) that willingness was lowest (figure 8.6).

Figure 8.6: Willingness to have Robert/Shona provide childcare – interaction between gender and income (mean responses)



Age

8.38 To some extent the results of the analysis by respondents' age are consistent with the findings for 2006. As table 8.5 shows respondents aged 54 and younger were generally more willing than people aged 55 and over to have Robert/Shona marry into the family. Similarly, people aged 25 to 54 years were more willing than older groups to have Robert/Shona provide childcare for someone in their family.

8.39 However, there were some additional correlations between age and attitudes in 2008. Most notably, people aged 35 to 54 years were more willing than those aged 75 and over to start working closely with Robert/Shona.

8.40 These differences are consistent with the age-based variation in attitudes towards mental health problems, reported in the previous chapter, and specifically the finding that the oldest groups of respondents were among those most likely to agree with the statements 'The public should be better protected from people with mental health problems', 'People with mental health problems are often dangerous' and 'I would find it hard to talk to someone with mental health problems'.

Table 8.5: Willingness to interact with person in scenarios by age respondents – mean responses

	16-24	25-34	35-44	45-54	55-59	60-64	65-74	75+
<i>Base:</i>	343	516	687	620	298	323	524	379
Move next door to Robert/Shona	3.90	3.85	3.96	3.83	3.85	3.77	3.63	3.51
Spend an evening socialising with Robert/Shona	3.89	3.89	3.98	3.92	3.89	3.87	3.68	3.35
Make friends with Robert/Shona	3.98	3.98	4.05	4.03	3.97	4.03	3.87	3.73
Start working closely with Robert/Shona	3.86	3.86	3.96	3.88	3.77	3.74	3.51	3.24
Have Robert/Shona marry into the family	3.48	3.47	3.52	3.34	3.20	2.96	2.65	2.48
Do Robert/Shona a favour if they asked you	4.22	4.27	4.37	4.34	4.32	4.34	4.25	4.13
Have Robert/Shona provide childcare for someone in your family	2.60	2.55	2.55	2.48	2.29	2.22	2.00	1.93
<i>Aggregate scores for all measures</i>	25.91	25.85	26.57	25.81	25.52	25.02	23.56	22.47

9 CONCLUSIONS

“There is no health without mental health”

(Scottish Government, 2009a, p.5)

- 9.1 Mental health improvement is an essential part of the Scottish Government’s wider commitment to addressing health and social inequalities. By concentrating on mental health improvement, the Government aims to make considerable progress in addressing the growing range of problems that are manifest where below average mental wellbeing or mental health problems exist. For example, in excessive drinking, substance misuse, violent and abusive behaviour, self-harm and suicide, obesity and poor sexual health.
- 9.2 To help inform its mental health improvement work, the Scottish Government commissioned the fourth National Scottish Survey of Attitudes Towards Mental Health, Mental Wellbeing and Mental Health Problems, in autumn 2008. The overall aims of the research were to examine the views and experiences of a representative sample of the Scottish population in relation to a spectrum of mental health-related issues; and to compare findings with relevant survey data. Specific areas explored in the research included: levels of mental health and wellbeing in the population; factors affecting mental health and wellbeing; experience of and recovery from mental health problems; and attitudes towards mental health problems.
- 9.3 Much work has been done in Scotland over recent years to promote good mental health and wellbeing. While some of this work has sought to target high risk groups, other work has been aimed at the general population as it is recognised by health professionals and policymakers that effective mental health improvement necessitates the integration of both targeted and universal public health strategies (Bramsfeld et al., 2006; Cuijpers et al., 2008; Rapee et al., 2006). However, one of the most consistent messages emerging from the survey is that significant inequalities remain in the distribution of mental health problems and mental wellbeing: People on a low income, those who find it difficult to manage on their income and those living in the most deprived areas of the country are more likely than average to have high GHQ12 scores and report personal or proxy experience of a mental health problem. The same groups are also less likely than other sections of the population to have above average mental wellbeing and an optimistic outlook on life, which may have implications for their levels of resilience in times of difficulty. The survey highlights optimism as a mechanism which may link inequality to mental wellbeing and which is potentially amenable to change via psychological therapies and/or the development of psychological or behavioural skills. Tackling social and economic inequality is central to raising the mental health and wellbeing of everyone in Scotland. As such, the Scottish Government’s plan to implement the *Equally Well* recommendations aimed at addressing mental health problems in deprived communities (Scottish Government 2008a) is a crucial development and it will be important to monitor the effects of this work in the future.

- 9.4 Once again, the survey findings also point towards a link between social isolation and poor mental health and wellbeing. Such findings underpin the importance of the Government's third priority described in *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (2009a), to promote Mentally Healthy Communities which value social cohesion and social inclusion. As noted in the previous report, however, it is not possible for a study such as this to identify causation and a different, longitudinal design would be required to investigate the direction of the relationship between social isolation and mental health and wellbeing (i.e. whether social isolation is itself a cause of poor mental health and wellbeing, or whether poor mental health and wellbeing leads to social isolation).
- 9.5 Still, it was clear that respondents themselves felt that spending time with close family and friends had a positive influence on their mental health, along with leisure activities and hobbies, good weather and financial security. Conversely, among the factors they commonly identified as having a negative influence on mental health and wellbeing were family problems, not having enough money, bad weather and pressures at work. The prominence of money, as both a positive and a negative influence, is worthy of particular attention. Given the current economic climate, it may be that money worries will become increasingly prominent in some people's minds, with possible implications for their mental health and wellbeing. While the survey results indicate that mental health problems are currently no more prevalent than was the case two years ago, it is notable that there has been a decrease in the proportion of people saying they feel optimistic about the future. While it remains to be seen how the economic situation will evolve in the future, it does appear to have the potential to affect people on a number of levels and it will be important that health service providers and policymakers keep this under review.
- 9.6 The prominence of work as a factor influencing mental health and wellbeing is also significant; not only because job security is a salient issue in the current economic climate, but because people spend a large proportion of their time at work with the effect that its overall impact on their quality of life, whether positive or negative, is often considerable (see, for example, Dame Carol Black, 2008 & Scottish Executive 2005a). Quite apart from this, poor mental health and wellbeing can have a substantial impact on the economy in terms of reduced productivity and sickness absence. In recognition of these issues, *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*, outlines a comprehensive programme of work aimed at promoting 'mentally healthy employment and working lives' (Scottish Government, 2009a).
- 9.7 With regard to public attitudes to mental health problems, the findings indicate that positive trends identified over previous waves of the survey may have at best plateaued for the time being. Certainly, the observed stability in agreement with the statement, 'If I were suffering from a mental health problem I wouldn't want people knowing about it', would suggest that current strategies aimed at reducing stigma will need to be considered in order to identify how further progress can be made. While people who have personal or proxy experience of a mental health problem tend to hold more

positive attitudes than those who have not, it is notable that the attitudes of those in the most deprived areas, where mental health problems are more common, are no more positive than average. These findings reinforce the point that exposure alone is not enough to promote positive changes in attitudes and that further promotional work is required to raise awareness of the need to address stigma and discrimination. In *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*, the Government has outlined a commitment to support 'see me' in delivering a social marketing campaign to improve public attitudes and behaviour towards those experiencing mental health illness and their carers. There is also a related commitment to deliver specific social marketing campaigns that address inequality and multiple discrimination and stigma. Again, it will be important that the impact of these initiatives is monitored in the long term to identify both progress and areas requiring further attention.

- 9.8 Notwithstanding the apparent stability in attitudes, there are signs that, in some quarters at least, perceptions of and behaviour towards people with mental health problems may be changing for the better. Between 2006 and 2008, there was a significant increase in the proportion of people with experience of a mental health problem who said they had received a positive message of recovery from professionals with whom they came into contact. It will be interesting to see whether there is further improvement on this measure in the future, following implementation of 'see me's planned strategy for tackling stigma within public services. However, any future evaluation of changes in attitudes must take due cognisance of the ever-changing economic climate and, indeed, of wider cultural shifts.
- 9.9 In terms of recovery from mental health problems, the findings once again underscore the fact that there are a broad range of influences which assist personal recovery and no two individuals' journey of recovery will be the same. Whatever a person's needs and preferred coping strategies, however, it is important that appropriate support services are available to all who may benefit from them. The new Scottish Recovery Indicator will be a crucial development in this respect, helping to ensure that recovery principles are realised in practice.
- 9.10 Overall, the results of the fourth National Scottish Survey of Attitudes Towards Mental Health Mental Wellbeing and Mental Health Problems, provide a timely indication of the status of public opinion on mental health-related issues and will provide an important benchmark against which the impact of future policies and initiatives can be measured.

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ANNEX A: ADVANCE LETTER



Ipsos MORI

Ipsos MORI Scotland
4 Wemyss Place
Edinburgh
EH3 6DH

The Householder
Our Ref:

Email: kate.sewel@ipsos.com

Dear Householder,

“Well? What do you think?”

I am writing to ask for your help with an important study we are conducting for the Scottish Government.

What is it about?

The study will identify the stresses and strains people experience and see how these affect them on a day-to-day basis. It covers topics like well-being and quality of life.

Your views will provide the Scottish Government with a better understanding of the challenges people face so they can develop policies to make things better. We have randomly selected a number of households across Scotland to take part and yours is one of them.

We rely on people's help to make sure the results represent the experiences of everyone in Scotland and we hope you will be able to make your views heard. Taking part is voluntary, but we find that about 70% of people agree to do so.

How do I take part?

You don't have to do anything: an interviewer will visit you soon. They will show you their **official identification card** and select an adult in your household to take part. The questions will take around 30 minutes. If you are busy when they come around, they will be happy to call back at another time.

Is the survey confidential?

Your answers will be treated in the strictest confidence. They will be used only for research and statistical purposes and you will not be personally identifiable. *No-one will try to sell you anything and you will not receive any 'junk mail' as a result.*

How can find out more?

If you would like to speak to someone about the study please call **freephone** 0808 238 5376, write to Kate Sewel at the above address, or email kate.sewel@ipsos.com. If you would like to complete the study in another language, including sign language, please contact Kate and she will make arrangements.

Thank you in advance for your help.

Yours faithfully,

A handwritten signature in black ink, appearing to read "Simon Braunholtz".

Simon Braunholtz
Managing Director, Ipsos MORI Scotland

ANNEX B: SURVEY ADMINISTRATION

B.1 An advance letter was sent to all sampled households. The letter was printed on headed paper and signed by the Managing Director of Ipsos MORI. Because the Postal Address File does not identify the names of householders, the letters were addressed 'Dear Householder'. The advance letter was designed to provide basic information about the survey, but to avoid giving prominence to the issue of mental health. The copy of the advance letter can be found in Annex A.

B.2 A contact sheet was designed and printed for each address in the sample, 2,038 in total. The contact sheets acted as a record of each visit for each selected address. They were fully data entered to record information on the number of calls made to achieve an interview, as well as the day and time of each interview. In addition it recorded important information on the outcome of the interview, i.e. successful interview, refusal information, no contact or other as tables B.1 and B.2 show.

B.3 All fieldwork on this project was conducted by Ipsos MORI's fully trained fieldforce. All interviewing on this project was conducted using CAPI (Computer Assisted Personal Interviewing) and CASI (Computer Assisted Self Interviewing). Interviewers were instructed to download their successful interviews at the end of each day so that the project team could monitor progress throughout fieldwork. Interviewers were also instructed to return all contact sheets (successful and otherwise) to the Ipsos MORI field department in London so that the data could be entered to monitor progress.

