

Attitudes towards mental illness

3

Nevena Ilic, Helen Henderson, Claire Henderson, Sara Evans-Lacko, Graham Thornicroft

Summary

- This chapter explores attitudes among adults aged 16 and over towards mental illness measured by the Community Attitudes toward the Mentally Ill (CAMI) scale. The CAMI measures attitudes to two factors: prejudice and exclusion; and tolerance and support for community care. Attitudes are analysed in relation to a range of socio-economic characteristics, and by people's knowledge and experience of mental illness.
- Attitudes towards the two factors were scored, and a mean score was calculated for each factor ranging from 0-100, with higher scores representing more positive attitudes (that is, less prejudiced/more tolerant).
- Overall, views were more positive in relation to prejudice and exclusion than to tolerance and support for community care, with mean scores of 76 and 71 respectively among all adults.
- Women consistently had significantly less prejudiced and more tolerant views than men. Women's mean score on prejudice and exclusion was 78, compared with 73 for men; the equivalent scores on tolerance and support for community care were 72 and 69.
- Attitudes towards mental illness varied according to age, with different patterns for the two factors. People aged 35-64 held the least prejudiced views (scores 77-79), while the most prejudiced attitudes were held by participants aged 65 and over (65-73). Attitudes relating to tolerance and support for community care were least positive among younger participants aged 16-34 (65-69), and were at a broadly equal level among participants from the age of 35 and over (71-74).
- Attitudes towards mental illness were associated with socio-economic indicators. Those living in the lowest income households or the most deprived areas were least likely to hold positive views in relation to prejudice and exclusion and to tolerance and support for community care. Scores on prejudice and exclusion ranged from 75 among women in lowest income households to 82 in the highest income households, compared with 69-76 among men. There was a similar pattern for scores on tolerance and support for community care; and these ranges were also very similar according to quintiles of area deprivation.
- Attitudes varied according to the highest level of educational qualification achieved. The least prejudiced and most tolerant attitudes were held by those with at least degree level education (79-83 for prejudice and exclusion, 72-76 for tolerance and support for community care). Those with no qualifications held the least positive attitudes (66-71 for both prejudice and exclusion and for tolerance and support for community care).
- There was also variation according to employment status. Those in employment held the most positive attitudes towards prejudice and exclusion (81 for women, 75 for men), while the least positive attitudes about prejudice and exclusion were held by retired participants (74 for women and 70 for men). In contrast, retired participants were the most positive on tolerance and support for community care (73 for both

women and men), and unemployed participants held the least positive attitudes (68 for women and 66 for men).

- Men and women who knew someone with a mental illness were statistically significantly more likely to hold less prejudiced and more tolerant views (80-83 for women and 75-77 for men on prejudice and exclusion, 73-77 and 69-73 respectively for tolerance and support for community care) than those who did not know anyone with a mental illness (equivalent scores were 70 and 68 on prejudice and exclusion, 67 for both men and women on tolerance and support for community care).
- Participants who had ever been diagnosed with some form of mental illness had more positive attitudes towards both factors. Women ever diagnosed with a common mental disorder scored 82 on prejudice and exclusion and 75 on tolerance and support for community care, with equivalent scores of 79 and 73 for men. Men and women who had never been diagnosed with a mental illness scored 77 and 73 on prejudice and exclusion respectively, and 71 and 69 on tolerance and support for community care.

3.1 Introduction

The importance of mental health has been increasingly recognised in recent years, and alongside this has grown an awareness of the need to talk about public attitudes to mental illness and reduce levels of stigma and discrimination in relation to mental illness. In 2001, the World Health Organisation (WHO) issued the first major report on the topic of mental health and recommended that the public be educated, stating that ‘well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other’.¹

The ‘Time to Change’ (TTC) campaign was launched in 2009, and continues to be led by Mind and Rethink Mental Illness charities. It has been described as ‘England’s largest programme to challenge mental health stigma and discrimination’.² In 2015 the government announced a policy for mental health service reform, which included making mental health part of the new national measure of well-being, and providing up to £16m of funding for the second phase of the TTC campaign.³ The focus on attitudes to mental health in policy continued in 2014, when the Department of Health released a report titled ‘Closing the Gap: Priorities for essential change in mental health’. One of the 25 priority actions within this report was to stamp out and ultimately remove discrimination in order to ‘help millions of people affected by mental health problems to fulfil their potential as active and equal citizens’.⁴ Looking to the future, in 2013 WHO announced a ‘Comprehensive Mental Health Action Plan 2013-2020’, which calls for a change in attitudes that perpetuate stigmatisation and discrimination around mental illness, emphasising that they often lead to a violation of human rights of persons with mental illness.⁵ All of these initiatives reiterate the importance of reducing discrimination relating to mental illness.

