Attitudes to Mental Health in Scotland: Scottish Social Attitudes Survey 2013

Health and Social Care

Attitudes to Mental Health in Scotland: Scottish Social Attitudes Survey 2013

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Responsibility for the opinions expressed in this report, and for all interpretation of the data, lies solely with the authors.

Susan Reid, Stephen Hinchliffe & Jennifer Waterton

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EXECUTIVE SUMMARY

1. This report presents findings on three questions relating to public attitudes to mental health:
   - How have attitudes to people with mental health problems changed over time?
   - What factors are related to people's attitudes towards people with mental health problems?
   - For those with direct experience of mental health problems, what have the social impacts been, what has helped or hindered their recovery, and have they received positive messages about their recovery?

2. The report uses data collected on the Scottish Social Attitudes (SSA) survey between June and October 2013. To address the question of change over time, SSA 2013 data are compared with data collected on four separate occasions (in 2002, 2004, 2006 and 2008) as part of the National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems. This survey series is referred to in what follows as the Well? survey(s). Methodological changes were implemented between the Well? survey series and SSA 2013. There were changes to the method of data collection for questions asked of those who had experienced mental health problems (face-to-face in the Well? series and self-complete in SSA 2013). There were also some alterations to question wording and question ordering. This means that findings on change over time should be treated with caution.

Knowing someone with a mental health problem

3. Around two-thirds of people said they knew someone who had 'ever experienced a mental health problem' (65%), a similar proportion to that found in both the 2006 and 2008 Well? surveys. This figure rose to almost 8 in 10 (79%) when people were asked whether they knew someone with any of 15 specific listed conditions.

4. Fifty-one percent of people said they knew someone who had experienced depression and nearly a third (30%) that they knew someone with dementia. Over a quarter (27%) knew someone who had experienced panic attacks and slightly under a quarter (23%) knew someone who had experienced an anxiety disorder. The proportions knowing someone with depression, dementia, or anxiety disorder have all increased significantly (by between 6% and 10%) since 2008.

Personal experience of mental health problems

5. A quarter of people (26%) said they had personally experienced a mental health problem at some point in their life time. This is consistent with the levels found in previous Well? surveys when the proportion ranged between 26% and 28% from 2002 to 2008. When people were asked whether a doctor or health professional had ever told them that they had a specific mental health problem, chosen from a list of 15 different types of mental health problems, this figure rose to almost one third (32%).

6. The most commonly cited mental health problem people had experienced was depression, with around 1 in 5 (21%) saying they had experienced depression at some point in their lives. The next most common conditions mentioned were panic attacks (9%) and anxiety disorders (8%). These were also the three most commonly mentioned problems in the 2008 Well? survey. The proportions who said they had experienced depression, anxiety disorder, or indeed any form of anxiety or stress disorder, had increased (by 4% in each case) since 2008.

7. Gender, age and income were all significantly related to the reported prevalence of mental health problems. In particular, women were more likely than men to say they had experienced a mental health problem (36% compared with 27%); people over 55 years were the age group least likely to say they had experienced a mental health problem (23%); and those in the lowest income group were more likely than those in the highest income group (41% compared with 25%) to have experienced a mental health problem.

Telling others about mental health problems and their social impacts

8. Among those who identified themselves as having experienced a mental health problem, 85% had told someone about it, a similar proportion to 2006 (85%) and 2008 (88%). In 2013, as in previous years, people were most likely to have told family and friends (more than 4 out of 5) with much smaller numbers having told their manager or boss (around 1 in 5) or a colleague (around 1 in 6).

9. Over one third of people (37%) who identified as having experienced a mental health problem had experienced some negative social impact (for example they had been discouraged from attending an event, been refused a job, or been verbally or physically abused). This was an increase from 2008, when the equivalent figure was 23% and a return to the level recorded in 2004 (36%).

10. In 2013 13% of people said they had been discouraged from attending an event by someone else. However, when asked whether they themselves had decided to avoid a social event because of the way they thought people would treat them, a substantially larger proportion (22%) said they had done so.

Recovery for those who had experienced mental health problems

11. In 2013 those who had experienced a problem were asked to identify the two or three most important factors that supported their recovery. The five factors chosen most often were: medication (42%); ‘support from family or friends’ (41%); ‘other forms of treatment/therapy (e.g. psychology, counselling, alternative treatments, support groups)’ (27%); ‘developing my own coping strategies’ (26%); and ‘finding out more about mental health (e.g. through support groups, leaflets, web information)’ (19%).

12. There have been quite substantial changes since 2008 in the factors chosen as supporting an individual’s recovery. In particular, there has been a sharp decline in the proportion choosing ‘family or friends’ (from 62% in 2008 to 41% in 2013) and choosing ‘having belief in myself’ (from 31% in 2008 to 15% in

2013). By contrast, there has been a substantial increase in the proportion selecting ‘other forms of treatment/therapy’ (from 19% in 2008 to 27% in 2013) and ‘finding out more about mental health’ (from 8% in 2008 to 19% in 2013).

13. In 2013 the five factors chosen most often as hindering people’s recovery by respondents with experience of a mental health condition were: ‘not acknowledging I had a problem’ (18%); ‘not understanding what was going on’ (16%); ‘not feeling able to tell people about my mental health problem’ (15%); ‘continuing to experience symptoms’ (13%); and ‘negative attitudes of people around me’ (11%). There has been very little change over time in relation to the factors that people regard as hindering their own recovery.

14. People with experience of a mental health problem were asked, ‘What does recovery mean to you?’, and given a list of response options. In 2013, the five most commonly chosen answer options were: ‘having a satisfying and fulfilling life’ (55%); ‘getting back to normal’ (46%); ‘taking charge of my life again’ (44%); ‘feeling able to cope in general’ (37%); and ‘getting more sleep’ (20%).

15. People with experience of a mental health problem were also asked to what extent professionals (nurses, doctors, support workers, etc.), and family and/or friends, gave them positive or negative messages about their recovery. Two-thirds (65%) received either a completely or mainly positive message from professionals. This is similar to the level recorded in 2006 (66%), but lower than in 2008 (73%). In relation to messages from family and/or friends, the proportion receiving a positive message declined, from 76% in 2006 and 79% in 2008 to 66% in 2013.

16. In 2013, a higher proportion of people said their family and/or friends gave them a completely positive message about their recovery (36%) than said the same about professionals (28%).

Knowledge, understanding and awareness of mental health problems

17. There is a great deal of consensus around the statement that ‘anyone can suffer from mental health problems’. Between 2002 and 2013 this figure has fluctuated between 93% and 98%, with a figure of 98% being recorded both in 2002 and in 2013. People also agree to a very large extent that those with mental health problems are not to blame for their condition. The figures have been fairly stable since 2002; in 2013, 89% disagreed that ‘people with mental health problems are largely to blame for their own condition’.

18. One-third (33%) agreed with the statement that ‘the majority of people with mental health problems recover’. This has fallen from 50% who agreed with this statement in 2002. In 2013, the proportion agreeing with this statement was substantially higher for those with personal experience of a mental health problem (44% of this group compared with 30% who had no personal experience).

Stigmatisation of people with mental health problems

19. Almost half (47%) said that if they were suffering from mental health problems, they 'wouldn't want people knowing about it'. This figure has ranged between 41% and 50% since 2002 but there has been no consistent pattern to the variation over time.

20. Around one in six (17%) said that they would find it difficult to talk to someone with a mental health problem, a figure which has been fairly stable since 2002. Those who were more likely to say they would find this difficult included men, those aged 65 or above, the self-employed, those with no educational qualifications, and those who did not know anyone who has experienced a mental health problem.

Individual and public rights of people with mental health problems

21. Nineteen percent agreed with the statement that 'people with mental health problems are often dangerous'. This figure was much higher in 2002 (32%) and since then has fluctuated between 15%-19%. Over a quarter (27%) of those who did not know anyone who had experienced a mental health problem held this view, compared with 15% who knew someone.

22. Over a quarter (28%) agreed that 'the public should be better protected from people with mental health problems'. This figure has fluctuated between 24%-35% over the period 2002-2013 with the highest figure recorded in 2002. Again, knowing someone who had experienced a mental health problem reduced the likelihood of agreeing the public should be better protected (24% of those who knew someone who had experienced a mental health problem, compared with 36% who did not).

23. More than 4 in 5 people (82%) agreed that 'people with mental health problems should have the same rights as anyone else'. The figure in 2013 is lower than when it was first recorded in 2002 (88%) and slightly lower than the 2008 figure (86%). However, it would require further evidence to establish whether this is a longer term downward trend and what reasons might underlie such a decline.

Sources of help for people with schizophrenia and depression

24. Two scenarios, one describing someone with schizophrenia and one describing someone with depression, were given to respondents. Respondents were then asked a range of associated questions: what would be the best sources of help for each of the individuals described, how likely would each individual be to harm themselves or other people, and how willing the respondent would be to interact with these individuals in different situations.

25. The most commonly mentioned source of help deemed to be appropriate for someone with symptoms of schizophrenia was a specialist mental health professional (86%), followed by a family doctor (70%) and a family member (62%). The same three categories were also chosen most frequently for someone with symptoms of depression, but the ranking was different with the family doctor chosen most often (77%) followed by the specialist mental

health professional (67%) and a family member (65%). Around twice as many people mentioned help from a friend or neighbour for the person with depression as for schizophrenia (21% compared with 11%).

26. Views on the best sources of help varied by age group. The youngest group (18-24) were more likely to mention family members and ‘someone with the same problem’ and less likely to mention a family doctor in both scenarios.

Likelihood of harming self/others for someone with schizophrenia or depression

27. Almost three-quarters of people (73%) thought that the person with symptoms of schizophrenia was likely to harm themself. This compared with 37% who thought the person with symptoms of depression was likely to harm themself.

28. In relation to harming others, more than two-fifths (43%) thought that the person with schizophrenia was likely to do something harmful or violent to others, compared with 10% who thought the person with depression would. Those who knew someone with schizophrenia were more likely than those who did not to think someone with schizophrenia would harm someone else (55% compared with 42%).

Willingness to interact with someone with schizophrenia or depression

29. Respondents were asked about their willingness to interact with those who have schizophrenia or depression in six situations including: making friends; having as a work colleague; having as a neighbour; and marrying into the family. More than one in five (22%) were not willing to interact with the person with schizophrenia in any of the ways mentioned compared with one in seven (15%) who said the same of the person with depression. Eight percent said they were willing to interact with the person with schizophrenia in all six ways, and 20% with the person with depression in all six ways.

30. Between three-fifths and two-thirds of people were willing to make friends with someone with schizophrenia (66%), have them as a work colleague (64%), or socialise with them (59%). However less than half (49%) were willing to have someone with schizophrenia as a neighbour and only one-third (34%) to have them marry into the family.

31. In relation to the description of someone with depression, around three-quarters (73%-76%) were willing to make friends with this person, have them as a work colleague, socialise with them, or have them as a neighbour. However less than half (45%) were willing to have someone with depression marry into the family.

32. Women were more willing than men to engage both with someone with schizophrenia and someone with depression, and those who knew someone who had experienced a mental health problem were more willing to interact with them than those who had not. Those aged 65 or above were less willing to interact with both someone with schizophrenia and someone with depression than those aged under 65.

Conclusion

33. Overall, the evidence from this current analysis is that attitudes towards mental health and those with mental health problems have been fairly stable in Scotland over the last decade. No clear trends towards either an overall reduction or an increase in stigmatising attitudes have been detected, although there have been a few notable changes in relation to individual questions.

1 INTRODUCTION

Background

1.1 In 2008, as part of its National Performance Framework, the Scottish Government set out its ambition to be a fair and inclusive society with opportunities for all its citizens to flourish[1]. This report focuses on one particular group of citizens – those with mental health problems[2] - and explores public attitudes to those experiencing mental health problems. This is a large group, with approximately one in four people experiencing some kind of mental health problem in any given year according to recent estimates[3].

1.2 The report presents findings from the 2013 Scottish Social Attitudes survey (SSA) and provides a detailed picture of public attitudes towards mental health problems in 2013. The report examines the extent to which individuals with mental health problems are able to live free from stigma, discrimination, injustice and inequality, and also explores attitudes to recovery among those who identified themselves as having or having had a mental health problem. Moreover, as this is the fifth time that the questions have been asked during the period 2002-2013 (see Paras 1.21-1.23 below) this report also provides valuable insight into whether - and if so how - public attitudes in this area are changing over time.

1.3 This introductory chapter outlines the rationale, context and aims of the survey, discusses why attitudes to mental health problems are of critical importance, outlines the previous research which has been undertaken, and summarises the report structure and conventions.

Research questions

1.4 This report presents findings on three key questions:

- How have attitudes to people with mental health problems changed over time?
- What factors are related to people's attitudes towards people with mental health problems?
- For those with direct experience of mental health problems, what have the social impacts been, what has helped or hindered their recovery, and have they received positive messages about their recovery?

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[1] http://www.scotland.gov.uk/About/Performance/scotPerforms

[2] We use the term 'mental health problem' throughout the report to include the experiences covered by the terms 'mental illness', 'mental disorders' and 'mental ill-health'.

[3] http://www.time-to-change.org.uk/mental-health-statistics-facts. One in four British adults experience a diagnosable mental health problem each year, and around one in six at any given time (Office for National Statistics, 2001). One in ten children also have a diagnosable disorder (Office for National Statistics, 2005).

Policy context

1.5 The mental health and wellbeing of populations has become an increasing global priority since the recommendations of the first major report on this topic (World Health Organisation (WHO), 2001) were adopted by the World Health Assembly of the WHO in 2002. From this time, there has been a focus on the importance of adopting policies and practices which would reduce stigma and discrimination, and aid recovery[4]. Indeed, the 2001 WHO report gave renewed emphasis to UN principles set out a decade earlier on the protection of persons with mental health problems and the improvement of mental health care which asserted that there should be *'no discrimination on the grounds of mental illness'*[5].

1.6 In Scotland post-devolution, the focus on improving mental health and mental wellbeing was initially addressed through the National Programme for Improving Mental Wellbeing (hereafter referred to as 'the National Programme') which was launched in October 2001 and ran until 2008. The National Programme formed part of the then Scottish Executive's wider policy on improving health and reducing inequalities. It articulated a vision *'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'*.

1.7 Through its lifetime the National Programme focused on raising awareness and promoting mental health and wellbeing; eliminating discrimination; preventing suicide; and promoting and supporting recovery. The legislative context for the National Programme was informed by the Human Rights Act (1998), which sets out the basic rights and freedoms to which all humans are entitled, and the Mental Health (Care and Treatment) (Scotland) Act 2003, which was designed to ensure that free and informed consent forms the basis of treatment for people experiencing mental health problems. A range of initiatives (see Paras 1.8-1.10 below) was launched during the early years of the National Programme.

1.8 'See me'[6], the national campaign in Scotland, launched in 2002 (and initially funded by the then Scottish Executive) to tackle stigma and discrimination, used 'social marketing'[7] approaches including: national publicity campaigns delivered through paid for advertising, supported by news and features targeted at the general population; targeted publicity campaigns aimed at specific groups or environments through, for instance, young people and workplace strands; work with journalists; and support for

[4] Recommendation 4 of the 2001 WHO report includes the statement 'Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of health services, and bring mental and physical health care closer to each other'.
[5] http://www.un.org/documents/ga/res/46/a46r119.htm
[6] From 2002-2013 'see me' was led by an alliance of five organisations: Scottish Association for Mental Health (SAMH); Support in Mind Scotland (originally known as NSF Scotland); the Royal College of Psychiatrists in Scotland; Penumbra; and the Highland Users Group. See this link for key organisations, funding, etc https://www.seemescotland.org/.
[7] 'Social marketing' approaches seek to harness commercial marketing techniques with socially minded campaign and change techniques to raise awareness, shift attitudes and ultimately change behaviours around particular, usually health-related, issues.

local activity through the provision of materials, advice and guidance. In 2013 it was reviewed by the Scottish Government and the re-launched 'see me' was launched in Nov 2013 (see Para 1.12).

1.9 The suicide prevention strategy 'Choose Life' (Scottish Government, 2002a) was also launched in 2002. Objectives for 'Choose Life' included raising awareness of the risk and protective factors for suicide; ensuring earlier and more effective care and support; improving and increasing the provision of services; removing stigma; providing support to families; improving the sensitivity of media reporting of suicide; and improving data collection. In addition Breathing Space[8] was launched as a free, confidential phone and web based service for people in Scotland experiencing low mood, depression or anxiety.

1.10 The Scottish Recovery Network (SRN), also funded by the Scottish Government, was launched in 2004 to promote and support recovery from mental health problems. A key element of the SRN's strategic plan is to ensure that mental health services and support are provided in a way which focuses on recovery. In addition, NHS Health Scotland was designated as a WHO Collaborating Centre for Health Promotion and Public Health Development in 2005.

1.11 Policy approaches to improving mental health and wellbeing and to reducing the stigma, discrimination, and social isolation experienced by those with mental health problems have continued to evolve in recent years. *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (Scottish Government, 2009a) identified six strategic priorities[9] one of which, *'improving the quality of life of those experiencing mental health problems and mental illness',* relates to reducing discrimination and stigma, and promoting social inclusion, physical health, and recovery. Most recently, following the introduction of the Equality Act 2010, which provided legal rights for disabled people (including those with mental health problems), the Scottish Government published *The Mental Health Strategy for Scotland: 2012-2015* (Scottish Government, 2012). This identified seven themes[10] including two on discrimination and recovery which are particularly pertinent to the module of questions developed for SSA 2013.

1.12 In 2013, a new £4.5 million investment to build on the 'see me' campaign, funded jointly by the Scottish Government and Comic Relief, was

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[8] Breathing Space was launched in Glasgow in 2002 and became a national phoneline service in 2004. http://www.breathingspacescotland.co.uk

[9] The six strategic priorities are: 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; and improving the quality of life of those experiencing mental health problems and mental illness.

[10] The seven themes are: working more effectively with families and carers; embedding more peer to peer work and support; increasing the support for self management and self-help approaches; extending the anti-stigma agenda forward to include further work on discrimination; focusing on the rights of those with mental illness; developing the outcomes approach to include personal, social, and clinical outcomes; ensuring we use new technology effectively to provide information and deliver evidence based services.

announced[11]. The new three year programme[12] is focused on building a broad movement of people in Scotland to tackle stigma and discrimination and changing behaviour in targeted settings to bring increased equality and life opportunity to people with mental health problems.

1.13 Most recently, SRN launched a new website 'Write to Recovery' where people can write and publish their stories as a way of promoting and supporting mental health recovery[13]. The Scottish Government also produced an updated suicide prevention strategy in 2013 (Scottish Government, 2013).

1.14 In Europe the Anti-Stigma Programme European Network (ASPEN)[14], founded in 2009, is a consortium of 20 EU partner sites (including the Mental Health Foundation in Glasgow) which aims to contribute towards the reduction of stigma and discrimination of people with depression and to communicate this knowledge to all relevant stakeholders. The most recent European Mental Health Action Plan (WHO, 2013), also places stigma and discrimination centre stage. The Plan highlights issues of non-engagement with services, lack of awareness, the promotion and dissemination of sound educational programmes, a rights based approach, and the importance of undertaking anti-stigma activities in communities.

1.15 Thus, the approaches in Scotland are highly congruent with those pursued in Europe and elsewhere. Indeed, a review of the first phase (2003-2006) of the National Programme concluded that *'Scotland is now known in WHO and the European Union as an exemplar of policy development and implementation in public mental health and has influenced policy in other countries'* (NHS Health Scotland, 2008b).

1.16 In terms of the wider socio-economic context, there was considerable change in economic and social conditions during the period in which the surveys, which form the basis of the analysis in this report, were conducted (2002-2013). These changes encompassed the global economic crisis, domestic public sector budget constraint, changes in employment opportunities, and changes in the value of household incomes. There is interest in the impacts of the recession and policy changes on health and wellbeing outcomes and on whether public attitudes may have shifted on particular social issues (which could include mental health) as a result of individuals' responses to the economic downturn. However, given the limitations of the cross-sectional survey approach, any changes which are found between the pre and post-recession periods in the data compared in this report cannot be directly attributed to the changing economic situation. This would require further research.

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[11] Scottish Government will contribute £3m and Comic Relief will contribute £1.5m to the programme.
[12] Responsibility for the delivery of the new programme will be shared by the Scottish Association for Mental Health (SAMH) and the Mental Health Foundation (MHF).
[13] http://www.writetorecovery.net/
[14] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61379-8/abstract

What is a stigmatising attitude in relation to mental health problems and why do attitudes matter?

1.17 In discussing action to tackle stigma and discrimination in relation to mental health problems, policy makers are most often referring to stigmatising and discriminatory behaviour – that is behaviour by individuals and institutions that either deliberately or inadvertently excludes people with mental health problems from enjoying the rights, dignity, services, social relationships, and resources available to others. This report does not explore discriminatory behaviour towards this group; rather the focus is on 'stigmatising attitudes'. The definition of a 'stigmatising attitude' employed in this report in relation to those with mental health problems (first developed for SSA 2002 which included a module of questions on discrimination of all kinds) is:

> '*One that directly or indirectly suggests that some social groups may not be entitled to engage in the full panoply of social, economic and political activities that are thought to be the norm for most citizens. In short, it is an attitude that openly or tacitly legitimates some form of social exclusion.*'

1.18 Policy makers should be interested in stigmatising attitudes as well as in discriminatory behaviours. First and foremost, attitudes often underpin behaviours. If the public believe that people with mental health problems should not be entitled to share the same rights and resources as others, then they are more likely to express this view through action that excludes individuals from that group. Second, even where people's attitudes do not translate into specific discriminatory behaviour, it might be argued that reducing the prevalence of stigmatising attitudes is an important part of building good relations between all sections of society. The importance of challenging stigmatising attitudes more generally (and not just in relation to those people with mental health problems) has been increasingly recognised, for example, in the 'One Scotland, many cultures' campaign[15].

1.19 Note that it is perfectly possible for discriminatory actions to occur in the absence of such attitudes – for example as a result of bias in institutional procedures or practice. As such, where the report states that stigmatising attitudes appear to be uncommon, this does not imply that discrimination itself is uncommon or that people with mental health problems are not likely to experience this.

Previous research

1.20 The first National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems (the Well? What do you think? survey) was commissioned in 2002 to provide baseline data in relation to the National Programme. Further rounds of the Well? What do you think? survey series (referred to in what follows as the Well? survey(s)) were commissioned in 2004, 2006, and 2008, and these were used to track

[15] http://www.scotland.gov.uk/News/Releases/2007/01/26113250

progress and help influence the work of the National Programme in relation to specific outcomes and objectives[16]. The 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 the factors affecting these
- Investigate people's direct experience of mental health problems and recovery from mental health problems
- Explore people's attitudes to mental health problems, including stereotypes and myths
- Explore people's attitudes to those who experience specific symptoms of mental health problems.

1.21 In relation to 2013, it was agreed to repeat a reduced set of questions which would focus mainly on attitudes, and which would not cover people's knowledge and personal wellbeing in great detail. It was also agreed that rather than conducting a separate survey focusing on mental health alone, the questions should be administered as a module on SSA. Questions about people's perceptions of their own health and lifestyle, their understanding of factors affecting mental health, and their sources of information on mental health problems were therefore omitted. The remaining questions concentrated on attitudes towards mental health problems, including stereotypes and myths; attitudes to those who experience specific mental health conditions; and people's direct experience of mental health problems and recovery.

1.22 Given that many of the questions included in SSA 2013 were also asked in the four Well? surveys, it is possible in principle to examine change over time. However, we comment below (see Para 1.25) on methodological issues which might impact on the comparisons.

Report structure

1.23 The remainder of the report is structured as follows:

- Chapter two discusses people's own personal experience of mental health problems and indirect experience through knowing family or friends who have had a mental health problem; whether or not people tell others about their mental health problems; and the social impact of having a mental health problem
- Chapter three looks at attitudes to recovery and the nature of the messages people with mental health problems receive about recovery from professionals, and from family and/or friends
- Chapter four summarises the findings on general perceptions of people with mental health problems, including myths and stereotypes
- Chapter five focuses on attitudes to those who experience specific mental health problems

[16] The findings from these surveys have been published by the Scottish Government (Scottish Government, 2002b, 2005, 2007, 2009b).

- Chapter six summarises the main findings and conclusions.

About the data

1.24 The Scottish Social Attitudes survey was established by ScotCen Social Research, an independent organisation based in Edinburgh and part of NatCen Social Research, the UK's largest independent social research agency. The survey provides robust data on changing social and political attitudes to inform both public policy and academic study. Around 1,500 face-to-face interviews are conducted annually (1,497 in 2013) with a representative probability sample of the Scottish population. Interviews are conducted in respondents' homes, using computer assisted personal interviewing. Most of the interview is conducted face-to-face by a ScotCen interviewer, but some questions each year are asked in a self-completion section. The survey has achieved a response rate of between 54% and 65% in each year since 1999 (in 2013, the response rate was 55%). The data are weighted to correct for over-sampling, non-response bias and to ensure they reflect the sex-age profile of the Scottish population. All sample sizes shown below the charts and tables show unweighted bases. Further technical details about the survey are included in Annex B.

1.25 Methodological changes were implemented between the Well? survey series and SSA 2013. There were changes to the method of data collection for questions asked of those who had experienced mental health problems (face-to-face in the Well? survey series and self-complete in SSA 2013). There were also some alterations to question wording and question ordering[17]. While these methodological differences are unlikely to affect the substantive conclusions, they do mean that some caution is required in interpreting trends.

Limitations of the data

1.26 The Scottish Social Attitudes survey is a quantitative survey which focuses on producing robust and reliable population estimates across a wide range of substantive topics. In common with other general population surveys, individuals living in specific settings where the incidence of mental health problems is known to be high (e.g. prisons, hospitals, residential care facilities) are not included in the sample. The survey does not allow questions about respondents' motivations or feelings to be examined in depth; this would require more detailed research using qualitative methods.

1.27 Questions for the SSA survey are developed through a rigorous and detailed process involving cognitive testing and extensive piloting. There is also discussion on a question-by-question basis of whether the most suitable approach is to use face-to-face or self-complete methods. This ensures that as far as possible questions will be interpreted in a uniform

[17] Given that previous Well? surveys focused solely on mental health topics, it was considered appropriate to ask all questions – even those of a sensitive nature – face-to-face. However, as SSA 2013 ranged over a wide number of topics, it was not thought appropriate to do this for the personal experience questions on the mental health module.

fashion, and that any social desirability bias – especially in relation to sensitive questions – will be minimised. However, it is acknowledged that variation in how questions are interpreted by respondents and the possibility of social desirability bias in such a complex area as mental health cannot be completely eliminated.

Analysis and reporting conventions

1.28 All percentages cited in this report are based on the weighted data (see Annex B for details) and are rounded to the nearest whole number. All differences described in the text (between years, or between different groups of people) are statistically significant at the 95% level or above, unless otherwise specified. This means that the probability of having found a difference of at least this size, if there was no actual difference in the population, is 5% or less. The term 'significant' is used in this report to refer to statistical significance, and is not intended to imply substantive importance. Further details of the significance testing and multivariate analysis conducted for this report are included in Annex B.

2 PERSONAL AND INDIRECT EXPERIENCE OF MENTAL HEALTH PROBLEMS

2.1 This chapter explores both respondents' own personal experience of mental health problems and their experience of others' mental health problems. People were asked what types of mental health problems they had personally experienced and whether they knew someone with experience of mental health problems. The chapter also examines the extent to which people tell others about any mental health problems, and the impacts that prejudice and discrimination have on the lives of those with such conditions.

2.2 In more detail this chapter covers:

- Whether people know someone close to them who has, or has ever had, a mental health problem and if so the type(s) of mental health problem someone they know has experienced
- Personal experience of mental health problems, the type of mental health problem(s), and how these varied across socio-demographic groups
- Whether people have told others about their mental health problem, who they have chosen to tell, and how these varied by socio-demographic factors and type of mental health problem they have
- What impacts, if any, other people's attitudes to their mental health problems have had on their lives, and how these varied by socio-demographic factors and levels of life satisfaction[18].

2.3 All of the questions discussed in this chapter were previously asked on the Well? What do you think? surveys (hereafter referred to as the 'Well? surveys'). This chapter explores, where possible, any significant changes that have occurred over time. As was noted in Chapter 1 (Para 1.25) any changes over time should be treated with caution given the change from a face-to-face methodology (2002-2008) to self-completion in 2013. Note that no direct comparisons can be made between the SSA 2013 responses and published Scottish prevalence data for mental health conditions (NHS Health Scotland, 2012). This is because there is a lack of comparability arising from the substantial methodological differences in how the data have been collected through different mechanisms.

Knowing someone with a mental health problem

2.4 Around two-thirds of people said they knew someone who had '*ever experienced a mental health problem'* (65%), a similar proportion as in the 2006 and 2008 Well? surveys. All respondents were then asked whether they knew anyone with one of a wide range of fifteen specific mental health

[18] Four questions on life satisfaction have been asked on SSA since 2006. This analysis uses data from the question on overall life satisfaction: 'And all things considered, how satisfied are you with your life as a whole nowadays?' The question has an 11 point scale running from 0 (extremely dissatisfied) to 10 (extremely satisfied). The mean score for satisfaction with 'life as a whole' was 8.05 in 2013. Three further questions were included in SSA 2013 focusing on satisfaction with job, with family or personal life and with general standard of living.

15 conditions which were listed[19]. A higher proportion (79%) then said that they knew someone with at least one of the listed mental health problems. This higher proportion who knew someone with a problem when they were able to choose from the list suggests that people may be unaware of the wide range of conditions which fall under the general umbrella term of 'mental health problems'.

2.5 Half said they knew someone who had experienced depression (51%) and nearly a third knew someone with dementia (30%). Over a quarter knew someone who had experienced panic attacks (27%) and slightly under a quarter knew someone who had an anxiety disorder (23%). The next most commonly chosen mental health problems that people knew someone with were severe stress (17%), post-natal depression (16%), nervous breakdown (15%), manic depression (14%) and eating disorders (13%) (see Table A.1 in Annex A).