Table B.1: Summary table and record of achievals

Summary		
	No.	% of total valid sample
Issued sample	2,038	
Out of scope addresses	160	
<hr/>		
Remaining valid sample	1,878	
Successful interviews	1,177	63
Refused	392	21
No contacts/other	309	17
<hr/>		
Achievals after number of calls		% of total achievals
Interviews achieved after 1 call	365	31
Interviews achieved after 2 calls	291	25
Interviews achieved after 3 calls	188	16
Interviews achieved after 4 calls	126	11
Interviews achieved after 5 calls	81	7
Interviews achieved after 6+ calls	126	11
Total achievals	1,177	

Table B.2: Final Outcomes

Final Outcomes – No contacts/other		
	No.	% of total valid sample
No contacts	239	13
Too ill	37	2
Away during fieldwork	10	1
Mother tongue required	8	*
Other	5	*
Withdrawn by Head Office	10	1
Total no contacts/property ineligible/other	469	25

ANNEX C: CONTACT SHEET

Ipsos
MORI/J34457

SCOTTISH GOVERNMENT
Better Futures Survey
CONTACT SHEET

«Barcode»

ADDRESS INFORMATION	AMEND ADDRESS IF NECESSARY	Address Number:		«Uniqid»
		Batch Number:		
	THE HOUSEHOLDER	Issue	Interviewer Name:	Number:
	«add01»	1		
	«add02»	2		
«add03»	3			
«add04»				
«add05»				

	WEEKDAY (1-7)	TIME (1-3)	DAY (1-31)	MONTH (1-12)	COMMENTS - record outcome of each call
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
TOTAL NUMBER OF CALLS (WRITE IN BOX)					
You must record at least 6 attempts in total to make appointment/complete interview before abandoning address. At least one call must be an evening and one at a weekend .					
CONTACT CODES:		DAY	MON = 1 ♦ TUES = 2 ♦ WED = 3 ♦ THURS = 4 ♦ FRI = 5 ♦ SAT = 6 ♦ SUN = 7		
		TIME	UP TO MIDDAY = 1 ♦ MIDDAY - 6PM = 2 ♦ 6PM ONWARDS = 3		

1.1.1 FINAL OUTCOME	Reissu
---------------------	--------

Successful interview		1	1
REFUSED	Refused before respondent selection	2	2
	Refused after respondent selection	3	3
	Entry to block/scheme refused by warden etc	4	4
NO CONTACT	Occupied, no contact at address after 6+ calls	5	5
	No contact with selected resident , 6+ calls	6	6
	Occupier in but not answering door after 6+ calls	7	7
	Unsure if occupied , no contact after 6+ calls	8	8
PROPERTY INELIGIBLE	Property vacant	9	9
	Property demolished/derelict	10	10
	Property not yet built	11	11
	Non-residential property	12	12
	Institution – no private household	13	13
	Not found – no trace of address	14	14
OTHER	Too ill to participate WRITE IN DESCRIPTION	15	15
	Away during fieldwork WRITE IN DATE BACK	16	16
	Mother tongue required WRITE IN LANGUAGE	17	17
	Other WRITE IN	18	18
	Withdrawn by Head Office	19	19

ESTIMATED CHARACTERISTICS	Composition: Elderly adult household	17	17
	Family with children	18	18
	Other	19	19
	Sex of person refusing: Male	20	20
	Female	21	21
	Ethnic Origin: White	22	22
	Other	23	23

1.1.2 REFUSAL		Reason
REASON FOR REFUSAL (MULTICODE OK)	Never does surveys	1
	Interview takes too long	2
	Taken part in too many surveys	3
	Interview is too intrusive	4
	Too busy at this time	5
	Always too busy	6
	Worried about misuse of information	7
	Worried about confidentiality	8
	Worried about safety/security	9
	Survey is a waste of money	10
	Not interested in helping government	11
	Not interested in the subject matter	12
	"Nothing in it for me"	13
	Don't want to talk about mental health	14
	Other (WRITE IN)	15
Do not recontact	16	

*** DWELLING INFORMATION AND SELECTION ***

Code property type of printed address:

House/bungalow – detached	<input type="checkbox"/>
House/bungalow – semi-detached	<input type="checkbox"/>
House/bungalow – mid terrace	<input type="checkbox"/>
House/bungalow – end terrace	<input type="checkbox"/>
Purpose built flat/maisonette/tenement(s) - building less than six floors	<input type="checkbox"/>
Purpose built flat/maisonette/tenement(s) - building six or more floors	<input type="checkbox"/>
Conversion flat/maisonette(s)	<input type="checkbox"/>
Hostel or bed and breakfast	<input type="checkbox"/>
Other (WRITE IN)	<input type="checkbox"/>

This section should be used to select the dwelling/household at which to carry out the interview. Carefully follow the instructions below.

A-1 How many dwellings are there at this address?

<input type="checkbox"/>	Just one	→ Interview at this dwelling, Go to B-1
<input type="checkbox"/>	More than one	→ Continue to A-2

A-2 Are there fewer than 10 dwellings at the address?

<input type="checkbox"/>	Yes. Write in the number of dwellings	
	then → Use the grid on page 3 to select the correct dwelling and insert number here – then, Continue to B-1	
<input type="checkbox"/>	No → Contact head office for instructions and then write the dwelling number here – then, Continue to B-1	

*** INTRODUCTION AND HOUSEHOLD SELECTION ***

Good morning/afternoon/evening. My name is from Ipsos MORI, the research company. You should have had a letter recently about an important survey we are conducting for the Scottish Government (SHOW COPY OF LETTER). The interview will take about 30 minutes.

I would like to assure you that all the information we collect will be kept in the strictest confidence by Ipsos MORI, and used for research purposes only. It will not be possible to identify any particular person, household, or address in the results.

B-1 How many households are there within the dwelling?

[NOTE: A household is one person or a group of people who have the accommodation as their only or main residence AND (for a group) either share at least one meal a day OR share the living accommodation, that is, a living room or sitting room.]

<input type="checkbox"/>	There is only one household in the dwelling → Attempt interview in that household, go to C-1	
<input type="checkbox"/>	There is more than one household in the dwelling → Use the grid on page 3 to select the correct household and write in number of household here, then, Continue to C-1	

*** RESPONDENT SELECTION ***

C-1 Can you tell me how many people aged 16 or over live at this address?
WRITE IN _____

- Exclude people aged 16+ who live elsewhere to study or work; spouses who are separated and no longer resident; people away for 6 months or more.
- Include people (normally living here) away for less than 6 months; people away at work or for whom this is main address; boarders and lodgers.

<input type="checkbox"/>	1 adult (age 16+) only → Go straight to interview	
<input type="checkbox"/>	2 or more adults → Continue to C-2	

C-2 Ask for first name or initial of each person aged 16 or over.
LIST ALL ADULTS AGED 16 AND OVER – LIST THEM BY GENDER, AND THEN WITHIN GENDER, BY AGE - List male household members first – start with the youngest, through to the oldest. Then do the same with female household members.

	First Name or Initial (male household members first –youngest through to oldest. Repeat for female household members)
01	
02	
03	
04	
05	
06	

	First Name or Initial Cont....
07	
08	
09	
10	
11	
12	

C-3 Use the grid below to select the right person for the interview and ring on grid above.
 [If there are 10 or more adults living in the household, contact head office for instructions]

Enter **Person Number** of selected person:

Enter **Name** of selected person _____

CONTINUE WITH INTERVIEW WITH SELECTED HOUSEHOLD MEMBER

*** SELECTION GRID ***

Use this grid to select dwelling, household and household member to interview. The top row indicates the number of potential units for each of these while the bottom row indicates the dwelling, household, and household member you should select for interview.

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

Once a selection has been made no substitutions are allowable

	1	2	3	4	5	6	7	8	9
NUMBER OF HOUSES/FLATS AT ADDRESS NUMBER OF HOUSEHOLDS No. OF ADULT HOUSEHOLD MEMBERS									
SELECTED HOUSE/FLAT SELECTED HOUSEHOLD SELECTED HOUSEHOLD MEMBER									

ANNEX D: QUESTIONNAIRE FOR THE 2008 SURVEY

Good morning/afternoon/evening. My name is ... from Ipsos MORI, the research organisation. You should have had a letter recently about an important survey we are conducting of the Scottish Government (SHOW COPY OF LETTER). The interview will take about 30 minutes.

I would like to reassure you that all the information we collect will be kept in the strictest confidence, and used for research purposes only. It will not be possible to identify any particular individual or address in the results.

Section A

A1. SHOWCARD A I'd like to start by asking some questions about your general health and lifestyle. First of all, how is your health in general? Would you say it was... SINGLE CODE

Very good	1
Good	2
Fair	3
Bad	4
Very bad	5
Don't know	6

()

A2 Do you have any long standing illness, disability or infirmity? By long-standing, I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time? SINGLE CODE

Yes	1
No	2

ASK IF YES AT A2. OTHERS GO TO A5

A3 Does this illness, disability or infirmity limit your activities in any way? SINGLE CODE

Yes	1
No	2

A5 SHOWCARD B How long have you lived in this neighbourhood? By this neighbourhood I mean within about 15 minutes walk of here? SINGLE CODE

Less than a year	1
One year, less than 2 years	2
Two years, less than five years	3
Five years, less than 10 years	4
10 years, less than 20 years	5

20 years or more	6
Don't know/can't remember	7

()

A6 SHOWCARD C How satisfied or dissatisfied are you with this neighbourhood as a place to live? SINGLE CODE

Very satisfied	1
Fairly satisfied	2
Neither satisfied nor dissatisfied	3
Fairly dissatisfied	4
Very dissatisfied	5
Don't know	6

()

A7 On average, how often do you see friends or relatives, who are not living with you? Would you say... SINGLE CODE. READ OUT

On most days	1
Once or twice a week	2
Once or twice a month	3
Less often than once a month	4
Never	5
Don't know	6

()

A10 Do you give up any time as a volunteer or as an organiser for any charities, clubs or organisations (in an unpaid capacity)? SINGLE CODE ONLY

Yes	1
No	2
Don't know	3

()

I am now going to describe two situations where people might need help. For each one, could you tell me if there is anyone you could ask for help?

A11 You are ill in bed and need help at home. Is there anyone you could ask for help? SINGLE CODE

A12 You are in financial difficulty and need to borrow some money to see you through the next few days. Is there anyone you could ask for help? SINGLE CODE

	A23	A24
	()	()
Yes	1	1
No	2	2
Don't know	3	3

()

A13 If you had a serious personal crisis, how many people, if any, do you feel you could turn to for comfort and support?



Section B

I'm now going to ask you some questions about your own emotions or how you feel about yourself - sometimes called mental health and well being.