Around one in four people in the UK experience a mental illness in their lifetime,^{6,7} yet experience of discrimination remains relatively high. The TTC campaign aimed to reduce levels of experience of discrimination by 5% from 2008 to 2011. There was a slight decrease over this period in the proportion of participants in the TTC evaluation surveys who reported one or more experiences of discrimination (91% to 88%), although it did not meet the 5% target, and it remains the case that the great majority of those with mental illness reported experience of discrimination in the last year.⁸

However, data from the national Attitudes to Mental Illness surveys show that since the beginning of the second phase of Time to Change, which started in 2011, there have been improvements in attitudes towards people with a mental illness.⁹ This includes findings that the proportion of those willing ‘to work with someone with a mental health problem’ increased by seven percentage points, from 69% in 2009 to 76% in 2013; while willingness to ‘continue a relationship with a friend with a mental health problem’ increased by six percentage points, from 82% in 2009 to 88% in 2013.¹⁰

Using data from the Health Survey for England (HSE) 2014, this chapter explores people’s current perceptions of, and stance towards, mental illness. This was done by measuring participants’ attitudes to prejudice and tolerance. In order to look into the factors which drive these attitudes, analyses within this chapter examine whether attitudes to mental illness differ by a range of demographic characteristics, including educational level and employment status, as well as participants’ experience and knowledge of mental illness.

3.2 Methods and Definitions

3.2.1 Methods

Community Attitudes towards the Mentally Ill scale

Community Attitudes toward the Mentally Ill (CAMI) is a scale developed by Taylor and Dear in 1981 to measure community attitudes towards people with mental illness. The original CAMI questionnaire consisted of 40 attitudinal statements about mental illness, with participants saying how much they agreed or disagreed with each statement on a 5-point Likert Scale.

For HSE 2014 a 12-item scale (CAMI-12) was used among adults aged 16 and over. This was a subset of the original statements, selected to show levels of mental health-related stigma and tolerance, and first used in the survey evaluating the Time to Change social marketing campaign.^{10,11} The CAMI questionnaire was administered in the self completion questionnaire during the interview visit.

Factor analysis

For the HSE 2014, an exploratory factor analysis was performed on the 12 attitude statements. Factor analysis is a statistical method used to describe variability among a group of correlated variables (in this case agreement or disagreement with the attitude statements) in terms of a potentially lower number of underlying factors. Factor analysis searches for joint variations in response to the underlying factors. With the CAMI statements, the factor analysis produced two factors,¹² which revealed themes of:

- Prejudice and exclusion
- Tolerance and support for community care.

An internal reliability test, Cronbach's Alpha, was run on the two factors, both of which were found to be internally reliable.¹³ The identification of the two factors was consistent with previous research, which ran a factor analysis on the 27 item version of the CAMI questionnaire used in the National Attitudes to Mental Illness survey.¹⁴

Scoring the attitude statements

The 12 CAMI statements were phrased in both positive and negative directions. Those relating to tolerance and support of community care expressed supportive attitudes towards mental illness where agreement was positive, while for those relating to prejudice and exclusion disagreement reflected more positive views. The degree of the participant's agreement or disagreement to each of the statements was rated on a 5-point Likert Scale, which was scored as follows for positive statements:

Agree strongly	100
Agree slightly	75
Neither agree nor disagree	50
Disagree slightly	25
Disagree strongly	0

Negative statements were scored in reverse, so that in each case, mean scores ranged from 0-100 and a higher score represented a more positive attitude (less prejudiced/more tolerant). There was also a sixth option of 'Don't know'; those choosing this option were excluded from the calculation of the mean score.

Table 3.1 shows the individual statements in the CAMI scale and the full distribution of responses to them, including the proportion of participants giving the response option 'don't know'. For most statements this is a relatively low proportion, between 2-10%, but for one statement, 'Most women who were once patients in a mental hospital can be trusted as babysitters', one in five adults chose the 'don't know' response (20%).

A single measure for each of the factors has been derived, representing levels of prejudice and exclusion, and tolerance and support for community care. This single measure for the factor takes the average of the mean scores from the individual statements relating to that factor. Participants were included in this average score if they had responded (i.e. not said 'don't know') to at least two of the six statements relating to the relevant factor.

This 'composite' mean score for each factor is used in the analyses throughout the chapter.

Table 3.1

Age standardisation

Most tables in this chapter that do not present an age breakdown are age-standardised. This allows comparisons between categories being examined after taking into account any differences there may be in age profiles. Both observed and age-standardised data are provided by region in the tables. Observed data can be used to examine actual prevalence or mean values within a region, needed, for example, for planning services. Age-standardised data are required for comparisons between regions to exclude age-related effects, and are discussed in the report text.