2.6 Comparing the figures from 2008 and 2013 (Figure 2.1 below) shows that there has been a significant increase in the proportion of people who know someone with depression, from 45% in 2008 to 51% in 2013. There has also been an increase of 8 percentage points in the proportion knowing someone with dementia, from 22% in 2008 to 30% in 2013 and a 10 percentage point increase in those knowing someone with an anxiety disorder (23% in 2013 compared with 13% in 2008). Figures from 2002 to 2008 did not show any increase in the proportion who knew people with these specific conditions, so the increase between 2008 and 2013 is not part of a longer term trend, but is a significant change in the last five years.

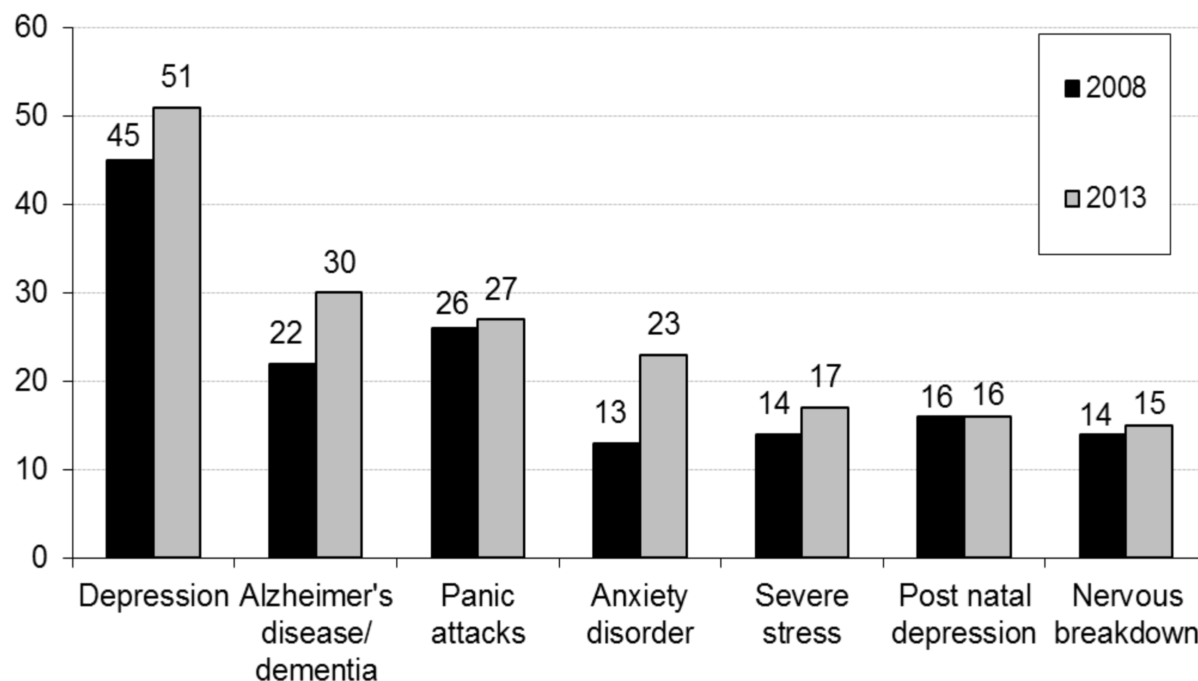
2.7 It is not clear why more people in 2013 reported that they knew someone with depression, dementia and anxiety disorders than in 2008. As noted above, there is no consistently reliable information available for Scotland on trends in the prevalence of these specific conditions, so it is not possible to conclude that this increase is directly related to increasing prevalence in the population. However, the main conclusion from the most recent overview report of Scotland's (adult) mental health is that 'the picture over the last decade can be summed up as broadly stable' and more specifically, that the indicator for 'common mental health problems' has shown no significant change over time (NHS Health Scotland, 2012). The increase in knowing someone with one of the listed conditions may be due to a range of factors including: more people being willing to seek help; improvements in diagnosis; more willingness to disclose to others; and better understanding among the general public.

2.8 This increase could potentially have a positive impact on stigmatising attitudes towards people with depression, dementia and anxiety disorders. Previous research carried out on SSA as part of a module on stigmatising attitudes (Ormston et al, 2011) showed that people who know someone

[19] Alzheimer's disease/dementia, anxiety disorder, depression, eating disorder (anorexia, bulimia), manic depression (bipolar affective disorder), nervous breakdown, obsessive/compulsive behaviour/disorder, panic attacks, personality disorder, phobias (e.g. agoraphobia), post-natal depression, schizophrenia, self-harm, severe stress, post traumatic stress disorder.

with a mental health problem were less likely than those who do not to hold stigmatising attitudes towards them.

Figure 2.1: Experience of mental health problems in someone you know (2008 & 2013)



Base: All respondents
Sample size: 2008=1,177; 2013=1,497

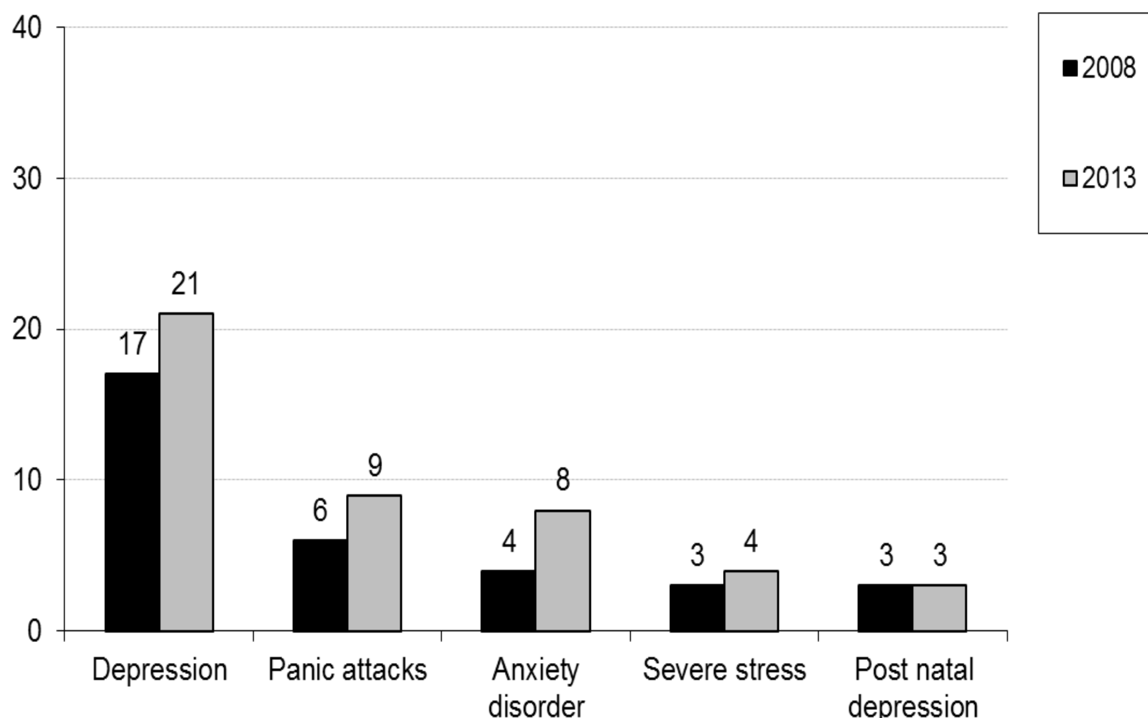
Personal experience of mental health problems

2.9 A quarter of people (26%) said they had personally experienced a mental health problem at some point in their life time. This is consistent with previous Well? surveys, where the proportion ranged between 26%-28% from 2002 to 2008. However, when people were asked whether a doctor or health professional had ever told them they had a specific mental health problem, chosen from a list of 15 different types, 32% of people identified themselves as having at least one of these problems. This increase (from 26% to 32%) is consistent with the finding discussed in Para 2.4 above in relation to the findings on the extent of mental health problems experienced by ‘someone you know’. In what follows, our analysis focuses on this larger group (32%). Therefore the remainder of this chapter is based on an analysis of 417 responses. Note that the smaller sample size has an impact on the sub-group analysis which is possible.

2.10 The most commonly cited mental health problem people had experienced was depression, with around 1 in 5 people (21%) saying they had experienced depression at some point in their lives (Figure 2.2 below). The next most common mental health problems were panic attacks (9%) and anxiety disorders (8%). These were also the three most commonly

mentioned problems in the 2008 Well? report (for full details see Table A.2 in Annex A). However, the proportion of people who said they had depression increased from 17% in 2008 to 21% in 2013 and the proportion who said they had been told they had an anxiety disorder increased from 4% in 2008 to 8% in 2013. If the different types of anxiety and stress disorders listed are combined together[20], we found that 15% of people said they had an anxiety or stress disorder. This is an increase from 11% in the 2008 Well? survey.

Figure 2.2: Personal experience of mental health problems (2008 & 2013)



Base: All respondents who identified as having a mental health problem.
Sample size: 2008=359; 2013=417

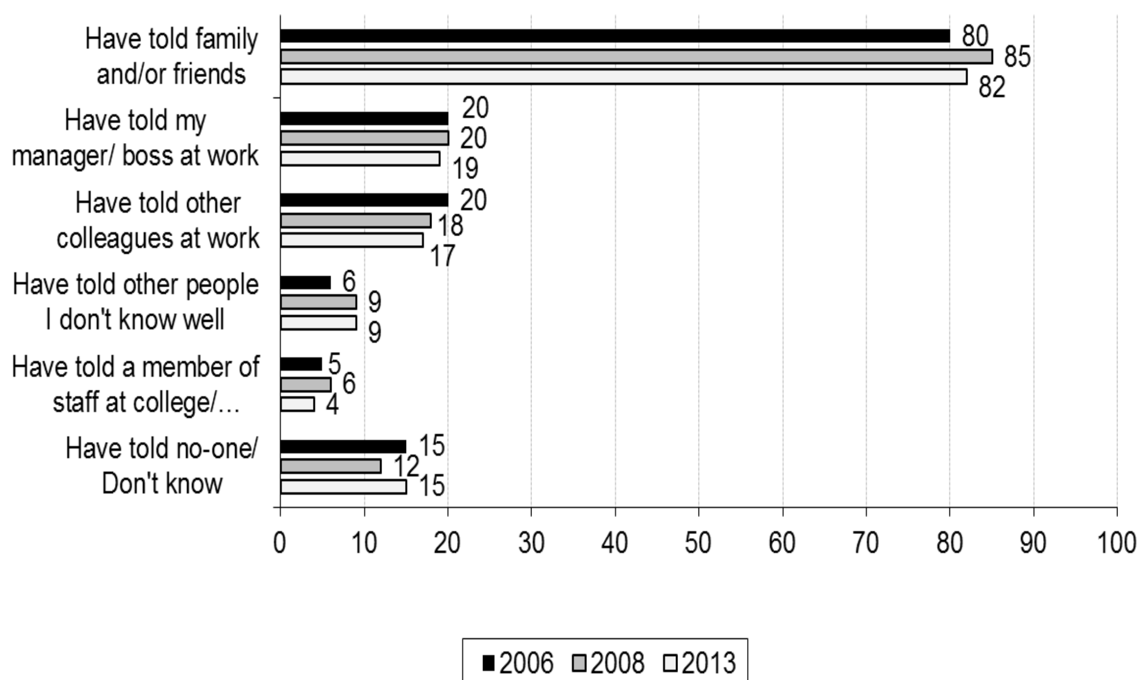
2.11 There were some significant variations in the prevalence of mental health problems between different socio-demographic groups, in particular gender, age and income (for full details see Table A.3 in Annex A). Women were more likely than men to say they had had a mental health problem (36% compared with 27% of men). People over 55 years old were the least likely to say they have had a mental health problem. Two in 5 of those in the lowest income group had a mental health problem (41%) compared with only a quarter of those in the highest income group (25%). There were no statistically significant differences based on people's level of education or the level of deprivation in the area where they lived.

[20] Categories combined to form the anxiety/ stress disorder category were: panic attacks, anxiety disorder, obsessive/compulsive behaviour/disorder, phobias and severe stress.

Telling others about mental health problems

2.12 Among those who identified themselves as having, or having had, a mental health problem, 85%[21] had told someone close to them about it, a similar proportion to 2008 when 88% had told someone about their mental health problem. Figure 2.3 shows that in 2013 around 4 out of 5 people had told family or friends about their mental health problems (82%), compared with only around 1 in 5 who had told their manager or boss at work and 17% who had told colleagues at work. These findings are similar to those in the 2006 and 2008 Well? surveys.

Figure 2.3: Telling others about mental health problems (2006, 2008 & 2013)



Base: All respondents who identified as having a mental health problem.
Sample size: 2006 = 384; 2008 = 359; 2013=417

2.13 Given that a very large majority (85%) had told someone about their mental health problem, it was not surprising to find that this proportion did not vary significantly across population sub-groups based on socio-demographic characteristics such as age, gender, education, income or area deprivation. However, despite this overall lack of variation, we did find that people with depression were more likely to have told someone about their mental health problem: 91% of people with depression had told someone about their problem, compared with 75% of people who had been diagnosed with other mental health conditions. People with anxiety disorders were also more likely to have told someone about it than those with other mental health problems: 90% compared with 81%.

[21] Eight percent had not told anyone, the remaining 7% are people who said ‘can’t choose or don’t know’.

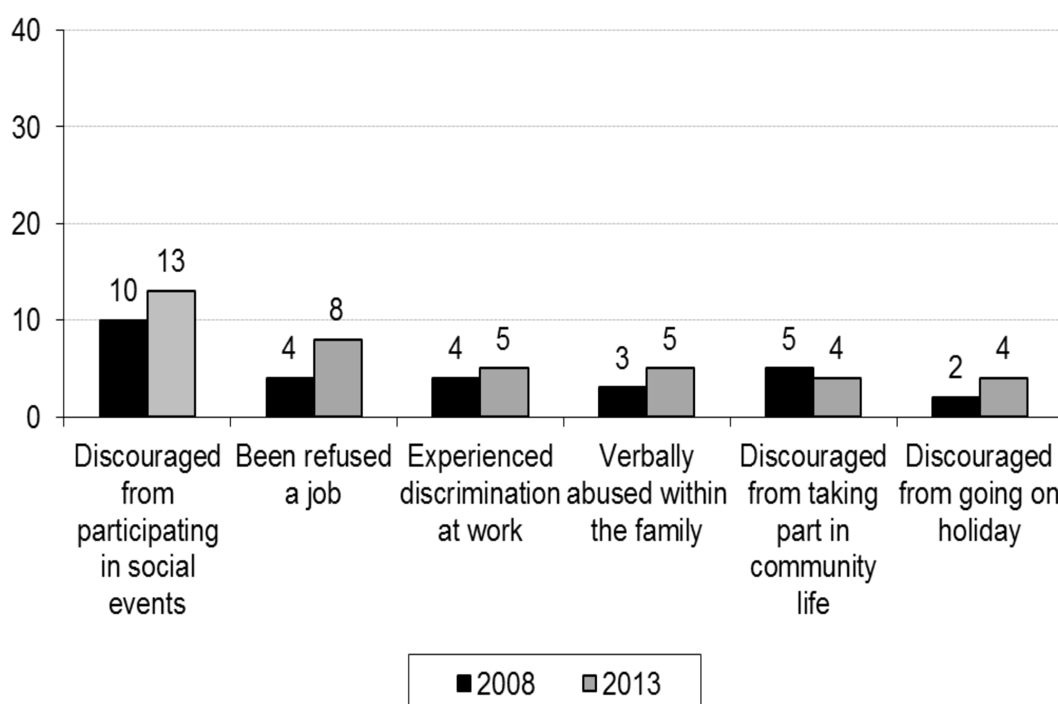
Social impact of mental health problems

2.14 The Mental Health Strategy for Scotland includes as one of its seven themes, the commitment to continue the anti-stigma work carried out through the 'see me' campaign and to extend this work further to '…focus on the experience of discrimination and exclusion that many people with mental illness experience.' The 'see me' campaign highlights different types of stigma including public stigma, self-stigma and direct discrimination (see also Corrigan, 2012). SSA 2013 captures evidence on all these different dimensions of stigma.

2.15 SSA 2013 asked those who had personal experience of mental health problems about any impacts on their lives due to others' attitudes to their mental health problems. The impacts identified covered examples of both public stigmatisation and direct discrimination. People were asked if they had experienced a range of different impacts including whether they had been discouraged from attending a social event, been refused a job or had been verbally or physically abused. Over a third (37%) of people in 2013 with a mental health problem said they had experienced at least one of the impacts listed in the question. The proportion who said that they had not experienced any of these impacts has changed over time. In 2013, 63% of people with mental health problems had not experienced any of these impacts, a reduction from the 77% recorded in 2008 and a return to levels in 2004 (64%).

2.16 Figure 2.4 shows that 13% of people said they had been discouraged from attending an event. Eight percent of people had been refused a job due to their mental health problems, 5% had been discriminated against at work and 3% had been overlooked or refused promotion. Combining people's responses around work-related discrimination showed that 12% of people felt their mental health problems had led to a negative experience in the workplace or job market. One in 20 people with mental health problems had been verbally abused in the family (5%) and a slightly smaller proportion (4%) had been verbally abused in public (for full details, see Table A.4 in Annex A). There have been no significant changes over time in the proportion who had experienced these social impacts.

Figure 2.4: Social impact of mental health problems (2008 & 2013)



Base: All respondents who identified as having a mental health problem.
Sample size: 2008 = 359; 2013=417

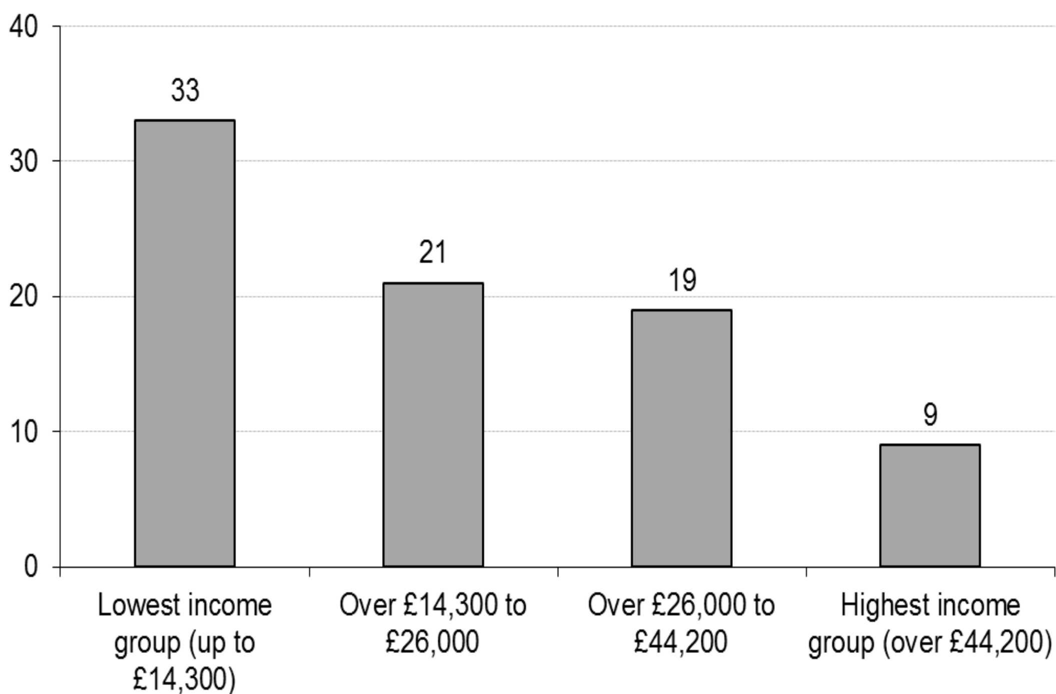
2.17 Men and women had different experiences of the social impact of their mental health problems, as did those on high and low incomes and those with above or below average levels of life satisfaction (for full details see Table A.5 in Annex A). Men were more likely than women to say they have been refused a job (11% of men compared with 5% of women). One in 5 people with a mental health problem in the lowest income group said they had been discouraged from attending a social event compared with only 3% of those in the highest income group. People in the lowest income group were also more likely to have been refused a job and to have been verbally abused by their family than those in the highest income group. Those with a lower than average level of life satisfaction were three times more likely to say they had been discouraged from attending a social event compared with those with average or above average levels of life satisfaction (21% compared with 7%).

2.18 Overall when people with mental health problems were asked whether they had been discouraged from attending an event because of the attitudes of others 13% of people said that they had. In addition a question exploring the potential impact that the anticipation of how others might regard them, and the subsequent possibility of self-stigmatisation, was also included. This question asked whether they had avoided a social event because of the way they thought people would treat them: 22% of people said that they had. This shows that concern about, or the anticipation of, potential discrimination can have a substantial impact on the choices that

people with mental health problems make about their participation in social events.

2.19 People on low incomes (Figure 2.5 below) and those with lower than average levels of life satisfaction were more likely to have avoided a social event due to concerns about how others would treat them because of their mental health problem. Thirty-three percent of those in the lowest income group, compared with 9% of those in the highest income group, had done so, and it was reported by twice as many people with low levels of life satisfaction compared with those with average or high levels (31% compared with 15%).

Figure 2.5: Whether avoided a social event by income (2013)



Base: All respondents who identified as having a mental health problem.
Sample size: 417

3 ATTITUDES TO MENTAL HEALTH RECOVERY

3.1 The findings in Chapter 3 are based on the analysis of questions about recovery which were only asked of those who have, or have had at some point in their life, a mental health problem. The sample size throughout is 417[22]. In particular this chapter explores:

- Views of which factors have supported or hindered their recovery
- How views about which factors support or hinder recovery varied across socio-demographic groups
- Views on what recovery means to people with mental health problems and how these varied between sub-groups
- Whether people with mental health problems have received positive or negative messages about recovery from professionals, from family and/or friends, and how these messages varied between sub-groups.

3.2 *The Mental Health Strategy for Scotland: 2012-2015* (Scottish Government, 2012) contains seven themes. Theme 6 relates to the continued support for a recovery-focused approach to mental health and states its aims as: *'Developing the outcomes approach to include personal, social and clinical outcomes'*. This builds on the Scottish Government's commitment to promoting the recovery approach which was first established in 2001 through the National Programme for Improving Mental Health and Wellbeing (see Chapter 1 for details). In 2004 the Scottish Recovery Network (SRN) was set up specifically to promote the recovery approach in Scotland. SRN developed the Scottish Recovery Indicator which supports mental health services to develop recovery-focused practice. Although there are different definitions of recovery, the SRN describe it as:

> *'being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.'*[23]

3.3 We recognise that there are multiple interpretations which may be applied to the idea of recovery in this context, and we cannot assume that the SRN conceptualisation is one which respondents have used when answering. In particular we cannot know whether our respondents think that recovery must mean that someone is 'symptom free'. We return to this point throughout this report, as part of our discussion of the interpretation of findings – particularly findings about trends over time.

3.4 The Scottish Social Attitudes survey asked people who identified themselves as having mental health problems about their attitudes to

[22] This small sample size has an impact on the level of analysis possible, in particular the amount of sub-group analysis which can be applied. All confidence intervals for estimates are much wider than for findings based on the full sample, and statistically significant differences between sub-groups require large differences between the groups under consideration.

[23] Scottish Recovery Network. Accessed at: http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html

recovery, as well as their experience of recovery from professionals, and from family and/or friends. These questions repeat those previously asked in 2004, 2006 and 2008 as part of the Well? survey series allowing us to track changes over time.

Factors supporting recovery

3.5 People who identified themselves as having, or having had, a mental health problem were first asked which two or three factors were most important in supporting their recovery. The response options included a wide range of potential factors which could support recovery including forms of treatment, interaction with others and self-help strategies. As respondents could choose up to three answer options for this question, the addition in 2006 of four new answer categories makes it difficult to make comparisons with 2004. The findings from 2004 and 2006 are included in Table 3.1 but the discussion focuses on changes between 2008 and 2013. Comparisons between years in the proportion choosing a specific answer category are affected if a different average number of answer categories was chosen in different years. Increases in percentages may simply be a feature of people choosing more responses in one year than in previous years. The average number of responses given to the question on factors that support recovery was similar in 2008 and 2013 allowing for a valid comparison (2.39 in 2008 and 2.29 in 2013).

3.6 In 2013 the five factors that support recovery which were chosen most often were (see Table 3.1 below):

- Medication (42%)
- Support from family or friends (41%)
- Other forms of treatment/therapy (e.g. psychology, counselling, alternative treatments, support groups) (27%)
- Developing my own coping strategies (26%)
- Finding out more about mental health (e.g. through support groups, leaflets, web information etc.) (19%)

Table 3.1: Factors supporting recovery (2004, 2006, 2008, 2013)

	2004	2006	2008	2013
	%	%	%	%
Medication	38	35	39	42
Support from family or friends	76	56	62	41
Other forms of treatment/therapy (e.g. psychology, counselling, alternative treatments, support groups)	29	30	19	27
Developing my own coping strategies	n/a	30	24	26
Finding out more about mental health (e.g. through support groups, leaflets, web information etc)	6	8	8	19
Having belief in myself	n/a	27	31	15
Having something worthwhile to do during the day (e.g. work, volunteering, education, hobbies etc.)	21	11	13	11
Having others believe in me	n/a	12	12	6
Support from colleagues/work	18	8	12	7
Support from people with a similar experience	14	11	13	3
Having a chance to contribute and be valued	n/a	2	5	3
I don't believe myself to be in recovery	2	*	2	2
Other	3	6	-	1
None of these	4	3	3	5
Don't know	*	*	*	7
Average no. of responses chosen	n/a	n/a	2.39	2.29
Weighted bases	*351*	*n/a*	*335*	*428*
Unweighted bases	*377*	*384*	*359*	*417*

Base = all respondents who identified as having a mental health problem.

3.7 In 2008 'support from family or friends' was the factor chosen most often by people with mental health problems with 62% saying it was important in their recovery. This was the second highest factor in 2013 but the proportion who chose this option had declined from 62% in 2008 to 41% in 2013. Similarly the proportion who chose 'having belief in myself' was 31%

in 2008, the third most popular response, but this dropped to the sixth most popular response in 2013 and was only chosen by 15% of those with mental health problems.

3.8 The proportion choosing the response ‘other forms of treatment/therapy’ has increased significantly since 2008 from 19% to 27%. And the proportion choosing ‘finding out more about mental health’ increased by 11 percentage points from 8% in 2008 to 19% in 2013.

How attitudes to factors that support recovery varied between sub-groups

3.9 In 2013 there were some differences in attitudes to recovery based on socio-demographic factors[24] (for full details see Table A.6 in Annex A). Figure 3.1 shows that women were more likely than men to include medication as one of the supporting factors they chose: 49% of women chose this option compared with only 31% of men. Almost twice as many women as men chose ‘other forms of treatment or therapy’ (33% of women compared with 17% of men). Men, however, were more likely to choose ‘developing my own coping strategies’ than women (32% of men compared with 22% of women[25]).

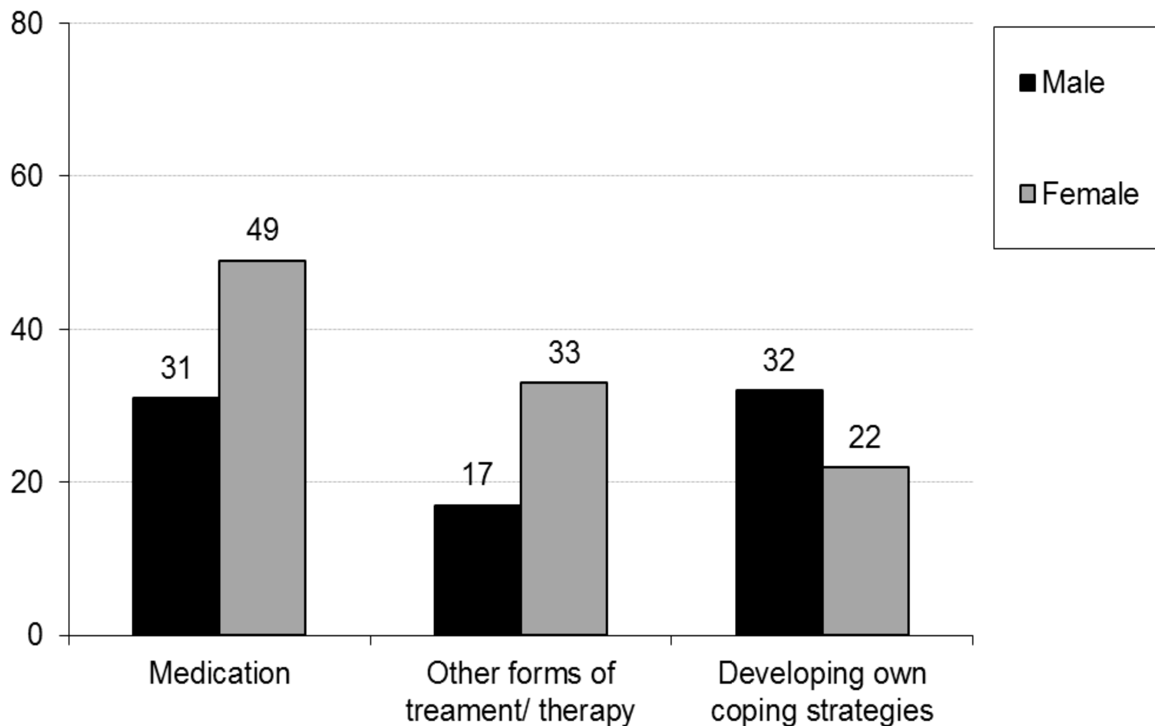
3.10 Age was only significantly related to believing that medication was important in supporting recovery. People over 45 years old were more likely than younger people to choose medication as a supporting factor in their recovery: 41% of people over 65 years old compared with 25% of those aged 18 to 24.