B1 What sorts of things, if any, have a positive or good effect on your own emotions or mental health and well being? DO NOT PROMPT. PROBE FULLY

Don't know		7	()
------------	--	---	-----

B2 And what, if any things have a negative or bad effect on your own emotions or mental health and well being? DO NOT PROMPT. PROBE FULLY

Don't know	9

B3 SHOWCARD D Thinking about all those things that might affect your own emotions or mental health and well being, how much control, if any, do you feel you have over them? SINGLE CODE

Complete control		1	
A good deal of control		2	
Some control		3	
A little control		4	
No control at all		5	
Don't know		6	()

WEMWBS

Below are some statements about feelings and thoughts

WE **Please tick the box that best describes your experience of each over the**
 MW **last two weeks**
 BS

	None of the time 1	Rarely 2	Some of the time 3	Often 4	All of the time 5
I've been feeling optimistic about the future					
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

GHQ12

B4 **Have you recently....**
been able to concentrate on whatever you're doing...SINGLE CODE

Better than usual	1
Same as usual	2
Less than usual	3
Much less than usual	4

B5 **lost much sleep over worry? SINGLE CODE**

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B6 felt you were playing a useful part in things? SINGLE CODE

More so than usual	1
Same as usual	2
Less useful than usual	3
Much less than usual	4

B7 felt capable of making decisions about things? SINGLE CODE

More so than usual	1
Same as usual	2
Less so than usual	3
Much less capable	4

B8 felt constantly under strain? SINGLE CODE

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B9 felt you couldn't overcome your difficulties? SINGLE CODE

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B10 been able to enjoy your normal day-to-day activities? SINGLE CODE

More so than usual	1
Same as usual	2
Less so than usual	3
Much less than usual	4

B11 been able to face up to your problems? SINGLE CODE

More so than usual	1
Same as usual	2
Less able than usual	3
Much less able	4

B12 been feeling unhappy and depressed? SINGLE CODE

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B13 **been losing confidence in yourself?** SINGLE CODE

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B14 **been thinking of yourself as a worthless person?** SINGLE CODE

Not at all	1
No more than usual	2
Rather more than usual	3
Much more than usual	4

B15 **been feeling reasonably happy, all things considered?** SINGLE CODE

More so than usual	1
About the same as usual	2
Less so than usual	3
Much less than usual	4

Section C

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

	Stro ngly agre e	Ten d to agre e	Neit her agre e nor disa gree	Ten d to disa gree	Stro ngly disa gree	Don' t kno w
If I was suffering from mental health problems, I wouldn't want people knowing about it	1	2	3	4	5	6
The public should be better protected from people with mental health problems	1	2	3	4	5	6
Anyone can suffer from mental health problems	1	2	3	4	5	6
I would find it hard to talk to someone with mental health problems	1	2	3	4	5	6
People are generally caring and sympathetic to people with mental health problems	1	2	3	4	5	6
People with mental health problems are often dangerous	1	2	3	4	5	6
The majority of people with mental health problems recover	1	2	3	4	5	6
People with mental health problems should have the same rights as anyone else	1	2	3	4	5	6
People with mental health problems are largely to blame for their own condition	1	2	3	4	5	6

C2 How common do you think it is for people to have mental health problems at some stage in their lives? Out of 100 people in Scotland, how many do you think will have a mental health problem at some point in their lives? WRITE IN



Don't know X

C3 From what you know has anyone close to you ever experienced a mental health problem or not? SINGLE CODE

Yes	1
No	2
Don't know	3
Refused	4

()

C4 SHOWCARD F From what you know, has anyone close to you ever been told by a doctor or other health professional, that they had one or other of these kinds of specific mental health problems? Just read out the letter or letters that apply. MULTICODE OK

Yes:		
A	Alzheimer's disease/Dementia	1
B	Anxiety disorder	2
C	Depression	3
D	Eating disorder (anorexia, bulimia)	4
E	Manic depression (bipolar affective disorder)	5
F	Nervous breakdown	6
G	Obsessive/compulsive behaviour/disorder	7
H	Panic attacks	8
I	Personality disorder	9
J	Phobias (e.g. agoraphobia)	0
K	Post-natal depression	X
L	Schizophrenia	Y
M	Self-harm	1
N	Severe stress	2
O	Post traumatic stress disorder	3
P	Yes been told he/she had problem but don't know what it was called	4
Q	Other (PLEASE WRITE IN AND CODE '2')	5

None of these	6
Don't know	7
Refused	8

()

C5 Have you ever personally experienced a mental health problem or not? SINGLE CODE

Yes	1
No	2
Don't know	3
Refused	4

()

C6 SHOWCARD G Have you ever been told by a doctor or other health professional, that you personally have had one or other of these kinds of specific mental health problems? Just read out the letter or letters that apply. MULTICODE OK

Yes:

A	Alzheimer's disease/Dementia	1
B	Anxiety disorder	2
C	Depression	3
D	Eating disorder (anorexia, bulimia)	4
E	Manic depression (bipolar affective disorder)	5
F	Nervous breakdown	6
G	Obsessive/compulsive behaviour/disorder	7
H	Panic attacks	8
I	Personality disorder	9
J	Phobias (e.g agoraphobia)	0
K	Post-natal depression	X
L	Schizophrenia	Y
M	Self-harm	1
N	Severe stress	2
O	Post traumatic stress disorder	3
P	Yes been told had problem but don't know what it was called	4
Q	Other (PLEASE WRITE IN AND CODE '2')	5
	None of these	6
	Don't know	7
	Refused	8

ASK ALL WHO SAY YES AT C5 OR ANY CODE (1-Y & 1-3) AT C6. OTHERS GO TO C8B

C6A SHOWCARD H Have you told anyone about your mental health problem, apart from your doctor or any other health professionals? Just read out the letter or letters that apply. MULTICODE OK

A	Yes, I have told family and/or friends	1
B	Yes I have told my manager/boss at work	2
C	Yes, I have told other colleagues at work	3
D	Yes, I have told a tutor/member of staff at college/university/other course	4
E	Yes I have told other people I don't know well	5
F	No I have told no-one	6

ASK ALL WHO SAY YES AT C5 OR ANY CODE (1-Y & 1-3) AT C6. OTHERS GO TO C8B

C8 SHOWCARD I Have you experienced any of the following as a result of other people's attitudes towards your mental health problem(s)? Just read out the letter or letters that apply. MULTICODE

A	("UNABLE TO" DELETED IN FIRST 4 OF THESE CODES) Discouraged from participating in social events, such as going out with friends	1
B	Discouraged from participating in children's school based activities	2
C	Discouraged from taking part in local community life	3
D	Discouraged from going on holiday	4
E	Been refused a job	5
F	Been overlooked/refused for promotion	6
G	Verbally abused in public	7
H	Verbally abused within the family	8
I	Physically abused in public	9
J	Physically abused within the family	0
K	Graffiti or rubbish targeted at the home	X
L	Experienced discrimination at work	Y

Other (PLEASE WRITE IN AND CODE ' ')	1
None of these	2
Don't know	3
Refused	4

()

ASK ALL WHO SAY YES AT C5 OR ANY CODE (1-Y & 1-3) AT C6

C8B Have you ever chosen to avoid a social event because of the way you think people will treat you because of your mental health problem(s)? SINGLE CODE

Yes	
No	
Don't know/can't remember	

ASK ALL WHO SAY YES AT C5 OR ANY CODE (1-Y & 1-3) AT C6

C10 SHOWCARD J Thinking again about the mental health problem(s) you have experienced, which two or three, if any, of the following were most important in supporting your recovery? Just read out the letter or letters that apply. CODE UP TO THREE

		C10
		()
A	Finding out more about mental health (e.g. through support groups, leaflets, web information etc.)	1
B	Medication	2
C	Other forms of treatment/therapy (e.g. psychology, counselling, alternative treatments, support groups)	3
D	Developing my own coping strategies	4
E	Support from colleagues/work	5
F	Support from family or friends	6
G	Support from people with a similar experience	7
H	Having something worthwhile to do during the day (e.g. work, volunteering education, hobbies etc.)	8
I	Having a chance to contribute and be valued	9
J	Having others believe in me	0

K	Having belief in myself	X
	Other (PLEASE WRITE IN AND CODE 'Y')	Y
L	I don't believe myself to be in recovery	1
	None of these	2
	Don't know	3

()

ASK ALL WHO SAY YES AT C5 OR ANY CODE (1-Y & 1-3) AT C6

C10 SHOWCARD K And what factors, if any, have most hindered your recovery?

B MULTICODE OK Just read out the letter or letters that apply. CODE UP TO THREE

		C10B
		()
A	Not acknowledging I had a problem	1
B	Not feeling able to tell people about my mental health problem	2
C	Negative attitudes of people around me	3
D	Not being able to access appropriate services or treatment	4
E	Not getting the right medication	5
F	Continuing to experience symptoms	6
G	Lack of support or understanding from family or friends	7
H	Lack of support or understanding from colleagues/work	
I	Lack of access to employment, education or training opportunities	8
	Not understanding what was going on	9
	Other (PLEASE WRITE IN AND CODE '0')	0
	None of these	X
	Don't know	Y

ASK ALL WHO SAY YES AT C5 OR ANY OR ANY CODE (1-Y & 1-3) AT C6
C12 What does recovery mean to you? DO NOT PROMPT. MULTICODE OK

Having a satisfying and fulfilling life	1
Taking charge of my life again	2
Getting back to normal	3
Fewer symptoms	4
Feeling able to cope in general	5
Getting back to work	6
Taking up training or education opportunities	7
No longer needing treatment or services (including medication)	8
Getting involved in activities I enjoy	9
Feeling more able to socialise	0
Getting more sleep	X
Other (PLEASE WRITE IN AND CODE ' ')	y
None of these	1
Don't know	2

()

C12 B SHOWCARD L To what extent have the professionals you have come into contact with (nurses, doctors, support workers etc.) given you a positive or negative message about your recovery? SINGLE CODE

Completely positive	
Mainly positive	
Mixed	
Mainly negative	
Completely negative	
Don't know	

C12 C SHOWCARD L AGAIN To what extent have the people around you (family, friends, colleagues, carers, etc) given you a positive or negative message about your recovery? SINGLE CODE

Completely positive	
Mainly positive	
Mixed	
Mainly negative	

Completely negative	
Don't know	

Section D

There are many ways in which people might form an impression of what mental health problems are. I'm interested to know how you have gained your understanding of mental health problems, and how they affect people's lives.

D1. SHOWCARD M Taking your answers from this card, which, if any, of the following have been important in forming your impression? MULTICODE OK Just read out the letter or letters that apply.

D2. ASK IF MORE THAN ONE MENTIONED AT D1. OTHERS GO TO D3
SHOWCARD M AGAIN Which one of these sources would you say was the most influential for you? SINGLE CODE

		D1	D2
		()	()
A	Personal contact or personal experience	1	1
B	Work	2	2
C	School/college	3	3
D	National newspapers	4	4
E	Local newspapers	5	5
F	Books/leaflets/magazines	6	6
G	Television news and current affairs programmes	7	7
H	Television soaps	8	8
I	Other TV	9	9
J	Radio	0	0
K	Word of mouth	X	X
L	Health professionals	Y	Y
M	Internet	1	1
	Other (PLEASE WRITE IN AND CODE ' ')	2	2
	None of these	3	3
	Don't know	4	4

()

Section E

Vignettes

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

E1 SHOWCARD N In your opinion, how likely or unlikely is it that Robert's/Shona's (CAPI: TO USE NAME FROM VIGNETTE IN REST OF SECTION) situation might be caused by each of the following? SINGLE CODE. READ OUT. ROTATE ORDER. TICK START

	Very likely	Somewhat likely	Some what unlikely	Very unlikely	Don't know
Robert's/Shona's own character or personality	1	2	3	4	5
Chemical imbalance in the brain	1	2	3	4	5
The way Robert/Shona was brought up	1	2	3	4	5
Stressful or disturbing events in Robert's/Shona's life	1	2	3	4	5
Genetic or inherited problem	1	2	3	4	5
Abuse Robert/Shona suffered as a child	1	2	3	4	5
Fate	1	2	3	4	5
Physical illness	1	2	3	4	5
Robert/Shona's own fault	1	2	3	4	5
The circumstances in which Robert/Shona lives	1	2	3	4	5

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

Someone in the family	1
A friend or neighbour	2
A nurse	3
A home help/carer/care assistant	4
A psychiatrist	5
A psychologist	6
A family doctor	7
A social worker	8
A qualified counsellor	9

A voluntary organisation or charity	0
Someone with the same problem	X
No one	1
Someone else (PLEASE WRITE IN AND CODE ' ')	2
None of these	3
Don't know	4

()

E3 SHOWCARD P **If all of the options on this card were possible, where do you think it would be best for Robert/Shona to live? Just read out the letter that applies** SINGLE CODE. JUST READ OUT THE LETTER THAT APPLIES. SINGLE CODE.