However, age-standardisation has not been used in Table 3.7, looking at employment status. This is because there the ‘retired’ group contains almost all older participants, whereas the other groups of economic activity contain very few; thus there are a number of blank cells in the weighting matrix of age by employment status, meaning that the age-standardisation does not work satisfactorily.

3.2.2 Definitions

The General Health Questionnaire, GHQ-12

The 12-item General Health Questionnaire (GHQ-12) is a widely used and validated measure of mental health.¹⁵ It was originally intended for use in general practice settings as a screening instrument for mental ill health but cannot be used to diagnose specific psychiatric problems. In HSE 2014, the GHQ-12 was administered via a self-completion booklet given to participants aged 13 and over; analysis in this chapter is based on adults aged 16 and over.

The questionnaire consists of twelve items measuring general levels of happiness; depression and anxiety; sleep disturbance; and ability to cope over the last few weeks. Each item is rated on a four-point scale, where a score of 0 is given to responses indicating that a symptom is present ‘not at all’ or ‘no more than usual’ and a score of 1 is given to responses indicating the symptom is present ‘rather more than usual’ or ‘much more than usual’. Consistent with previous HSE surveys, a GHQ-12 score of 4 or more is referred to as a ‘high GHQ-12 score’, indicating probable psychological disturbance or mental ill health.

Mental illness categories

Chapter 2 examines experience, diagnosis and treatment of a range of mental illnesses. In this chapter attitudes to mental illness are examined according to whether people have ever been diagnosed with broad categories of mental illnesses, as described in more detail in Chapter 2. Table 3A shows the summary categories, and the individual conditions and disorders included within each one. It should be noted that some people have been diagnosed with more than one illness within a category, and that some have illnesses in more than one of the summary categories, and therefore the categories are not mutually exclusive.

Table 3A	
Mental illness types	
Common mental disorder	Phobia Panic attacks Post-traumatic stress Generalised anxiety disorder Depression Post-natal depression Obsessive compulsive disorder
Serious mental illness	Bipolar disorder Eating disorder Nervous breakdown Personality disorder Psychosis or schizophrenia
Other including complex disorders	Attention deficit hyperactivity disorder (ADHD) Attention deficit disorder (ADD) Dementia Seasonal affective disorder Any other mental, emotional or neurological problem or condition
Alcohol or drug dependence	

3.3 Attitudes towards mental illness

3.3.1 Attitudes towards mental illness, by age and sex

Views among adults aged 16 and over were more positive about prejudice and exclusion (mean score 76) than about tolerance and support for community care (mean score 71).

Figure 3A shows how mean scores for the two factors varied between men and women. In each case, women had statistically significantly higher scores, and thus more positive attitudes, than men.

