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Well? What do you think? (2006): The third national Scottish survey of public attitudes to mental health, mental wellbeing and mental health problems

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The National Programme for Improving Mental Health and Wellbeing was launched by the Scottish Executive in October 2001. To inform the work of the National Programme, and provide relevant baseline data, the Executive commissioned the first *Well? What do you think?* survey in 2002 and a second in 2004. In 2006, the Executive commissioned Ipsos MORI to undertake the third survey, using a refined version of the questionnaire to reflect key policy developments since 2004. The survey was carried out among a representative sample of 1,216 adults aged 16+ in Scotland.

Main Findings

- Three quarters of people interviewed said their general health was good. Respondents showed a good understanding of factors likely to affect their mental health and wellbeing, valuing strong relationships with those close to them, leisure activities and a good social life.
- People on low incomes, those experiencing difficulties with their finances and those living in deprived areas were the most likely to rate their general health as poor and to be susceptible to mental ill-health.
- The majority felt they had people they could turn to if they were experiencing personal difficulties. People with experience of mental ill-health were less likely to say they had people they could rely on in a crisis than those with no such experience.
- The percentage of respondents with personal experience of mental health problems has remained stable at just over 25% through all 3 sweeps of the survey to date. However, the percentage who say they have experienced *no difficulties* in terms of other people's attitudes to their problems has risen by almost 10 percentage points since 2004.
- Four in five respondents had seen, heard or read an advert or promotion about mental health in the past year. Findings indicate a correlation between experience of mental health problems and awareness of a range of campaigns, initiatives and promotional activity.
- Responses to a battery of attitudinal statements on mental ill-health are, in general, consistent with the 2004 survey. The proportion agreeing that 'the public should be better protected from people with mental health problems' increased to the level recorded in 2002, despite a decrease in 2004, although there was no rise since 2004 in the proportion of respondents agreeing with the statement that 'people with mental health problems are often dangerous'.
- Respondents considered a scenario describing a man or woman experiencing symptoms of depression, schizophrenia or stress. Willingness to interact with the person depicted was lowest among those who considered the schizophrenia scenarios. Respondents were consistently more willing to interact with a woman than a man displaying the same symptoms.

The Scottish Government

Background and Methods

The National Programme for Improving Mental Health and Wellbeing was launched by the Scottish Executive in October 2001. To help inform the work of the National Programme, as one part of the Scottish Executive's health improvement actions, and to provide relevant baseline data, the Executive commissioned the first National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems (*Well? What do you think?*) in 2002. The survey was repeated in 2004 to track progress towards the achievement of the National Programme's objectives, and to help influence future work. Since the 2004 survey, there have been a number of developments in the mental health improvement policy arena, with the number of campaigns and initiatives associated with the mental health improvement agenda growing. Against this backdrop, the Scottish Executive commissioned Ipsos MORI to conduct the third *Well? What do you think?* survey in 2006.

The survey was undertaken among a representative sample of 1,216 Scottish adults and conducted face-to-face in respondents' homes between 16th October 2006 and 21st January 2007. All fieldwork was conducted using Computer Assisted Personal Interviewing (CAPI).

Aims and objectives

As in 2002 and 2004, the overall aims of the 2006 survey were to examine the views and experiences of a representative sample of the adult Scottish population in relation to a spectrum of mental health-related issues. Specific objectives of the 2006 survey were to:

- Investigate people's perceptions of their own general health and lifestyle
- Explore people's understanding of the concepts of mental health and wellbeing, and their assessment of factors affecting their own mental health and wellbeing
- Investigate experience of mental health problems and recovery from mental health problems
- Investigate sources of information on mental health issues
- Explore awareness and understanding of promotional activity associated with mental health improvement work
- Explore attitudes to mental health problems
- Explore attitudes to those who experience specific symptoms of mental ill-health
- Compare findings with the 2002 and 2004 surveys and, as far as data are comparable, with findings from similar surveys.

Findings

General Health and Lifestyle

Just over three-quarters of respondents rated their general health as good (76%), with positive ratings more common among younger respondents, those in higher income brackets, those living in less deprived areas of the country, and those with a low mental ill-health score and good mental wellbeing.