3.11 Differences in levels of educational qualifications were related to whether people chose ‘other forms of treatment or therapy’ or ‘developing my own coping strategies’. People with degrees were more likely than those with no formal qualifications to choose ‘other forms of treatment or therapy’ (38% compared with 18%). Similarly there were marginally significant differences[26] between those with higher levels of qualifications (degrees or Highers) and those with Standard grades or no formal qualifications in the proportions who chose ‘developing my own coping strategies’ (about 1 in 3 of those with higher levels of qualifications compared with 1 in 5 of those with Standard Grades and 1 in 6 with no formal qualifications).

3.12 An exploratory analysis was undertaken to examine whether the perspectives of people with different types of mental health diagnosis were distinctive. However, due to the small numbers of people in the sample with specific diagnoses and the number of people with more than one diagnosis, it was not possible to draw any substantive conclusions from this analysis.

[24] The top 5 factors were explored in relation to differences based on age, gender, income, education and area deprivation.
[25] This difference was only marginally significant (p=0.074).
[26] p=0.064

Figure 3.1: Factors supporting recovery by gender (2013)



Base: All respondents who identified as having a mental health problem
Sample size: 417

Factors hindering recovery

3.13 People were also asked to choose up to three factors which hindered their recovery. In 2013 the five factors chosen most often were (see Table 3.2):

- Not acknowledging I had a problem (18%)
- Not understanding what was going on (16%)
- Not feeling able to tell people about my mental health problem (15%)
- Continuing to experience symptoms (13%)
- Negative attitudes of people around me (11%)

3.14 A much larger proportion of people chose at least one factor which supported their recovery than selected a factor which they thought hindered their recovery. Eighteen percent of people chose the most popular response (‘not acknowledging I had a problem’) compared with 42% of people who chose the most popular response in relation to factors supporting recovery (‘medication’). This is explained in part by the fact that 27% of people chose ‘none of these’ and 14% said they could not choose an answer in relation to what factors hindered their recovery. This compares with only 5% of people who chose ‘none of these’ for factors supporting recovery and 7% who said they could not choose. There has been very little change over time in relation to the factors chosen that hinder people’s recovery.

Table 3.2: Factors hindering recovery (2006, 2008, 2013)

	2006	2008	2013
	%	%	%
Not acknowledging I had a problem	19	17	18
Not understanding what was going on	17	19	16
Not feeling able to tell people about my mental health problem	12	15	15
Continuing to experience symptoms	17	19	13
Negative attitudes of people around me	13	11	11
Not being able to access appropriate services or treatment	4	7	9
Lack of support or understanding from family or friends	9	6	8
Not getting the right medication	6	12	7
Lack of access to employment, education or training opportunities	4	5	6
Lack of support or understanding from colleagues/work	5	6	5
Other	6	*	1
None of these	34	34	27
(Can't choose / Don't know)	2	4	14
Average no. of responses chosen	n/a	1.91	2.00
Sample size	*384*	*359*	*417*

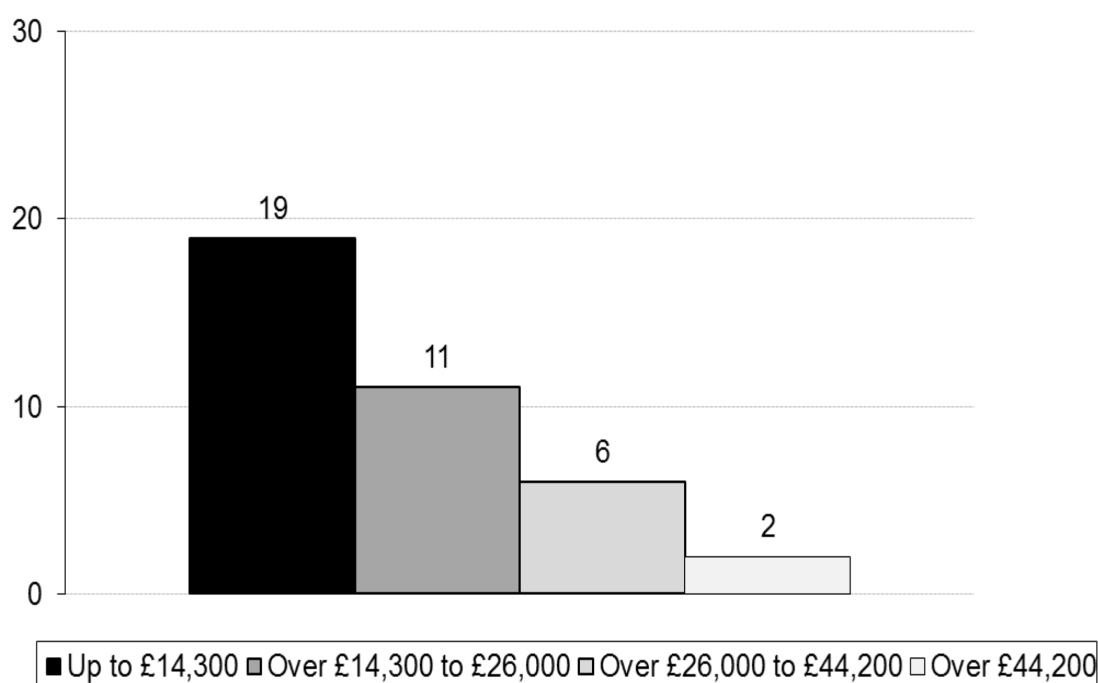
Base = All respondents who identified as having a mental health problem.
Sample size: 417

How attitudes to factors that hinder recovery varied between sub-groups

3.15 In 2013 there was very little variation between socio-demographic groups in people's views on the factors that hindered recovery (for full details see Table A.7 in Annex A). Men were more likely than women to say that 'not understanding what was going on' hindered their recovery: 22% of men compared with 12% of women. People on lower incomes were more likely to say that the 'negative attitudes of people around me' hindered their recovery compared with all other income groups (Figure 3.2 below): 19% of those in the lowest income group compared with 2% of those in the highest income group. And those educated to degree level, compared with all other groups, were more likely to say that 'continuing to experience symptoms'

had hindered their recovery: 24% of those with degrees, compared with between 6-10% of those with lower levels of, or no formal, qualifications.

Figure 3.2: Negative attitudes of people around me by income (2013)



Base: All respondents who identified as having a mental health problem
Sample size: 417

What recovery means?

3.16 People with a mental health problem were asked: 'What does recovery mean to you?' and could choose as many answer options as applied to them from a list of possible factors[27]. Change over time is not included in this section of the report due to the difficulty in clarifying whether these changes are genuine or a feature of the different data collection methods. The five most commonly chosen answer options in 2013 were (for full results see Table A.8 in Annex A):

- Having a satisfying and fulfilling life (55%)
- Getting back to normal (46%)
- Taking charge of my life again (44%)
- Feeling able to cope in general (37%)
- Getting more sleep (20%)

3.17 With regard to what recovery means to people, the only demographic factors which showed a significant association were gender and education (for full details see Table A.9 in Annex A). Women were more likely than men to say that recovery means 'feeling able to cope in general' (42% compared with 30% of men). People with higher levels of education (degrees or Highers) were more likely than those with lower levels of

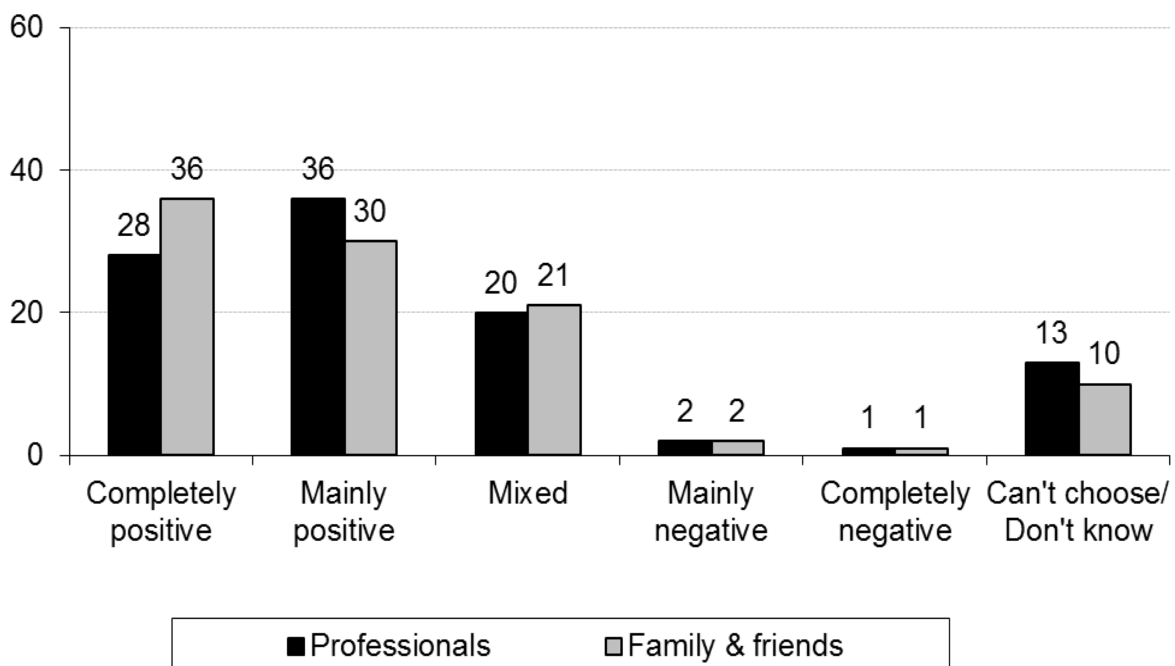
[27] The average number of responses given in 2013 was 3.01 and in 2008 was 1.83.

education to choose ‘taking charge of my life again’ and ‘feeling able to cope in general’.

Messages about recovery from professionals, and from family and/or friends

3.18 People with mental health problems were asked to what extent professionals (nurses, doctors, support workers etc), and family and/or friends, gave them a positive or negative message about their recovery (Figure 3.3 below). The possible answer categories were: completely positive, mainly positive, mixed, mainly negative and completely negative. Hope and optimism have been evidenced to be core elements of personal recovery (Leamy et al, 2011). As such it is important that the messages which are shared with people experiencing problems are positive. Overall, the vast majority of people received either a completely or mainly positive message from both professionals, and from family and/or friends. A higher proportion of people said that their family and/or friends gave them a completely positive message about their recovery (36%) than said the same about professionals (28%). Twenty percent of people said they had received ‘mixed’ messages about their recovery from professionals and 21% had from their family and/or friends. Only 2% of people said they were given either a mainly or completely negative message about their recovery from professionals and 3% said this of their family and/or friends.

Figure 3.3: Messages about recovery from professionals, and from family and/or friends (2013)



Base: All respondents who identified as having a mental health problem.
Sample size: 417

3.19 In 2013, 65% of people received either a completely or mainly positive message about their recovery from professionals. This is similar to the

levels recorded in 2006, when 66% of people received a positive message from professionals, although lower than the proportion recorded in 2008 (73%), which had been cautiously interpreted in the 2008 Well? survey report as the start of an upward trend. However, given the lower proportion in 2013, there is no evidence of an upward trend.

3.20 In both 2006 and 2008 over three-quarters of people had received positive messages from family and/or friends (76% and 79% respectively). This proportion had declined by 13 percentage points between 2008 and 2013 from 79% to 66%. The reasons for this change are unclear. This decline may reflect different understandings of the use of the term 'recovery' in the context of mental health; for example, some may view 'recovery' as living symptom-free while others may see it as living well and managing on-going symptoms. However, more in-depth, qualitative research would be needed to explore how people understand 'recovery', both in terms of their own experience and in a wider sense.

3.21 Both income and education levels showed a significant association with how positive the messages were that people received about their recovery from professionals (for full details see Table A.10 in Annex A). People in the lowest income group were less likely than those in higher income groups to have received a positive message from professionals about their recovery. A similar pattern was seen in relation to positive messages from family and/or friends.

3.22 People with degrees were more likely than those with lower levels of educational qualifications to have received a positive message about their recovery: 76% of those with degrees compared with 64% with no formal qualifications and 56% with either Highers or Standard Grade level education said they had had a positive message from professionals. Education levels were not, however, significantly related to messages about recovery from family and/or friends.

3.23 Those with lower than average levels of life satisfaction[28] were less likely to say that they had received positive messages about their recovery, from both professionals and family and/or friends, than those with average or high levels. Fifty-seven percent of people with below average levels of life satisfaction compared with 71% of those with average or above levels said they had received positive messages about their recovery from professionals.

[28] Overall in 2013 29% of people had 'below average' life satisfaction. The proportion of people who fall into the below average score is low because a large proportion of respondents gave an 'average' score of 8. While the exact mean was 8.39, respondents were only able to respond in whole numbers.

4 PUBLIC PERCEPTIONS OF MENTAL HEALTH PROBLEMS

4.1 This chapter examines attitudes towards and understanding of mental health problems. All respondents (1,497) were asked how much they agreed or disagreed with nine statements about mental health[29]. The same set of statements was included in each of the four previous Well? surveys which ran between 2002 and 2008. This means we are able to explore change over time.

4.2 These statements covered a wide range of issues including: their own individual attitudes towards people with mental health problems; their understanding of the causes and consequences of mental health problems; and the ways in which others and wider society perceive and treat people with mental health problems.

4.3 The nine statements were:

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

4.4 The difficulties faced by many people with mental health problems are exacerbated by the stigma and discrimination they face, at work, within the family, and as part of their local community. The stigma around mental health problems means that people often do not wish to talk about or seek help (Jorm, 2000; Scottish Government 2012). As we have already seen, those who knew someone with a mental health problem had different attitudes from those who did not. Other studies have shown that direct social contact with people with mental health problems can change attitudes (McDaid, 2008). The 'see me' programme (see Paras 1.8 & 1.13) aims to fully engage people with lived experience of mental health problems and others in an active process of overcoming stigma and discrimination, focused on achieving behaviour change in specific settings and publicly to end the negative impacts of stigma and discrimination.

4.5 Evidence from the SSA in 2010 (Ormston et al, 2011) showed that stigmatising attitudes towards people who experience depression from time

[29] These statements were asked in a random order, to minimise the potential for findings to be affected by the ordering of the questions.

to time were fairly prevalent. Two in five people felt that someone who experienced depression from time to time was unsuitable to be a primary school teacher, the second highest level among the nine distinct social groups who were asked about[30]. However, this had decreased from 51% in 2006. Views were somewhat less negative when asked whether they would feel unhappy if a member of their family married someone who experiences depression from time to time; 21% said they would feel unhappy.

Approach to analysis

4.6 Responses to each of nine statements were recorded on a five-point agree-disagree scale. The statements divide into those for which:

- a response of ‘agree’ or ‘strongly agree’ can be seen as a positive response[31], demonstrating an awareness of the issue or a lack of prejudice;
- a response of ‘agree’ or ‘strongly agree’ can be seen as a negative response[32];
- and one, that ‘people are generally caring and sympathetic to people with mental health problems’, which is ambiguous[33].

4.7 In order to provide a structure for the analysis, we have grouped these nine statements into three categories: knowledge, understanding and awareness (4 items); stigma (2 items): and individual and public rights (3 items).

4.8 In terms of sub-group analysis, we examined a wide range of socio-demographic, experiential and attitudinal factors collected on the survey which were expected, on the basis of previous research, to have an association with people’s attitudes to mental health problems. The factors were:

- Socio-demographic factors (age, gender, income, level of education, social class, urban-rural and area deprivation)
- Experience of mental health (personal experience or knowing someone with mental health problems)
- Social attitudes (levels of trust, community support and attitudes to ethnic diversity)

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[30] The other groups asked about were: gypsy/travellers (46%); someone who from time to time experiences depression (41%); someone aged 70 (39%); someone who has had a sex change operation (31%); gay men and lesbians (18%); a Muslim person (15%); a black or Asian person (6%); men (2%) and women (less than 1%).

[31] ‘Anyone can suffer from mental health problems’; ‘The majority of people with mental health problems recover’; and ‘People with mental health problems should have the same rights as anyone else’.

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

[33] The ambiguity arises because agreement could mean that people really are caring and sympathetic towards those with mental health problems, or it could mean a lack of awareness of the way people with mental health problems are often stigmatised.

4.9 The social attitudes measures are based on a range of different questions which were included in other SSA 2013 modules. The questions on levels of social trust and community support were collected as part of the core module on SSA 2013 funded by the Scottish Government[34]. The question measuring levels of social trust was: 'Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?' A range of measures of levels of community support were included in SSA 2013. The question used in this chapter was how much people agreed or disagreed that: 'If my home was empty, I could count on one of my neighbours to keep an eye on it.'

4.10 The questions on attitudes to ethnic diversity were funded by the ESRC as part of a module on the constitutional future of Scotland. In SSA 2013 respondents were asked if they agreed that Scotland would lose its identity if more Muslims, more blacks and Asians, or more Eastern Europeans came to live here. These questions are used here as a measure of the acceptance of diversity within Scotland. Previous evidence from SSA 2010 (Ormston et al, 2011) showed a significant association between agreeing that Scotland would lose its identity if it were more ethnically diverse and acceptance that 'sometimes there is good reason for people to be prejudiced against certain groups'.

4.11 We have highlighted important sub-group differences in the text, with more detailed tables provided in Annex A. Important differences have been determined through a combination of tests of statistical significance and regression analysis[35].

Knowledge, understanding, and awareness

4.12 Table 4.1 below shows the levels of agreement with the four statements which relate to knowledge, understanding and awareness, and how these have changed over time.

[34] See the full report at: http://www.scotland.gov.uk/Publications/2014/06/3033/downloads.
[35] See Annex B – Technical Details of the Survey for further description of the regression analysis conducted.

Table 4.1: Level of agreement with statements demonstrating knowledge, understanding and awareness of mental health issues, 2002 to 2013

	% Strongly agree/Tend to agree				
	2002	**2004**	**2006**	**2008**	**2013**
Anyone can suffer from mental health problems	98	97	97	93	98
People are generally caring and sympathetic to people with mental health problems	36	39	40	40	39
The majority of people with mental health problems recover	50	46	46	42	33
People with mental health problems are largely to blame for their own condition	7	6	4	4	5
Sample size	*1381*	*1401*	*1216*	*1177*	*1497*

Anyone can suffer from mental health problems

4.13 Anyone can experience a mental health problem, and indeed, around one in four people do each year[36]. Mental health problems can be triggered by a range of factors, including childhood abuse, social isolation, poverty, poor housing, the death of someone close, trauma, head injury, long-term physical ill-health, stress, and caring for a partner or someone close[37]. Misuse of drugs or alcohol may sometimes lead to poor mental health, but the direction of causality is more commonly in the other direction (Frisher et al, 2005).

4.14 In 2013, 98% agreed with the statement that anyone can suffer from mental health problems. There has been very little change in this figure since the first Well? survey in 2002, except for a slightly anomalous result in 2008. It appears that the public understand that mental health problems are widespread.

4.15 With such a high figure, it is not surprising to find that there is little variation between attitudes in terms of age, education, area deprivation or other factors (for full details see Table A.11 in Annex A). Most people in all sub-groups recognised that anyone can suffer from mental health problems. However, there was some significant variation in the percentage who ‘strongly agreed’ with this statement. In particular, 79% of those who knew someone with a mental health problem agreed strongly that anyone can suffer from mental health problems compared with only 61% of those who did not know anyone with a mental health problem.

[36] One in four British adults experience a diagnosable mental health problem each year, and around one in six at any given time (Office for National Statistics, 2001). One in ten children also have a diagnosable disorder (Office for National Statistics, 2005).
[37] See www.mentalhealth.org.uk; www.mind.org.uk

The majority of people with mental health problems recover

4.16 There is an increasing focus on recovery in mental health, both in Scotland and internationally. However, as discussed in Chapter 3 (Para 3.3), 'recovery' may be interpreted in a variety of different ways by both members of the public and those who have experienced mental health problems. The aim of recovery-based approaches is to support people to be able to live meaningful and satisfying lives, with or without the presence of symptoms.

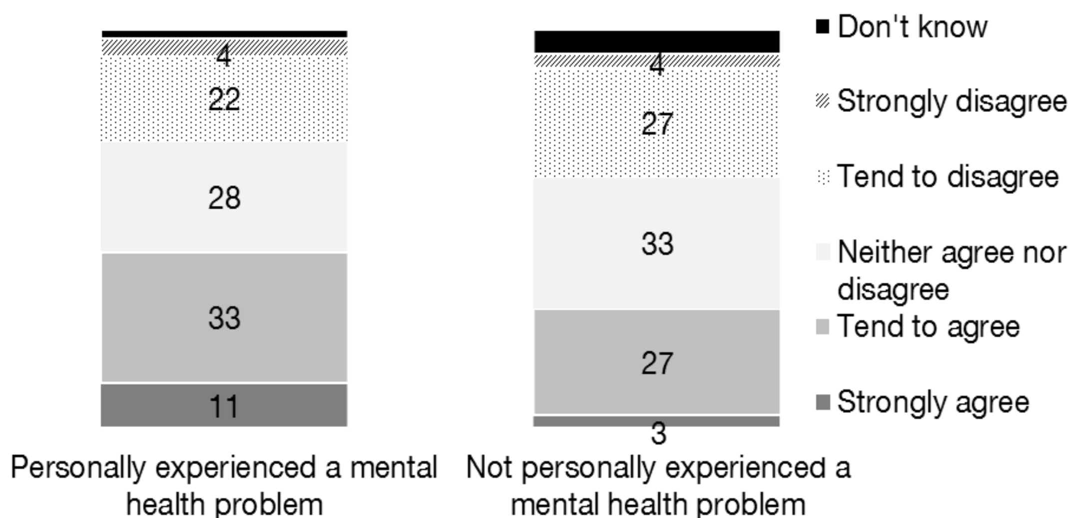
4.17 A third in 2013 (33%) thought that 'the majority of people with mental health problems recover'. This has fallen from a half (50%) in 2002. The reasons for this are not clear. It may reflect a change in the interpretation of the term 'recover' in this context, which may be viewed by some to mean a definitive 'cure' or symptom-free life, while for others it may represent a more nuanced idea of living well and managing with ongoing symptoms. As noted in Para 3.20, in-depth exploration of people's understanding of 'recovery' would be needed before drawing any conclusions about factors driving this change over time.

4.18 Whether someone has personal experience of mental health problems[38] is associated with the belief that 'the majority of people with mental health problems recover'. Forty-four percent of those who had experienced mental health problems agreed that 'the majority of people with mental health problems recover' compared with 30% of people who had never experienced a mental health problem (Figure 4.1 below).

4.19 Sub-groups which had a more pessimistic view about recovery included men and younger people[39]. Those in the lowest income group appeared to be most optimistic about the possibility of recovery, a finding that remained significant even when other factors were taken into account. In particular, 40% of those with a household income of up to £14,300 a year agreed that the majority recover, compared with 30% of those earning over £44,200 a year (see Table A.12 in Annex A).

[38] This question was asked on the self-completion questionnaire which was completed by 1340 respondents.
[39] Age is only significant at the 10% level.

Figure 4.1: 'The majority of people with mental health problems recover' by personal experience of mental health problems (2013)



Base: all respondents.
Sample size: 341 (personal experience); 973 (no personal experience); 26 (Can't choose/refused)

People with mental health problems are largely to blame for their own condition

4.20 Nine out of ten people (89%) disagreed that 'people with mental health problems are largely to blame for their own condition', while just 5% agreed with the statement. These figures have remained fairly stable since the first Well? survey in 2002.

4.21 Neither personal experience of mental health problems, nor knowing someone with a mental health problem, was significantly associated with believing that people with mental health problems are largely to blame for their own condition. Differences were seen in terms of gender, education, and socio-economic classification[40] (for full details see Table A.13 in Annex A). Men (6%), those in routine or semi-routine occupations (10%), and those with no educational qualifications (9%) were the most likely to agree that people are to blame for their own condition (compared with 3% of women, 2% in managerial and professional occupations, and 2% of those with degrees).

People are generally caring and sympathetic to people with mental health problems

4.22 As suggested earlier, the level of agreement with the statement that 'people are generally caring and sympathetic to people with mental health problems' can be interpreted in different ways. For example, it may be an indicator of the level of public sympathy, or it could indicate a lack of

[40] Once all of these variables are included in a regression model, the differences exhibited according to level of education can be accounted for by those of the other variables.

awareness by respondents of the stigmatisation and discrimination experienced by people with mental health problems. In 2013, 39% of people agreed that people are ‘sympathetic to people with mental health problems’. As Table 4.1 (above) shows, there has been very little change in the proportion agreeing with this statement over the last decade. Those working in public health policy, services and advocacy would like to see both more sympathetic attitudes towards those with mental health problems and greater awareness and reduced acceptability of mental health-associated stigma and discriminatory behaviour. It is difficult to say whether an increase or a decrease in the 39% in agreement would be seen as a positive change given the different ways in which the data could be interpreted.

4.23 Among those who have had personal experience of mental health problems about a quarter agreed that ‘people are generally caring and sympathetic to people with mental health problems’. This is substantially lower than the figure for the population of Scotland as a whole. It could be argued that the views of people with mental health problems are the best indication of how caring people really are towards those with mental health problems as their perspective will be shaped by their direct personal experience.

4.24 Those who were more likely to agree that people are caring and sympathetic to those with mental health problems included men, those aged under 25, and those aged 65 or above, the self-employed, those in routine or semi-routine occupations, those with no qualifications, and those who did not know anyone with a mental health problem (for full details see Table A.14 in Annex A).

Stigmatisation of people with mental health problems

4.25 Table 4.2 shows the level of agreement with the two statements which indicate levels of stigma towards those with mental health problems.

Table 4.2: Strongly agree/tend to agree with statements demonstrating the stigma towards those with mental health problems, 2002 to 2013

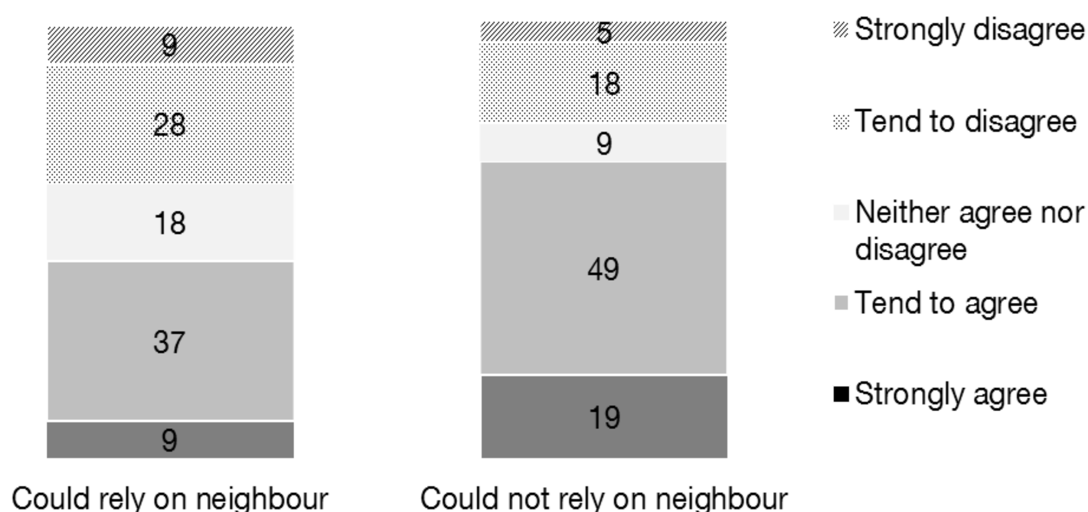
	% Strongly agree/Tend to agree				
	2002	**2004**	**2006**	**2008**	**2013**
If I was suffering from mental health problems, I wouldn't want people knowing about it	50	45	41	44	47
I would find it hard to talk to someone with mental health problems	20	15	17	15	17
Sample size	*1381*	*1401*	*1216*	*1177*	*1497*

If I were suffering from mental health problems, I wouldn't want people knowing about it

4.26 Almost half (47%) said that if they were suffering from mental health problems, they 'wouldn't want people knowing about it', a figure that has only changed slightly since 2002. The survey does not gather data on the various reasons why individuals would or do not want others to know about their mental health problems.

4.27 Of the factors listed in Para 4.7, only one of them, the measure of community support experienced by people, was significantly associated with whether or not one would want other people to know about one's mental health problems (Figure 4.2 below). Those who felt they could rely on a neighbour to look after their home if it were empty were much less likely than those who could not to say they would not want people to know if they had mental health problems (for full details see Table A.15 in Annex A).