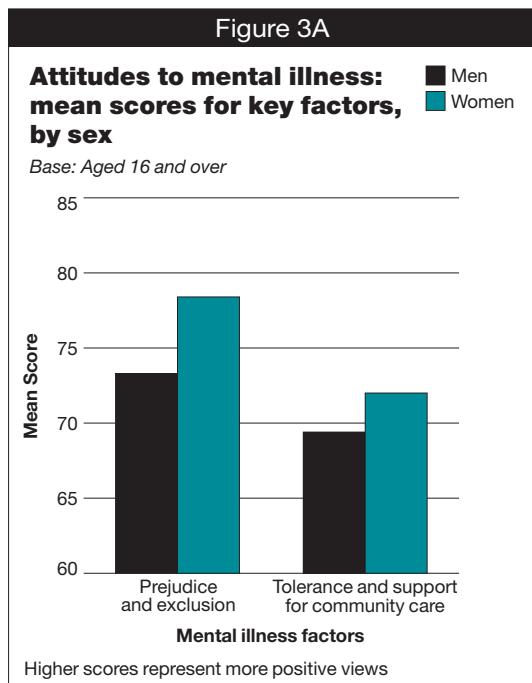
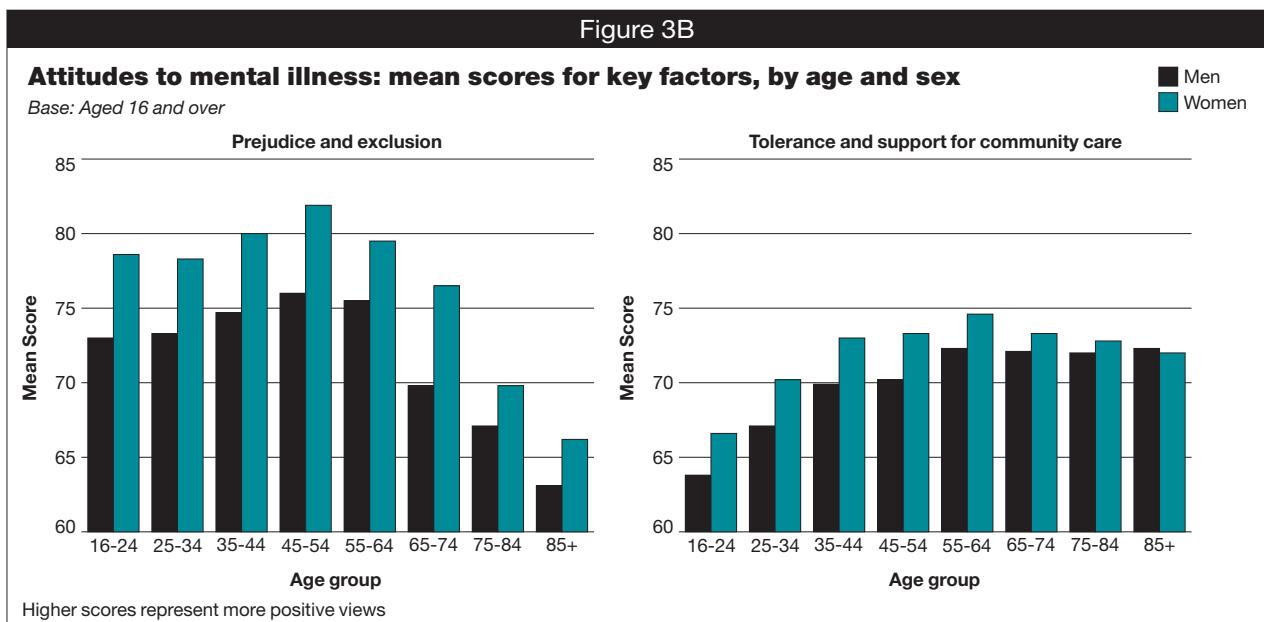


Figure 3B shows how views on the two factors varied according to age among men and women. There was statistically significant variation in each case, but with different patterns for the two factors.

For prejudice and exclusion, attitudes were most positive (that is, least prejudiced) among participants aged between 35 and 64, while the most negative attitudes were held by participants aged 65 and over.

Attitudes relating to tolerance and support for community care were least positive among younger participants aged 16-35, and were at a broadly similar level among participants from the age of 35 and over.