A	In their own (or family's) home	1
B	In special housing with professional support in the community	2
C	In a residential or nursing home	3
D	In hospital	4
	Other PLEASE WRITE IN AND CODE '5'	5
	Don't know	6

()

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

	Self	Others
Very likely	1	1
Somewhat likely	2	2
Somewhat unlikely	3	3
Very unlikely	4	4
Don't know	5	5

()

E5 SHOWCARD R **How willing would you be to....?** READ OUT. ROTATE ORDER. TICK START

Very willing	Fairly willing	Neither willing nor unwilling	Fairly unwilling	Very unwilling	Don't know
--------------	----------------	-------------------------------	------------------	----------------	------------

Move next door to Robert/Shona	1	2	3	4	5	6
Spend an evening socialising with Robert/Shona	1	2	3	4	5	6
Make friends with Robert/Shona	1	2	3	4	5	6
Start working closely with Robert Shona	1	2	3	4	5	6
Have Robert Shona marry into the family	1	2	3	4	5	6
Do Robert/Shona a favour if they asked you to	1	2	3	4	5	6
Have Robert/Shona provide childcare for someone in your family (e.g. babysitting, childminding)	1	2	3	4	5	6

E6 How likely or unlikely do you think it is that Robert/Shona's freedoms and rights might have to be limited because of their illness? SINGLE CODE

Very likely	1
Fairly likely	2
Not very likely	3
Not at all likely	4
Don't know	5

()

E7 SHOWCARD S (AND THE SCENARIO SHOWCARD) The description I read out/you read earlier for Shona/Robert was designed with one particular mental health problem in mind. Which one of these do you think it is most likely to be? Just read out the letter that applies. SINGLE CODE

Alzheimer's disease/Dementia	1
Anxiety disorder	2
Depression	3
Eating disorder (anorexia, bulimia)	4
Manic depression (bipolar affective disorder)	5
Nervous breakdown	6
Obsessive/compulsive behaviour/disorder	7
Panic attacks	8
Personality disorder	9
Phobias (e.g. agoraphobia)	0
Post-natal depression	X
Schizophrenia	Y

Self-harm	1
Severe stress	2
Post traumatic stress disorder	3
Other	4
Don't know	5
Refused	6

Section F

Please be as honest and accurate as you can throughout. Try not to let your response to one statement influence your responses to other statements. There are no "correct" or "incorrect" answers. Answer according to your own feelings, rather than how you think "most people" would answer.

In uncertain times, I usually expect the best. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

If something can go wrong for me, it will. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

I'm always optimistic about my future. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

I hardly ever expect things to go my way. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

I rarely count on good things happening to me. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

Overall, I expect more good things to happen to me than bad. SINGLE CODE

I agree a lot	1
I agree a little	2
I neither agree nor disagree	3
I disagree a little	4
I disagree a lot	5

Section G – Demographic information

F1 What was your age last birthday WRITE IN

Don't know
Refused

F2 CODE RESPONDENTS GENDER

Male	1
Female	2

F3 SHOWCARD T. **What is your ethnic group?** SINGLE CODE ONLY

A	White	
	Scottish	1
	English	2
	Welsh	3
	Northern Irish	4
	British	
	Irish	
	Gypsy/traveller	
	Polish	
	Any other White ethnic WRITE IN	
B	Mixed or Multiple ethnic groups	
	Any WRITE IN	
C	Asian, Asian Scottish or Asian British	
	Pakistani, Pakistani Scottish or Pakistani British	
	Indian, Indian Scottish or Indian British	
	Bangladeshi, Bangladeshi Scottish or Bangladeshi British	
	Chinese, Chinese Scottish or Chinese British	
	Other WRITE IN	
D	African, Caribbean or Black	
	African, African Scottish, African British	
	Caribbean, Caribbean Scottish, Caribbean British	
	Black, Black Scottish, Black British	
	Other WRITE IN	
E	Other ethnic group	
	Arab	
	Other WRITE IN	

F4 HOUSEHOLD COMPOSITION. **And how many people aged under 16 live in your household?**

0	1
1	2
2	3
3	4
4	5
5+	6

F4B HOUSEHOLD COMPOSITION. **And how many people aged 16 and over live in your household?**

0	1
1	2
2	3
3	4
4	5
5+	6

F5 SHOWCARD U. **What is your household's total income from all sources over the last 12 months?** Just read out the letter from the card. SINGLE CODE.

	Per week	Per year	
A	Less than £100	Less than £5,200	1
B	£100 to £199	£5,200 to £10,399	2
C	£200 to £299	£10,400 to £15,599	3
D	£300 to £499	£15,600 to £25,999	4
E	£500 to £699	£26,000 to £36,399	5
F	£700 to £949	£36,400 to £49,399	6
G	£950 to £1,199	£49,400 to £62,399	7
H	£1,200 to £1,499	£62,400 to £77,999	8
I	£1,500 or more	£78,000 or more	9
	Refused		0
	Don't know		X

F6 SHOWCARD V. **How easy or difficult do you find it to manage on your household's income?**

Very easy	1
Fairly easy	2
Manageable	3
Fairly difficult	4
Very difficult	5
Don't know	6

F7 SHOWCARD W

Please look at this card and tell me which, if any, of these qualifications you have. Just read out the letter or letters that apply. MULTICODE OK

A - School Leaving Certificate, NQ Unit

B - O Grade, Standard Grade, GCSE, GCE O level, CSE, NQ Access 3 Cluster, Intermediate 1, Intermediate 2, Senior Certificate or equivalent

C - GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1, SVQ Level 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent

D - Higher Grade, Advanced Higher, CSYS, A Level, AS Level, Advanced Senior Certificate or equivalent

E - GNVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, SCOTVEC National Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent

F - HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent

G - First Degree, Higher degree, SVQ Level 5 or equivalent

H - Professional qualifications e.g. teaching, accountancy

L – Other school examinations not already mentioned

M – Other post-school but pre-Higher Education examinations not already mentioned

N – Other higher education qualifications not already mentioned

No qualifications

Don't know

Refusal

F8 SHOWCARD X. Which of these apply to you? CODE ALL THAT APPLY

A	In paid work	1
B	Local or government training scheme (GTS)	2
C	Modern Apprenticeship	3
D	Registered unemployed/signing on for JSA	4
E	Not registered but seeking work	5
F	At home/not seeking work	6
G	Long-term sick or disabled	7
H	Retired	8
I	Full-time education	9
J	Carer (for example, of an elderly relative person or someone with a permanent sickness or disability)	0
	Other (PLEASE SPECIFY)	X

F9 SHOW CARD Y. In which of these ways do you occupy this accommodation?

SINGLE CODE

Buying with mortgage/loan	1
Own it outright	2
Part rent/part mortgage	3
Rents (including rents paid by housing benefit)	4
Living here rent free	5
Other WRITE IN	6
Don't know	7
Refused	8

F10 Is there a car or van normally available for use by you or any members of your household?

Yes	1
No	2

Thank you very much for your help with this survey. The Scottish Government may be conducting further research in the next 12 to 18 months. Would you be willing to take part in this future research? If you agree to this, your contact details will be passed to the Scottish Government for this purpose.

Yes	1
No	2

ANNEX E: MULTIVARIATE ANALYSIS TECHNIQUES

E.1 Regression analysis is a technique used to identify factors that contribute to an outcome and to give an indication of the relative strength of these factors. The most common form of regression is linear regression, which is analogous to drawing a 'line of best fit' through the data. The regression process considers each one of the contributory factors under consideration and systematically tests combinations of those factors to find the collection of factors that most accurately defines the outcome. In the context of the 2008 survey, regression analysis was used to identify which variables have the strongest relationship with attitudes to mental health problems.

E.2 Segmentation analysis is a way of simplifying survey questions into a smaller number of themes or 'factors' by grouping together items that are answered in similar ways. The process involves factor analysis to identify the common themes, followed by cluster analysis to segment the sample into groups based on these themes. The demographic composition of each of the typologies can then be analysed. Segmentation analysis was used to provide a fuller picture of responses to the attitudinal statements presented in the survey, including the extent to which responses vary among different groups of respondents.

E.3 Correlation analysis compares two variables and assesses to what extent (i.e. how strongly) they are related to each other. The best way to visualise correlation is in terms of a scatterplot. The x-axis represents one variable and the y-axis represents another variable. Each respondent has a score on variable 1 and a score on variable 2, so each respondent can be represented as a point on this scatterplot. The pattern of points formed by plotting each respondent will dictate the strength and direction of correlation. A strongly correlated pair of variables will form a pattern resembling a straight line. The orientation of the line will dictate the direction of the correlation. If the line slopes upwards (i.e. from bottom-left to top-right), then the correlation is positive. If the slope is downwards, then the correlation is negative. However, as with regression analysis, correlation analysis can identify only an association between variables; it cannot tell us if the association is causal, or the direction of causality.

E.4 The aggregation of responses across variables provides another means of generalising about the ways in which particular types of questions are answered by different groups of respondents. Typically, it involved allocating a score to respondents which reflects their pattern of responding across a number of questions, and then considering to what extent higher and lower scores are correlated with other attitudes and behaviours. In the present study, this approach was used in a number of different ways. For example, respondents were given a 'social engagement' score based on their answers to the questions concerning their informal support networks and civic participation.

ANNEX F: STATISTICAL SIGNIFICANCE AND RELIABILITY

Statistical significance

F.1 The formula used for calculating significant differences between sub-groups is as follows:

the standard deviations for two sub-groups are calculated as SD1 and SD2

1) Calculate an "overall" or "pooled" SD for the two groups together. This is very close to the weighted average; weighted by the relative sizes of the sub-groups in the sample.

$$SD_p = \sqrt{\frac{(n_1 - 1).SD_1^2 + (n_2 - 1).SD_2^2}{(n_1 + n_2 - 2)}}$$

2) Use this pooled measure to calculate the Standard Error of the Difference (SED) between the sub-group means, i.e.:

$$SED = SD_p \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}$$

3) Divide the difference between the sub-groups scores that you observe, by the SED. If the size of this result (technically referred to as the "t-score") is greater than 1.96 (i.e. either less than -1.96 or greater than +1.96), then the difference is statistically significant at the 95% confidence level. In other words, there is sufficient evidence that scores in the underlying population are different for the two sub-groups. Thus:

$$t = \frac{(x_1 - x_2)}{SED}$$

Statistical Reliability

F.2 The respondents to the questionnaire are only a sample of the total 'population'. We cannot therefore be certain that the figures obtained are exactly those we would have if everybody had been interviewed (the 'true' values). However, we can predict the variation between the sample results and the 'true' values from a knowledge of the size of the samples on which the results are based and the number of times that a particular answer is given.

F.3 The confidence with which we can make this prediction is usually chosen to be 95% - that is, the chances are 19 in 20 that the 'true' value will fall within a specified range. The table below illustrates the predicted ranges for different sample sizes and percentages results at the '95% confidence interval', based on a random sample.

Table F.1: Predicted ranges for different sample sizes at the 95% confidence interval

Size of sample on which survey result is based	Approximate sampling tolerances applicable to percentages at or near these levels		
	10% or 90% +	30% or 70% +	50% +
100 interviews	6	9	10
200 interviews	4	6	7
300 interviews	3	5	6
500 interviews	3	4	4
1,000 interviews	2	3	3
1,177 interviews	2	3	3

F.4 For example, on a question where 50% of the people in a sample of 1,177 respond with a particular answer, the chances are 95 in 100 that this result would not vary by more than three percentage points, plus or minus from a complete coverage of the entire population using the same procedures. However, while it is true to conclude that the "actual" result (95 times out of 100) lies anywhere between 47% and 53%, it is proportionately more likely to be closer to the centre of this band (i.e. at 50%).

F.5 Tolerances are also involved in the comparison of results from different parts of a sample. A difference, in other words, must be of at least a certain size to be considered statistically significant. The following table is a guide to the sampling tolerances applicable to comparisons.