Figure 4.2: 'If I were suffering from a mental health problem I wouldn't want people knowing about it' by whether could rely on a neighbour (2013)



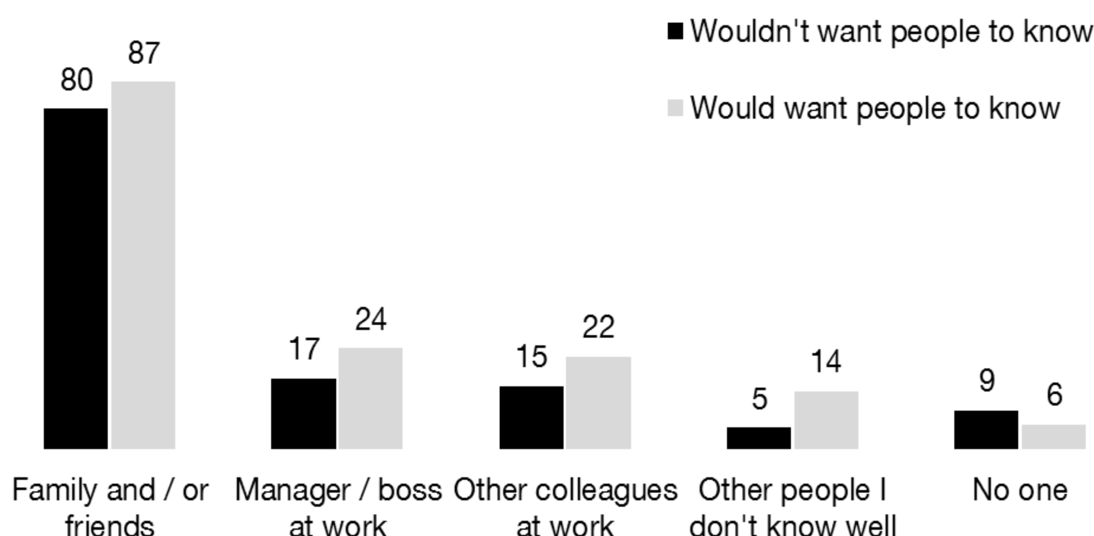
Don't know was chosen by 1% or less.
Base: all respondents
Sample size: 1312 (could rely on neighbour); 130 (could not rely on neighbour)

4.28 For those who said they had personally experienced a mental health problem at some point in their life time[41], we examined how their responses to this statement related to whether they actually told people about their mental health problems, or not. Figure 4.3 below shows that even among those who wanted people to know about their mental health problems, the people they would tell would be largely limited to family and friends. The only significant difference between those who would not want people to

[41] Note that the base for this question is 352. Larger differences between sub-groups are required in order to establish statistical significance.

know and those who would was in terms of telling more distant people. Five percent of those who agreed they would not want people to know had told people they did not know well about their mental health problem, compared with 14% of those who said they would want people to know.

Figure 4.3: Whom have told about mental health problem, by whether would want people to know about own mental health problems (2013)



Base: All those who said they had experienced a mental health problem
Sample size: 191 (wouldn't want people to know); 161 (would want people to know)

I would find it hard to talk to someone with mental health problems

4.29 Around one in six (17%) said that they 'would find it hard to talk to someone with mental health problems', a figure which has changed little since 2002. Thus, it appears that people are much more concerned about people knowing about their own problems than they are about talking with others with mental health problems.

4.30 There was greater variation between sub-groups with respect to whether people would 'find it hard to talk to someone with mental health problems' compared with the statement about whether people would want others to know about their own mental health problems (for full details see Table A.16 in Annex A). Those who were more likely to agree they would 'find it hard to talk to someone with mental health problems' were: men, those aged 65 or above, the self-employed, those with no qualifications[42], those who did not know anyone who has had a mental health problem, those who cannot rely on a neighbour[43], and those who had negative views about ethnic diversity.

[42] Education is not significantly associated with finding it hard to talk to someone with mental health problems once other factors are taken into account in a regression model.
[43] The association between being able to rely on a neighbour and finding it hard to talk to someone with mental health problems is only significant at the 10% level.

4.31 For example, 26% of those aged 65 or above agreed they would ‘find it hard to talk to someone with mental health problems’, compared with 10% of those aged between 45 and 54. And 11% of those who knew someone with a mental health problem agreed with this statement, compared with 28% of those who did not. Not surprisingly, the group least likely to find it hard to talk to someone with a mental health problem were those who have personally experienced mental health problems: only 7% of this group agreed with the statement, compared with 19% of those who did not have personal experience.

Individual and public rights

4.32 The final three statements examined attitudes that were more clearly of a discriminatory nature, although they also contain elements of knowledge and understanding, highlighting the point that discrimination is often about a lack of knowledge rather than overt prejudice. These statements were: ‘people with mental health problems are often dangerous’; ‘the public should be better protected from people with mental health problems’; and ‘people with mental health problems should have the same rights as anyone else’.

4.33 While there is some evidence that those with very serious mental health problems may be more likely to commit violent crimes (see for example, Appleby et al, 2014, Fazel et al, 2014, Van Dorn et al, 2012), there is also evidence that they are more likely to be the victims of crime (see, for example, Pettit et al, 2013).

4.34 Table 4.3 below shows the levels of agreement with the three statements about the perceived danger from people with mental health problems and the balance between individual and public rights, and how these have changed over time.

Table 4.3: Level of agreement with statements about perceived danger from people with mental health problems and the balance between individual and public rights (2002 to 2013)

	% Strongly agree/Tend to agree				
	2002	**2004**	**2006**	**2008**	**2013**
People with mental health problems are often dangerous	32	15	16	19	19
The public should be better protected from people with mental health problems	35	24	32	25	28
People with mental health problems should have the same rights as anyone else	88	88	85	86	82
Sample size	*1381*	*1401*	*1216*	*1177*	*1497*

People with mental health problems are often dangerous

4.35 Overall, 19% of people agreed with the statement 'people with mental health problems are often dangerous'. This is a slight increase on the level reported in 2004, but well below that reported in 2002. There has been no change at all since 2008.

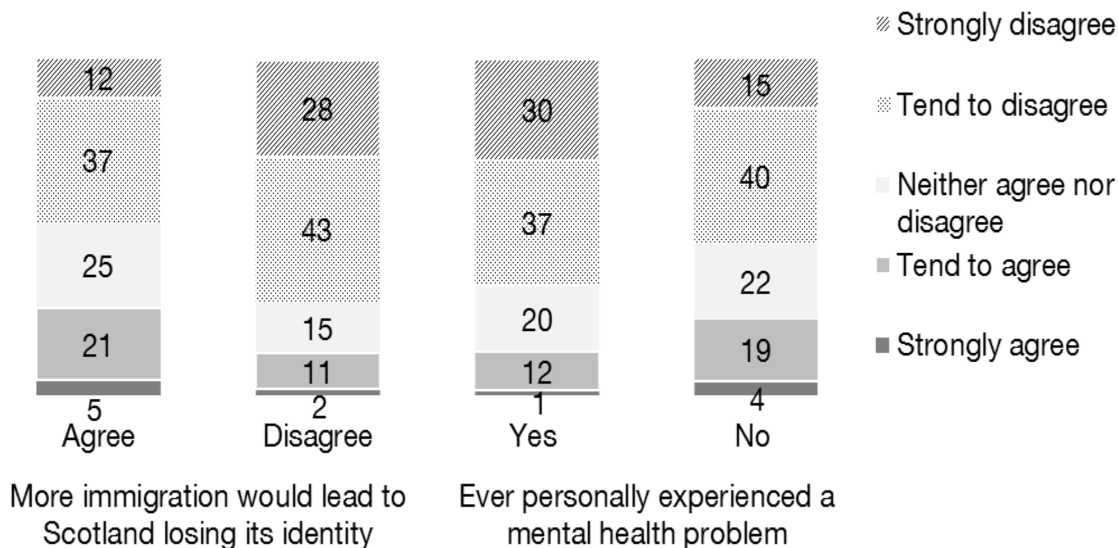
4.36 There were apparent differences in terms of socio-demographic characteristics[44], for example, men, those aged 65 or above, and those with Standard grades or no formal educational qualifications were more likely to agree that 'people with mental health problems are often dangerous' (for full details see Table A.17 in Annex A). However, after conducting regression analysis these factors were no longer significant, or were only marginally significant. There were much stronger associations with whether people knew someone with a mental health problem and whether people felt that Scotland would lose its identity if there was more immigration. The suggested reason for the association between attitudes to immigration and stigmatising attitudes to people with mental health problems (see Para 4.9) is that this question taps into people's general levels of acceptance of diversity, prejudice and discrimination.

4.37 Twenty-seven percent of those who did not know someone with a mental health problem, compared with 15% of those who did, agreed that 'people with mental health problems are often dangerous'. Around a quarter (26%) of those who agreed that more immigration from specific groups would lead to Scotland losing its identity agreed that 'people with mental health problems are often dangerous', compared with 13% of those who did not (Figure 4.4 below).

4.38 Personal experience of mental health problems, and whether people felt that most people can be trusted were also associated[45] with believing that 'people with mental health problems are often dangerous' (Figure 4.4 below). Those with personal experience of mental health problems and those who thought most people could be trusted were less likely to agree that 'people with mental health problems are often dangerous'.

[44] When bivariate analysis was conducted.
[45] These associations were only marginally significant.

Figure 4.4: 'People with mental health problems are often dangerous' by attitudes to ethnic diversity and personal experience of mental health problems



Don't know was chosen by 1% or less
Base: all respondents
Sample size: 854 (agreement with immigration statement); 435 (disagreement with immigration statement); 341 (personal experience of mental health problems); 973 (no personal experience)

The public should be better protected from people with mental health problems

4.39 Over a quarter of people (28%) agreed that 'the public should be better protected from people with mental health problems'. The proportion agreeing with the statement has fluctuated over the years, with the largest change between 2002 and 2004. The figure for 2013 is not significantly different from that in the 2008 Well? survey.

4.40 As with the previous statement, knowing someone with mental health problems reduced the likelihood of agreeing that the public should be better protected. Twenty-four percent of those who knew someone with a mental health problem agreed that 'the public should be better protected from people with mental health problems', compared with 36% of those who did not. Those who agreed that increased immigration would lead to Scotland losing its identity were more likely to agree that 'the public should be better protected from people with mental health problems'. Thirty-six percent of those who agreed that increased immigration would lead to Scotland losing its identity agreed that the public should be better protected, compared with 17% who disagreed. Having no formal educational qualifications, being aged 65 or above, and not having neighbours to turn to for support were also all associated with higher levels of agreement that the public should be better protected (for full details see Table A.18 in Annex A).

People with mental health problems should have the same rights as anyone else

4.41 Eighty-two percent agreed that 'people with mental health problems should have the same rights as anyone else'. This has fallen from 88% in 2002. While this finding is likely to be disappointing to those who defend and seek to improve the rights of people with mental health problems, the reasons for the change are not clear.

4.42 The strongest predictor of disagreement that people with mental health problems should have the same rights was attitudes to ethnic diversity. Eleven percent of people who agreed that increased immigration would affect Scotland's identity disagreed that 'people with mental health problems should have the same rights as anyone else', compared with 5% of those who disagreed that increased immigration would negatively affect Scotland's identity. Not trusting people in general and not being able to turn to neighbours for advice and support were also associated with disagreement with the statement, as was having no personal experience of mental health problems (for full details see Table A.19 in Annex A).

5 PUBLIC ATTITUDES TOWARDS PEOPLE DISPLAYING THE SYMPTOMS OF SCHIZOPHRENIA AND DEPRESSION

5.1 This chapter looks at attitudes towards two specific mental health problems and their symptoms. Scenarios describing someone with schizophrenia and someone with depression were given to each of the respondents. They were then asked what would be the best sources of help for each of them, how likely they would be to harm themselves or other people, and how willing they would be to interact with them in different situations. All respondents were given the same descriptions of two different scenarios: one about someone with schizophrenia and one about someone with depression. However, half the sample was told that the scenarios described someone with schizophrenia and someone with depression, and the other half were just told the scenario described someone with a mental health problem. Scenarios about people with different types of mental health problems were presented in the previous Well? surveys. However, the content of the scenarios was changed substantially between 2008 and 2013 so comparisons over time are not possible[46].

5.2 The two different introductions to the scenarios were as follows:

This card describes someone who has schizophrenia - please read through it or I can read it out if you prefer. I'd then like to ask you some questions about this person; or

This card describes someone who has a mental health problem – please read through it or I could read it out if you prefer…

The first scenario, as it appeared on the card, read:

Andy was doing pretty well until six months ago. But then things started to change. He thought that people around him were criticising him and talking behind his back. Andy heard voices even though no one else was around. These voices told him what to do and what to think. Andy couldn't work any more, stopped joining in with family activities and started to spend most of the day in his room.

A similar introduction was provided for the second scenario, using either the term 'depression' or a 'mental health problem'. The second scenario read:

Stephen has been feeling really down for about six months and his family have noticed that he hasn't been himself. He doesn't enjoy things the way he normally would. He wakes up early in the morning with a flat heavy feeling that stays with him all day long. 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.

[46] The Well? surveys used three different scenarios, one describing someone with depression, one describing someone with schizophrenia, and one describing someone with stress. Half the respondents were given versions which described a man, and half given versions describing a woman. In none of the scenarios was the diagnosis mentioned.

5.3 Nine questions were asked following each scenario:

- Say it was possible for Andy/Stephen to get help from some people or other sources. Which of the following would be the best three sources of help? (from a list of nine options)
- In your opinion, how likely, or unlikely, is it that Andy/Stephen would do something harmful or violent to…
    - …himself?
    - …other people?
- How willing, or unwilling, would you be to …
    - …move next door to Andy/Stephen?
    - …spend an evening socialising with Andy/Stephen?
    - …make friends with Andy/Stephen?
    - …have Andy/Stephen as a workmate or colleague?
    - …have Andy/Stephen marry into the family?
    - …have Andy/Stephen provide childcare for someone in your family?

5.4 The scenarios were intended to encourage the respondent to think about a person, rather than just 'a label'. Including a specific diagnostic label in the introductions for half the sample tested whether there was any reaction to the labels.

Approach to analysis

5.5 The analysis has been divided into three sections. The first looks at responses to the question about the best sources of help, the second at responses to the questions about the likelihood of causing harm, and the third at responses to the questions on willingness to interact with the people in the scenarios.

5.6 Attitudes to schizophrenia and attitudes to depression have mostly been considered separately. In the section on willingness to interact, we also examined the extent to which individual respondents held the same or different attitudes to people with schizophrenia or depression.

5.7 Most of the analysis combined the views of those given a label for the condition described and those who were not, as there were no significant differences in the attitudes to these two groups. Where there were significant differences between responses from the two groups, these are discussed.

5.8 How attitudes varied between sub-groups was explored in relation to socio-demographic factors, area level factors, mental health experience and

social attitudes. This analysis was conducted using the same factors as in the previous chapter[47], with the following amendments:

- Measures of trust, community support and attitudes to ethnic diversity were not considered in relation to the questions on sources of help
- Whether the respondent personally knew anyone close who has had schizophrenia was used to analyse responses to the questions about the person with schizophrenia
- Whether the respondent personally knew anyone close who has had depression, and whether the respondent had experienced depression themselves, were used to analyse responses to the questions following the scenario about depression

5.9 Important sub-group differences have been highlighted in the text, with more detailed tables in Annex A. Again, important differences were determined through a combination of tests of statistical significance and regression analysis.

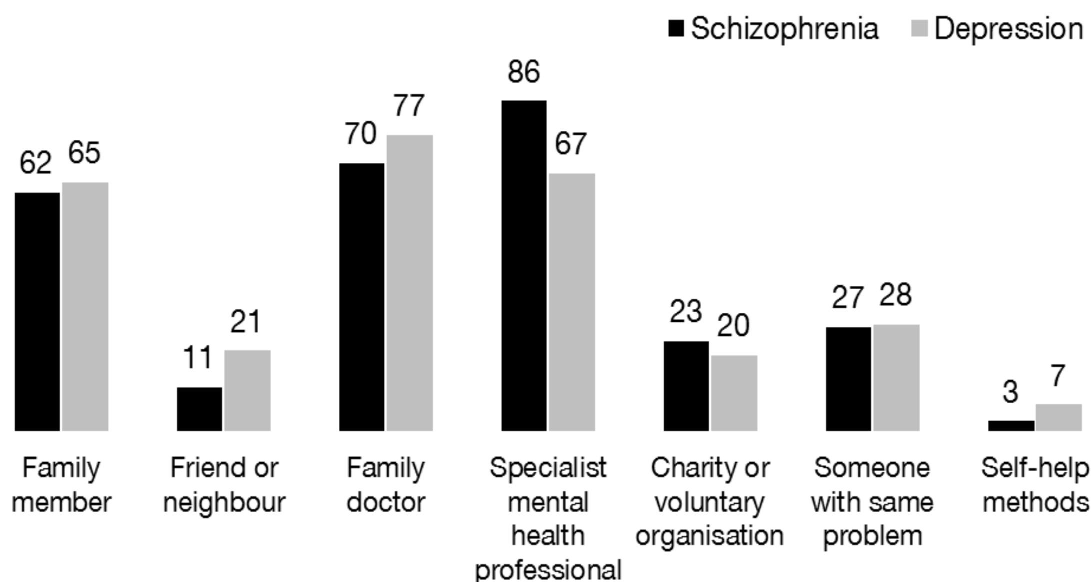
Sources of help

5.10 The most commonly mentioned source of help deemed appropriate for someone with the symptoms of schizophrenia, was a specialist mental health professional (86%), followed by a family doctor (70%) and a family member (62%) (Figure 5.1 below). Around a third of people (34%) mentioned all three of these[48]. The other answer options were chosen by less than a third. The same three categories also dominated responses for the scenario describing someone with the symptoms of depression. However, it is interesting that for someone with depression the most commonly mentioned category was family doctor (77%), followed by the specialist mental health professional (67%) and a family member (65%). Over a quarter (28%) chose these as their top three sources.

5.11 The difference between responses to the two scenarios showed that more people recognised that the person with schizophrenia had a need for specialist involvement. Around twice as many people mentioned help from a friend or neighbour for the person with depression (21%, compared with 11%). While there was an expectation that family members may take on some of the responsibility for providing support for people with both schizophrenia or depression, that expectation was rarely extended to friends or neighbours in the case of schizophrenia. Self-help methods were very rarely mentioned as one of the three best sources of help for either scenario (Figure 5.1 below).

[47] Age; gender; income; level of education; social class; area deprivation; whether respondent lives in an urban area, small town, or rural area; whether respondent knows someone close who has, or has ever had, a mental health problem; whether respondent personally has, or has ever had, a mental health problem; if respondent thinks other people can generally be trusted; whether respondent could rely on a neighbour to look after their home (a measure of community support); if respondent thinks Scotland would lose its identity with more immigration from specific groups (a measure of attitudes to ethnic diversity).
[48] Respondents were asked to list up to three sources of help.

Figure 5.1: Three best sources of help for someone with schizophrenia or depression (2013)



Base: all respondents
Sample size: 1,497

Named and unnamed conditions and suggested sources of help

5.12 When responses to the scenarios were considered according to whether respondents were given a label in addition to the symptoms, there were very few differences, suggesting people generally recognised the nature of these conditions, even if they did not know what the conditions actually were. One difference of note was that when presented only with the symptoms of schizophrenia, 73% mentioned the family doctor as one of the best sources of help. When the term schizophrenia was also mentioned, only 67% mentioned the doctor.

How views on suggested sources of help for someone with schizophrenia and someone with depression varied between sub-groups

5.13 Views on the best sources of help varied by age group, whether people knew someone with a mental health problem and their own personal experience of mental health problems. The youngest age group (18 to 24 years old) were considerably more likely than other age groups to mention family members and someone with the same problem as sources of help both for those with schizophrenia and for those with depression. To a lesser degree this group were also more likely to mention friends and neighbours as a source of help and they were less likely to mention seeking help from a family doctor in both cases. The youngest age group were also more likely to suggest self-help methods as a source of help for someone with depression.

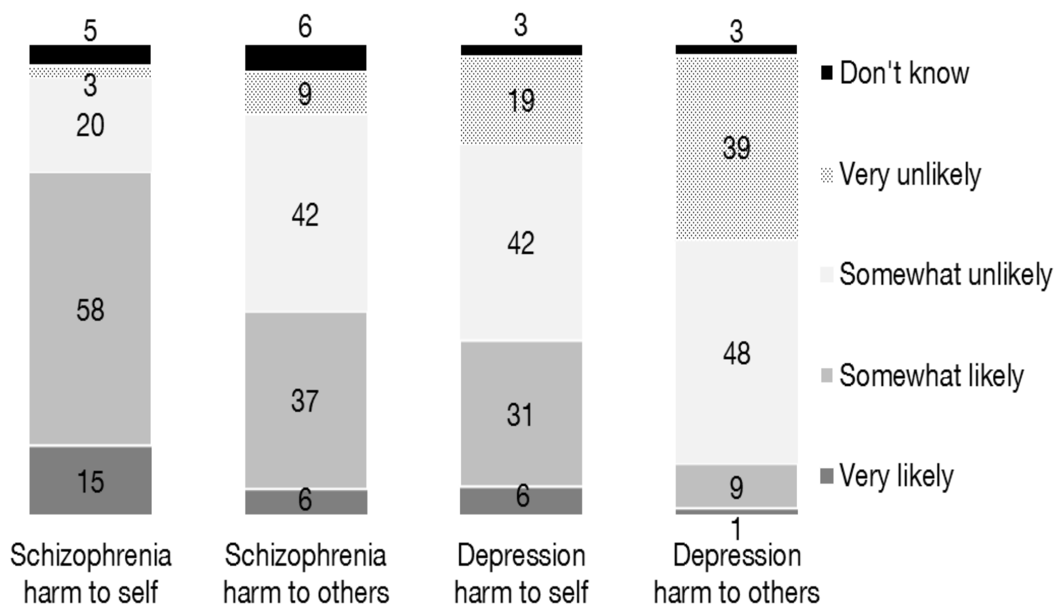
5.14 Those who knew someone with a mental health problem were more likely than those who did not to mention help from a specialist health professional and help from a charity or voluntary organisation for someone with schizophrenia (89% compared with 80% for the specialist health professional and 25% compared with 19% for the charity). Those who had ever personally experienced depression were slightly more likely than those who had not to suggest self-help methods as a source of help for those with depression (11% compared with 6%).

Likelihood of harming self or others

5.15 Respondents were asked how likely it was that those described in the scenarios would do something harmful or violent to themselves or to others. It is possible that a wide range of types of harm or violence may have been considered by respondents in giving their answers.

5.16 Almost three-quarters (73%) of people thought that the person with symptoms of schizophrenia was likely to harm themselves (Figure 5.2 below). People with schizophrenia are indeed more at risk of self-harm than others, with around half of this group self-harming at some time in their life (NICE, 2012). Approximately 5% of people diagnosed with schizophrenia die by suicide (Hor et al, 2010), with around one in five suicides in those aged under 35 being attributed to schizophrenia (Appleby et al, 2014).

Figure 5.2: Likelihood of someone showing the symptoms of schizophrenia or the symptoms of depression harming themselves or others (2013)



Base: all respondents
Sample size: 1,497

5.17 Depression is also associated with suicidal thoughts and self-harm, although the risk of serious harm is smaller than for someone with

schizophrenia. More than two-thirds of those attending an accident and emergency department at a hospital for self-harm would meet the criteria for being diagnosed with depression at the time they are assessed (NICE, 2012). Thirty-seven percent thought that the person with symptoms of depression was likely to harm themselves, demonstrating that overall people believe that someone with depression was less likely to harm themselves than someone with schizophrenia (Figure 5.2 above).

5.18 More than two-fifths (43%) thought that the person with schizophrenia was likely to do something harmful or violent to others. One in ten thought that the person with depression was likely to do something harmful to others (Figure 5.2 above).

How views on likelihood of someone with schizophrenia harming others varied between sub-groups

5.19 The strongest predictor of whether people thought someone with schizophrenia was likely to harm other people was the measure of attitudes to diversity. Forty-eight percent of those who agreed that Scotland would lose its identity if there were increased immigration from specific groups said it was likely that someone with schizophrenia would harm someone else, compared with 40% of those who disagreed. This matches what was found in the previous chapter with respect to the statements that ‘people with mental health problems are often dangerous’ and the ‘public should be better protected from people with mental health problems’ (Paras 4.34 and 4.38). Such attitudes did not predict whether people thought someone with depression would harm others.

5.20 The only other significant factor associated with the likelihood of someone with schizophrenia harming others was whether the respondent knew anyone close to them with schizophrenia. One lay perception might be that a lack of knowledge could increase someone’s views of the likelihood of someone with schizophrenia causing harm to others. However, it was actually those who knew someone with schizophrenia who were more likely to think someone with schizophrenia would harm someone else (55% of those who knew someone with schizophrenia compared with 42% of those who did not).

How views on likelihood of someone with schizophrenia harming themself varied between sub-groups

5.21 People’s views on ethnic diversity were also a predictor of whether they thought someone with schizophrenia was likely to harm themselves (76% of those who agreed that Scotland would lose its identity with increased immigration said it was likely compared with 68% of those who disagreed). Other factors associated with thinking someone with schizophrenia was likely to harm themselves included gender (women were more likely than men to think this); income (those on middle incomes were the most likely to think this); urban-rural (those in remote rural areas were the least likely to think this); and trust (those who generally thought that ‘most people can be

trusted' were less likely to think someone with schizophrenia would harm themselves).

How views on the likelihood of someone with depression harming others varied between sub-groups

5.22 Those who had personally experienced depression, or knew someone who had experienced depression, were less likely to think that someone with depression would harm someone else (7% of both those with personal and indirect experience of depression, compared with 11% of those who had not personally experienced depression, and 15% of those who did not know anyone who had). People who were generally trusting were also less likely to think that someone with depression would do something harmful to others.

How views on the likelihood of someone with depression harming themself varied between sub-groups

5.23 Younger people were the most likely to think someone with depression would harm themselves. Sixty-one percent of those aged 18 to 24 and 40% of those aged 25 to 34 thought that someone with depression was likely to harm themself, compared with 28% to 35% of those in the older age groups. This may be a reflection of the fact that self-harm is much more prevalent in young adults and adolescents (Nock, 2010) and therefore awareness of self-harm may be higher among these age groups. Those who were less trusting of others in general[49] were also more likely to think that someone with depression would harm themselves.

Willingness to interact with someone with schizophrenia

5.24 A set of six questions linked to each of the scenarios asked about people's willingness to interact in a range of situations[50] with the person depicted. More than one in five (22%) were not willing to interact with someone with schizophrenia in any of the ways mentioned, while only 8% were willing to interact in all the different ways.

5.25 Around two thirds of people said they were willing to make friends with someone with schizophrenia (66%) and a slightly smaller proportion were willing to spend an evening socialising with someone with schizophrenia (59%). Around half (49%) said they were willing to move next door to someone with schizophrenia, a third were willing to have them marry into their family (33%), but only one in ten were willing to have them provide childcare for someone in their family (10%) (see Figure 5.3 below).

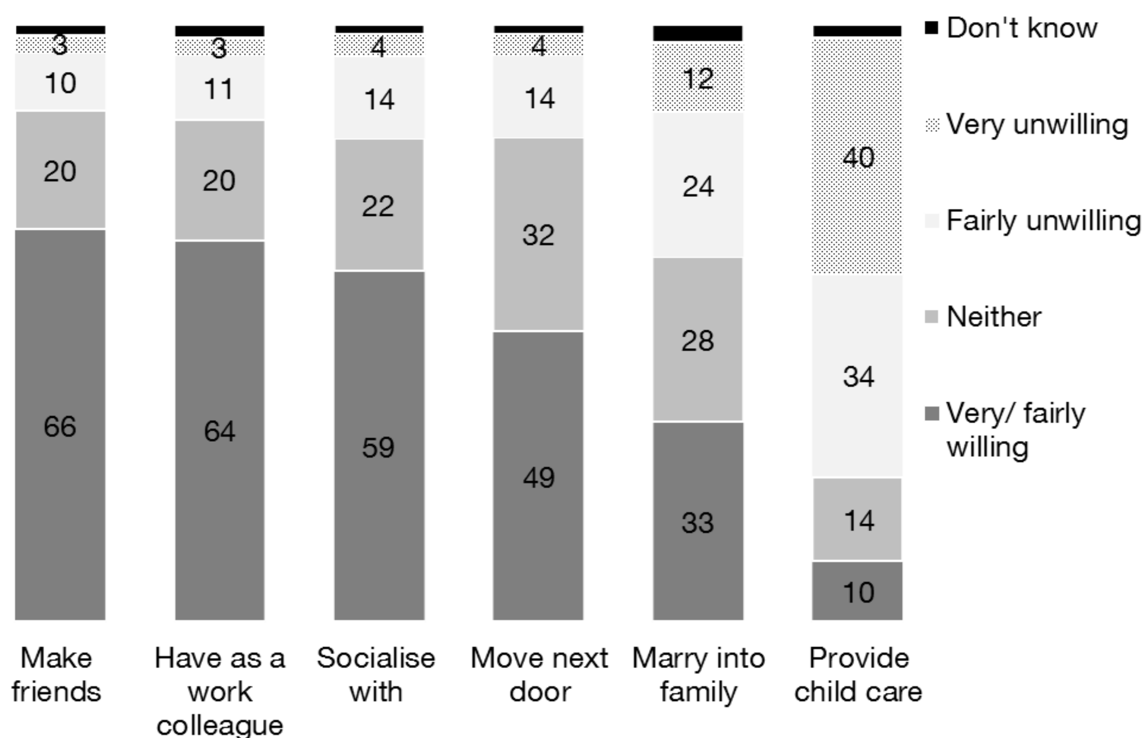
5.26 Respondents were also asked about work situations. Someone with schizophrenia is covered under the Equality Act 2010 and any

[49] Respondents who chose 'you can't be too careful in dealing with people' rather than 'most people can be trusted'.
[50] Being willing to make friends with someone with schizophrenia, have them as a work colleague, spend an evening socialising with them, move next door to them, have them marry into the family, and have them provide childcare for a family member.

discrimination at work because of this illness would be considered illegal. Around-two thirds of people said they were willing to have someone with schizophrenia as a work colleague (64%). However, one in seven (14%) said they would be unwilling to have someone with schizophrenia as a work colleague.

5.27 Responses to these questions were highly correlated. In general, for those who said they were willing for someone with schizophrenia to provide child care for someone in their family, they were also willing for them to marry into the family. Similarly, if they were willing for someone with schizophrenia to marry into the family, they also tended to be willing to make friends with, socialise with, move next door to someone with schizophrenia and to have them as a work colleague.