Table 3.2, Figures 3A, 3B

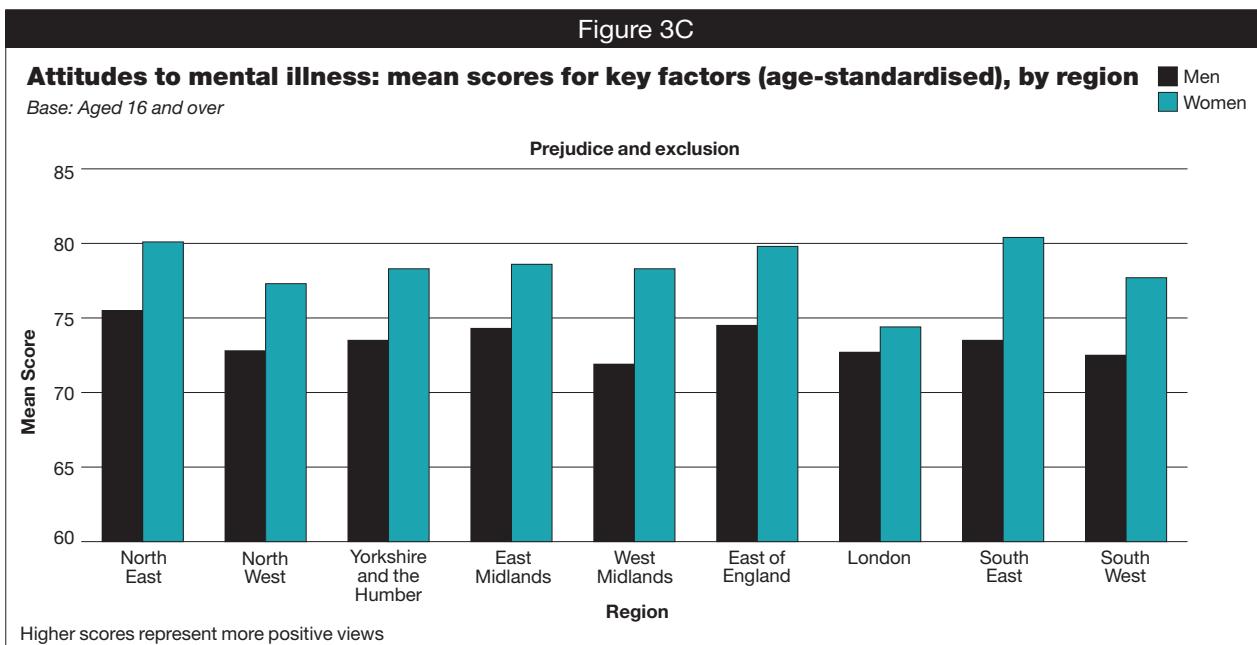


3.3.2 Attitudes towards mental illness, by region

Views on prejudice and exclusion varied according to region, as shown in Figure 3C. There was no statistically significant variation in attitudes to tolerance and support for community care.

The most positive attitudes about prejudice and exclusion were held by both men and women in the North East and East of England, and men in the East Midlands and women in the South East (scores of 74-76 among men, 80 among women). The most negative attitudes about prejudice and exclusion were found among men in the West Midlands and women in London (scores of 72 and 74 respectively).¹⁶

Table 3.3, Figure 3C



3.3.3 Attitudes towards mental illness, by equivalised household income

The HSE uses the measure of equivalised household income, which takes into account the number of adults and dependent children in the household as well as overall household income.¹⁷ Households are divided into quintiles (fifths) based on this measure. There was statistically significant variation by equivalised household income in attitudes towards both prejudice and exclusion and tolerance and support for community care.

Participants from households with the highest incomes held the most positive attitudes for both factors (that is, they were least prejudiced and most tolerant), while those from households with the lowest incomes held the least positive attitudes. As Figure 3D shows, mean scores for both men and women generally decreased with decreasing equivalised household income.

Table 3.4, Figure 3D

3.3.4 Attitudes towards mental illness, by Index of Multiple Deprivation

There was a similar pattern of variation by area deprivation, as measured by the Index of Multiple Deprivation, in attitudes towards both prejudice and exclusion and tolerance and support for community care.

Figure 3E shows that participants from the least deprived areas held the most positive attitudes for both factors, while those from the most deprived areas held the least positive attitudes.

Table 3.5, Figure 3E

3.3.5 Attitudes towards mental illness, by highest educational qualification

Attitudes to mental illness were analysed according to the highest level of educational qualifications achieved, the categories being degree and above, A-level or equivalent, GCSE or equivalent, and no qualifications. There were broadly similar proportions in each group (22-27%).¹⁸ Attitudes varied according to people's qualification level, as Figure 3F shows.