Table F.2: Sampling tolerances

Size of samples compared	Differences required for significance at or near percentage levels		
	10% or 90% +	30% or 70% +	50% +
100 and 100	8	13	14
200 and 200	6	9	10
200 and 400	5	8	9
200 and 500	5	8	8
500 and 500	4	6	6
700 and 300	4	6	7
700 and 400	4	6	6
1,000 and 100	8	13	14

Table F.3: Demographic sub-group comparisons

Size of samples compared	Differences required for significance at or near percentage levels		
	10% or 90% +	30% or 70% +	50% +
Males vs. females (563 vs. 614)	3	5	6
Age 16-24 vs. 65-74 (168 vs. 135)	7	10	11
Easy to manage on income vs. difficult (531 vs. 182)	5	8	8
Good or very good general health vs. bad or very bad general health (873 vs. 96)	6	10	11

ANNEX G: ADDITIONAL MULTIVARIATE ANALYSIS UNDERTAKEN

1) Analysis of the relationship between the number of positive and negative influences on mental wellbeing mentioned by respondents, and a) their GHQ12 scores and b) their level of mental wellbeing (as measured through WEMWEBS)

G.1 Previous research has shown that the absence of positive influences on mental wellbeing, rather than the presence of negative influences, is crucial in predicting suicidal behaviour⁴⁰. Accordingly, analysis was undertaken to explore whether there was a relationship between the number of positive and negative influences mentioned by respondents, and their GHQ12 and WEMEBS scores.

G.2 For the purpose of the analysis three new variables were created: one representing the total positive number of influences mentioned by each respondent (QB1), another representing the total number of negative influences mentioned (QB2), and a third representing a composite net influences variable which combined the relative presence of negative and positive influences. Zero-order correlational analysis was then undertaken to explore i) the relationship between the number of positive influences that respondents mention and their GHQ12 and WEMWBS scores and ii) the relationship between the number of negative influences that respondents mention and their GHQ12 and WEMWBS scores. In addition, regression analysis was used to explore *simultaneously* the relationship between the number of positive *and* negative mentions and GHQ12 and WEMWBS scores - thus providing a measure of the *relative* importance of the reporting of positive and negative influences. The analysis was repeated for those who have experience of mental health problems (both proxy and personal) and those who do not.

G.3 On the whole, the analysis revealed that neither the number nor the type of positive and negative influences mentioned by respondents were found to be correlated with their GHQ12 and WEMWBS scores.

2) Segmentation analysis of attitudes to mental health problems

G.4 The purpose of this analysis was to identify whether the nine attitudinal statements could be grouped into a smaller number of themes or 'factors' depending on the responses they elicit and, if so, to what extent respondents fell into distinct, like-minded groupings in relation to these factors.

G.5 The analysis involved a two-stage process. Firstly, factor analysis was used to identify related statements. As in 2006, this analysis produced a four factor solution, although the constituent statements of the four factors differed slightly this time around (table G.1 below).

⁴⁰ O'Connor et al, 2007. Predicting Short-term Outcome in Wellbeing Following Suicidal Behaviour: The Conjoint Effects of Social Perfectionism and Positive Future Thinking. *Behaviour Research and Therapy*, 45, 1543-1555

Table G.1: Factor analysis: 4 factor solution

Factor	Constituent attitudinal statements
1	-People with mental health problems are often dangerous -The public should be better protected from people with mental health problems -People with mental health problems are largely to blame for their own condition -I would find it hard to talk to someone with mental health problems
2	-Anyone can suffer from mental health problems -People with mental health problems should have the same rights as anyone else
3	-If I were suffering from a mental health problem, I wouldn't want people knowing about it
4	-The majority of people with mental health problems recover -People are generally caring and sympathetic to people with mental health problems

G.6 Cluster analysis was undertaken to identify to what extent respondents fell into like-minded groups on the basis of their attitudes in relation to each factor. A range of possible cluster solutions were identified, with the strongest of these comprising four clusters. As in 2006, none of the four clusters was particularly distinct, either in attitudinal or socio-demographic terms. However, the analysis did yield some interesting findings, several of which reinforced bivariate analyses presented in chapter 7. Most notably it showed that:

- attitudes to mental health problems tend to be characterised by ambivalence, with individuals holding both positive and negative views.
- men who have no qualifications and live in the most deprived areas of the country tend to hold the most negative attitudes to mental health problems
- attitudes also tend to be more negative than average among people past retirement age
- people with degree- or professional-level qualifications tend to hold the most liberal attitudes to mental health problems, although they are also the group most likely to agree that 'If I were suffering from a mental health problem, I wouldn't want people knowing about it.'

ANNEX H: MEDIATION ANALYSIS

H.1 Mediation analysis is used in the report to:

- explore whether and to what extent the relationship between a) socio-economic status and GHQ12 scores and b) socio-economic status and mental wellbeing can be explained by respondents' feelings of control over the factors affecting their mental health; and
- explore whether the relationship between socio-economic status and GHQ scores and mental wellbeing can be explained by respondents' level of trait optimism

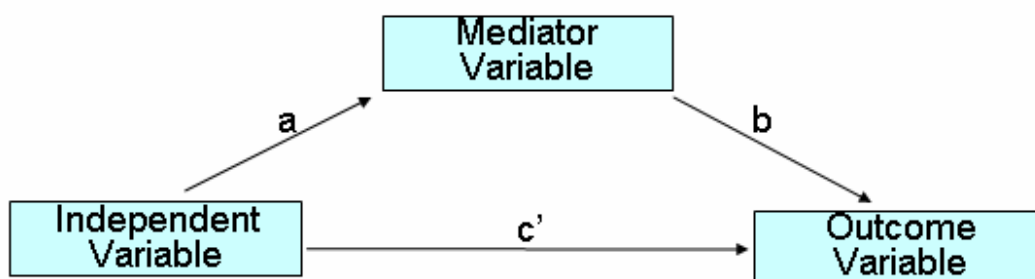
H.2 To provide a clear illustration of how mediation analysis works, the following comprises a worked example of the approach. The example aims to answer the following question:

Is the relationship between socio-economic status and mental wellbeing mediated by perceptions of control (over factors that influence wellbeing)?

H.3 For this analysis, a variant on linear regression known as mediation analysis is used. This technique was pioneered by Baron & Kenny in 1986 and builds a theoretical framework of how the affect of a predictor (i.e. independent) variable on an outcome variable can be mediated by an intermediate variable.

Principles of Mediation Analysis

H.4 The central idea in this model is that the effects of stimuli on behaviour are mediated by various intervening or 'mediating' factors, as illustrated below.



H.5 The diagram shows that:

- The direct impact of the independent variable on the outcome is 'c'.
- The impact of the mediator variable on the outcome is 'b'.
- The impact of the independent variable on the mediator variable is 'a'.

H.6 Three necessary conditions are required to be in place for mediation to exist:

1. The independent variable must affect the mediator
2. The independent variable must affect the outcome
3. The mediator must affect the outcome when regressed with the independent variable on the outcome.

H.7 Both socio-economic status and perceptions of control are thought to influence mental wellbeing in some way. It is proposed that socio-economic status has some direct influence on mental wellbeing, but this affect is mediated by the perceptions of control. In order to test this, the mediation model (above) is applied to these three variables, and the effects a , b and c' are measured.

H.8 The measure of socio-economic status (the independent variable) used in the analysis is income. The mediator variable in the example is respondents' feelings of control over factors affecting their mental health and wellbeing. The outcome variable is mental wellbeing (as measured by WEMWBS).

Application of Mediation Analysis

H.9 The idea behind mediation analysis is that when a relationship is tested between income and mental wellbeing, a proportion of the effect is due to income affecting the outcome directly, and a proportion of the effect is indirect and due to the effect that a separate variable (the 'mediator variable', which in this example is perception of control) has on the mental wellbeing.

H.10 If the effect of income on mental wellbeing is tested without accounting for any other influences, then we measure the total effect. By removing the effect that perception of control has on mental wellbeing, we find the unique effect that income has on the outcome.

H.11 Three conditions are tested and evaluated to test for this. Firstly, that income does indeed affect mental wellbeing. If not, then there is no relationship in the first place, and mediation is not relevant. Secondly, that income affects perception of control. Finally, that perception of control affects mental wellbeing, even after the effect of income is taken into account. If not, then whatever effect that income has on the perception of control, it is not going to have any knock-on effects on mental wellbeing, so no mediation can occur.

H.12 When all these conditions are in place, then we can assume the mediation model. The amount of mediation can be measured by assessing the effect of the driver on the outcome, then assessing the change in effect once the mediator is introduced into the equation.

Condition 1: The independent variable must affect the mediator variable

H.13 The income variable is regressed against the mediator variable in order to test condition 1 on income. The output below shows that there is a significant relationship with the mediator (at the 1% significance level).

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations		
		B	Std. Error	Beta			Zero-order	Partial	Part
1	(Constant)	3.350	.083		40.144	.000			
	bincom HOUSEHOLD INCOME (ANUALLY)	.083	.025	.114	3.349	.001	.114	.114	.114

a. Dependent Variable: rb3 B3 - Thinking about all those things that might affect your own emotions or mental health and well being, how much control, if any, do you feel you have over them?

Condition 2: The independent variable must affect the dependent variable (mental wellbeing)

H.14 The direct effect of the independent variable (income) on the outcome variable (mental wellbeing) is tested by regressing the dependent variable on the independent variable. The table below shows that a relationship between income and mental wellbeing exists.

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations		
		B	Std. Error	Beta			Zero-order	Partial	Part
1	(Constant)	44.646	.810		55.135	.000			
	bincom HOUSEHOLD INCOME (ANUALLY)	1.612	.241	.226	6.699	.000	.226	.226	.226

a. Dependent Variable: WEMWBS WEMWBS Score

Condition 3: The mediator variable must affect the outcome variable (mental wellbeing) in the presence of the independent variable

H.15 The mediation analysis is completed by regressing the outcome variable on both the mediator and independent variables. The mediation relationship is shown to exist if and only if the mediator variable is adjudged to affect mental wellbeing while controlling for income. Model 2 in the tables below shows that, even in the presence of the income, the mediator variable yields a t-statistic of above 10. This is very strongly significant.

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations		
		B	Std. Error	Beta			Zero-order	Partial	Part
1	(Constant)	44.600	.812		54.900	.000			
	bincom HOUSEHOLD INCOME (ANUALLY)	1.621	.241	.227	6.717	.000	.227	.227	.227
2	(Constant)	31.851	1.267		25.131	.000			
	bincom HOUSEHOLD INCOME (ANUALLY)	1.307	.223	.183	5.857	.000	.227	.199	.182
	rb3 B3 - Thinking about all those things that might affect your own emotions or mental health and well being, how much control, if any, do you feel you have over them?	3.811	.306	.389	12.446	.000	.409	.396	.386
3	(Constant)	35.163	1.157		30.399	.000			
	rb3 B3 - Thinking about all those things that might affect your own emotions or mental health and well being, how much control, if any, do you feel you have over them?	4.014	.310	.409	12.937	.000	.409	.409	.409

a. Dependent Variable: WEMWBS WEMWBS Score

Measuring the size of mediation

H.16 By simply subtracting the unstandardised coefficient of the independent variable in model 1 of the condition 3 tables (effect of income in isolation) from the corresponding variable in model 2 of the condition 3 tables (effect of income once the mediator is accounted for), the effect of mediation can be evaluated. The results are summarised here:

Outcome	Predictor	Total Effect	Mediated Effect	Mediation
WEMWBS	Income	1.621	1.307	19.4%

H.17 It can be concluded that perceptions of control (over factors that influence mental wellbeing) have a substantial (but not a total) mediation effect on the relationship between income and mental wellbeing.

ANNEX I: MENTAL HEALTH PROBLEM SCENARIOS – QUESTION BY QUESTION ANALYSIS

I.1 This annex comprises a question by question analysis of findings from the section of the questionnaire that focused on mental health problem scenarios.