Figure 5.3: Willingness to interact with someone showing symptoms of schizophrenia (2013)



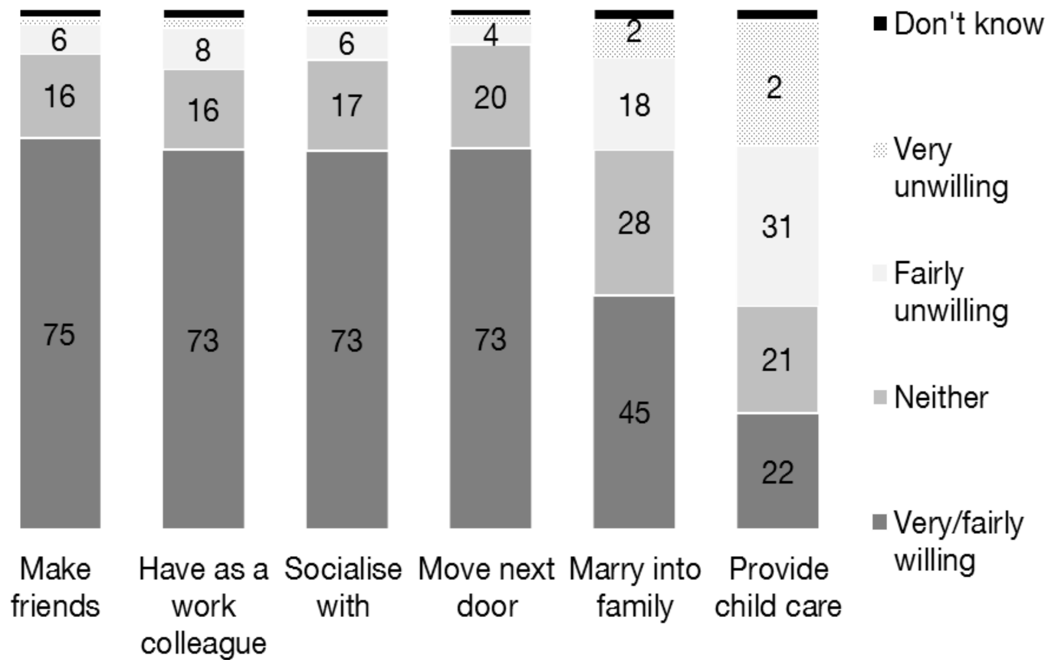
Don't know was chosen by 3% or less in each category.
Base: all respondents
Sample size: 1,497

Willingness to interact with someone with depression

5.28 Responses to the questions on willingness to interact with someone with depression were even more highly correlated than they were for someone with schizophrenia. Nearly everyone who was willing for someone with depression to provide child care for someone in their family was also willing for them to marry into the family. And nearly everyone who was willing for

them to marry into the family was willing to interact in all four of the other ways. Twenty percent were willing to interact with someone with depression in all of the ways mentioned and 15% in none of these situations.

Figure 5.4: Willingness to interact with someone showing symptoms of depression (2013)



Don't know was chosen by 2% in each category.
Base: all respondents
Sample size: 1,497

5.29 Around three quarters said they were willing to make friends with someone with depression, to have them as a work colleague, to socialise with them, and to move next door to them (Figure 5.4 above). However, fewer than half said they were willing to have someone with depression marry into the family, and a fifth said they were unwilling for someone with depression to marry into their family. Given the fact that around 50% of people knew someone with depression, as discussed in Chapter 2 (see Para 2.5), these figures show quite high levels of discrimination where it would not necessarily be expected. Less than a quarter of people said they would be willing to have someone with depression provide childcare (23%).

How willingness to interact with someone with schizophrenia varied between sub-groups

5.30 Given the high correlation between the different types of interaction, it is not surprising to find the same factors tended to be associated with responses to each of the questions. Women were more likely than men to say they would be willing to make friends with someone with schizophrenia, have

them as a work colleague, socialise with them, move next door to them, and have them marry into the family. Older people, the self-employed, those who did not know anyone with a mental health problem, those who had not personally experienced a mental health problem, and those who said increased immigration would affect Scotland's identity, also tended to be less willing to interact in each of these ways.

5.31 However, the question on whether people were willing for someone with schizophrenia to provide childcare did show a different pattern of responses. Knowing someone close to you with schizophrenia was the only significant factor associated with being willing to have someone with schizophrenia provide childcare[51]. One in five who knew someone with schizophrenia (19%) said they would be willing to have someone with schizophrenia provide childcare, compared with around one in ten (9%) who did not.

How willingness to interact with someone with depression varied between sub-groups

5.32 Gender, age, income and knowing someone with a mental health problem were associated with willingness to interact with someone with depression. Women and those who knew someone with a mental health problem were more likely to say they would be willing to move next door to someone with depression, to spend an evening socialising with them, to make friends with them, to have them as a work colleague, and to have them marry into the family. Those aged 65 or above and those on lower incomes were less willing to do each of these things[52].

5.33 Again, the question about childcare was slightly different, with the only significant factors being age and general trust in others[53]. Only 11% of those aged 65 and above said they would be willing to have someone with depression provide childcare, compared with nearly a third of those aged 18 to 34. Those who thought that most people can be trusted were more likely to say they would be willing to have someone with depression provide childcare: 26% of those who thought most people can be trusted compared with 14% of those who thought 'you can't be too careful in dealing with people'[54].

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[51] Having personal experience of mental health problems also increased the likelihood of being willing to have someone with schizophrenia provide childcare in the bivariate analysis, however, this was no longer significant when other factors were taken into account in the regression analysis.

[52] Whether people agreed that Scotland would lose its identity if there was more immigration showed some weaker associations with the different aspects of interaction. Other differences such as those based on level of education, on knowing someone with depression, or having personal experience of mental ill-health were not significant in the regression analysis.

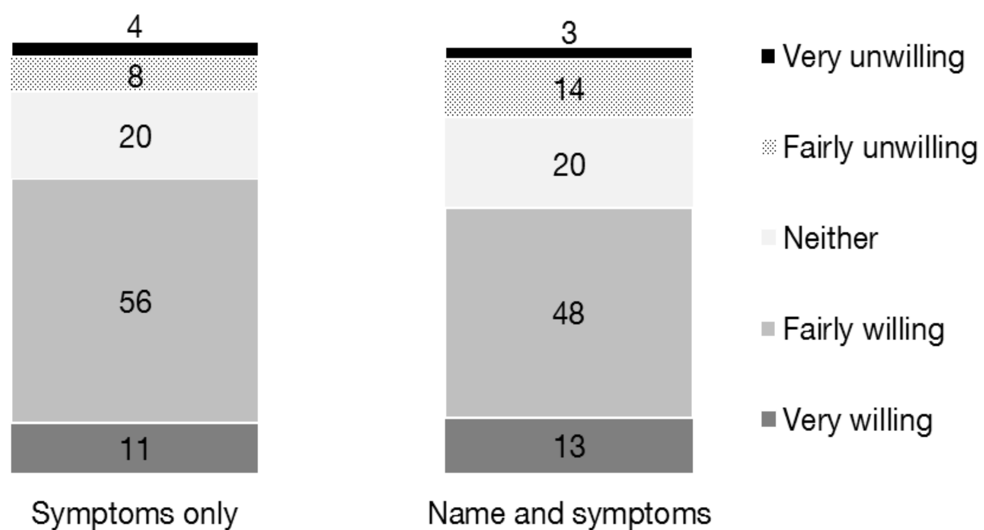
[53] Factors that were still significant after the regression analysis.

[54] Personal and indirect experience of mental health were significant in the bivariate analysis but were no longer significant in the regression analysis.

Named and unnamed conditions and willingness to interact

5.34 There were few differences according to whether the condition was named in the scenario, suggesting the terms ‘schizophrenia’ and ‘depression’ tend not to add to stigmatisation of those with these mental health problems. The only difference of note, that may be of concern in a workplace environment, was that those who were told that the person had schizophrenia were more likely to be unwilling to have them as a work colleague (17%) compared with 12% of those who were only told the symptoms (see Figure 5.5 below).

Figure 5.5: Willingness to have someone with schizophrenia as a work colleague by whether told only symptoms, or that they had schizophrenia (2013)



Don’t know was chosen by 3% or less in each category.
Base: all respondents
Sample size: 759 (symptoms only); 738 (name and symptoms)

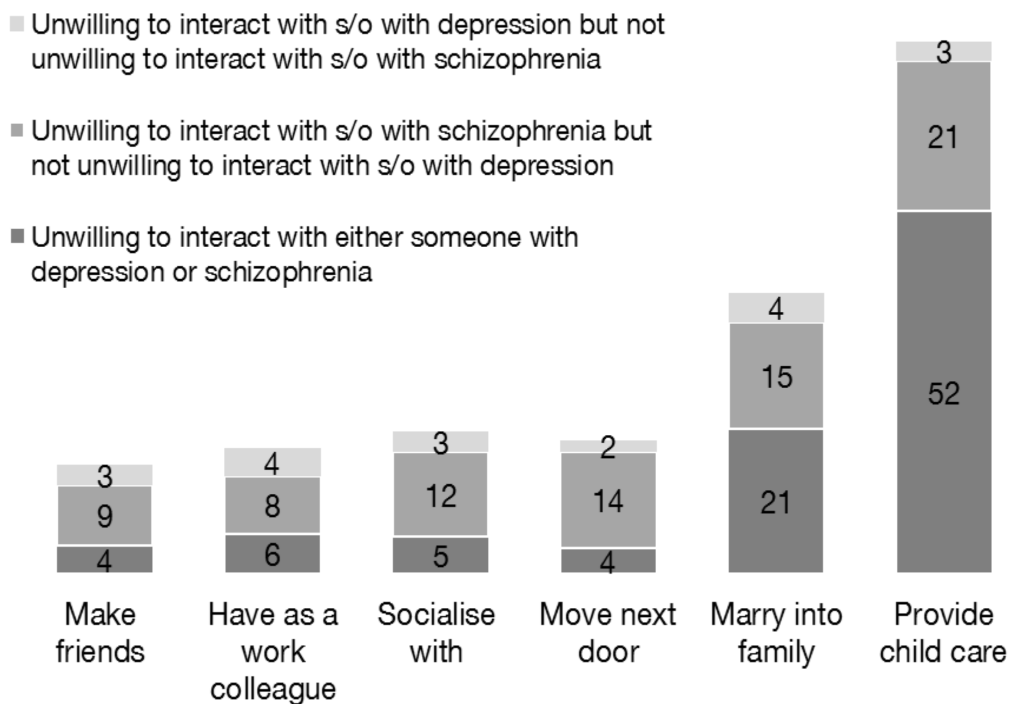
Attitudes towards both schizophrenia and depression

5.35 It might be expected that those who held negative attitudes towards the person with symptoms of depression would also hold negative attitudes towards the person with symptoms of schizophrenia, but this was not always the case.

5.36 Figure 5.6 (below) shows that between 16% and 20% of people were unwilling to interact with either or both those with depression or schizophrenia in relation to making friends, having them as a work colleague, socialising with them, or moving next door. About 40% were unwilling for either or both to marry into the family and 76% were unwilling to have them provide childcare. Between 2% and 4% of people said they were unwilling to interact with someone with depression, in each of the ways mentioned, but were not unwilling to interact with someone with schizophrenia.

5.37 In the situations where most people were willing to interact with either someone with schizophrenia or depression, the proportion who were unwilling to interact with someone with depression but were willing to interact with someone with schizophrenia were high. At least a third of those who were unwilling to make friends with someone with depression were not unwilling to make friends with the person with schizophrenia. The same is true for having them as work colleagues, socialising with them and moving next door to them. The reasons for this are not clear, but may partly be an artefact of the small numbers involved.

Figure 5.6: Whether unwilling to interact with someone with schizophrenia and someone with depression



Base: all respondents
Sample size: 1,497

6 CONCLUSIONS

6.1 The mental health and wellbeing of populations, and in particular adopting policies and practices which reduce stigma and discrimination for those experiencing mental health problems of all kinds, has been a focus of policy making both in Scotland and internationally since the early 2000s. Based on our analysis of SSA 2013 and the earlier Well? surveys, this final chapter sets out our main conclusions in relation to how attitudes to people with mental health problems have changed over the last decade, what factors are related to public attitudes towards people with mental health problems, and what the experiences of those with mental health problems have been.

6.2 Post-devolution Scottish policy in this area has emphasised human rights, improving recovery, reducing inequality, and promoting social justice. This approach has incorporated policy and practice initiatives to reduce both stigmatising attitudes and discriminatory behaviours (that is behaviour by individuals and institutions that either deliberately or inadvertently excludes people with mental health problems from enjoying the rights, dignity, services, social relationships, and resources available to others). Reducing the prevalence of stigmatising attitudes is important in its own right and helps to build good relations between all sections of society. Moreover, since attitudes often underpin behaviour, reducing stigmatising attitudes might also be expected to reduce discriminatory behaviour in the longer term.

6.3 The analysis in this report uses data from SSA 2013 together with data from previous Well? surveys conducted between 2002 and 2008. Together these surveys cover a period (2002-2013) which includes the relatively strong economic phase preceding the start of the downturn in 2007 and the years of economic austerity, uncertainty and public sector budget constraint which have followed.

6.4 It might be expected that the recession would have an impact on the prevalence of mental health problems. However, the evidence which would be needed to explore this is far from conclusive. The most recent overview (based on a wide range of sources[55]) of Scotland-specific data for mental health and wellbeing, together with trends over time, presents a fairly mixed picture (NHS Health Scotland, 2012). The detailed analysis of time trends show, for example, that rates of suicide have improved, that there has been no significant change in the incidence of common mental health problems, and that levels of possible alcohol dependency[56] have increased. Moreover, time trend data are not (yet) available for some key indicators (mental wellbeing, depression, anxiety and deliberate self-harm) leaving,

[55] Sources include: the Scottish Health Survey; the Scottish Household Survey; the Scottish Crime and Justice Survey; the Scottish House Conditions Survey; Annual Population Survey; Scottish House Conditions Survey; Scottish Social Attitudes survey; National Records Scotland; the Family Resources Survey

[56] Based on scoring 2 or above on the CAGE alcohol dependency questionnaire, indicating possible alcohol dependency in the previous 3 months.

according to the report, ‘a fair amount of uncertainty regarding how adult mental health has changed over recent years’.

6.5 SSA 2013 and the previous Well? surveys showed that the proportion with personal experience of mental health problems has remained fairly stable since 2002 at around one-quarter, as has the proportion who said they knew someone with any kind of mental health problem (around two-thirds). Women, those in the lowest income group, and those under 55 were more likely to say they had had personal experience of a mental health problem. The condition with which respondents were most familiar was depression; over one half of all respondents (51%) said they knew someone with depression. Despite the overall stability in the proportion who knew someone with a mental health problem, there has been an increase of between 6% and 10% since 2008 in those saying they knew someone with depression, dementia or an anxiety disorder.

6.6 Overall, the evidence from this report indicates that public attitudes towards mental health and those with mental health problems have been fairly stable in Scotland over the last decade, with no clear trend towards either a reduction or an increase in stigmatising attitudes being detected. However, there have also been a few important changes relating to specific questions (see below) which cannot be fully explained by the survey data alone. Moreover, it is not possible to say, on the basis of this analysis, whether the patterns which have been observed would have been different had the economy not gone into recession in 2008.

6.7 In some areas this stability provides evidence of continued widespread acceptance and tolerance of people with mental health problems by the general public. For example, there is almost universal acceptance of the possibility of ‘anyone’ experiencing a mental health problem (between 93% and 98% believed so on all five occasions that the question was asked between 2002 and 2013) and almost universal disagreement that people experiencing mental health problems are ‘largely to blame’ for their condition (93%-96% disagreed on all five occasions).

6.8 However, alongside these tolerant attitudes, responses also indicated that the public hold a range of stigmatising attitudes, none of which has decreased over time[57]. In particular: almost half of respondents (between 41% and 50% in each of the five surveys) would not want people to know if they experienced a mental health problem; about 1 in 5 (between 15% and 20%) would find it hard to talk to someone with mental health problems; between one-quarter and one-third (25% to 35%) thought the public should be better protected from people with mental health problems; and the proportion who thought people with mental health problems are dangerous remained consistent (between 15% and 19% in the period 2004-2013, although a higher figure was recorded in 2002).

[57] Although these (four) attitudes have fluctuated over time there has been no consistent pattern of either increase or decrease in the proportions adopting stigmatising attitudes.

6.9 Contrasted with this fairly stable picture are two attitudes that have shown some change over time, although in neither case is there an obvious explanation. First, the proportion who thought ‘people with mental health problems should have the same rights as anyone else’ was lower in 2013 (82%) than when it was first recorded in 2002 (88%) and slightly lower than the 2008 figure (86%).

6.10 Second, the proportion of people who agreed that ‘the majority of people with mental health problems recover’ has shown a clear downward trend over time from 50% in 2002 to 33% in 2013. This latter finding may simply be an artefact of different interpretations of the terminology employed. It is unclear whether respondents interpret mental health recovery as living symptom-free or living well and managing ongoing symptoms. Greater public debate and more visible discussion of mental health may also have affected the conceptualisation of ‘recovery’ which respondents are applying. It is notable that those with personal experience of mental health problems were more likely than those without to agree that ‘the majority of people with mental health problems recover’ (44% of those with personal experience compared to 30% of those without).

6.11 In relation to public attitudes towards people showing the symptoms of depression and schizophrenia, in 2013[58] there was evidence that a sizeable minority (15% in the case of someone with depression and 22% in the case of someone with schizophrenia) were unwilling to have any form of social interaction with these individuals. This would appear to indicate that at least 1 in 7 hold distinctly stigmatising attitudes towards people displaying symptoms of schizophrenia or depression. A smaller, but still not insignificant proportion (9% in the case of depression and 14% in the case of schizophrenia), were unwilling to have this person as a work colleague.

6.12 However, large numbers of the general population displayed inclusive attitudes towards people displaying symptoms of schizophrenia and depression. More than three-quarters (76%) would be willing to make friends with someone with depression and two-thirds (66%) with someone with schizophrenia. Moreover, almost one-half (45%) were willing for someone with depression to marry into the family, and one-third (34%) for someone with schizophrenia.

6.13 Views on whether someone with schizophrenia or depression might do something harmful to others varied considerably according to the condition being considered. Almost half (43%) believed this was possible in the case of schizophrenia compared with just 1 in 10 for depression. Given the low likelihood that someone with a mental health problem will harm others, this overestimate of the risk by the general public indicates a need for education and awareness-raising to foster better public understanding.

6.14 The evidence specifically in relation to those who have personal experience of mental health problems is mixed, with some aspects remaining stable over time and some showing marked changes. The changes which were

[58] No comparisons over time are possible because of changes to question wording between years.

found are not easy to interpret or explain (see below) and further research would be required to elucidate the factors which underlie them.

6.15 Three main features have remained fairly stable over time for those with personal experience of mental health problems. First, the extent to which they would tell others about their mental health problems has not changed. In 2013, 85% said they had told ‘someone’, 19% said they had told their manager or boss at work, and 17% said they had told other colleagues at work. These figures are similar to those recorded in 2006 and 2008. The figures for those who would be comfortable telling their boss suggest that there is more work to be done in creating supportive and stigma-free workplaces.

6.16 Second, the factors which people identified as hindering their recovery have been stable over time. The five factors chosen most frequently in 2013 were: ‘not acknowledging I had a problem’ (18%); ‘not understanding what was going on’ (16%); not feeling able to tell people’ (15%); ‘continuing to experience symptoms’ (13%); and ‘negative attitudes of those around me’ (11%). Note that this last factor is a direct indicator of the extent of stigmatising attitudes which those with mental health problems encounter. These factors highlight a range of potential policy and practice considerations for the future.

6.17 Third, the social impacts reported by those who had personal experience of mental health problems increased between 2008 and 2013 but were at a similar level to those found in 2004. In 2004, 36% reported a social impact of any kind compared with 23% in 2008, and 37% in 2013. (The reason for the increase between 2008 and 2013 is not clear.) There is some evidence to suggest that the anticipation of discrimination, and the self-stigma which partly arises from this, might be greater than the likelihood of actually experiencing discrimination. Whilst 13% of respondents with a mental health problem said they had been discouraged by others from attending an event, 22% said they had themselves chosen to avoid a social event because of the way they thought people would treat them. Note that this latter figure was even higher (33%) for those in the lowest income group.

6.18 There were two main aspects of the experience of those with mental health problems which demonstrated substantial change over time. Again, the reasons for these changes are unclear. First, the proportion of those with mental health problems who received a positive message about their recovery from professionals, and from family and/or friends, has declined. Sixty-five percent of people with mental health problems received a positive message from professionals about their recovery in 2013 compared with 73% in 2008. Similarly, 66% received a positive message from family and/or friends about their recovery in 2013 compared with 79% in 2008. Further work should be directed at understanding the reasons for this change.

6.19 Second, the extent to which particular factors were identified by those with experience of a mental health problem as helping their recovery have changed quite substantially since 2008. There was consistency in the

extent to which respondents chose ‘medication’ as a supporting factor (about two-fifths in 2008 and 2013) and ‘developing my own coping strategies’ (about one-quarter on each occasion). However, the proportion choosing ‘support from family or friends’ decreased substantially (from 62% to 41%) as did the proportion choosing ‘having belief in myself’ (from 31% to 15%). By contrast, the proportion choosing ‘other forms of treatment/therapy’ increased (from 19% to 27%) as did the proportion choosing ‘finding out more about mental health’ (from 8% to 19%). Additional research is needed to explain these changes.

6.20 In 2013, as in previous years, attitudes to mental health varied between socio-demographic subgroups. Across a range of attitudes women showed more tolerant and inclusive attitudes than men, whilst older people, aged 65 and over, were more likely than others to hold stigmatising attitudes. Those with higher levels of education, managerial and professional occupations, and higher incomes were less likely to hold stigmatising attitudes than those with no formal educational qualifications, those in routine or semi-routine occupations and those with lower incomes.

6.21 In addition, a range of other social attitudes were associated with the likelihood of holding stigmatising attitudes. In particular, believing that increased ethnic diversity would cause Scotland to lose its identity was associated with a greater likelihood of holding stigmatising attitudes, whilst believing that ‘most people can be trusted’ was associated with a lower likelihood of holding stigmatising attitudes.

6.22 In addition, analysis of SSA 2013 also showed that across a range of attitudes, those who have experienced a mental health problem themselves or who know someone with a mental health problem were less likely than others to hold stigmatising attitudes. This reinforces previous findings from earlier SSA surveys (Ormston et al, 2011).

6.23 The differences by gender and age may be at least partly explained by the differential extent to which particular subgroups have personal experience of a mental health problem. Consistently, women and those aged under 55 have reported more personal experience of mental health problems whilst conversely men and older people have reported less personal experience.

6.24 In conclusion, the prevalence of stigmatising attitudes towards those with mental health problems has remained fairly stable over the last decade. The myths and stereotypes attached to people with mental health problems have not substantially reduced over this period. With the evidence indicating that those who know someone with mental health problems are less likely to hold stigmatising attitudes, continued focus on work to break down the barriers which prevent people with mental health problems being open about their condition should decrease stigma and prejudice in the longer term.

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ANNEX A – DETAILED TABLES

Notes on tables

- '*' indicates less than 0.5 percent but greater than zero
- '-' indicates no respondents gave this answer
- All figures are rounded to the nearest whole number

Chapter 2 detailed tables

Table A.1: Whether know someone with a specific mental health problem? (2008 & 2013)

	2008	2013
	%	%
Depression	45	51
Alzheimer's disease/ dementia	22	30
Panic attacks	26	27
Anxiety disorder	13	23
Severe stress	14	17
Post-natal depression	16	16
Nervous breakdown	14	15
Manic depression (bipolar affective disorder)	11	14
Self-harm	10	14
Eating disorder	9	13
Obsessive/compulsive behaviour/disorder	8	9
Schizophrenia	8	9
Phobias (e.g. agoraphobia)	6	8
Personality disorder	4	5
Post traumatic stress disorder	5	5
Been told he/she had problem but don't know what it was called	3	3
Other	3	1
None of these	26	21
Don't know/ refused	4	-
Weighted bases	*1177*	*1497*
Unweighted bases	*1177*	*1497*

Table A.2: Personal experience of specific mental health problems (2008 & 2013)

	2008	2013
	%	%
Depression	17	21
Alzheimer's disease/ dementia	*	2
Panic attacks	6	9
Anxiety disorder	4	8
Severe stress	3	4
Post-natal depression	3	3
Nervous breakdown	2	2
Manic depression (bipolar affective disorder)	*	1
Self-harm	1	2
Eating disorder	1	2
Obsessive/compulsive behaviour/disorder	*	1
Schizophrenia	*	1
Phobias (e.g. agoraphobia)	1	1
Personality disorder	1	1
Post traumatic stress disorder	1	1
Been told he/she had problem but don't know what it was called	1	1
Other	*	*
None of these	70	66
Don't know/ refused	3	
Weighted bases	*1177*	*1340*
Unweighted bases	*1177*	*1340*

Table A.3: Whether has a mental health problem by age, gender, income, education and area deprivation 2013

	Identified as having a mental health problem	*Weighted bases*	*Unweighted bases*
	%		
ALL	**32**	***1340***	***1340***
Age			
18-24	35	*158*	*89*
25-34	35	*211*	*166*
35-44	38	*221*	*200*
45-54	39	*250*	*261*
55-64	29	*208*	*251*
65+	19	*293*	*373*
Gender			
Male	27	*639*	*595*
Female	36	*701*	*745*
Annual household income			
Up to £14,300	41	*264*	*312*
Over £14,300 to £26,000	38	*256*	*280*
Over £26,000 to £44,200	29	*257*	*233*
Over £44,200	25	*277*	*251*
Highest educational qualification			
Degree/Higher Education	32	*482*	*472*
Highers/A-levels	37	*230*	*216*
Standard Grades/GCSEs	29	*354*	*349*
No recognised qualification	31	*268*	*298*
Area deprivation			
Most deprived	34	*216*	*198*
2	33	*287*	*268*
3	33	*282*	*302*
4	31	*282*	*355*
Least deprived	28	*273*	*273*

Table A.4: Social impact of having mental health problems (2002, 2004, 2006, 2008 & 2013)

	2002	2004	2006	2008	2013
		%	%	%	%
Discouraged from participating in social events	12	15	11	10	13
Refused a job	6	4	5	4	8
Discriminated against at work	7	6	5	4	5
Verbally abused within the family	7	6	4	3	5
Verbally abused in public	8	5	2	3	4
Discouraged from taking part in local community life	4	6	4	5	4
Discouraged from going on holiday	3	4	4	2	4
Discouraged from participating in child's school based activities	1	2	2	1	3
Overlooked/refused for promotion	4	5	3	3	3
Physically abused within the family	4	4	2	3	2
Physically abused in public	3	2	*	3	1
Graffiti or rubbish targeted at the home	1	1	1	1	*
Other	2	2	2	*	*
None of these	68	64	75	77	63
Weighted bases	*415*	*351*	*n/a*	*335*	*428*
Unweighted bases	*440*	*377*	*384*	*359*	*417*

Table A.5: Social impact of having a mental health problem by age, gender, income, education and area deprivation 2013

	Been refused a job	Discouraged from participating in social events	Verbally abused within the family	*Weighted bases*	*Unweighted bases*
	%	%	%		
ALL	**8**	**13**	**5**	***428***	***417***
Age					
18-24	10	12	10	*56*	*27*
25-34	10	8	7	*74*	*61*
35-44	3	18	4	*83*	*77*
45-54	10	11	5	*98*	*104*
55-64	8	17	5	*60*	*76*
65+	5	9	3	*57*	*72*
Gender					
Male	11	13	6	*174*	*150*
Female	5	12	5	*253*	*267*
Annual household income					
Up to £14,300	17	20	14	*107*	*123*
Over £14,300 to £26,000	7	10	3	*99*	*100*
Over £26,000 to £44,200	3	4	2	*75*	*64*
Over £44,200	2	3	2	*71*	*65*
Highest educational qualification					
Degree/Higher Education	5	11	3	*153*	*148*
Highers/A-levels	15	9	11	*85*	*80*
Standard Grades/GCSEs	3	12	6	*103*	*99*
No recognised qualification	9	19	3	*84*	*88*
Area deprivation					
Most deprived	7	17	5	*74*	*72*
2	6	16	8	*94*	*92*
3	11	7	2	*94*	*95*
4	10	12	8	*87*	*100*
Least deprived	3	12	4	*77*	*58*
Life satisfaction					
Below average	7	21	7	*185*	*180*
Average and above	8	7	4	*243*	*237*

Chapter 3 detailed tables

Table A.6: Main factors supporting recovery by age, gender, income, education and area deprivation 2013

	Medication	Support from family/ friends	Other forms of treatment or therapy	Developing my own coping strategies	*Weighted bases*	*Unweighted bases*
	%	%	%	%		
ALL	**42**		**27**	**26**	***428***	***417***
Age						
18-24	25	55	30	40	*58*	*27*
25-34	33	45	25	26	*74*	*61*
35-44	36	37	22	29	*83*	*77*
45-54	48	42	36	27	*98*	*104*
55-64	64	38	25	16	*60*	*76*
65+	41	32	18	21	*57*	*72*
Gender						
Male	31	41	17	32	*174*	*150*
Female	49	41	33	22	*253*	*267*
Annual household						
Up to £14,300	40	37	26	27	*107*	*123*
Over £14,300 to	47	41	23	30	*99*	*100*
Over £26,000 to	39	44	37	26	*75*	*64*
Over £44,200	38	48	22	32	*71*	*65*
Highest qualification						
Degree/Higher	43	43	38	32	*153*	*148*
Highers/A-levels	35	45	17	33	*85*	*80*
Standard	41	33	26	20	*103*	*99*
No recognised	47	43	18	16	*84*	*88*
Area deprivation						
Most deprived	40	38	34	20	*74*	*72*
2	42	38	21	31	*94*	*92*
3	49	44	28	25	*94*	*95*
4	43	39	31	31	*87*	*100*
Least deprived	33	46	21	23	*77*	*58*

Table A.7: Factors hindering recovery by age, gender, income, education and area deprivation 2013