Figure 3D

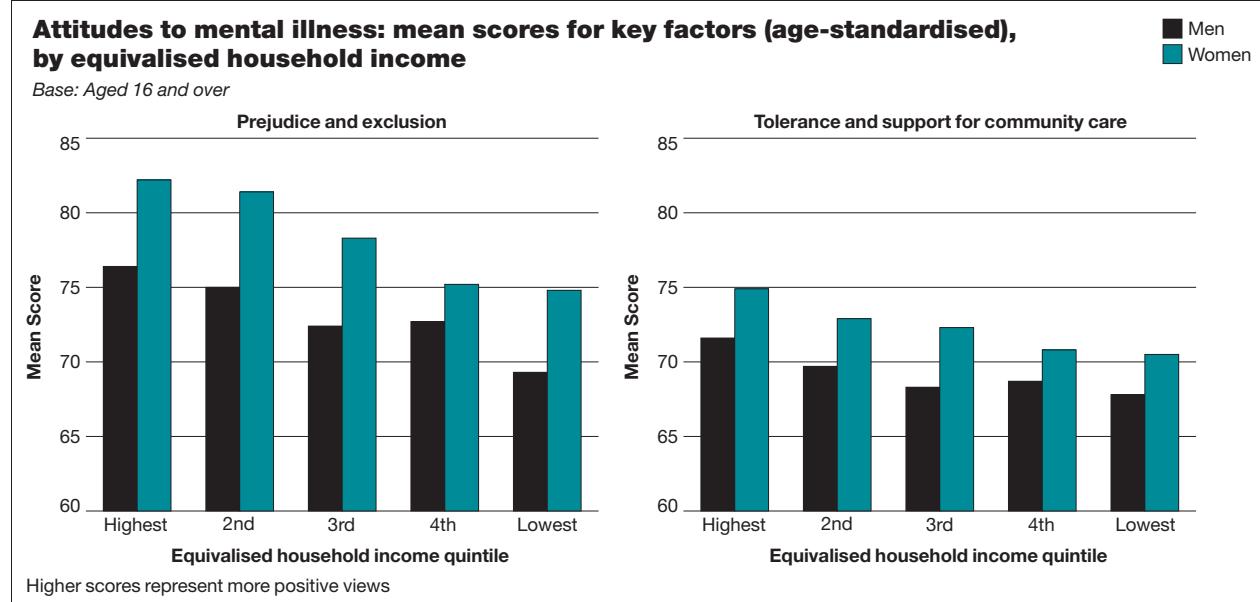
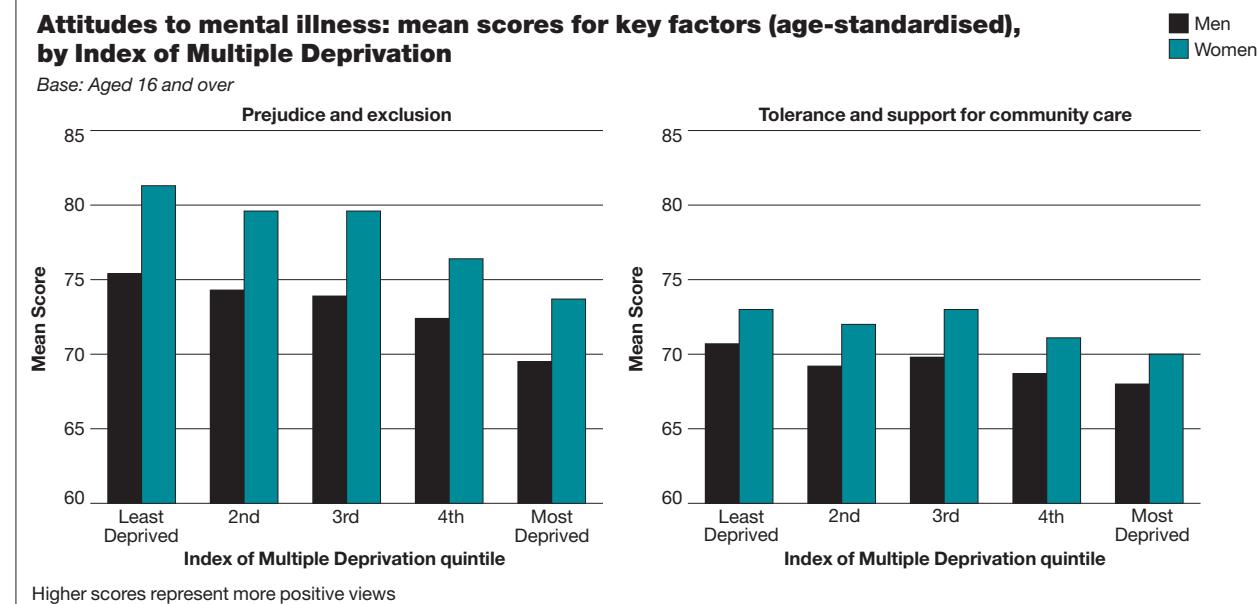


Figure 3E



Participants with at least degree level qualifications held more positive attitudes for both factors, while those with no qualifications held the least positive attitudes. There were decreasing scores in between for those with A-level or equivalent, and GCSE-level qualifications.