Around 9 in 10 respondents were satisfied with their local neighbourhood. People living in less deprived areas of the country were significantly more likely to be satisfied than those in the most deprived areas. Levels of satisfaction were also significantly higher in rural than in urban locations. People with good mental wellbeing were more likely to be satisfied than those with poor mental wellbeing.

The majority of respondents (83%) said they see friends or relatives who are not living with them at least once a week, while 12% said they do so once or twice a month and 5%, less often. The survey revealed that people with good mental wellbeing were more likely than those with poor mental wellbeing to see friends or family on a frequent basis.

The vast majority of respondents felt they had people they could turn to if they were experiencing personal difficulties, such as a few days' illness in bed, or financial problems. There was little variation in the findings by key sub-group, but people with personal experience of mental ill-health were less likely than those with no such experience to feel they had people they could rely on in an emergency.

There was also a correlation between respondents' levels of social engagement (as defined by their informal support networks and their level of civic participation) and the number of people they felt they could turn to in a personal crisis – the more socially engaged had significantly more people they could turn to than the less socially engaged.

Mental health and wellbeing

Respondents completed the GHQ12, a validated screening instrument designed to detect possible psychiatric morbidity in the general population. As in the 2004 survey, the majority of respondents (83%) were classified as having no or few signs of possible psychiatric disorder ('low mental ill-health scores'), while approximately a fifth were assessed as displaying signs of possible psychiatric disorder ('high mental ill-health scores').

The 2006 survey also included the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), designed to measure *positive* mental wellbeing. On the basis of their responses to WEMWBS, 14% of respondents were classified as having 'good' mental wellbeing, 73% as having 'average' mental wellbeing and 14% as having 'poor' mental wellbeing.

Factors commonly identified by respondents as having a positive effect on their emotions, mental health and mental wellbeing were spending time with family and friends, leisure activities, hobbies and a good social life. Factors considered to have a negative effect were weather, work, not having enough money and physical illness.

Around two-thirds of respondents felt they had a good deal or complete control over things that affect their mental health and wellbeing, compared with 8% who felt they had little or no control. Among those most likely to feel in control were people aged 16 to 24 years, those who found it easy to manage on their income and those with good mental wellbeing.

Experience of mental health problems

Consistent with findings from the 2002 and 2004 surveys, two thirds of respondents said someone close to them had experienced a mental health problem and around a quarter (28%) of those interviewed had personally experienced a mental health problem. The specific problems most commonly experienced by respondents were depression, and neurotic and stress-related disorders. Among those most likely to have experienced mental ill-health were women, those who found it difficult to manage on their income, those with a high mental ill-health score at interview and those with poor mental wellbeing.

Among those who had experienced a problem, the proportion who said they had experienced ***no difficulties*** in terms of other people's attitudes had risen by almost 10 percentage points since 2004, to 75%. One in 5 said they had at some time chosen to avoid a social event because of the way they *thought* other people would react to their mental health problem. This is significantly higher than the proportion who had *actually* been discouraged from attending such an event.

Factors that respondents felt had been most important in supporting their recovery process were support from family and friends, medication and developing their own coping strategies.

Most respondents said they had received positive messages about their recovery from professionals and people close to them. Those who had received positive messages were more likely to have a low mental ill-health score and good mental wellbeing than those who had received negative messages.

Attitudes towards mental ill-health

Attitudes towards mental ill-health were fairly consistent with the 2004 survey. Thus, almost all (97%) respondents agreed that 'anyone can suffer from a mental health problem', 85% agreed that 'people with a mental health problem should have the same rights as anyone else' 46% agreed that 'the majority of people with mental health problems recover' and 40% agreed that 'people are generally caring and sympathetic to people with mental health problems'. The percentages of respondents agreeing with some of the more negative statements also show little change since 2004: 17% said 'I would find it hard to talk to someone with a mental health problem', and 4% said 'people with mental health problems are largely to blame for their own condition'.