I.2 There were six scenarios in total with the effect that each was considered by a relatively small sub-sample of respondents (c200). This point should be borne in mind when considering the aggregate level findings. To allow for sub-group analysis of the findings, the data for the 2002, 2004, 2006 and 2008 surveys have been combined, thus quadrupling the effective sample sizes (small sample sizes preclude sub-group analysis of the 2008 results alone).

Depression scenario

Scenario text

Male version

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

Female version

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

Causes of symptoms of depression

I.3 The main perceived causes of the symptoms in the depression scenario were stressful or disturbing events in Robert's/Shona's life, a chemical imbalance in the brain, physical illness and Robert's/Shona's own character or personality. However, over half of respondents also mentioned abuse Robert/Shona suffered as a child and a genetic or inherited problem. Causes mentioned comparatively less frequently were fate (29%) and Robert/Shona's own fault (14%). There were no differences between the results for the male and female versions of the scenarios.

I.4 Comparing the results with those from the previous ‘Well?’ survey, there has been an increase in the proportion attributing the symptoms in the female version of the scenario to the way Shona was brought up (from 33% to 48%). Among those shown the male version of the scenario, the proportion attributing the symptoms to abuse Robert suffered as a child has similarly increased (from 49% to 59%) (Table I.1).

Table I.1: Depression – likely causes

	% Likely							
	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
<i>Base: All presented with scenario</i>								
	%	%	%	%	%	%	%	%
Robert’s/Shona’s own character or personality	51	45	64	62	48	41	52	61
A chemical imbalance in the brain	64	66	67	71	69	69	62	69
The way Robert/Shona was brought up	45	37	39	45	36	44	33	48
Stressful or disturbing events in Robert’s/Shona’s life	93	92	88	90	92	93	87	85
Genetic or inherited problem	55	45	52	53	50	46	51	52
Abuse Robert/Shona suffered as a child	61	52	49	59	52	57	56	56
Fate	31	24	26	29	25	19	19	22
Physical illness	83	65	68	63	74	72	60	63
Robert’s/Shona’s own fault	21	21	19	14	14	13	9	15
The circumstances in which Robert/Shona lives	n/a	n/a	72	71	n/a	n/a	73	67

I.5 The high mention of stressful or disturbing events in the 2008 and earlier ‘Well?’ surveys is consistent with findings from a recent study of depression literacy in Alberta, Canada (Wang et al, 2007), in which 90% of respondents attributed depressive symptoms to ‘traumatic’ experiences. In other respects, however, the results of the two studies are quite different with higher proportions of the Canadian sample attributing depression to childhood abuse or a genetic or inherited problem. To some extent these differences may reflect the fact that the methodology for the two surveys differed, as did the scenario and question wording used.

I.6 Analysis of the combined data for all four ‘Well?’ surveys conducted to date revealed that older age groups were more likely than younger age groups to attribute the symptoms of depression to Robert’s/Shona’s own character or personality (male version: 72% of those aged 75 and over compared with 42% of those aged 25 to 34 years), the circumstance in which Robert/Shona lives (female version: 47% of those aged 75 and over compared with 26% of those aged 16 to 24 years) and fate (male version: 40% of those aged 75 and over compared with 24% of those aged 25 to 34 years). Younger age groups were more likely to think the symptoms were due to a chemical imbalance in the brain (female version: 82% of those aged 24 to 35 years

compared with 49% of those aged 75 and over) or stressful or disturbing events in Robert's/Shona's life (male version: 96% of those aged 25 to 34 years and 35 to 44 years compared with 82% of those aged 75 and over).

I.7 There was further variation by gender; men were more likely than women to mention the way Robert/Shona was brought up (female version: 45% versus 37%) while women were more likely than men to mention a chemical imbalance in the brain (male version: 71% versus 62%). Among those shown the female version of the scenario, men were more likely than women to suggest the symptoms were caused by Robert's/Shona's own character or personality (56% versus 45%) or Robert's/Shona's own fault (17% versus 9%). Among those shown the male version, women were more likely than men to mention abuse suffered as a child (59% versus 50%) and physical illness (74% versus 65%).

Most appropriate sources of support for the person in the depression scenario

I.8 Asked to consider the most appropriate sources of support for the person in the depression scenario, respondents most commonly suggested a family doctor, a qualified councillor or someone in the family. The next most common responses were someone with the same problem, a friend or neighbour and a psychiatrist. There were no differences depending on which version of the scenario respondents were shown.

I.9 Between 2006 and 2008, there were decreases in the proportions of respondents who felt that a male displaying symptoms of depression would best be supported by someone in the family, someone with the same problem, or a friend or neighbour, as table I.2 shows. At the same time, the proportion who felt that a female with symptoms of depression would best be supported by a psychiatrist increased.

Table I.2: Depression – most appropriate sources of support

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
A family doctor	66	71	72	65	56	65	64	60
Someone in the family	42	53	56	45	38	52	48	41
A qualified counsellor	59	51	44	51	58	47	52	54
A psychiatrist	29	26	29	27	33	26	21	30
Someone with the same problem	33	25	17	29	34	21	23	25
A friend or neighbour	23	17	18	28	28	36	24	28
A psychologist	15	17	18	19	20	15	21	18
A voluntary organisation/charity	7	11	14	12	11	16	9	4
A social worker	9	7	4	5	5	6	7	6
A nurse	3	3	1	4	3	4	5	8
A home help/carer	3	2	*	3	4	4	3	2
No one	1	2	1	-	-	2	3	-
None of these	-	-	-	-	-	-	-	-
Don't know	-	*	-	*	-	-	-	1

I.10 Younger respondents were more likely than older respondents to think a friend or neighbour (male version: 31% of those aged 16 to 24 years versus 16% of those aged 65 to 74 years) or someone else with the same problem (female version: 31% of those aged 16 to 24 years versus 14% of those aged 75 and over) would be the best person to help Robert/Shona. Older respondents were more likely to suggest that the best person to help Robert/Shona would be a family doctor (79% of those aged 65 to 70 years compared with 58% of those aged 16 to 24 years). There were no other sub-group differences.

Most appropriate place for person in the depression scenario to live

I.11 Three-quarters of respondents felt that the best place for the person in the depression scenario to live would be in their own, or their family's, home. This result has remained static on 2006 (table I.3). Respondents living in the least deprived areas (female: 87% versus 64% of those living in the most deprived areas) and those with degree-level qualifications (male: 90% versus 60% of those with no qualifications) were more likely than to think that the best place for Robert/Shona to live would be their own home.

Table I.3: Depression – most appropriate place for Robert/Shona to live⁴¹

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Their own (or family's) home	80	78	75	81	75	75
Special housing with professional support in the community	14	15	20	13	13	20
A residential or nursing home	1	1	3	1	3	1
A hospital	2	2	2	3	4	2
Don't know	3	4	*	2	5	2

Likelihood of person with symptoms of depression harming self/others

I.12 Respondents were divided on the question of whether the person in the depression scenario was likely to do something harmful or violent to him/herself: roughly equal proportions thought this likely as unlikely. At table I.4 shows, there were no differences depending on which version of the scenario respondents were shown and the results are in line with those recorded over previous waves of the survey.

Table I.4: Depression – Likelihood of doing harm to self

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	10	5	9	8	11	10	8	6
Somewhat likely	41	42	39	39	44	39	42	40
Somewhat unlikely	32	36	28	34	24	29	29	33
Very unlikely	11	11	14	13	18	17	15	14
Don't know	6	6	9	6	4	5	7	7

I.13 Relatively few respondents thought the person in the depression scenario was likely to do something harmful or violent to others. Again, the figures have remained stable on 2006, despite an increase between 2004 and 2006 in the proportion who thought it likely that a male with depression might do something harmful or violent to others (table I.5).

⁴¹ In 2002, the response categories used in the question differed to those adopted for subsequent waves meaning the results are not directly comparable. They are therefore excluded from this table and from the inter-wave sub-group analysis.

Table I.5: Depression – Likelihood of doing harm to others

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	*	1	2	3	1	3	1	3
Somewhat likely	21	10	17	14	11	10	14	9
Somewhat unlikely	41	41	31	40	39	36	32	43
Very unlikely	33	40	40	36	46	48	48	40
Don't know	5	7	10	7	3	4	5	5

Willingness to interact with the person in the depression scenario

I.14 A majority of respondents shown the depression scenarios said they would be willing to move next door to Robert/Shona, make friends with them, spend an evening socialising with them, work closely with them and move next door to them. However, fewer than half said they would be willing to have Robert/Shona marry into their family or provide childcare for someone in their family. In the 2006 survey, respondents were generally more willing to interact with a female showing symptoms of depression than with a male showing the same symptoms. No such differences were apparent in 2008, however (Table I.6).

I.15 Reflecting this, there has been a notable increase in the proportion of those shown the male version of the scenario who would be willing to spend an evening socialising with Robert or work closely with him.

Table I.6: Depression – willingness to interact with someone displaying symptoms

<i>Base: All presented with scenario</i>	% Willing							
	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Move next door to Robert/Shona	62	79	65	65	74	75	70	62
Spend evening socializing with Robert/Shona	67	75	60	75	68	81	79	73
Make friends with Robert/Shona	75	82	71	78	74	86	82	76
Work closely with Robert/Shona	61	73	54	68	54	80	70	63
Have Robert/Shona marry into the family	32	49	34	40	46	57	47	42
Do Robert/Shona a favour if they asked you to	88	90	88	92	88	92	94	88
Have Robert/Shona provide childcare for someone in your family (e.g. babysitting)	n/a	23	15	21	n/a	28	21	17

I.16 Age was a significant variable concerning willingness to interact with Robert/Shona. Younger people were more likely than older people to be willing to move next door to Robert/Shona (female version: 76% of those aged 25 to 34 years compared to 48% of those aged 75 and over), to spend an evening socialising with them (male version: 75% of those aged 35 to 44 years compared to 49% of those aged 75 and over), to work closely with them (male: 70% of those aged 25 to 34 years compared to 37% of those aged 75 and over), and to have them marry into the family (female version: 61% of those aged 35 to 44 years compared to 26% of those aged 65 to 74 years).

I.17 Women were more willing than men to make friends with Robert/Shona (female version: 86% versus 75%), and work closely with them (male: 67% versus 59%). Among those shown the female version of the scenario, women were also more likely than men to move next door to Shona (76% versus 65%), spend an evening socialising with her (83% versus 69%), and have her marry into the family (54% versus 42%).

I.18 There were also differences by experience of mental health problems. Those who had personal experience of a problem were more likely than those who did not to be willing to move next door to Robert/Shona (male version: 79% versus 70%), and work closely with them (female version: 81% versus 69%).

Freedoms and rights of person showing symptoms of depression

I.19 Around three in five respondents thought it unlikely that Robert's/Shona's freedoms and rights might have to be limited because of their symptoms, while around two in five thought it likely. These results are very similar to those recorded in 2006 (Table I.7).

Table I.7: Depression – likelihood that Robert's/Shona's freedoms and rights might have to be limited

	Male scenario		Female scenario	
	2006	2008	2006	2008
<i>Base: All presented with scenario</i>				
	%	%	%	%
Very likely	6	5	4	7
Fairly likely	32	34	31	27
Not very likely	26	30	27	34
Not at all likely	27	26	30	24
Don't know	10	5	8	7

Ability to diagnose symptoms of depression

I.20 Respondents were asked to select, from a list of options, the condition that was most likely to have caused the symptoms in the depression scenario. As table I.8 shows a majority – 76% of those shown the male version of the scenario and the same proportion of those shown the female version – gave the correct diagnosis. This figure is consistent with the result from previous 'Well?' surveys (Table I.8) and from the Canadian study, cited above (76%).