	Not understanding what was going on	Continuing to experience symptoms	Negative attitudes of people around me	*Weighted bases*	*Unweighted bases*
	%	%	%		
ALL	**16**	**13**	**11**	***428***	***417***
Age					
18-24	19	25	18	*56*	*27*
25-34	24	16	12	*74*	*61*
35-44	15	9	14	*83*	*77*
45-54	11	13	10	*98*	*104*
55-64	20	13	9	*60*	*76*
65+	9	5	6	*57*	*72*
Gender					
Male	22	13	12	*174*	*150*
Female	12	14	11	*253*	*267*
Annual household					
Up to £14,300	20	14	19	*107*	*123*
Over £14,300 to	14	9	11	*99*	*100*
Over £26,000 to	15	17	6	*75*	*64*
Over £44,200	24	12	2	*71*	*65*
Highest educational					
Degree/Higher	18	24	7	*153*	*148*
Highers/A-levels	22	7	18	*85*	*80*
Standard Grades/GCSEs	8	6	16	*103*	*99*
No recognised	17	10	8	*84*	*88*
Area deprivation					
Most deprived	16	12	11	*74*	*72*
2	12	15	15	*94*	*92*
3	18	14	10	*94*	*95*
4	16	9	9	*87*	*100*
Least deprived	19	16	12	*77*	*58*

Table A.8: What recovery means (2006, 2008 & 2013)

	2006	2008	2013
	%	%	%
Having a satisfying and fulfilling life	20	18	55
Getting back to normal	49	53	46
Taking charge of my life again	38	24	44
Feeling able to cope in general	32	27	37
Getting more sleep	6	1	20
Feeling more able to socialise	7	6	19
Getting involved in activities I enjoy	8	6	17
No longer needing treatment or services	5	6	16
Fewer symptoms	9	8	15
Getting back to work	6	10	11
Taking up training or education opportunities	n/a	n/a	4
Other	n/a	3	1
None of these	n/a	2	5
Can’t choose/ don’t’ know	2	3	4
Weighted bases	*n/a*	*335*	*428*
Unweighted bases	*384*	*359*	*417*

Table A.9: What recovery means by age, gender, income, education and area deprivation 2013

	Taking charge of my life again	**Feeling able to cope in general**	***Weighted bases***	***Unweighted bases***
	%	**%**		
ALL	**44**	**37**	***428***	***417***
Age				
18-24	47	45	*56*	*27*
25-34	50	37	*74*	*61*
35-44	40	40	*83*	*77*
45-54	47	36	*98*	*104*
55-64	46	35	*60*	*76*
65+	29	30	*57*	*72*
Gender				
Male	38	30	*174*	*150*
Female	47	42	*253*	*267*
Annual household income				
Up to £14,300	38	29	*107*	*123*
Over £14,300 to £26,000	44	40	*99*	*100*
Over £26,000 to £44,200	49	44	*75*	*64*
Over £44,200	43	38	*71*	*65*
Highest educational qualification				
Degree/Higher Education	51	44	*153*	*148*
Highers/A-levels	55	44	*85*	*80*
Standard Grades/GCSEs	39	31	*103*	*99*
No recognised qualification	24	25	*84*	*88*
Area deprivation				
Most deprived	38	25	*74*	*72*
2	37	39	*94*	*92*
3	46	41	*94*	*95*
4	52	42	*87*	*100*
Least deprived	45	37	*77*	*58*

Table A.10: Positive messages from professionals and family/friends by age, gender, income, education and area deprivation 2013

	Completely/ mainly positive message from professionals	Completely/ mainly positive message from family/ friends	*Weighted bases*	*Unweighted bases*
	%	%		
ALL	**65**	**66**	***428***	***417***
Age				
18-24	50	58	*56*	*27*
25-34	62	64	*74*	*61*
35-44	68	65	*83*	*77*
45-54	65	65	*98*	*104*
55-64	69	75	*60*	*76*
65+	71	68	*57*	*72*
Gender				
Male	64	62	*174*	*150*
Female	65	68	*253*	*267*
Annual household income				
Up to £14,300	50	50	*107*	*123*
Over £14,300 to £26,000	67	66	*99*	*100*
Over £26,000 to £44,200	82	83	*75*	*64*
Over £44,200	76	72	*71*	*65*
Highest educational qualification				
Degree/Higher Education	76	73	*153*	*148*
Highers/A-levels	56	61	*85*	*80*
Standard Grades/GCSEs	56	56	*103*	*99*
No recognised qualification	64	69	*84*	*88*
Area deprivation				
Most deprived	55	60	*74*	*72*
2	62	57	*94*	*92*
3	76	75	*94*	*95*
4	64	67	*87*	*100*
Least deprived	64	69	*77*	*58*

Chapter 4 detailed tables

Table A.11: Anyone can suffer from mental health problems by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
All	**73**	**25**	**1**	**1**	*	***1497***	***1497***
Gender							
Male	67	30	2	*	*	*716*	*669*
Female	78	20	1	1	*	*781*	*828*
Age							
18-24	77	22	0	1	0	*177*	*93*
25-34	78	19	3	0	0	*238*	*180*
35-44	76	23	1	0	0	*248*	*217*
45-54	76	22	1	1	*	*278*	*279*
55-64	75	24	1	1	0	*232*	*280*
65+	61	35	2	1	1	*324*	*448*
NS-SEC							
Never worked	79	21	0	0	0	*88*	*72*
Managerial & professional	80	18	1	*	*	*470*	*477*
Intermediate occupations	68	31	*	0	0	*182*	*176*
Self-employed	57	42	1	0	1	*106*	*130*
Lower supervisory & technical	70	26	1	2	1	*153*	*153*
Semi-routine & routine	70	26	3	1	*	*454*	*453*
Highest educational qualification							
Degree/HE	81	18	*	0	*	*538*	*509*
Highers/A-levels	79	20	*	1	*	*257*	*236*
Standard Grade/GCSE	64	33	1	1	*	*395*	*382*
None	65	30	4	*	0	*299*	*360*

A.11 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Income							
up to £14,300	73	24	1	2	*	*290*	*346*
over £14,300 up to £26,000	65	32	2	0	1	*276*	*303*
over 26,000 up to £44,200	78	21	1	*	0	*271*	*241*
over £44,200	78	21	*	*	*	*294*	*260*
Don't know	71	29		*	0	*168*	*139*
Refused/ Not answered	70	24	4	1	0	*197*	*206*
Area deprivation							
1 - Most deprived	72	26	*	*	*	*236*	*216*
2	72	23	3	2	0	*331*	*307*
3	74	24	1	*	*	*310*	*336*
4	71	27	1	*	*	*316*	*398*
5 - Least deprived	75	24	1	0	1	*305*	*240*
Urban-rural							
Large Urban Areas	76	23	1	*	*	*620*	*431*
Other Urban Areas	73	23	2	1	1	*466*	*390*
Accessible Small Towns	69	31	0	0	0	*98*	*101*
Remote Small Towns	64	32	3	*	0	*56*	*126*
Accessible Rural	68	30	1	0	0	*180*	*283*
Remote Rural	72	25	1	2	0	*77*	*166*

A.11 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Anyone close ever experienced mental health problem							
Yes	79	20	*	*	*	*967*	*971*
No	61	34	3	1	*	*524*	*520*
Ever personally experienced a mental health problem							
Yes	87	12	0	1	*	*344*	*341*
No	69	29	1	1	*	*960*	*973*
Could rely on neighbour to keep an eye on empty home							
Agree	73	25	1	1	*	*1285*	*1312*
Neither agree nor disagree	54	33	12	0	2	*49*	*50*
Disagree	80	17	3	0	*	*158*	*130*
Whether think most people can be trusted							
Most people can be trusted	74	25	1	*	*	*771*	*822*
Can't be too careful in dealing with people	72	25	2	1	*	*682*	*631*
Don't know	75	24	1	0	0	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	68	29	1	1	*	*789*	*854*
Neither agree nor disagree	67	30	2	1	0	*197*	*196*
Disagree	83	16	*	*	*	*497*	*435*

Don’t know/Refused: 1% or less for all categories

Table A.12: The majority of people with mental health problems recover by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
All	**5**	**28**	**32**	**25**	**4**	**5**	***1497***	***1497***
Gender								
Male	4	24	34	27	4	7	*716*	*669*
Female	7	32	31	24	3	3	*781*	*828*
Age								
18-24	4	20	38	33	3	2	*177*	*93*
25-34	4	27	40	21	2	6	*238*	*180*
35-44	5	31	31	26	4	3	*248*	*217*
45-54	7	28	32	26	3	4	*278*	*279*
55-64	7	33	28	23	4	5	*232*	*280*
65+	5	28	28	26	5	9	*324*	*448*
NS-SEC								
Never worked	8	30	30	26	3	2	*88*	*72*
Managerial & professional	6	29	33	22	4	5	*470*	*477*
Intermediate occupations	6	22	33	29	2	8	*182*	*176*
Self-employed	5	27	39	18	5	6	*106*	*130*
Lower supervisory & technical	2	26	35	29	3	4	*153*	*153*
Semi-routine & routine	5	30	30	26	4	5	*454*	*453*
Highest educational qualification								
Degree/HE	5	29	37	22	2	5	*538*	*509*
Highers/A-levels	7	24	31	28	6	4	*257*	*236*
Standard Grade/GCSE	6	30	30	24	4	6	*395*	*382*
None	4	29	28	30	4	5	*299*	*360*

A.12 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Income								
up to £14,300	7	33	28	24	4	3	*290*	*346*
over £14,300 up to £26,000	4	26	33	28	4	4	*276*	*303*
over 26,000 up to £44,200	5	34	34	22	4	2	*271*	*241*
over £44,200	5	25	36	26	2	7	*294*	*260*
Don't know	2	27	29	30	4	8	*168*	*139*
Refused/ Not answered	7	24	32	23	3	9	*197*	*206*
Area deprivation								
1 – Most deprived	8	26	24	31	4	7	*236*	*216*
2	5	26	36	26	3	5	*331*	*307*
3	4	32	33	23	4	3	*310*	*336*
4	6	28	33	23	4	6	*316*	*398*
5 - Least deprived	4	28	33	26	3	6	*305*	*240*
Urban-rural								
Large Urban Areas	5	27	31	27	4	6	*620*	*431*
Other Urban Areas	5	27	36	26	3	4	*466*	*390*
Accessible Small Towns	6	36	30	22	2	4	*98*	*101*
Remote Small Towns	5	28	34	20	4	9	*56*	*126*
Accessible Rural	5	33	29	24	5	3	*180*	*283*
Remote Rural	11	26	29	20	3	11	*77*	*166*

A.12 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Anyone close ever experienced mental health problem								
Yes	6	31	31	24	4	4	*967*	*971*
No	3	24	35	27	3	7	*524*	*520*
Ever personally experienced a mental health problem								
Yes	11	33	28	22	4	2	*344*	*341*
No	3	27	33	27	4	6	*960*	*973*
Could rely on neighbour to keep an eye on empty home								
Agree	5	29	32	25	3	5	*1285*	*1312*
Neither agree nor disagree	5	15	50	13	14	3	*49*	*50*
Disagree	7	23	32	29	3	5	*158*	*130*
Whether think most people can be trusted								
Most people can be trusted	6	29	33	23	3	5	*771*	*822*
Can't be too careful in dealing with people	5	27	31	28	4	5	*682*	*631*
Don't know	3	29	35	23	3	7	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	6	28	31	26	4	6	*789*	*854*
Neither agree nor disagree	2	29	37	23	3	6	*197*	*196*
Disagree	6	27	34	26	4	3	*497*	*435*

Refused: Less than 1% for all categories

Table A.13: People with mental health problems are largely to blame for their own condition by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
All	**2**	**3**	**5**	**26**	**63**	***1497***	***1497***
Gender							
Male	3	3	6	29	58	*716*	*669*
Female	1	3	5	24	67	*781*	*828*
Age							
18-24	4	1	3	23	69	*177*	*93*
25-34	2	1	8	26	63	*238*	*180*
35-44	1	6	5	24	63	*248*	*217*
45-54	1	2	5	26	66	*278*	*279*
55-64	2	1	6	23	67	*232*	*280*
65+	1	5	5	33	53	*324*	*448*
NS-SEC							
Never worked	2		5	30	61	*88*	*72*
Managerial & professional	1	1	4	24	69	*470*	*477*
Intermediate occupations	1	2	4	29	65	*182*	*176*
Self-employed	*	4	7	34	54	*106*	*130*
Lower supervisory & technical	*	3	7	25	65	*153*	*153*
Semi-routine & routine	4	6	7	25	57	*454*	*453*
Highest educational qualification							
Degree/HE	1	1	4	22	72	*538*	*509*
Highers/A-levels	3	1	3	25	68	*257*	*236*
Standard Grade/GCSE	1	5	6	29	59	*395*	*382*
None	3	6	8	33	48	*299*	*360*

A.13 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Income							
up to £14,300	3	5	5	30	56	*290*	*346*
over £14,300 up to £26,000	2	5	7	25	61	*276*	*303*
over 26,000 up to £44,200	1	1	4	32	61	*271*	*241*
over £44,200	2	*	6	21	70	*294*	*260*
Don't know	1	2	2	28	66	*168*	*139*
Refused/ Not answered	2	4	7	23	64	*197*	*206*
Area deprivation							
1 - Most deprived	3	3	3	25	64	*236*	*216*
2	1	3	10	27	58	*331*	*307*
3	*	3	5	27	63	*310*	*336*
4	2	2	4	30	60	*316*	*398*
5 - Least deprived	2	4	4	22	69	*305*	*240*
Urban-rural							
Large Urban Areas	2	3	3	24	67	*620*	*431*
Other Urban Areas	1	3	7	25	63	*466*	*390*
Accessible Small Towns	2	7	5	24	61	*98*	*101*
Remote Small Towns		3	13	29	55	*56*	*126*
Accessible Rural	1	4	6	37	51	*180*	*283*
Remote Rural	3	1	7	28	58	*77*	*166*

A.13 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Anyone close ever experienced mental health problem							
Yes	2	2	3	23	69	*967*	*971*
No	2	4	10	32	51	*524*	*520*
Ever personally experienced a mental health problem							
Yes	2	2	2	24	69	*344*	*341*
No	2	3	7	28	60	*960*	*973*
Could rely on neighbour to keep an eye on empty home							
Agree	2	3	5	27	62	*1285*	*1312*
Neither agree nor disagree			12	19	68	*49*	*50*
Disagree	1	4	5	22	67	*158*	*130*
Whether think most people can be trusted							
Most people can be trusted	2	3	4	24	66	*771*	*822*
Can't be too careful in dealing with people	2	3	7	30	58	*682*	*631*
Don't know		1	5	22	72	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	2	4	6	32	56	*789*	*854*
Neither agree nor disagree	1	*	9	33	57	*197*	*196*
Disagree	2	3	4	15	76	*497*	*435*

Don’t know: 2% or less for all categories
Refused: 1% or less for all categories

Table A.14: People are generally caring and sympathetic to people with mental health by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
All	**4**	**35**	**16**	**36**	**8**	***1497***	***1497***
Gender							
Male	6	37	20	31	6	*716*	*669*
Female	3	32	13	41	10	*781*	*828*
Age							
18-24	2	45	17	30	5	*177*	*93*
25-34	7	33	24	29	7	*238*	*180*
35-44	5	24	10	47	12	*248*	*217*
45-54	1	32	17	41	9	*278*	*279*
55-64	5	31	18	38	8	*232*	*280*
65+	6	42	13	32	7	*324*	*448*
NS-SEC							
Never worked	3	28	16	39	13	*88*	*72*
Managerial & professional	2	27	15	47	8	*470*	*477*
Intermediate occupations	3	30	20	41	7	*182*	*176*
Self-employed	5	46	10	27	9	*106*	*130*
Lower supervisory & technical	4	39	21	28	7	*153*	*153*
Semi-routine & routine	6	40	17	30	8	*454*	*453*
Highest educational qualification							
Degree/HE	2	28	15	48	7	*538*	*509*
Highers/A-levels	3	31	16	41	9	*257*	*236*
Standard Grade/GCSE	5	39	19	28	7	*395*	*382*
None	9	42	14	23	11	*299*	*360*

A.14 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Income							
up to £14,300	8	34	13	33	10	*290*	*346*
over £14,300 up to £26,000	5	37	16	32	9	*276*	*303*
over 26,000 up to £44,200	2	36	16	40	6	*271*	*241*
over £44,200	4	29	15	43	8	*294*	*260*
Don't know	3	36	18	37	6	*168*	*139*
Refused/ Not answered	2	35	21	32	8	*197*	*206*
Area deprivation							
1 - Most deprived	6	34	20	30	9	*236*	*216*
2	5	36	21	30	9	*331*	*307*
3	5	35	10	41	8	*310*	*336*
4	4	35	15	40	6	*316*	*398*
5 - Least deprived	2	33	15	42	8	*305*	*240*
Urban-rural							
Large Urban Areas	4	31	20	37	8	*620*	*431*
Other Urban Areas	3	38	14	38	7	*466*	*390*
Accessible Small Towns	7	31	8	40	14	*98*	*101*
Remote Small Towns	6	28	20	40	5	*56*	*126*
Accessible Rural	7	38	14	30	10	*180*	*283*
Remote Rural	6	40	10	35	8	*77*	*166*

A.14 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Anyone close ever experienced mental health problem							
Yes	3	30	15	41	10	*967*	*971*
No	6	43	19	28	4	*524*	*520*
Ever personally experienced a mental health problem							
Yes	3	23	15	44	14	*344*	*341*
No	4	39	16	34	7	*960*	*973*
Could rely on neighbour to keep an eye on empty home							
Agree	4	34	16	37	8	*1285*	*1312*
Neither agree nor disagree	1	23	29	38	6	*49*	*50*
Disagree	3	40	14	34	8	*158*	*130*
Whether think most people can be trusted							
Most people can be trusted	4	36	14	40	6	*771*	*822*
Can't be too careful in dealing with people	4	33	19	32	11	*682*	*631*
Don't know	2	39	14	40	5	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	6	39	16	31	8	*789*	*854*
Neither agree nor disagree	2	31	17	42	8	*197*	*196*
Disagree	2	29	15	44	9	*497*	*435*

Don’t know: 2% or less for all categories
Refused: 1% or less for all categories

Table A.15: If I was suffering from mental health problems, I wouldn't want people knowing about it by demographic, area, experience of mental health and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
All	**10**	**38**	**17**	**26**	**8**	**1**	***1497***	***1497***
Gender								
Male	10	39	17	25	8	1	*716*	*669*
Female	10	36	18	27	8	1	*781*	*828*
Age								
18-24	13	31	24	27	4	0	*177*	*93*
25-34	11	36	19	26	8	1	*238*	*180*
35-44	8	43	19	21	9	1	*248*	*217*
45-54	9	38	17	24	11	2	*278*	*279*
55-64	10	42	14	26	7	0	*232*	*280*
65+	9	36	14	32	8	1	*324*	*448*
NS-SEC								
Never worked	14	36	20	23	5	2	*88*	*72*
Managerial & professional	9	40	16	25	9	1	*470*	*477*
Intermediate occupations	7	38	19	30	6		*182*	*176*
Self-employed	9	44	13	27	6	0	*106*	*130*
Lower supervisory & technical	13	29	18	29	8	2	*153*	*153*
Semi-routine & routine	10	37	18	25	9	1	*454*	*453*
Highest educational qualification								
Degree/HE	7	40	16	27	8	1	*538*	*509*
Highers/A-levels	10	32	18	30	9	1	*257*	*236*
Standard Grade/GCSE	12	38	18	24	7	1	*395*	*382*
None	11	37	17	25	9	0	*299*	*360*

A.15 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Income								
up to £14,300 p.a.	13	31	13	30	11	2	*290*	*346*
over £14,300 up to £26,000 p.a.	10	42	16	25	8	0	*276*	*303*
over 26,000 up to £44,200 p.a.	7	41	22	25	5	0	*271*	*241*
over £44,200 p.a	8	41	15	25	10	1	*294*	*260*
Don't know	9	31	22	32	5	1	*168*	*139*
Refused/Not answered	10	39	19	22	8	1	*197*	*206*
Area deprivation								
1 - Most deprived	13	33	16	27	10	1	*236*	*216*
2	10	35	20	29	5	1	*331*	*307*
3	9	42	16	25	8	*	*310*	*336*
4	9	36	21	25	10	1	*316*	*398*
5 - Least deprived	8	43	13	26	8	2	*305*	*240*
Urban-rural								
Large Urban Areas	9	39	18	25	9	1	*620*	*431*
Other Urban Areas	12	37	16	27	7	1	*466*	*390*
Accessible Small Towns	6	35	18	33	8	0	*98*	*101*
Remote Small Towns	8	33	27	21	10	1	*56*	*126*
Accessible Rural	9	41	17	24	9	0	*180*	*283*
Remote Rural	9	37	13	33	8	*	*77*	*166*
Anyone close ever experienced a mental health problem								
Yes	10	37	16	27	10	1	*967*	*971*
No	10	40	20	25	5	*	*524*	*520*

A.15 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Ever personally experienced a mental health problem								
Yes	15	33	12	26	13	1	*344*	*341*
No	9	39	17	27	7	1	*960*	*973*
Could rely on neighbour to keep an eye on empty home								
Agree	9	37	18	28	9	1	*1285*	*1312*
Neither agree nor disagree	9	37	37	15	2	0	*49*	*50*
Disagree	19	49	9	18	5	0	*158*	*130*
Whether think most people can be trusted								
Most people can be trusted	9	39	17	26	9	*	*771*	*822*
Can't be too careful in dealing with people	11	37	18	27	7	1	*682*	*631*
Don't know	3	32	12	29	15	10	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	11	35	18	27	8	1	*789*	*854*
Neither agree nor disagree	8	41	25	19	7	0	*197*	*196*
Disagree	8	41	12	29	9	1	*497*	*435*

Refused: 1% or less for all categories

Table A.16: I would find it hard to talk to someone with mental health problems by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
All	**3**	**14**	**10**	**35**	**38**	***1497***	***1497***
Gender							
Male	3	19	11	36	30	*716*	*669*
Female	2	10	9	33	46	*781*	*828*
Age							
18-24	0	13	8	38	41	*177*	*93*
25-34	3	14	14	31	38	*238*	*180*
35-44	3	13	8	32	43	*248*	*217*
45-54	1	9	9	34	46	*278*	*279*
55-64	2	14	7	41	37	*232*	*280*
65+	5	21	14	33	26	*324*	*448*
NS-SEC							
Never worked	1	10	8	32	50	*88*	*72*
Managerial & professional	2	9	10	38	41	*470*	*477*
Intermediate occupations	3	18	14	30	34	*182*	*176*
Self-employed	6	18	13	37	27	*106*	*130*
Lower supervisory & technical	2	14	8	37	39	*153*	*153*
Semi-routine & routine	3	18	10	33	35	*454*	*453*
Highest educational qualification							
Degree/HE	1	10	9	40	41	*538*	*509*
Highers/A-levels	2	12	9	31	46	*257*	*236*
Standard Grade/GCSE	4	17	8	35	37	*395*	*382*
None	5	21	17	30	27	*299*	*360*

A.16 Continued

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**	***Weighted bases***	***Unweighted bases***
	%	%	%	%	%		
Income							
up to £14,300	6	14	10	37	32	*290*	*346*
over £14,300 up to £26,000	2	15	9	33	42	*276*	*303*
over 26,000 up to £44,200	1	10	10	36	43	*271*	*241*
over £44,200	1	13	7	39	39	*294*	*260*
Don't know	2	21	12	31	33	*168*	*139*
Refused/ Not answered	4	16	14	28	37	*197*	*206*
Area deprivation							
1 - Most deprived	3	18	7	31	40	*236*	*216*
2	3	14	10	35	39	*331*	*307*
3	3	13	11	32	41	*310*	*336*
4	2	16	8	38	37	*316*	*398*
5 - Least deprived	3	12	14	37	34	*305*	*240*
Urban-rural							
Large Urban Areas	3	17	9	34	36	*620*	*431*
Other Urban Areas	2	10	11	33	44	*466*	*390*
Accessible Small Towns	4	14	7	41	34	*98*	*101*
Remote Small Towns	4	10	15	33	37	*56*	*126*
Accessible Rural	2	17	10	35	36	*180*	*283*
Remote Rural	2	17	11	36	34	*77*	*166*

A.16 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Anyone close ever experienced mental health problem							
Yes	1	10	8	35	46	*967*	*971*
No	6	22	14	35	23	*524*	*520*
Ever personally experienced a mental health problem							
Yes	1	6	7	32	55	*344*	*341*
No	3	16	11	36	35	*960*	*973*
Could rely on neighbour to keep an eye on empty home							
Agree	3	14	10	35	38	*1285*	*1312*
Neither agree nor disagree	3	4	18	37	38	*49*	*50*
Disagree	1	21	7	32	38	*158*	*130*
Whether think most people can be trusted							
Most people can be trusted	2	13	10	34	40	*771*	*822*
Can't be too careful in dealing with people	3	16	10	35	35	*682*	*631*
Don't know	1	13	10	28	48	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	4	16	11	36	33	*789*	*854*
Neither agree nor disagree	0	12	18	28	42	*197*	*196*
Disagree	1	12	7	36	44	*497*	*435*

Don't know/Refused: 1% or less for all categories

Table A.17: People with mental health problems are often dangerous by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
All	**3**	**16**	**22**	**39**	**19**	**1**	***1497***	***1497***
Gender								
Male	3	18	23	37	17	*	*716*	*669*
Female	3	14	21	41	20	1	*781*	*828*
Age								
18-24	1	15	25	42	18	0	*177*	*93*
25-34	3	10	25	39	22	0	*238*	*180*
35-44	2	15	20	43	19	1	*248*	*217*
45-54	4	12	22	38	24	*	*278*	*279*
55-64	3	17	19	41	20	1	*232*	*280*
65+	4	26	23	35	11	1	*324*	*448*
NS-SEC								
Never worked	5	10	33	32	21	0	*88*	*72*
Managerial & professional	2	11	17	44	25	1	*470*	*477*
Intermediate occupations	4	16	22	45	12	1	*182*	*176*
Self-employed	3	21	33	34	8	0	*106*	*130*
Lower supervisory & technical	5	19	21	40	15	1	*153*	*153*
Semi-routine & routine	3	21	24	34	18	1	*454*	*453*
Highest educational qualification								
Degree/HE	3	9	17	46	24	1	*538*	*509*
Highers/A-levels	0	13	23	37	26	1	*257*	*236*
Standard Grade/GCSE	3	22	25	39	11	*	*395*	*382*
None	5	24	28	29	13	1	*299*	*360*

A.17 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Income								
up to £14,300	2	21	22	35	18	2	*290*	*346*
over £14,300 up to £26,000	4	21	19	35	21	1	*276*	*303*
Over 26,000 up to £44,200	4	12	21	43	20	0	*271*	*241*
Over £44,200	3	8	20	46	23	0	*294*	*260*
Don't know	4	16	25	43	13	0	*168*	*139*
Refused/ Not answered	1	22	29	34	12	1	*197*	*206*
Area deprivation								
1 - Most deprived	4	16	24	38	17	1	*236*	*216*
2	2	17	22	40	18	1	*331*	*307*
3	4	13	24	42	16	*	*310*	*336*
4	2	16	22	40	20	*	*316*	*398*
5 - Least deprived	4	19	20	35	22	1	*305*	*240*
Urban-rural								
Large Urban Areas	4	17	21	39	19	*	*620*	*431*
Other Urban Areas	3	13	23	40	20	1	*466*	*390*
Accessible Small Towns	2	17	23	41	16	2	*98*	*101*
Remote Small Towns	1	16	34	31	18	0	*56*	*126*
Accessible Rural	2	22	22	40	14	0	*180*	*283*
Remote Rural	2	17	17	38	24	1	*77*	*166*

A.17 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Anyone close ever experienced mental health problem								
Yes	2	13	21	41	23	*	*967*	*971*
No	5	22	26	35	11	1	*524*	*520*
Ever personally experienced a mental health problem								
Yes	1	12	20	37	30	1	*344*	*341*
No	4	19	22	40	15	1	*960*	*973*
Could rely on neighbour to keep an eye on empty home								
Agree	3	15	21	41	19	1	*1285*	*1312*
Neither agree nor disagree		16	31	28	25	0	*49*	*50*
Disagree	4	23	26	32	16	0	*158*	*130*
Whether think most people can be trusted								
Most people can be trusted	2	15	20	39	23	1	*771*	*822*
Can't be too careful in dealing with people	4	18	24	39	15	*	*682*	*631*
Don't know	4	2	34	46	12	3	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	5	21	25	37	12	*	*789*	*854*
Neither agree nor disagree	*	10	29	40	21	0	*197*	*196*
Disagree	2	11	15	43	28	1	*497*	*435*

Refused: 1% or less for all categories

Table A.18: The public should be better protected from people with mental health problems by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
All	**6**	**22**	**25**	**29**	**17**	**1**	***1497***	***1497***
Gender								
Male	8	23	26	28	13	1	716	669
Female	5	21	23	30	20	1	781	828
Age								
18-24	4	16	23	32	25	1	*177*	*93*
25-34	6	21	23	29	21	0	*238*	*180*
35-44	6	13	23	39	19	*	*248*	*217*
45-54	6	22	27	26	17	2	*278*	*279*
55-64	8	20	27	29	15	1	*232*	*280*
65+	7	33	25	23	10	3	*324*	*448*
NS-SEC								
Never worked	9	27	27	21	15	2	*88*	*72*
Managerial & professional	5	19	22	34	19	1	*470*	*477*
Intermediate occupations	8	25	24	28	12	3	*182*	*176*
Self-employed	10	25	34	21	8	1	*106*	*130*
Lower supervisory & technical	4	23	20	32	21	1	*153*	*153*
Semi-routine & routine	7	23	26	27	18	0	*454*	*453*
Highest educational qualification								
Degree/HE	5	19	20	37	18	1	*538*	*509*
Highers/A-levels	1	14	29	28	26	1	*257*	*236*
Standard Grade/GCSE	8	25	25	25	15	2	*395*	*382*
None	10	28	29	22	9	1	*299*	*360*