There were also some shifts in attitudes since 2004. The proportion of people agreeing with the statement, 'If I were suffering from mental health problems, I wouldn't want people knowing about it' has continued to decline, from 50% in 2002 to 45% in 2004 and 41% in 2006. At the same time, however, the proportion of people agreeing that 'the public should be better protected from people with mental health problems' (32%) returned to the level recorded in 2002 (35%) despite a significant decrease in 2004 (24%).

The increase in the proportion who feel the public should be better protected does not appear to reflect a general negative shift in attitudes to people with mental health problems. After a significant reduction (32% to 15%) between 2002 and 2004, there was no further change in the proportion of respondents believing that 'people with mental health problems are often dangerous' (16%).

Attitudes towards specific symptoms of mental ill-health

Each respondent was presented with one of six scenarios describing either a man (Robert) or a woman (Shona) displaying symptoms characteristic of depression, schizophrenia or stress. Without being told the condition with which the symptoms were associated, respondents were asked a series of questions about the person in the scenario.

The majority of respondents felt that the best place for Robert/Shona to live would be in their own home with support from family or friends, whatever the symptoms they were experiencing. However, a significant minority of those shown the schizophrenia scenarios thought Robert/Shona should live in special housing with support in the community.

The person in the scenario depicting symptoms of schizophrenia was judged to be more likely to harm him/herself than the person experiencing depression or stress. Among those shown the female version of the schizophrenia scenario, the percentage suggesting that

Shona might harm herself has fallen by 10 percentage points between 2004 and 2006. Few respondents thought that Robert/Shona was likely to harm others, but it was the person experiencing schizophrenia who was felt to be most likely to cause harm to others.

For all of the scenarios, majorities said they would be willing to interact with Robert/Shona under a range of circumstances. These included doing them a favour, moving next door to them and spending an evening socialising with them. However, smaller proportions were willing to have Robert/Shona marry into the family or to let Robert/Shona provide childcare for someone in their family.

Across the three waves of the survey, willingness to interact with Robert/Shona was highest among those shown the stress scenario and lowest among those shown the schizophrenia scenario. Respondents were consistently more willing to interact with a female than with a male displaying the same symptoms.

Willingness to engage with the person in the scenario declined between 2004 and 2006, despite increasing on several of the measures between 2002 and 2004.

In each of the survey waves, the majority of those shown the depression scenarios were able to diagnose the symptoms correctly. Respondents were less successful at identifying stress and schizophrenia, although responses to the schizophrenia scenarios indicated their awareness that the symptoms they were being asked to consider required more formal, or higher, levels of support.

Sources of information on mental health problems and awareness of campaigns and initiatives

Sources of information that respondents felt had been important in forming their impressions about mental health problems were personal contact or experience (mentioned by 59%) and television news or current affairs (45%). Newspapers, work, word of mouth and health professionals were also mentioned by relatively large numbers of people.

Four in five (79%) respondents said they had seen, read or heard an advert or promotion about mental health or mental health problems in the last year – a higher proportion than in 2004 (72%). Over half had seen an advert or promotion in the cinema, while around a third mentioned leaflets in a doctor's or other type of surgery and 20% mentioned newspaper adverts. The proportions mentioning television/cinema adverts and newspaper adverts have both increased significantly since 2004, by 9 and 5 percentage points respectively.

Respondents were asked whether or not they had heard of a number of key initiatives associated with improving mental health in Scotland. The 'see me…' campaign and 'Choose Life' had the highest profile, with 37% and 32% respectively saying they had heard of these. The figure for 'Choose Life' is 6 percentage points higher than in 2004. Around a quarter of respondents had heard of 'Breathing Space', and 'Well' Magazine, with the figure for 'Breathing Space' also up on 2004 – by 10 percentage points.

Awareness of the various campaigns and initiatives was found to be correlated with more positive attitudes to mental ill-health, including willingness to interact with people with mental health problems.