Table I.8: Depression – Diagnosis

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Alzheimer's Disease/dementia	-	-	1	-	1	*
Anxiety disorder	6	3	4	2	5	3
Depression	69	69	76	75	75	76
Eating disorder (anorexia, bulimia)	-	-	-	-	1	-
Manic depression	5	5	3	4	3	3
Nervous breakdown	6	6	6	7	5	1
Obsessive compulsive disorder	-	1	-	-	*	-
Panic attacks	1	-	1	*	*	*
Personality disorder	5	2	4	2	1	5
Phobia	-	*	-	*	-	-
Post-natal depression	-	-	-	2	2	*
Post-traumatic stress disorder	n/a	1	1	n/a	*	-
Schizophrenia	1	1	1	1	1	2
Self-harm	-	-	*	*	*	-
Severe stress	5	3	3	3	4	5
Don't know	*	*	2	1	*	4

I.21 Respondents educated to degree level were more likely than those with no qualifications to diagnose the symptoms correctly (male version: 91% versus 66%).

I.22 There was no other socio-demographic based variation but it is worth noting that people who gave the correct diagnosis were among those most willing to move next door to Robert/Shona, spend an evening socialising with them, make friends with them, start working closely with them and have them marry into the family. In contrast, people who gave an *incorrect* diagnosis were among those most likely to agree that people with a mental health problem are often dangerous and that the public should be better protected from people with mental health problems. These findings suggest that improving mental health literacy may help to promote more positive attitudes to people with mental health problems.

Schizophrenia scenario

Scenario text

Schizophrenia (male)

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

Schizophrenia (female)

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

Causes of symptoms of schizophrenia

I.23 Overall, respondents felt that the most likely causes of the symptoms in the schizophrenia scenario were stressful or disturbing events in Robert's/Shona's life and a chemical imbalance in the brain. However, a majority also mentioned Robert's/Shona's own character or personality, abuse Robert/Shona suffered as a child, a genetic or inherited problem and physical illness. As can be seen from table I.9, respondents shown the male version of the scenario were more likely than those shown the female version to attribute the symptoms to character or personality.

I.24 These results are in line with those from the previous surveys, despite an increase between 2004 and 2006 in the proportion suggesting that the symptoms in the male version of the scenario were attributable to Robert's own character or personality.

Table I.9: Schizophrenia – likely causes

	% Likely							
	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
<i>Base: All presented with scenario</i>								
	%	%	%	%	%	%	%	%
Robert's/Shona's own character or personality	56	51	75	68	60	50	52	57
A chemical imbalance in the brain	75	76	73	74	77	78	67	70
The way Robert/Shona was brought up	49	48	45	41	41	38	42	48
Stressful or disturbing events in Robert's/Shona's life	90	90	91	87	89	94	91	86
Genetic or inherited problem	62	57	63	57	60	58	58	58
Abuse Robert/Shona suffered as a child	59	63	59	60	61	64	59	61
Fate	26	24	27	22	24	23	18	25
Physical illness	58	56	54	55	68	59	50	54
Robert's/Shona's own fault	15	12	20	12	18	9	11	14
The circumstances in which Robert/Shona lives	n/a	n/a	78	54	n/a	n/a	65	63

I.25 Men were more likely than women to attribute the symptoms in the schizophrenia scenario to Robert's/Shona's character or personality (male version: 38% versus 21%), while women were more likely to attribute the symptoms to a chemical imbalance in the brain (male version: 79% versus 71%). Among those shown the male version of the scenario, men were more likely than women to attribute the symptoms to stressful or disturbing events in Robert's life (92% versus 87%).

I.26 There were few other notable sub-group differences but the oldest group of respondents were among those most likely to attribute the symptoms to Robert's/Shona's character or personality (50% of people aged 75 years and over, compared with, for example, 19% of people aged 25 to 34 years). Meanwhile, among those shown the female version of the scenario, people with personal or proxy experience of a mental health problem were more likely than those with no such experience to attribute the symptoms to a chemical imbalance in the brain (79% and 80% versus 71% respectively). Those with personal experience of a problem were also *less* likely than those with no such experience to suggest the symptoms were Robert's/Shona's own fault (9% versus 15%).

Most appropriate sources of support for the person in the schizophrenia scenario

I.27 A family doctor was generally seen as the most appropriate source of support for the person in the schizophrenia scenario but a family member a qualified councillor and a psychiatrist were also commonly mentioned. More respondents

shown the male version of the scenario than the female version mentioned someone in the family. The results are very much in line with those for 2006, as table I.10 illustrates.

Table I.10: Schizophrenia – most appropriate sources of support

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
A family doctor	55	60	56	54	55	55	55	52
Someone in the family	42	39	56	51	31	36	43	39
A qualified counsellor	47	53	46	46	53	50	43	40
A psychiatrist	52	50	46	41	46	48	49	50
Someone with the same problem	21	18	19	20	28	25	16	24
A friend or neighbour	15	16	17	23	19	17	25	22
A psychologist	27	26	21	25	26	30	23	25
A voluntary organisation/charity	4	12	8	10	8	11	10	12
A social worker	12	6	9	7	5	10	10	9
A nurse	4	3	5	3	5	5	2	3
A home help/carer	9	3	3	9	6	2	2	8
No one	*	-	-	-	*	-	-	-
None of these	-	-	-	*	-	-	-	-
Don't know	*	2	*	2	-	-	-	1

I.28 Men were more likely than women to suggest that the person in the schizophrenia scenario could best be helped by a family member (male version: 53% versus 43%), whereas women were more likely to suggest a qualified counsellor (male version: 54% versus 41%).

Most appropriate place for person in the schizophrenia scenario to live

I.29 Most respondents felt that the best place for the person in the schizophrenia scenario to live would be in their own or their family's home, but the figure was appreciably lower than in the case of the depression scenario. Indeed, around a third felt that the person in the schizophrenia scenario should live in special housing with professional support in the community. There were no differences depending on which version of the scenario respondents were shown and the results are largely unchanged since the previous survey (Table I.11).

Table I.11: Schizophrenia – most appropriate place for Robert/Shona to live

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Their own (or family's) home	58	54	53	61	58	53
Special housing with professional support in the community	30	33	33	31	30	37
A residential or nursing home	4	3	5	4	2	3
A hospital	3	5	6	3	5	4
Don't know	4	4	3	1	4	2

I.30 Mention of special housing was highest among people aged 75 and over (male version: 36% compared with 16% of people aged 16 to 24 years) and those with no personal or proxy experience of a mental health problem (male version: 30% versus 16% of those with personal experience of a problem). Among those shown the female version of the scenario, people aged 75 and over were more likely than younger groups to mention a residential or nursing home (18% versus 0% of people aged 16 to 24 years).

Likelihood of person with symptoms of schizophrenia harming self/others

I.31 Sixty per cent of those shown the male version of the scenario and 64% of those shown the female version felt that the person in the schizophrenia scenario was likely to do something harmful or violent to themselves. Again these results are consistent with those for 2006 (table I.12).

Table I.12: Schizophrenia – Likelihood of doing harm to self

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	10	11	12	8	18	11	12	17
Somewhat likely	54	56	54	52	50	55	53	47
Somewhat unlikely	22	20	14	18	19	26	14	22
Very unlikely	12	5	8	12	8	4	10	9
Don't know	3	8	12	9	5	3	12	6

I.32 Around a third of respondents felt that the person in the schizophrenia scenario was likely to do something harmful or violent to others. Among those shown the female version of the scenario, the figure has increased since 2006 (from 22% to 35%), bringing it back to the level recorded in 2004.

I.33 Among those shown the male version of the scenario, younger groups were more likely than people aged 55 and over to think that Robert might do something harmful to himself (77% of those aged 16 to 24 years, compared with 38% of those aged 75 and over) or others (53% versus 25%). There were no other notable subgroup differences for this measure.

Table I.13: Schizophrenia – Likelihood of doing harm to others

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	4	5	4	5	5	5	5	4
Somewhat likely	35	35	33	27	31	27	17	31
Somewhat unlikely	37	34	27	37	36	42	37	36
Very unlikely	21	20	22	21	21	22	27	22
Don't know	4	6	13	10	6	4	15	7

Willingness to interact with the person in the schizophrenia scenario

I.34 A majority of respondents were willing to interact with the person in the schizophrenia scenario under a range of circumstances. Specifically, most said they would be willing to do Robert/Shona a favour, make friends with them, spend an evening socialising with them and work closely with them. Again, however, the figures are generally lower than those recorded for the depression scenario. Most notably, only around one in ten respondents said they would be happy for the person in the schizophrenia scenario to provide childcare for someone in their family.

I.35 As can be seen in table I.14, the results for the male and female version of the schizophrenia scenario are much more consistent than was the case in the previous surveys. Indeed, the only notable difference that emerges is that respondents were more willing to make friends with a female displaying symptoms of schizophrenia than with a male displaying the same symptoms.

Table I.14: Schizophrenia – willingness to interact with someone displaying symptoms

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Move next door to Robert/Shona	62	58	58	52	68	74	61	54
Spend evening socializing with Robert/Shona	68	65	57	60	75	74	68	65
Make friends with Robert/Shona	66	76	64	62	81	80	72	72
Work closely with Robert/Shona	63	63	50	55	65	72	66	63
Have Robert/Shona marry into the family	28	27	26	33	42	44	36	34
Do Robert/Shona a favour if they asked you to	91	88	84	84	94	94	85	87
Have Robert/Shona provide childcare for someone in your family (e.g. babysitting)	n/a	10	10	10	n/a	23	15	11

I.36 Older people were more *unwilling* than younger groups to work closely with Robert/Shona (male version: 34% of people aged 75 and over versus 16% of people aged 16 to 24 years), have them marry into the family (66% versus 22%) and have them provide childcare for someone in their family (77% versus 41%).

I.37 People with no personal experience of a mental health problem were more unwilling than those with such experience to work closely with Robert/Shona (male version: 20% versus 13%), have them marry into the family (40% versus 32%), and have them provide childcare for someone in their family (66% versus 49%).

I.38 Among those shown the female version of the scenario, women were more willing than men to spend an evening socialising with Shona (75% versus 66%), make friends with her (78% versus 70%) or start working closely with her (71% versus 62%).

Freedoms and rights of person showing symptoms of schizophrenia

I.39 A majority of respondents – 59% of those shown the male version of the scenario and 65% of those shown the female version – felt it likely that Robert’s/Shona’s freedoms and rights might have to be limited. Around a third in each case thought this unlikely. These results are the virtual reverse of those recorded for the depression scenario (table I.15).

I.40 Among those shown the female version of the scenario, there has been an increase since 2006 in the proportion who felt Shona’s freedoms and rights might have to be limited (from 52% to 65%).

I.41 There were no notable sub-group differences for this measure.

Table I.15: Schizophrenia – likelihood that Robert’s/Shona’s freedoms and rights might have to be limited

<i>Base: All presented with scenario</i>	Male scenario		Female scenario	
	2006	2008	2006	2008
	%	%	%	%
Very likely	13	14	7	16
Fairly likely	38	45	45	49
Not very likely	23	23	20	21
Not at all likely	11	10	14	8
Don’t know	16	8	14	6

Ability to diagnose symptoms of schizophrenia

I.42 As in 2006, fewer than half of respondents were able to correctly diagnose the symptoms of schizophrenia. Indeed, around one in ten attributed the symptoms to depression or a nervous breakdown. A similar proportion felt unable to give a response (table I.16).