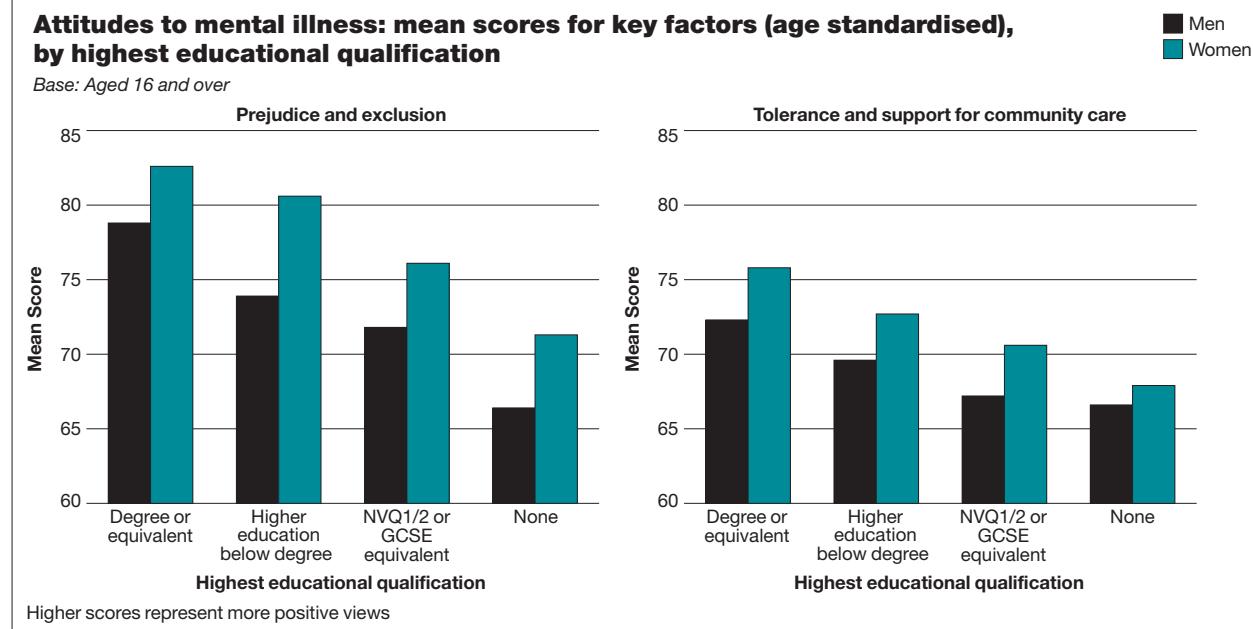
Table 3.6, Figure 3F

3.3.6 Attitudes towards mental illness, by employment status

There was statistically significant variation by employment status towards both prejudice and exclusion and tolerance and support for community care, with notably different patterns for the two different factors as shown in Figure 3G. The majority were in employment (63% of men and 50% of women), while 20% of men and 24% of women were retired. Smaller proportions were unemployed (5% of both men and women) or economically inactive¹⁹ (12% and 21% respectively).²⁰

The least prejudiced attitudes were held by those in employment, decreasing through those who were unemployed or otherwise inactive, while the least positive attitudes were held by retired participants (reflecting the less positive views already noted for older participants in Section 3.3.1).

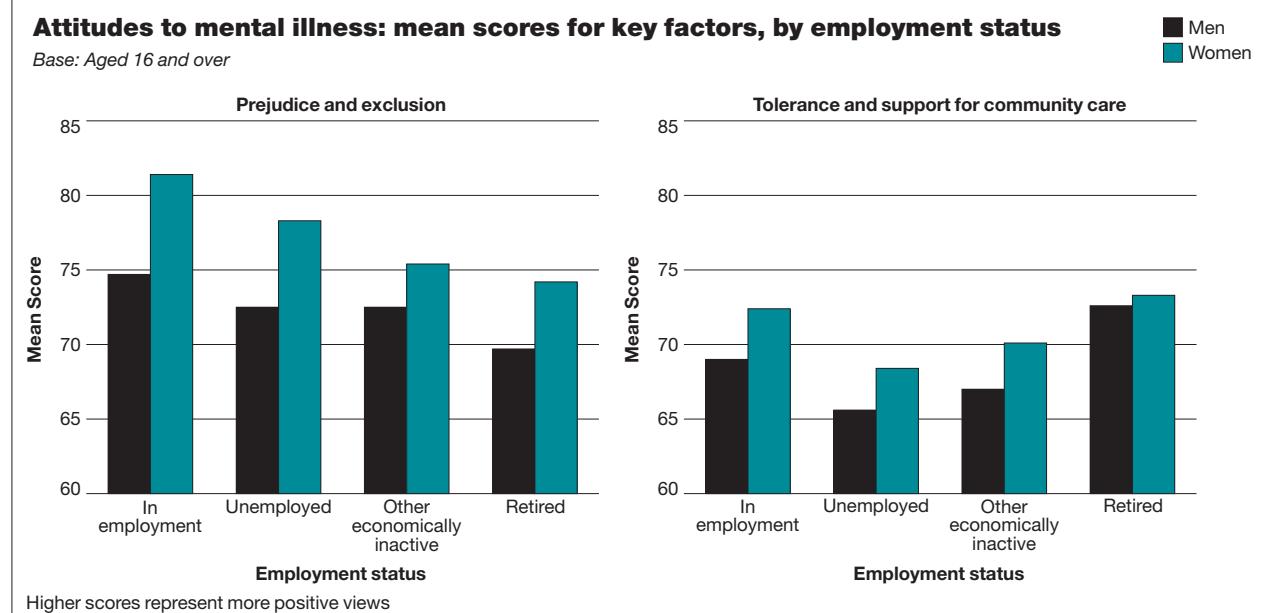
Figure 3F



In contrast, the most positive attitudes towards tolerance and support for community care were held by retired participants, followed by those in employment. Unemployed participants held the least positive attitudes. In analyses so far there has been a consistent pattern of more positive attitudes among women than men, but it is notable that views about tolerance were very similar between retired men and women.