Conclusions

People on lower incomes, people who experience difficulty managing financially and people who live in more deprived areas are the most likely to rate their general health as poor and to be more susceptible to mental ill-health. A recent study on the epidemiology of suicide showed that people who have a low income *and* live in a deprived area are at heightened risk of dying by suicide, and that the gap between suicide rates in the highest and lowest social classes increases as socio-economic deprivation worsens (Platt et at, 2007). Findings from this (*Well?*) study indicate that there may be an enhanced risk with regard to general and mental health, as well as suicide. It would be useful to examine these effects in more detail with a view to developing more targeted support services.

The series of correlations found in this study between aspects of social isolation and lifetime experience of mental ill-health support evidence from other research. However, it is not possible for a cross-sectional study such as this to establish causation. Longitudinal research would be required to investigate the direction of the relationship.

The percentage of respondents who say they have personal experience of mental health problems has remained stable, at just over 25%. However, it is encouraging to note that, among those who report such experience, the percentage who have encountered ***no difficulties*** in terms of other people's attitudes has risen by almost 10 percentage points since 2004. The proportion of respondents who had chosen to avoid a social event because of the way they *thought* people would react to their mental health problem is twice as high as the proportion who said they had *actually been* discouraged from participating in such events. This 'self-stigmatisation' and fear of rejection clearly have the potential to limit an individual's behaviour.

Findings indicate a correlation between experience of mental health problems (proxy or personal) and recognition of a range of campaign and initiatives. This suggests that these

initiatives are reaching those to whom they are likely to be most helpful. However, the engagement of people who do not have, or are unwilling to divulge, such experience is vital to increasing mental health literacy in Scotland.

People living in areas of multiple deprivation, where incidence of mental ill-health is higher, may be more likely to come into contact with those experiencing such problems. However, findings indicate that stigmatisation is no less common in such areas. This implies that exposure to mental health problems is not, by itself, enough to change attitudes and understanding. Although education and information campaigns in deprived areas may be of help, it is also likely that focussing more intensive support resources in such areas will be of considerable benefit.

There are clear indications from this survey that males exhibiting symptoms of mental ill-health are more likely to be avoided and viewed with suspicion than females. Men are also more likely than women to avoid social contact with people exhibiting such symptoms. Perhaps both these themes can be explored and used in the modelling of future campaign activity.

Many of those who hold the most positive attitudes toward people with mental health problems also say they would be reluctant to disclose a mental health problem to others. This is a potent reminder of the prejudice still surrounding, or still perceived by respondents as surrounding, mental ill-health. People are unlikely to feel comfortable disclosing a problem until they are confident that this prejudice has been dealt with. These findings have important implications for the implementation of the *Delivering for Mental Health* strategy (Scottish Executive, 2006), in particular with respect to the 'responding better to depression, anxiety and stress' and the 'early detection and intervention in self-harm and suicide prevention' components. If the strategy's commitments are to be met, it is important that people feel able to talk about their symptoms.

The addition of WEMWBS to the survey reinforces the importance of strong social networks in promoting ***positive*** mental health. Similarly, the observed link between high WEMWBS scores and both low deprivation and satisfaction with neighbourhoods points towards the significance of the physical environment in promoting wellbeing.

Findings from the present study also suggest that further research on positive mental wellbeing would be valuable. For example, it would be useful to investigate the extent to which WEMWBS is tapping other psychosocial concepts, such as resilience, to determine the extent to which they buffer the effects of adverse environmental influences on mental health.

In addition, the general significance of WEMWBS as a potential predictor of attitudes and behaviours underscores the importance of focusing on the promotion of positive mental wellbeing and not just engaging with mental distress. This is consistent with the current and planned direction of mental health policy in Scotland.

While the three surveys carried out to date have allowed the monitoring of trends in behaviour, experience and attitude across a range of mental health issues, we need to recognise that attitudes and behaviours are multi-factorial. To test the correlations that have been found, and to establish causation, would require a different, longitudinal research design.

The survey reinforces the message that a range of factors impact on mental health, wellbeing and attitudes and behaviours. The recent restructuring of the Scottish government, bringing together a range of areas under the portfolio of health and wellbeing, may offer new opportunities for effecting and sustaining changes in the mental health of Scotland's population.

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