A.18 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Income								
up to £14,300	7	23	26	24	18	1	*290*	*346*
over £14,300 up to £26,000	9	23	22	29	16	1	*276*	*303*
over 26,000 up to £44,200	6	19	27	30	18	*	*271*	*241*
over £44,200	5	19	22	34	18	1	*294*	*260*
Don't know	5	26	23	27	17	2	*168*	*139*
Refused/ Not answered	6	24	29	27	13	1	*197*	*206*
Area deprivation								
1 - Most deprived	6	23	25	24	19	2	*236*	*216*
2	7	23	22	31	17	*	*331*	*307*
3	6	19	26	31	17	1	*310*	*336*
4	5	20	27	30	17	1	*316*	*398*
5 - Least deprived	7	23	23	27	17	2	*305*	*240*
Urban-rural								
Large Urban Areas	7	24	21	31	15	1	*620*	*431*
Other Urban Areas	6	20	26	30	17	1	*466*	*390*
Accessible Small Towns	4	20	30	25	20	0	*98*	*101*
Remote Small Towns	4	22	27	26	19	2	*56*	*126*
Accessible Rural	6	23	28	21	21	1	*180*	*283*
Remote Rural	8	16	24	35	15	2	*77*	*166*

A.18 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%	%		
Anyone close ever experienced mental health problem								
Yes	4	20	23	30	21	1	*967*	*971*
No	10	26	27	27	9	1	*524*	*520*
Ever personally experienced a mental health problem								
Yes	3	20	22	29	24	2	*344*	*341*
No	7	24	24	29	15	1	*960*	*973*
Could rely on neighbour to keep an eye on empty home								
Agree	6	21	24	30	17	1	*1285*	*1312*
Neither agree nor disagree	6	7	48	29	10	0	*49*	*50*
Disagree	9	29	22	21	18	1	*158*	*130*
Whether think most people can be trusted								
Most people can be trusted	7	20	23	30	19	1	*771*	*822*
Can't be too careful in dealing with people	6	24	26	28	15	1	*682*	*631*
Don't know	1	27	32	29	10	1	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	8	28	25	24	14	1	*789*	*854*
Neither agree nor disagree	6	15	33	32	14	1	*197*	*196*
Disagree	3	14	22	37	23	1	*497*	*435*

Refused: 1% or less for all categories

Table A.19: People with mental health problems should have the same rights as anyone else by demographic, area, mental health experience and social attitudes

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
All	**52**	**30**	**10**	**6**	**2**	***1497***	***1497***
Gender							
Male	49	31	11	7	1	*716*	*669*
Female	55	28	8	6	2	*781*	*828*
Age							
18-24	56	24	12	2	5	*177*	*93*
25-34	53	24	13	8	2	*238*	*180*
35-44	56	27	7	8	3	*248*	*217*
45-54	55	31	7	5	1	*278*	*279*
55-64	55	31	7	6	1	*232*	*280*
65+	43	36	11	8	0	*324*	*448*
NS-SEC							
Never worked	52	28	5	10	6	*88*	*72*
Managerial & professional	60	27	7	5	1	*470*	*477*
Intermediate occupations	45	38	7	10	*	*182*	*176*
Self-employed	36	38	15	11	0	*106*	*130*
Lower supervisory & technical	51	28	16	2	2	*153*	*153*
Semi-routine & routine	51	29	12	7	2	*454*	*453*
Highest educational qualification							
Degree/HE	60	25	8	5	2	*538*	*509*
Highers/A-levels	57	28	9	6	0	*257*	*236*
Standard Grade/GCSE	45	35	7	9	3	*395*	*382*
None	46	31	15	7	*	*299*	*360*

A.19 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Income							
up to £14,300	52	26	12	6	3	*290*	*346*
over £14,300 up to £26,000	48	33	10	8	1	*276*	*303*
over 26,000 up to £44,200	55	29	7	6	3	*271*	*241*
over £44,200	56	29	8	6	1	*294*	*260*
Don't know	51	28	10	9	2	*168*	*139*
Refused/ Not answered	50	32	11	5	1	*197*	*206*
Area deprivation							
1 - Most deprived	56	22	9	9	4	*236*	*216*
2	51	30	12	5	1	*331*	*307*
3	55	27	9	6	2	*310*	*336*
4	50	35	8	6	0	*316*	*398*
5 – Least deprived	50	31	9	6	2	*305*	*240*
Urban-rural							
Large Urban Areas	52	30	9	6	3	*620*	*431*
Other Urban Areas	53	27	10	8	1	*466*	*390*
Accessible Small Towns	64	27	6	4	0	*98*	*101*
Remote Small Towns	48	32	15	5	0	*56*	*126*
Accessible Rural	46	32	12	8	1	*180*	*283*
Remote Rural	52	33	12	2	1	*77*	*166*

A.19 Continued

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	*Weighted bases*	*Unweighted bases*
	%	%	%	%	%		
Anyone close ever experienced mental health problem							
Yes	59	26	7	5	2	*967*	*971*
No	40	35	14	9	1	*524*	*520*
Ever personally experienced a mental health problem							
Yes	70	22	3	2	2	*344*	*341*
No	47	32	10	8	2	*960*	*973*
Could rely on neighbour to keep an eye on empty home							
Agree	52	32	8	6	1	*1285*	*1312*
Neither agree nor disagree	54	25	20	2	0	*49*	*50*
Disagree	59	10	15	9	7	*158*	*130*
Whether think most people can be trusted							
Most people can be trusted	56	31	8	5	*	*771*	*822*
Can't be too careful in dealing with people	49	28	11	8	3	*682*	*631*
Don't know	57	32	11	0	0	*41*	*41*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	47	32	10	10	1	*789*	*854*
Neither agree nor disagree	49	33	14	3	1	*197*	*196*
Disagree	64	25	6	3	3	*497*	*435*

Don’t know/Refused: 1% or less for all categories

Chapter 5 detailed tables

Table A.20: Best sources of help for Andy (schizophrenia), combined sample - % mentioned

	Family member	Friend or neighbour	Family doctor	Specialist mental health professional	Charity or voluntary organisation	Someone with same problem	Self-help methods	No one could really help	Someone else	None of these	*Weighted bases*	*Unweighted bases*
All	**62%**	**11%**	**70%**	**86%**	**23%**	**27%**	**3%**	*****	**1%**	*****	***1497***	***1497***
Age of respondent												
18-24	77%	16%	53%	85%	14%	42%	3%	-	3%	-	*177*	*93*
25-34	69%	9%	61%	86%	24%	28%	3%	*	2%	2%	*238*	*180*
35-44	58%	13%	71%	86%	30%	28%	4%	*	-	-	*248*	*217*
45-54	62%	9%	79%	90%	26%	21%	1%	-	-	1%	*278*	*279*
55-64	58%	10%	75%	85%	24%	27%	3%	-	*	-	*232*	*280*
65+	54%	12%	72%	82%	21%	23%	3%	*	*	-	*324*	*448*
Anyone close ever experienced a mental health problem												
Yes	62%	10%	69%	89%	25%	26%	3%	*	1%	-	*967*	*971*
No	62%	14%	71%	80%	19%	28%	2%	*	1%	1%	*524*	*520*
Anyone close ever experienced schizophrenia												
Yes	68%	12%	66%	87%	28%	15%	2%	-	5%	-	*127*	*115*
No	62%	11%	70%	86%	23%	28%	3%	*	*	*	*1361*	*1375*

Table A.20: continued

	Family member	Friend or neighbour	Family doctor	Specialist mental health professional	Charity or voluntary organisation	Someone with same problem	Self-help methods	No one could really help	Someone else	None of these	*Weighted bases*	*Unweighted bases*
Ever personally experienced a mental health problem												
Yes	59%	11%	72%	89%	26%	25%	3%	-	2%	-	*344*	*341*
No	65%	12%	70%	87%	23%	26%	3%	*	1%	-	*960*	*973*

Table A.21: Best sources of help for Stephen (depression), combined sample - % mentioned

	Family member	Friend or neighbour	Family doctor	Specialist mental health professional	Charity or voluntary organisation	Someone with same problem	Self-help methods	No one could really help	Someone else	None of these	*Weighted bases*	*Unweighted bases*
All	**65%**	**21%**	**77%**	**67%**	**20%**	**28%**	**7%**	*	**1%**	**-**	***1497***	***1497***
Age of respondent												
18-24	82%	32%	45%	66%	13%	41%	13%	-	3%	-	*177*	*93*
25-34	69%	17%	68%	66%	24%	26%	7%	-	2%	-	*238*	*180*
35-44	65%	30%	84%	65%	18%	24%	5%	*	2%	-	*248*	*217*
45-54	64%	17%	85%	70%	20%	29%	5%	-	*	-	*278*	*279*
55-64	66%	19%	86%	65%	18%	28%	6%	-	1%	-	*232*	*280*
65+	50%	16%	81%	68%	22%	23%	6%	*	*	-	*324*	*448*
Anyone close ever experienced a mental health problem												
Yes	66%	21%	77%	67%	21%	29%	8%	*	1%	-	*967*	*971*
No	63%	21%	77%	67%	18%	25%	5%	-	1%	-	*524*	*520*
Anyone close ever experienced depression												
Yes	67%	22%	76%	68%	20%	30%	8%	*	1%	-	*769*	*753*
No	62%	20%	78%	66%	20%	25%	5%	*	1%	-	*720*	*737*
Ever personally experienced a mental health problem												
Yes	66%	22%	79%	68%	18%	27%	11%	*	2%	-	*344*	*341*
No	66%	22%	78%	67%	21%	27%	6%	*	1%	-	*960*	*973*

Table A.21: continued

	Family member	Friend or neighbour	Family doctor	Specialist mental health professional	Charity or voluntary organisation	Someone with same problem	Self-help methods	No one could really help	Someone else	None of these	*Weighted bases*	*Unweighted bases*
Ever personally experienced depression												
Yes	66%	22%	83%	67%	15%	28%	11%	-	2%	-	*279*	*272*
No	65%	22%	76%	68%	21%	27%	6%	*	1%	-	*1055*	*1062*

Table A.22: How likely Andy (schizophrenia) would harm someone else, combined sample

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Don't know	Weighted bases	Unweighted bases
All	**6%**	**37%**	**42%**	**9%**	**6%**	***1497***	***1497***
Anyone close ever experienced schizophrenia							
Yes	8%	47%	34%	9%	2%	*127*	*115*
No	5%	37%	43%	9%	6%	*1361*	*1375*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	7%	42%	37%	9%	5%	*789*	*854*
Neither agree nor disagree	3%	30%	53%	5%	8%	*197*	*196*
Disagree	5%	35%	45%	10%	5%	*497*	*435*

Refused: Less than 1% for all categories

Table A.23: How likely Andy (schizophrenia) would harm himself, combined sample

	Very likely	Somewhat likely	Some-what unlikely	Very unlikely	Don't know	*Weighted bases*	*Unweighted bases*
All	**15%**	**58%**	**20%**	**3%**	**5%**	***1497***	***1497***
Respondent sex							
Male	13%	55%	24%	3%	5%	*716*	*669*
Female	16%	61%	17%	3%	4%	*781*	*828*
Household income quartiles							
up to £14,300 p.a.	19%	52%	18%	4%	7%	*290*	*346*
over £14,300 up to £26,000 p.a.	19%	61%	14%	1%	4%	*276*	*303*
over 26,000 up to £44,200 p.a.	16%	63%	19%	1%	1%	*271*	*241*
over £44,200 p.a	10%	58%	25%	3%	4%	*294*	*260*
Don't know	6%	65%	18%	6%	5%	*168*	*139*
Refused/Not answered	13%	47%	27%	3%	9%	*197*	*206*
Urban-rural classification							
Large Urban Areas	16%	58%	19%	2%	5%	*620*	*431*
Other Urban Areas	14%	60%	19%	2%	4%	*466*	*390*
Accessible Small Towns	12%	64%	14%	2%	7%	*98*	*101*
Remote Small Towns	15%	56%	21%	1%	7%	*56*	*126*
Accessible Rural	17%	52%	25%	2%	3%	*180*	*283*
Remote Rural	5%	51%	28%	8%	9%	*77*	*166*
Whether think most people can be trusted							
Most people can be trusted	14%	53%	26%	2%	5%	*771*	*822*
Can't be too careful in dealing with people	17%	62%	14%	3%	4%	*682*	*631*
Don't know	3%	80%	13%	3%	2%	*41*	*41*

Table A.23: continued

	Very likely	Somewhat likely	Some-what unlikely	Very unlikely	Don't know	*Weighted bases*	*Unweighted bases*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity							
Agree	18%	58%	17%	3%	4%	*789*	*854*
Neither agree nor disagree	11%	62%	19%	2%	5%	*197*	*196*
Disagree	11%	57%	25%	2%	4%	*497*	*435*

Refused: Less than 1% for all categories

Table A.24: How likely Stephen (depression) would harm someone else, combined sample

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Don't know	*Weighted bases*	*Unweighted bases*
All	**1%**	**9%**	**48%**	**39%**	**3%**	***1497***	***1497***
Anyone close ever experienced depression							
Yes	0%	7%	44%	47%	1%	*769*	*753*
No	3%	12%	51%	30%	4%	*720*	*737*
Ever personally experienced depression							
Yes	0%	6%	40%	52%	1%	*279*	*272*
No	2%	9%	49%	38%	2%	*1055*	*1062*
Whether think most people can be trusted							
Most people can be trusted	1%	9%	46%	42%	3%	*771*	*822*
Can't be too careful in dealing with people	2%	11%	49%	35%	3%	*682*	*631*
Don't know	3%	1%	55%	40%	1%	*41*	*41*

Refused: Less than 1% for all categories

Table A.25: How likely Stephen (depression) would harm himself, combined sample

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Don't know	*Weighted bases*	*Unweighted bases*
All	**6%**	**31%**	**42%**	**19%**	**3%**	***1497***	***1497***
Respondent sex							
Male	6%	28%	45%	18%	3%	*716*	*669*
Female	5%	34%	39%	20%	2%	*781*	*828*
Whether think most people can be trusted							
Most people can be trusted	6%	28%	44%	19%	3%	*771*	*822*
Can't be too careful in dealing with people	6%	36%	39%	17%	3%	*682*	*631*
Don't know	12%	14%	47%	26%	1%	*41*	*41*

Refused: Less than 1% for all categories

Table A.26: How willing to make friends with Andy (schizophrenia), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**13%**	**53%**	**20%**	**10%**	**3%**	**2%**	***1497***	***1497***
Respondent sex								
Male	13%	46%	22%	12%	4%	3%	*716*	*669*
Female	13%	58%	18%	8%	2%	1%	*781*	*828*
Age of respondent								
18-24	16%	55%	18%	11%			*177*	*93*
25-34	15%	49%	17%	8%	5%	5%	*238*	*180*
35-44	17%	48%	23%	9%	3%	0%	*248*	*217*
45-54	12%	55%	22%	7%	2%	1%	*278*	*279*
55-64	14%	54%	18%	11%	2%	1%	*232*	*280*
65+	8%	54%	20%	12%	4%	2%	*324*	*448*
NS-SEC								
Never worked	11%	55%	19%	10%	4%		*88*	*72*
Managerial & professional	14%	51%	23%	7%	3%	1%	*470*	*477*
Intermediate occupations	10%	52%	18%	17%	3%	0%	*182*	*176*
Self-employed	7%	54%	21%	12%	5%	0%	*106*	*130*
Lower supervisory & technical	17%	51%	21%	7%	4%		*153*	*153*
Semi-routine & routine	14%	54%	17%	9%	2%	3%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	15%	54%	19%	9%	3%	1%	*967*	*971*
No	10%	50%	21%	11%	4%	3%	*524*	*520*

Table A.26: continued

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
Ever personally experienced a mental health problem								
Yes	16%	54%	18%	9%	2%	1%	*344*	*341*
No	13%	52%	21%	10%	4%	0%	*960*	*973*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	13%	53%	17%	11%	4%	1%	*789*	*854*
Neither agree nor disagree	9%	52%	28%	6%	2%	3%	*197*	*196*
Disagree	15%	52%	22%	8%	1%	1%	*497*	*435*

Refused: 1% or less for all categories

Table A.27: How willing would you be to have Andy (schizophrenia) as work colleague, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**12%**	**52%**	**20%**	**11%**	**3%**	**2%**	***1497***	***1497***
Respondent sex								
Male	10%	46%	22%	14%	5%	3%	*716*	*669*
Female	14%	57%	19%	8%	2%	1%	*781*	*828*
Age of respondent								
18-24	11%	57%	17%	12%	3%		*177*	*93*
25-34	15%	55%	16%	7%	3%	4%	*238*	*180*
35-44	16%	50%	22%	7%	3%	1%	*248*	*217*
45-54	12%	52%	21%	10%	3%	1%	*278*	*279*
55-64	12%	54%	19%	10%	3%	1%	*232*	*280*
65+	8%	46%	23%	16%	4%	3%	*324*	*448*
NS-SEC								
Never worked	11%	55%	24%	7%	3%	-	*88*	*72*
Managerial & professional	14%	53%	20%	7%	3%	2%	*470*	*477*
Intermediate occupations	10%	51%	20%	16%	2%	1%	*182*	*176*
Self-employed	6%	44%	22%	22%	5%	1%	*106*	*130*
Lower supervisory & technical	18%	41%	25%	12%	3%	1%	*153*	*153*
Semi-routine & routine	10%	57%	18%	10%	3%	2%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	15%	54%	19%	9%	2%	1%	*967*	*971*
No	8%	48%	23%	13%	5%	3%	*524*	*520*
Ever personally experienced a mental health problem								
Yes	18%	55%	17%	7%	2%	1%	*344*	*341*
No	11%	51%	22%	11%	4%	1%	*960*	*973*

Table A.27: continued

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	11%	51%	20%	12%	4%	1%	*789*	*854*
Neither agree nor disagree	8%	48%	26%	10%	4%	2%	*197*	*196*
Disagree	16%	56%	18%	8%	1%	1%	*497*	*435*

Refused: 1% or less for all categories

Table A.28: How willing would you be to spend evening socialising with Andy (schizophrenia), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**11%**	**48%**	**22%**	**14%**	**4%**	**1%**	***1497***	***1497***
Respondent sex								
Male	11%	43%	22%	16%	5%	2%	*716*	*669*
Female	11%	52%	22%	11%	3%	1%	*781*	*828*
Age of respondent								
18-24	13%	46%	22%	18%			*177*	*93*
25-34	12%	49%	19%	10%	6%	4%	*238*	*180*
35-44	11%	52%	23%	9%	4%	*	*248*	*217*
45-54	9%	52%	22%	12%	3%	1%	*278*	*279*
55-64	15%	48%	20%	15%	3%		*232*	*280*
65+	7%	42%	25%	18%	6%	2%	*324*	*448*
NS-SEC								
Never worked	13%	51%	24%	8%	4%	-	*88*	*72*
Managerial & professional	12%	49%	22%	12%	3%	1%	*470*	*477*
Intermediate occupations	9%	43%	26%	18%	2%	1%	*182*	*176*
Self-employed	8%	35%	31%	15%	11%	-	*106*	*130*
Lower supervisory & technical	13%	50%	22%	11%	4%	-	*153*	*153*
Semi-routine & routine	9%	52%	18%	16%	4%	2%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	13%	51%	21%	11%	3%	*	*967*	*971*
No	8%	43%	24%	17%	5%	3%	*524*	*520*

Table A.28: continued

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
Ever personally experienced a mental health problem								
Yes	14%	53%	19%	10%	4%	1%	*344*	*341*
No	10%	47%	23%	15%	4%	*	*960*	*973*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	10%	46%	21%	16%	6%	1%	*789*	*854*
Neither agree nor disagree	7%	49%	26%	12%	3%	3%	*197*	*196*
Disagree	14%	51%	23%	11%	1%	1%	*497*	*435*

Refused: 1% or less for all categories

Table A.29: How willing would you be to move next door to Andy (schizophrenia), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**12%**	**37%**	**32%**	**14%**	**4%**	**1%**	***1497***	***1497***
Respondent sex								
Male	10%	33%	34%	16%	5%	2%	*716*	*669*
Female	13%	41%	31%	12%	2%	*	*781*	*828*
Age of respondent								
18-24	14%	42%	32%	11%	1%	-	*177*	*93*
25-34	13%	36%	28%	14%	5%	4%	*238*	*180*
35-44	12%	40%	29%	15%	3%	*	*248*	*217*
45-54	10%	39%	31%	13%	4%	2%	*278*	*279*
55-64	13%	34%	37%	14%	2%		*232*	*280*
65+	10%	32%	36%	15%	5%	1%	*324*	*448*
NS-SEC								
Never worked	12%	47%	28%	9%	4%		*88*	*72*
Managerial & professional	12%	34%	34%	14%	3%	1%	*470*	*477*
Intermediate occupations	10%	35%	29%	23%	2%	-	*182*	*176*
Self-employed	7%	31%	40%	14%	8%	-	*106*	*130*
Lower supervisory & technical	13%	44%	28%	10%	5%		*153*	*153*
Semi-routine & routine	11%	37%	33%	13%	3%	3%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	14%	39%	30%	13%	3%	*	*967*	*971*
No	8%	33%	36%	16%	4%	3%	*524*	*520*

Table A.29: continued

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
Ever personally experienced a mental health problem								
Yes	15%	44%	25%	11%	4%	1%	*344*	*341*
No	11%	35%	35%	15%	4%	*	*960*	*973*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	10%	36%	32%	17%	5%	1%	*789*	*854*
Neither agree nor disagree	10%	30%	43%	11%	3%	3%	*197*	*196*
Disagree	15%	42%	30%	10%	2%	1%	*497*	*435*

Refused: 1% or less for all categories

Table A.30: How willing would you be to have Andy (schizophrenia) marry into your family, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**7%**	**27%**	**28%**	**24%**	**12%**	**3%**	***1497***	***1497***
Respondent sex								
Male	5%	21%	30%	24%	15%	4%	*716*	*669*
Female	8%	32%	25%	25%	9%	1%	*781*	*828*
Age of respondent								
18-24	10%	36%	35%	15%	4%		*177*	*93*
25-34	9%	43%	19%	12%	11%	5%	*238*	*180*
35-44	10%	28%	33%	17%	11%	2%	*248*	*217*
45-54	5%	27%	29%	28%	8%	3%	*278*	*279*
55-64	7%	23%	27%	27%	13%	1%	*232*	*280*
65+	2%	11%	25%	38%	20%	3%	*324*	*448*
NS-SEC								
Never worked	5%	25%	39%	23%	7%	-	*88*	*72*
Managerial & professional	10%	27%	28%	23%	9%	3%	*470*	*477*
Intermediate occupations	2%	27%	24%	31%	14%	1%	*182*	*176*
Self-employed	3%	11%	35%	34%	17%		*106*	*130*
Lower supervisory & technical	9%	32%	25%	20%	13%	1%	*153*	*153*
Semi-routine & routine	5%	28%	27%	21%	14%	5%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	8%	31%	27%	22%	10%	2%	*967*	*971*
No	4%	20%	29%	28%	15%	4%	*524*	*520*

Table A.30: continued

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
Ever personally experienced a mental health problem								
Yes	8%	38%	22%	22%	9%	1%	*344*	*341*
No	6%	25%	29%	24%	13%	2%	*960*	*973*
If more Muslims, Eastern Europeans or Blacks and Asians, Scotland would lose its identity								
Agree	5%	22%	28%	27%	16%	2%	*789*	*854*
Neither agree nor disagree	5%	31%	26%	24%	11%	3%	*197*	*196*
Disagree	10%	33%	28%	20%	6%	2%	*497*	*435*

Refused: 1% or less for all categories

Table A.31: How willing would you be to have Andy (schizophrenia) provide childcare, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	*Weighted bases*	*Unweighted bases*
All	**2%**	**8%**	**14%**	**34%**	**40%**	***1497***	***1497***
Anyone close ever experienced schizophrenia							
Yes	6%	13%	13%	34%	32%	*127*	*115*
No	2%	7%	14%	34%	40%	*1361*	*1375*

Don’t know/Refused: 2% or less for all categories

Table A.32: How willing to make friends with Stephen (depression), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**22%**	**54%**	**16%**	**6%**	**1%**	**1%**	***1497***	***1497***
Respondent sex								
Male	16%	52%	20%	7%	2%	2%	*716*	*669*
Female	27%	55%	12%	5%	1%	1%	*781*	*828*
Age of respondent								
18-24	30%	54%	12%	1%	3%	-	*177*	*93*
25-34	29%	45%	17%	5%	-	4%	*238*	*180*
35-44	22%	59%	16%	2%	1%	*	*248*	*217*
45-54	22%	56%	17%	4%	-	2%	*278*	*279*
55-64	20%	54%	16%	7%	1%	1%	*232*	*280*
65+	11%	54%	18%	12%	3%	1%	*324*	*448*
NS-SEC								
Never worked	22%	50%	14%	9%	3%	2%	*290*	*346*
Managerial & professional	20%	55%	17%	7%	1%		*276*	*303*
Intermediate occupations	31%	52%	14%	2%	1%	*	*271*	*241*
Self-employed	21%	58%	17%	3%	*	*	*294*	*260*
Lower supervisory & technical	21%	55%	15%	8%	*	2%	*168*	*139*
Semi-routine & routine	11%	54%	22%	6%	2%	4%	*197*	*206*
Anyone close ever experienced a mental health problem								
Yes	25%	55%	14%	4%	1%	*	*967*	*971*
No	16%	51%	20%	8%	1%	3%	*524*	*520*

Refused: 1% or less for all categories

Table A.33: How willing would you be to have Stephen (depression) as work colleague, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**21%**	**52%**	**16%**	**8%**	**2%**	**2%**	***1497***	***1497***
Respondent sex								
Male	15%	49%	19%	10%	3%	3%	*716*	*669*
Female	25%	55%	12%	6%	1%	1%	*781*	*828*
Age of respondent								
18-24	30%	48%	13%	5%	4%	-	*177*	*93*
25-34	27%	47%	14%	8%	-	4%	*238*	*180*
35-44	23%	56%	17%	2%	1%	1%	*248*	*217*
45-54	21%	57%	16%	5%	*	2%	*278*	*279*
55-64	20%	55%	12%	9%	3%	1%	*232*	*280*
65+	9%	50%	19%	15%	4%	2%	*324*	*448*
NS-SEC								
Never worked	21%	50%	14%	9%	3%	2%	*88*	*72*
Managerial & professional	19%	51%	19%	9%	2%	*	*470*	*477*
Intermediate occupations	31%	48%	15%	4%	1%	*	*182*	*176*
Self-employed	19%	58%	15%	6%	1%	*	*106*	*130*
Lower supervisory & technical	18%	52%	13%	12%	3%	2%	*153*	*153*
Semi-routine & routine	11%	55%	18%	8%	2%	6%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	24%	55%	13%	6%	1%	1%	*967*	*971*
No	14%	48%	21%	11%	3%	3%	*524*	*520*

Refused: 1% or less for all categories

Table A.34: How willing would you be to spend evening socialising with Stephen (depression), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**21%**	**52%**	**17%**	**6%**	**2%**	**1%**	***1497***	***1497***
Respondent sex								
Male	16%	49%	21%	8%	3%	2%	*716*	*669*
Female	25%	55%	14%	5%	1%	*	*781*	*828*
Age of respondent								
18-24	28%	54%	14%	1%	3%	-	*177*	*93*
25-34	26%	46%	17%	5%	1%	4%	*238*	*180*
35-44	22%	56%	17%	3%	1%	*	*248*	*217*
45-54	22%	55%	18%	3%	-	2%	*278*	*279*
55-64	22%	54%	14%	7%	2%	1%	*232*	*280*
65+	11%	47%	22%	15%	3%	1%	*324*	*448*
NS-SEC								
Never worked	21%	43%	19%	11%	4%	2%	*88*	*72*
Managerial & professional	19%	56%	17%	7%	2%	-	*470*	*477*
Intermediate occupations	30%	51%	14%	4%	1%	*	*182*	*176*
Self-employed	23%	53%	18%	4%	1%	*	*106*	*130*
Lower supervisory & technical	19%	60%	13%	5%	1%	2%	*153*	*153*
Semi-routine & routine	11%	52%	24%	7%	2%	4%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	24%	54%	15%	5%	2%	*	*967*	*971*
No	15%	48%	23%	9%	2%	3%	*524*	*520*

Refused: 1% or less for all categories

Table A.35: How willing would you be to move next door to Stephen (depression), combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**24%**	**49%**	**20%**	**4%**	**1%**	**1%**	***1497***	***1497***
Respondent sex								
Male	19%	49%	22%	5%	2%	2%	*716*	*669*
Female	29%	49%	18%	3%	1%	*	*781*	*828*
Age of respondent								
18-24	30%	54%	12%	1%	3%	-	*177*	*93*
25-34	31%	47%	16%	2%	0%	4%	*238*	*180*
35-44	26%	51%	19%	2%	1%	*	*248*	*217*
45-54	25%	51%	19%	3%	-	2%	*278*	*279*
55-64	25%	46%	22%	4%	2%	1%	*232*	*280*
65+	13%	46%	27%	10%	3%	1%	*324*	*448*
NS-SEC								
Never worked	23%	46%	20%	5%	4%	2%	*88*	*72*
Managerial & professional	24%	48%	21%	7%	1%	-	*470*	*477*
Intermediate occupations	33%	45%	19%	2%	*	*	*182*	*176*
Self-employed	25%	50%	20%	3%	1%	*	*106*	*130*
Lower supervisory & technical	22%	61%	12%	3%	*	2%	*153*	*153*
Semi-routine & routine	14%	48%	28%	3%	1%	4%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	28%	50%	17%	3%	1%	*	*967*	*971*
No	16%	47%	26%	5%	2%	3%	*524*	*520*

Refused: 1% or less for all categories

Table A.36: How willing would you be to have Stephen (depression) marry into your family, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**13%**	**32%**	**28%**	**18%**	**7%**	**2%**	***1497***	***1497***
Respondent sex								
Male	9%	26%	32%	20%	9%	3%	*716*	*669*
Female	16%	38%	24%	15%	5%	1%	*781*	*828*
Age of respondent								
18-24	22%	36%	26%	11%	5%		*177*	*93*
25-34	21%	38%	25%	10%	3%	4%	*238*	*180*
35-44	14%	36%	29%	14%	6%	1%	*248*	*217*
45-54	9%	35%	34%	16%	3%	2%	*278*	*279*
55-64	13%	32%	29%	18%	7%	1%	*232*	*280*
65+	4%	21%	24%	31%	17%	2%	*324*	*448*
NS-SEC								
Never worked	11%	32%	22%	20%	12%	3%	*88*	*72*
Managerial & professional	12%	34%	28%	18%	8%	1%	*470*	*477*
Intermediate occupations	21%	36%	27%	12%	4%	0%	*182*	*176*
Self-employed	14%	35%	34%	12%	3%	1%	*106*	*130*
Lower supervisory & technical	12%	28%	28%	19%	11%	2%	*153*	*153*
Semi-routine & routine	4%	24%	29%	28%	8%	5%	*454*	*453*
Anyone close ever experienced a mental health problem								
Yes	16%	37%	28%	13%	5%	1%	*967*	*971*
No	7%	23%	28%	26%	12%	3%	*524*	*520*

Refused: 1% or less for all categories

Table A.37: How willing would you be to have Stephen (depression) provide childcare, combined sample

	Very willing	Fairly willing	Neither	Fairly unwilling	Very unwilling	Don't know	*Weighted bases*	*Unweighted bases*
All	**5%**	**18%**	**21%**	**31%**	**24%**	**2%**	***1497***	***1497***
Age of respondent								
18-24	10%	20%	26%	33%	11%	-	*177*	*93*
25-34	6%	25%	18%	27%	21%	4%	*238*	*180*
35-44	5%	19%	22%	26%	27%	1%	*248*	*217*
45-54	3%	20%	23%	34%	17%	3%	*278*	*279*
55-64	5%	16%	21%	35%	22%	1%	*232*	*280*
65+	1%	9%	17%	30%	39%	2%	*324*	*448*
Whether think most people can be trusted	6%	20%	21%	30%	21%	2%	*771*	*822*
Most people can be trusted	3%	15%	20%	31%	29%	2%	*682*	*631*
Can't be too careful in dealing with people	5%	9%	26%	44%	15%	1%	*41*	*41*

Refused: 1% or less for all categories

ANNEX B –TECHNICAL DETAILS OF THE SURVEY

The Scottish Social Attitudes series

1. The Scottish Social Attitudes (SSA) survey was launched by the Scottish Centre for Social Research (ScotCen) in 1999, following the advent of devolution. Based on annual rounds of interviews of between 1,200 to 1,500 people drawn using probability sampling (based on a stratified, clustered sample)59, it aims to facilitate the study of public opinion and inform the development of public policy in Scotland. In this it has similar objectives to the British Social Attitudes (BSA) survey, which was launched by ScotCen's parent organisation, the National Centre for Social Research (NatCen) in 1983. While BSA interviews people in Scotland, these are usually too few in any one year to permit separate analysis of public opinion in Scotland (see Park, et al, 2013 for more details of the BSA survey).