Table I.16: Schizophrenia – Diagnosis

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Alzheimer’s Disease/dementia	1	1	*	*	1	1
Anxiety disorder	6	8	4	6	3	7
Depression	10	17	21	17	19	12
Eating disorder (anorexia, bulimia)	-	*	-	-	1	-
Manic depression	6	4	6	4	8	4
Nervous breakdown	11	11	11	12	10	12
Obsessive compulsive disorder	2	2	1	3	1	2
Panic attacks	3	1	1	1	2	1
Personality disorder	8	7	9	8	4	5
Phobia	1	1	*	3	1	-
Post-natal depression	-	*	-	1	1	-
Post-traumatic stress disorder	n/a	*	2	n/a	2	-
Schizophrenia	44	35	37	36	39	45
Self-harm	-	1	-	-	1	2
Severe stress	4	2	1	6	2	3
Don’t know	1	4	5	-	1	9

I.43 Women were more likely than men to correctly diagnose schizophrenia (Male version: 34% versus 22%), while older respondents were among those most likely to attribute to the symptoms to depression (male version: 23% of people aged 75 and over versus 8%).

I.44 As in the case of depression, people with degree-level qualifications were more likely than those with no qualifications to give the correct diagnosis (male version: 58% versus 24%).

I.45 Again, there was also a relationship between respondents' diagnoses and their attitudes towards people with mental health problems. Those who gave the correct diagnosis were less likely than average to agree that the public should be better protected from people with mental health problems, that people with mental health problems are often dangerous, and *more* likely to agree that people with mental health problems should have the same rights as anyone else. They were also more willing to do Robert/Shona a favour or have them provide childcare for someone in their family.

Stress scenario

Scenario text

Male version

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

Female version

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

Causes of symptoms of stress

I.46 The main cause of the symptoms in the stress scenario was felt to be stressful or disturbing events in Robert's/Shona's life, although a majority of respondents also mentioned Robert's/Shona's own character or personality, the circumstances in which Robert/Shona lives, a chemical imbalance in the brain and physical illness.

I.47 These findings are broadly consistent with the 2006 results. However, whereas more of those shown the male version of the scenario than the female version mentioned Robert/Shona's upbringing in 2006, no such difference emerged in 2008 (table I.17).

Table I.17: Stress – likely causes

	% Likely							
	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
<i>Base: All presented with scenario</i>								
	%	%	%	%	%	%	%	%
Robert's/Shona's own character or personality	69	56	67	74	71	56	68	73
Chemical imbalance in the brain	57	57	53	62	56	54	56	56
The way Robert/Shona was brought up	48	45	42	50	46	39	52	51
Stressful or disturbing events in Robert's/Shona's life	90	88	87	90	85	84	89	87
Genetic or inherited problem	51	44	46	49	46	42	44	48
Abuse Robert/Shona suffered as a child	52	50	47	46	46	44	49	43
Fate	28	30	28	27	29	37	27	24
Physical illness	61	55	60	60	69	64	54	62
Robert's/Shona's own fault	20	21	23	20	21	19	16	19
The circumstances in which Robert/Shona lives	n/a	n/a	73	71	n/a	n/a	76	74

I.48 There were few sub-group differences in the findings but among those shown the male version of the scenario, men were more likely than women to attribute the symptoms to a character or personality disorder (71% versus 63%) or the way Robert was brought up (53% versus 41%). Among those shown the female version of the scenario, more men than women attributed the symptoms to a genetic or inherited problem (50% versus 42%).

Most appropriate sources of support for the person in the stress scenario

I.49 As in the case of the depression and schizophrenia scenarios, a family doctor, a family member and a qualified councillor were seen as being the most appropriate people to help Robert/Shona. However, there was some variation depending on which version of the scenario respondents were shown. Those shown the male version were more likely than those shown the female version to mention a psychiatrist or a psychologist, while those shown the female version were more likely to mention a friend or neighbour.

I.50 Comparing the results with those from 2006, the proportions who felt that the best person to help a male with symptoms of stress would be a psychologist or a psychiatrist has increased. At the same time, the proportion who felt that a psychologist would be the best person to help a female with the same symptoms has decreased (table I.18).

Table I.18: Stress – most appropriate sources of support

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
A family doctor	63	64	62	62	66	58	61	65
Someone in the family	47	53	60	54	41	48	50	52
A qualified counsellor	53	47	44	46	52	42	44	50
A psychiatrist	27	25	18	27	22	20	19	16
Someone with the same problem	37	29	23	24	28	31	24	22
A friend or neighbour	22	31	28	28	33	45	43	42
A psychologist	16	15	18	21	19	15	17	10
A voluntary organisation/charity	6	5	9	9	12	8	8	7
A social worker	8	5	10	5	8	8	9	5
A nurse	2	3	1	3	4	2	4	3
A home help/carers	5	4	2	3	6	3	3	3
No one	*	*	-	-	-	1	-	-
None of these	-	-	-	-	-	-	-	-
Don't know	-	1	1	1	-	1	1	1

I.51 Among those shown the male version of the scenario, more men than women suggested that Robert would best be helped by a social worker (10% versus 5%), whereas more women suggested a qualified counsellor (51% versus 43%). Meanwhile, younger respondents were more likely than older groups to suggest someone in the family (70% of people aged 16 to 24 years, compared with 45% of people aged 75 and over), while the oldest groups were more likely to mention a psychiatrist (36% of people aged 75 and over compared with 18% of people aged 16 to 24 years).

I.52 Of those respondents shown the female version of the scenario, women were more likely than men to suggest that Shona would best be helped by a doctor (67% versus 59%) while people with personal experience of a mental health problem were more likely than those with no such experience to suggest Shona would best be helped by someone with the same problem (35% versus 27%).

Most appropriate place for the person in the stress scenario to live

I.53 A large majority of respondents felt that the best place for the person in the stress scenario to live would be in their own, or their family’s home, consistent with the result for the 2006 survey (table I.19).

Table I.19: Stress – most appropriate place for Robert/Shona to live

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Their own (or family's) home	84	83	86	82	81	88
Special housing with professional support in the community	10	12	11	14	12	9
A residential or nursing home	1	-	1	1	3	2
A hospital	1	*	1	-	1	*
Don't know	2	3	2	-	*	1

I.54 There were very few sub-groups differences in the findings but people aged 75 and over were much more likely than younger groups to suggest that someone with symptoms of stress should live in special housing. This difference was most marked for the female version of the scenario (35% versus 4% of people aged 16 to 24 years).

Likelihood of person with symptoms of stress harming self/ others

I.55 The majority of those shown the stress scenario thought it unlikely that Robert/Shona might do something harmful or violent to themselves. There were no differences depending on the gender of the person in the scenario and the results have remained stable since 2006.

Table I.20: Stress – Likelihood of doing harm to self

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	3	2	5	2	6	1	1	1
Somewhat likely	21	19	17	19	17	20	23	16
Somewhat unlikely	44	47	44	48	39	45	31	43
Very unlikely	30	26	26	27	33	27	39	34
Don't know	2	7	9	4	6	7	6	6

I.56 Consistent with the findings in table I.20, very few respondents thought it likely that the person in the stress scenario would do something harmful or violent to others. Again, the results are in line with those for 2006.

Table I.21: Stress – Likelihood of doing harm to others

<i>Base: All presented with scenario</i>	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
	%	%	%	%	%	%	%	%
Very likely	2	1	3	2	1	*	1	1
Somewhat likely	13	11	15	11	11	9	9	7
Somewhat unlikely	40	44	29	39	31	43	31	36
Very unlikely	43	38	44	45	51	42	52	52
Don't know	2	6	8	3	6	6	6	6

Willingness to interact with the person in the stress scenario

I.57 More so than in the cases of depression and schizophrenia, respondents were generally willing to interact with someone displaying symptoms of stress. Indeed around nine in ten were willing to do Robert/Shona a favour and around seven in ten were willing to move next door to them, spend an evening socialising with them, make friends with them and work closely with them. Still, less than half were willing to have Robert/Shona provide childcare for someone in their family.

I.58 Once again, variation by the gender of the person in the scenario was much less apparent than in the 2006 survey. Indeed, the 2008 data suggests that there are no circumstances under which people would rather interact with a female displaying symptoms of stress, than with a male displaying the same symptoms (table I.22).

Table I.22: Stress – willingness to interact with someone displaying symptoms

	Male scenario				Female scenario			
	2002	2004	2006	2008	2002	2004	2006	2008
<i>Base: All presented with scenario</i>	%	%	%	%	%	%	%	%
Move next door to Robert/Shona	82	79	67	71	77	82	75	74
Spend evening socializing with Robert/Shona	79	79	75	74	87	84	78	75
Make friends with Robert/Shona	87	86	81	77	92	88	80	81
Work closely with Robert/Shona	82	78	67	67	74	80	71	71
Have Robert/Shona marry into the family	54	52	47	49	56	67	53	50
Do Robert/Shona a favour if they asked you to	95	94	85	92	97	95	93	91
Have Robert/Shona provide childcare for someone in your family (e.g. babysitting)	n/a	33	26	29	n/a	41	34	37

I.59 The oldest groups of respondents were more *unwilling* than younger groups to work closely with Robert/Shona (male version: 21% of people aged 75 and over compared with 5% of people aged 16 to 24 years) and have them provide childcare for someone in their family (63% versus 21%). Similarly, significantly fewer older than younger respondents said they would be willing to have Robert/Shona marry into the family (28% versus 65%).

I.60 There were few other sub-group differences but people with no personal or proxy experience of a mental health problem were more unwilling than those with personal experience of a problem to have Robert/Shona provide childcare for someone in their family (Male version: 44% versus 30%).

Freedom and rights of person showing symptoms of stress

I.61 Twenty-nine per cent of those shown the male version of the stress scenario and 20% of those shown the female version thought Robert's/Shona's freedoms and rights might have to be limited because of their condition. These figures are lower than the comparable results for both the depression and schizophrenia scenarios.

I.62 However, since 2006, there has been an increase in the proportion of respondents suggesting that a male displaying symptoms of stress might have to have their freedoms and rights limited (table I.23). Among those shown the female version, the results have remained stable.

Table I.23: Stress – likelihood that Robert's/Shona's freedoms and rights might have to be limited

<i>Base: All presented with scenario</i>	Male scenario		Female scenario	
	2006	2008	2006	2008
	%	%	%	%
Very likely	2	6	5	3
Fairly likely	16	23	21	17
Not very likely	31	30	31	38
Not at all likely	40	36	35	38
Don't know	11	5	9	5

I.63 People aged 75 and over were among those most likely to suggest that Robert's/Shona's freedoms might have to be limited (male version: 27% compared with 6% of people aged 16 to 24 years).

Ability to diagnose symptoms of stress

I.64 As in the 2006 surveys, only around one in ten respondents who were shown the stress scenario were able to diagnose the symptoms described correctly. Around half suggested Robert/Shona was suffering from depression, while around one in five suggested he/she had an anxiety disorder. There was no sub-group variation in the findings and no relationship was observed between respondents' diagnoses and their wider attitudes to people with mental health problems (table I.24).

Table I.24: Stress – Diagnosis

<i>Base: All presented with scenario</i>	Male scenario			Female scenario		
	2004	2006	2008	2004	2006	2008
	%	%	%	%	%	%
Alzheimer's Disease/dementia	1	-	1	*	-	*
Anxiety disorder	17	17	17	16	21	22
Depression	48	50	52	50	46	48
Eating disorder (anorexia, bulimia)	-	*	-	*	-	-
Manic depression	*	2	1	2	2	-
Nervous breakdown	7	4	5	4	6	4
Obsessive compulsive disorder	*	-	2	-	-	*
Panic attacks	2	1	1	1	3	5
Personality disorder	3	2	1	3	1	2
Phobia	-	-	-	-	*	-
Post-natal depression	-	*	-	1	-	2
Post-traumatic stress disorder	n/a	*	1	n/a	1	1
Schizophrenia	1	-	3	1	1	-
Self-harm	-	2	-	*	-	-
Severe stress	15	11	12	17	13	11
Don't know	*	3	3	-	1	5

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