2. The SSA survey has been conducted annually each year since 1999, with the exception of 2008. The survey has a modular structure. In any one year it typically contains three to five modules, each containing 40 questions. Funding for its first two years came from the Economic and Social Research Council, while from 2001 onwards different bodies have funded individual modules each year. These bodies have included the Economic and Social Research Council, the Scottish Government and various charitable and grant awarding bodies, such as the Nuffield Foundation and Leverhulme Trust. 2013 funders were the Scottish Government, Economic and Social Research Council, NHS Health Scotland, University of Edinburgh and the Scottish Institute for Policing Research.

The 2013 survey

3. The 2013 survey contained modules of questions on:

   - Attitudes to government, the economy, health and social care services and social capital - funded by the Scottish Government
   - Attitudes to mental health and recovery – funded by the Scottish Government
   - Attitudes to alcohol – funded by NHS Health Scotland
   - Constitutional change – funded by the ESRC and University of Edinburgh

[59] Like many national surveys of households or individuals, in order to attain the optimum balance between sample efficiency and fieldwork efficiency the sample was clustered. The first stage of sampling involved randomly selecting postcode sectors. The sample frame of postcode sectors was also stratified (by urban-rural, region and the percentage of people in non-manual occupations) to improve the match between the sample profile and that of the Scottish population. For further details of the sample design, see Para 6 below.

- Attitudes to policing – funded by the Scottish Institute for Policing Research and ScotCen.

4. Findings from the modules funded by the Scottish Government will be available in reports published on their website (www.scotland.gov.uk). Separate programmes of dissemination are planned for each of the other modules. This technical annex covers the methodological details of the survey as well as further discussion of the analysis techniques used in this report.

Sample design

5. The survey is designed to yield a representative sample of adults aged 18 or over, living in Scotland. The sample frame is the Postcode Address File (PAF), a list of postal delivery points compiled by the Post Office. The detailed procedure for selecting the 2013 sample was as follows:

    i. 110 postcode sectors were selected from a list of all postal sectors in Scotland, with probability proportional to the number of addresses in each sector for addresses in urban areas and a probability of twice the address count for sectors in rural areas (i.e. the last 3 categories in the Scottish Government's 6 fold urban-rural classification). Prior to selection the sectors were stratified by Scottish Government urban-rural classification[60], region and percentage of household heads recorded as being in non-manual occupations (SEG 1-6 and 13, taken from the 2001 Census).

    ii. 28 addresses were selected at random from each of these 110 postcode sectors

    iii. Interviewers called at each selected address and identified its eligibility for the survey. Where more than one dwelling unit was present at an address, all dwelling units were listed systematically and one was selected at random using a computer generated random selection table. In all eligible dwelling units with more than one adult aged 18 or over, interviewers had to carry out a random selection of one adult using a similar procedure.

Response rates

6. The Scottish Social Attitudes survey involves a face-to-face interview with respondents and a self-completion section (completed using Computer Assisted Personal Interviewing). The numbers completing each stage in 2013 are shown in Table 1. See Bromley, Curtice and Given (2005) for technical details of the 1999-2004 surveys, Given and Ormston (2006) for details of the 2005 survey, Cleghorn, Ormston and Sharp (2007) for the 2006 survey, Ormston (2008) for the 2007 survey, Ormston (2010) for the

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[60] See http://www.scotland.gov.uk/Publications/2008/07/29152642/7 for details.

2009 survey and Ormston and Reid (2011 & 2012) for the 2010 and 2011 surveys.

Table 1: 2013 Scottish Social Attitudes survey response

	No.	%
Addresses issued	3,080	
Vacant, derelict and other out of scope [1]	339	11
Achievable or 'in scope'	2741	
Unknown eligibility [2]	9	*
Interview achieved	1497	55
Self-completion completed	1340	49
Interview not achieved		
Refused [3]	851	31
Non-contacted [4]	187	7
Other non-response [5]	196	7

Notes to table

1 This includes empty / derelict addresses, holiday homes, businesses and institutions, and addresses that had been demolished.

2 'Unknown eligibility' includes cases where the address could not be located, where it could not be determined if an address was residential and where it could not be determined if an address was occupied or not.

3 Refusals include: refusals prior to selection of an individual; refusals to the office; refusal by the selected person; 'proxy' refusals made by someone on behalf of the respondent; and broken appointments after which a respondent could not be re-contacted.

4 Non-contacts comprise households where no one was contacted after at least 6 calls and those where the selected person could not be contacted.

5 'Other non-response' includes people who were ill at home or in hospital during the survey period, people who were physically or mentally unable to participate and people with insufficient English to participate.

Sample size for previous years

7. The table below shows the achieved sample size for the full SSA sample (all respondents) for all previous years.

Table 2: *Scottish Social Attitudes* survey sample size by year

Survey year	Achieved sample size
1999	1482
2000	1663
2001	1605
2002	1665
2003	1508
2004	1637
2005	1549
2006	1594
2007	1508
2009	1482
2010	1495
2011	1197
2012	1229
2013	1497

Weighting

8. All percentages cited in this report are based on weighted data. The weights applied to the SSA 2013 data are intended to correct for three potential sources of bias in the sample:

    - Differential selection probabilities
    - Deliberate over-sampling of rural areas
    - Non-response

9. Data were weighted to take account of the fact that not all households or individuals have the same probability of selection for the survey. For example, adults living in large households have a lower selection probability than adults who live alone. Weighting was also used to correct the over-sampling of rural addresses. Differences between responding and non-responding households were taken into account using information from the census about the area of the address as well as interviewer observations about participating and non-participating addresses. Finally, the weights were adjusted to ensure that the weighted data matched the age-sex profile of the Scottish population (based on 2012 mid-year estimates from the General Register Office for Scotland).

10. In addition to the usual weighting on SSA a special weight was developed specifically for any questions in the section conducted by computer assisted self-complete (CASI), to adjust for differences in the profile of those who agreed to complete the CASI and those who refused.

Fieldwork

11. Fieldwork for the 2013 survey ran between June and October 2013, with 78% of interviews completed by the end of August and 91% by the end of September. An advance postcard, followed by an advance letter were sent to all addresses and were followed up by a personal visit from a ScotCen interviewer. Interviewers were required to make a minimum of 6 calls at different times of the day (including at least one evening and one weekend call) in order to try and contact respondents. All interviewers attended a one day briefing conference prior to starting work on the study.

12. Interviews were conducted using face-to-face computer-assisted interviewing (a process which involves the use of a laptop computer, with questions appearing on screen and interviewers directly entering respondents' answers into the computer). All respondents were asked to fill in a self-completion questionnaire using the interviewer's laptop. If the respondent preferred, the questions could be read out by the interviewer. Table 1 (above) summarises the response rate and the numbers completing the self-completion section in 2013.

Analysis variables

13. Most of the analysis variables are taken directly from the questionnaire and are self-explanatory. These include age, sex, household income, and highest educational qualification obtained.

National Statistics Socio-Economic Classification (NS-SEC)

14. The most commonly used classification of socio-economic status used on government surveys is the National Statistics Socio-Economic Classification (NS-SEC). SSA respondents were classified according to their own occupation, rather than that of the 'head of household'. Each respondent was asked about their current or last job, so that all respondents, with the exception of those who had never worked, were classified. The seven NS-SEC categories are:

    - Employers in large organisations, higher managerial and professional
    - Lower professional and managerial; higher technical and supervisory
    - Intermediate occupations
    - Small employers and own account workers
    - Lower supervisory and technical occupations
    - Semi-routine occupations
    - Routine occupations.

The remaining respondents were grouped as 'never had a job' or 'not classifiable'.

Scottish Index of Multiple Deprivation (SIMD)

15. The Scottish Index of Multiple Deprivation (SIMD)[61] 2009 measures the level of deprivation across Scotland – from the least deprived to the most deprived areas. It is based on 38 indicators in seven domains of: income, employment, health, education skills and training, housing, geographic access and crime. SIMD 2009 is presented at data zone level, enabling small pockets of deprivation to be identified. The data zones are ranked from most deprived (1) to least deprived (6,505) on the overall SIMD 2009 and on each of the individual domains. The result is a comprehensive picture of relative area deprivation across Scotland.

16. The analysis in this report used a variable created from SIMD data indicating the level of deprivation of the data zone in which the respondent lived in quintiles, from most to least deprived.[62]

[61] See http://www.scotland.gov.uk/Topics/Statistics/SIMD/ for further details on the SIMD.

[62] These variables were created by the ScotCen/NatCen Survey Methods Unit. They are based on SIMD scores for all datazones, not just those included in the sample – so an individual who lives in the most deprived quintile of Scotland will also be included in the most deprived quintile in the *SSA* dataset.

Analysis techniques

Significance testing

17. Where this report discusses differences between two percentages (either across time, or between two different groups of people within a single year), this difference is significant at the 95% level or above, unless otherwise stated. Differences between two years were tested using standard z-tests, taking account of complex standard errors arising from the sample design. Differences between groups within a given year were tested using logistic regression analysis, which shows the factors and categories that are significantly (and independently) related to the dependent variable (see below for further detail). This analysis was done in PASW 18, using the CS logistic function to take account of the sample design in calculations.

Regression analysis

18. Regression analysis aims to summarise the relationship between a 'dependent' variable and one or more 'independent' explanatory variables. It shows how well we can estimate a respondent's score on the dependent variable from knowledge of their scores on the independent variables. This technique takes into account relationships between the different independent variables (for example, between education and income, or social class and housing tenure). Regression is often undertaken to support a claim that the phenomena measured by the independent variables cause the phenomenon measured by the dependent variable. However, the causal ordering, if any, between the variables cannot be verified or falsified by the technique. Causality can only be inferred through special experimental designs or through assumptions made by the analyst.

19. All regression analysis assumes that the relationship between the dependent and each of the independent variables takes a particular form. This report was informed by logistic regression analysis – a method that summarises the relationship between a binary 'dependent' variable (one that takes the values '0' or '1') and one or more 'independent' explanatory variables. The tables in this annex show how the odds ratios for each category in significant explanatory variables compares to the odds ratio for the reference category (always taken to be 1.00).

20. Taking Model 2 (below), the dependent variable is agreeing that 'The majority of people with mental health problems recover'. If the respondent either agreed or strongly agreed that 'The majority of people with mental health problems recover' the dependent variable takes a value of 1. If not, it takes a value of 0. An odds ratio of above 1 means that, compared with respondents in the reference category, respondents in that category have higher odds of agreeing that 'The majority of people with mental health problems recover'. Conversely, an odds ratio of below 1 means they have lower odds of saying this than respondents in the reference category. The 95% confidence intervals for these odds ratios are also important. Where the confidence interval does not include 1, this category is significantly

different from the reference category. If we look at age in Model 2, we can see that those aged 55-64 years old had an odds ratio of 2.27, indicating that they have higher odds compared with those aged 18 to 24 years old (who were the reference category). The 95% confidence interval (1.29-3.99) does not include 1, indicating this difference is significant.

21. The significance of each independent variable is indicated by 'P'. A p-value of 0.05 or less indicates that there is less than a 5% chance we would have found these differences between the categories just by chance if in fact no such difference exists, while a p-value of 0.01 or less indicates that there is a less than 1% chance. P-values of 0.05 or less are generally considered to indicate that the difference is highly statistically significant, while a p-value of 0.06 to 0.10 may be considered marginally significant.

22. The models below show the final model for each variable, which was produced using the Complex Survey command (CS Logistic) in PASW 18. CS Logistic models can account for complex sample designs (in particular, the effects of clustering and associated weighting) when calculating odds ratios and determining significance. The models shown below include only those variables found to be significant after the regression models were run using CS logistic.

Regression models

Table 1: Factors associated with disagreeing that 'Anyone can suffer from mental health problems.' (2013)

Dependent variable encoding **1 = Disagreeing 'Anyone can suffer from mental health problems'** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Knowing someone with a mental health problem (p=0.029)		
No (reference)	1.00	
Yes	0.43	0.17-1.10

Nagelkerke R2 = 23.6%
Other factors included in model but which were not significant after other factors were accounted for were: sex, age, socio-economic grouping, income, level of education, urban-rural, whether experienced a mental health problem, whether feel that most people can be trusted.

Table 2: Factors associated with agreeing that 'The majority of people with mental health problems recover' (2013)

Dependent variable encoding 1 = Agreeing 'The majority of people with mental health problems recover' 0 = All other respondents	Odds ratio	95% confidence interval
Gender (p=0.001)		
Female (reference)	1.00	
Male	0.64	0.49-0.84
Age (p=0.083)		
18-24 (reference)	1.00	
25-34	1.42	0.76-2.87
35-44	1.70	0.87-3.31
45-54	1.62	0.93-2.82
55-64	2.27	1.29-3.99
65+	1.58	0.85-2.93
Income (p=0.022)		
Up to £14,300 (reference)	1.00	
Over £14,300 to £26,000	0.61	0.42-0.89
Over £26,000 to £44,200	0.89	0.61-1.30
Over £44,200	0.56	0.37-0.85
Having personal experience of mental health problems (p=0.011)		
No (reference)	1.00	
Yes	1.77	1.23-2.55

Nagelkerke R2 = 8.6%
Other factors included in model but which were not significant after other factors were accounted for were: socio-economic grouping, level of education, area deprivation, urban-rural, knowing someone with a mental health problem, having a neighbour to keep an eye on your home, whether feel that most people can be trusted, agreeing that increased immigration would lead to Scotland losing its identity.

Table 3: Factors associated with agreeing that 'People with mental health problems are largely to blame for their own condition' (2013)

Dependent variable encoding **1 = Agreeing 'People with mental health problems are largely to blame for their own condition'** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Gender (p=0.075)		
Female (reference)	1.00	
Male	1.89	1.07-3.34
Socio-economic grouping (p=0.044)		
Employers/mgrs & professional (reference)	1.00	
Intermediate occupations	1.17	0.27-5.05
Small employers/ own account workers	1.32	0.35-4.97
Lower supervisory & technical	0.92	0.25-3.38
Semi-routine & routine occupations	3.55	1.31-9.65
Never worked/ not classified	1.09	0.19-6.34
Increased immigration would lead to Scotland losing its identity (p=0.054)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	0.13	0.02-0.72
Strongly agree/agree	0.93	0.45-1.91

Nagelkerke R2 = 18.8%

Other factors included in model but which were not significant after other factors were accounted for were: age, income, level of education, area deprivation, urban-rural, knowing someone with a mental health problem, whether experienced a mental health problem, whether feel that most people can be trusted, having a neighbour to keep an eye on your home.

Table 4: Factors associated with agreeing that 'People are generally caring and sympathetic to people with mental health problems' (2013)

Dependent variable encoding 1 = Agreeing 'People are generally caring and sympathetic to people with mental health problems' 0 = All other respondents	Odds ratio	95% confidence interval
Gender (p=0.075)		
Female (reference)	1.00	
Male	1.25	0.98-1.59
Age (p=0.014)		
18-24 (reference)	1.00	
25-34	0.74	0.38-1.43
35-44	0.43	0.23-0.83
45-54	0.46	0.24-0.85
55-64	0.44	0.24-0.80
65+	0.68	0.36-1.28
Socio-economic grouping (p=0.044)		
Employers/mgrs & professional (reference)	1.00	
Intermediate occupations	0.98	0.66-1.48
Small employers/ own account workers	2.04	1.30-3.22
Lower supervisory & technical	1.47	0.88-2.43
Semi-routine & routine occupations	1.59	1.08-2.34
Never worked/ not classified	1.72	1.01-2.92
Education (p=0.031)		
No recognised qualification	1.00	
Degree/ Higher education	0.53	0.33-0.85
Highers/ A-levels	0.54	0.35-0.86
Standard grades/ GCSEs	0.82	0.58-1.17
Urban-rural (p=0.046)		
Urban (reference)	1.00	
Small town	0.91	0.60-1.36
Rural	1.37	0.97-1.94
Knowing someone with a mental health problem (p=0.009)		
No (reference)	1.00	
Yes	0.65	0.47-0.90
Having personal experience of mental health problems (p=0.011)		
No (reference)	1.00	
Yes	0.59	0.41-0.83
If my home was empty, I could count on one of my neighbours to keep an eye on it (p=0.061)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.48	0.24-0.98
Disagree/ disagree strongly	1.42	0.88-2.29
Social trust (p=0.077)		
Most people can be trusted (reference)	1.00	
You can't be too careful in dealing with people	0.72	0.53-0.98
Increased immigration would lead to Scotland losing its identity (p=0.054)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	1.09	0.70-1.68
Strongly agree/agree	1.50	1.06-2.12

Nagelkerke R2 = 14.4%
Other factors included in model but which were not significant after other factors were accounted for were: income, area deprivation.

Table 5: Factors associated with agreeing that 'If I was suffering from mental health problems, I wouldn't want people knowing about it'

Dependent variable encoding **1 = Agreeing 'If I was suffering from mental health problems, I wouldn't want people knowing about it'** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
If my home was empty, I could count on one of my neighbours to keep an eye on it (p = 0.000)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.97	0.44-2.12
Disagree/ disagree strongly	2.82	1.94-4.10

Nagelkerke R2 = 5.8%
Other factors included in model but which were not significant after other factors were accounted for were: sex, age, socio-economic grouping, income, level of education, area deprivation, urban-rural, knowing someone with a mental health problem, whether experienced a mental health problem, whether feel that most people can be trusted, agreeing that increased immigration would lead to Scotland losing its identity.

Table 6: Factors associated with agreeing that 'I would find it hard to talk to someone with mental health problems' (2013)

Dependent variable encoding **1 = Agreeing 'I would find it hard to talk to someone with mental health problems'** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Gender (p=0.000)		
Female (reference)	1.00	
Male	2.41	1.75-3.33
Age (p=0.033)		
18-24 (reference)	1.00	
25-34	1.56	0.64-3.80
35-44	1.66	0.81-3.38
45-54	0.83	0.40-1.74
55-64	1.25	0.56-2.79
65+	2.11	0.96-4.61
Socio-economic grouping (p=0.049)		
Employers/mgrs & professional (reference)	1.00	
Intermediate occupations	2.03	1.22-3.39
Small employers/ own account workers	1.37	0.71-2.66
Lower supervisory & technical	1.01	0.53-1.92
Semi-routine & routine occupations	1.59	0.94-2.68
Never worked/ not classified	2.09	0.98-4.45
Knowing someone with a mental health problem (p=0.000)		
No (reference)	1.00	
Yes	0.43	0.29-0.63
If my home was empty, I could count on one of my neighbours to keep an eye on it (p = 0.015)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.31	0.11-0.89
Disagree/ disagree strongly	1.70	1.01-2.86

Nagelkerke R2 = 19.6%
Other factors included in model but which were not significant after other factors were accounted for were: income, level of education, area deprivation, urban-rural, whether experienced a mental health problem, whether feel that most people can be trusted, agreeing that increased immigration would lead to Scotland losing its identity.

Table 7: Factors associated with agreeing that ‘People with mental health problems are often dangerous’ (2013)

Dependent variable encoding 1 = Agreeing ‘People with mental health problems are often dangerous’ 0 = All other respondents	Odds ratio	95% confidence interval
Gender (p=0.068)		
Female (reference)	1.00	
Male	1.43	0.97-2.09
Area deprivation (p=0.084)		
Least deprived (5th) (reference)	1.00	
Most deprived (1st)	0.45	0.22-0.91
2nd	0.52	0.27-0.99
3rd	0.44	0.26-0.77
4th	0.54	0.28-1.07
Knowing someone with a mental health problem (p=0.005)		
No (reference)	1.00	
Yes	0.62	0.45-0.87
Having personal experience of mental health problems (p=0.088)		
No (reference)	1.00	
Yes	0.68	0.43-1.07
If my home was empty, I could count on one of my neighbours to keep an eye on it (p=0.028)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.81	0.29-2.24
Disagree/ disagree strongly	2.34	1.24-4.35
Social trust (p=0.072)		
Most people can be trusted (reference)	1.00	
You can’t be too careful in dealing with people	1.28	0.91-1.80
Increased immigration would lead to Scotland losing its identity (p=0.000)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	0.67	0.37-1.22
Strongly agree/agree	1.78	1.16-2.71

Nagelkerke R2 = 17.3%
Other factors included in model but which were not significant after other factors were accounted for were: age, socio-economic grouping, income, level of education, urban-rural, whether experienced a mental health problem.

Table 8: Factors associated with agreeing that 'The public should be better protected from people with mental health problems' (2013)

Dependent variable encoding 1 = Agreeing 'The public should be better protected from people with mental health problems' 0 = All other respondents	Odds ratio	95% confidence interval
Gender (p=0.018)		
Female (reference)	1.00	
Male	1.51	1.08-2.13
Age (p=0.091)		
18-24 (reference)	1.00	
25-34	1.44	0.63-3.30
35-44	0.91	0.45-1.87
45-54	1.47	0.67-3.19
55-64	1.28	0.63-2.58
65+	1.91	0.94-3.88
Education (p=0.013)		
No recognised qualification	1.00	
Degree/ Higher education	0.83	0.55-1.26
Highers/ A-levels	0.41	0.24-0.72
Standard grades/ GCSEs	0.94	0.60-1.48
Knowing someone with a mental health problem (p=0.029)		
No (reference)	1.00	
Yes	0.70	0.51-0.96
If my home was empty, I could count on one of my neighbours to keep an eye on it (p = 0.006)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.51	0.23-1.14
Disagree/ disagree strongly	2.02	1.23-3.31
Increased immigration would lead to Scotland losing its identity (p=0.000)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	1.42	0.82-2.46
Strongly agree/agree	2.45	1.61-3.74

Nagelkerke R2 = 14.4%

Other factors included in model but which were not significant after other factors were accounted for were: socio-economic grouping, income, area deprivation, urban-rural, whether experienced a mental health problem, whether feel that most people can be trusted.

Table 9: Factors associated with agreeing that 'People with mental health problems should have the same rights as anyone else' (2013)

Dependent variable encoding **1 = Agreeing 'People with mental health problems should have the same rights as anyone else'** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Having personal experience of mental health problems (p=0.023)		
No (reference)	1.00	
Yes	0.37	0.18-0.75
If my home was empty, I could count on one of my neighbours to keep an eye on it (p=0.031)		
Strongly agree/agree (reference)	1.00	
Neither agree nor disagree	0.60	0.15-2.38
Disagree/ disagree strongly	2.48	1.19-5.17
Social trust (p=0.041)		
Most people can be trusted (reference)	1.00	
You can't be too careful in dealing with people	1.79	1.06-3.02
Increased immigration would lead to Scotland losing its identity (p=0.006)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	0.78	0.30-2.04
Strongly agree/agree	2.13	1.05-4.32

Nagelkerke R2 = 13.9%
Other factors included in model but which were not significant after other factors were accounted for were: sex, age, socio-economic grouping, income, level of education, area deprivation, urban-rural, knowing someone with a mental health problem.

Table 10: Factors associated with someone with schizophrenia harming others (2013)

Dependent variable encoding 1 = Thinking it likely that someone with schizophrenia would harm others 0 = All other respondents	Odds ratio	95% confidence interval
Knowing someone with schizophrenia (p=0.014)		
No (reference)	1.00	
Yes	1.92	1.15-3.22
Increased immigration would lead to Scotland losing its identity (p=0.002)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	0.71	0.46-1.11
Strongly agree/agree	1.50	1.08-2.11

Nagelkerke R2 = 7.1%
Other factors included in model but which were not significant after other factors were accounted for were: sex, age, socio-economic grouping, education, income, area deprivation, urban-rural, having a neighbour to keep an eye on your home, whether feel that most people can be trusted, having personal experience of mental health problems, knowing someone with a mental health problem, knowing the diagnosis was schizophrenia.

Table 11: Factors associated with someone with schizophrenia harming themself (2013)

Dependent variable encoding 1 = Thinking it likely that someone with schizophrenia would harm themselves 0 = All other respondents	Odds ratio	95% confidence interval
Gender (p=0.033)		
Female (reference)	1.00	
Male	0.74	0.56-0.98
Income (p=0.010)		
Up to £14,300 (reference)	1.00	
Over £14,300 to £26,000	1.77	1.03-3.07
Over £26,000 to £44,200	1.57	0.93-2.63
Over £44,200	0.90	0.54-1.50
Urban-rural (p=0.020)		
Urban (reference)	1.00	
Small town	1.08	0.77-1.51
Rural	0.66	0.47-0.91
Social trust (p=0.003)		
Most people can be trusted (reference)	1.00	
You can't be too careful in dealing with people	1.72	1.26-2.34
Increased immigration would lead to Scotland losing its identity (p=0.008)		
Disagree/ disagree strongly (reference)	1.00	
Neither agree nor disagree	1.23	0.75-2.02
Strongly agree/agree	1.72	1.22-2.44

Nagelkerke R2 = 12.7%
Other factors included in model but which were not significant after other factors were accounted for were: age, socio-economic grouping, education, area deprivation, having personal experience of mental health problems, knowing someone with a mental health problem, knowing someone with schizophrenia, knowing the diagnosis was schizophrenia.

Table 12: Factors associated with someone with depression harming others (2013)

Dependent variable encoding **1 = Thinking it likely that someone with depression would harm others** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Social trust (p=0.031)		
Most people can be trusted (reference)	1.00	
You can't be too careful in dealing with people	1.68	1.06-2.65
Knowing someone with depression (p=0.005)		
No (reference)	1.00	
Yes	0.44	0.25-0.78
Having personal experience of depression (p=0.079)		
No (reference)	1.00	
Yes	0.46	0.22-0.96

Nagelkerke R2 = 14.2%
Other factors included in model but which were not significant after other factors were accounted for were: sex, age, socio-economic grouping, education, income, area deprivation, urban-rural, having a neighbour to keep an eye on your home, agreeing that increased immigration would lead to Scotland losing its identity, having personal experience of mental health problems, knowing the diagnosis was depression.

Table 13: Factors associated with someone with depression harming themself (2013)

Dependent variable encoding **1 = Thinking it likely that someone with depression would harm themselves** **0 = All other respondents**	**Odds ratio**	**95% confidence interval**
Age (p=0.000)		
18-24 (reference)	1.00	
25-34	0.40	0.22-0.72
35-44	0.21	0.23-0.12
45-54	0.32	0.16-0.63
55-64	0.31	0.17-0.58
65+	0.24	0.13-0.44
Social trust (p=0.024)		
Most people can be trusted (reference)	1.00	
You can't be too careful in dealing with people	1.26	0.96-1.66

Nagelkerke R2 = 9.5%
Other factors included in model but which were not significant after other factors were accounted for were: sex, socio-economic grouping, education, income, area deprivation, urban-rural, having personal experience of mental health problems, knowing someone with a mental health problem, knowing someone with depression, having personal experience of depression, agreeing that increased immigration would lead to Scotland losing its identity, knowing the diagnosis was depression.

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