Table 3.7, Figure 3G

Figure 3G



3.3.7 Attitudes towards mental illness, by closest person with mental illness and sex

Participants were asked the question ‘Who is the person closest to you who has or has had some kind of mental illness?’ The response categories included the participant him/herself, immediate family, partner, or other family, friends or acquaintances; and those that did not know anyone with mental illness were also identified. This question provides information about the extent to which participants’ views about mental illness may be based either on their own experience, or that of people they know with mental illness.

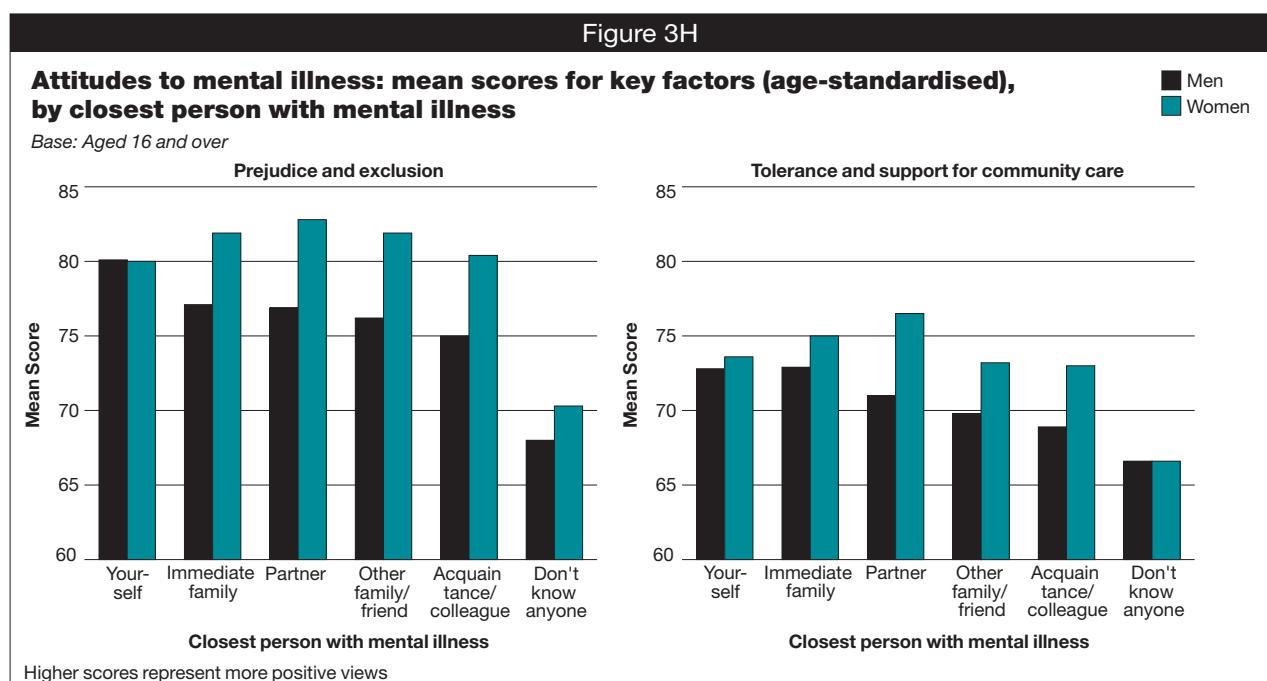
In this context, only small proportions of participants said they themselves had (either currently or in the past) had a mental illness (3% of men, 5% of women),²¹ and similarly few

said that the closest person they knew with a mental illness was their partner (7% and 5% respectively). A much larger group mentioned immediate family (26% of men, 32% of women), or other family members or friends (21% and 23%). 5-6% mentioned an acquaintance or colleague. 37% of men and 31% of women said that they did not know anyone who had had a mental illness.²²

Figure 3H shows that there was statistically significant variation in attitudes according to this measure for both factors. In each case, there was a difference between those who did not know anyone with a mental illness and the other participants, with much lower scores (68-70 for prejudice and exclusion, 67 for tolerance and support for community care) among those without family, friends or acquaintances with mental illness. Among those who had themselves had a mental illness, or knew someone who had, scores for the prejudice and exclusion factor ranged between 75-80 for men and 80-83 for women; on tolerance and support for community care, the equivalent ranges were 69-73 for men and 73-77 among women.

Figure 3H suggests some variation between groups, and a slightly different pattern between men and women; however, because some of the groups are quite small (men who have had mental illness themselves, men or women with a partner or acquaintance/colleague who has had a mental illness), the margins of error are quite wide and the patterns are not statistically significantly different between men and women.

Table 3.8, Figure 3H



3.3.8 Attitudes towards mental illness, by knowledge of mental illness

As well as the 12 attitude statements relating to prejudice and tolerance within the CAMI questionnaire, a statement on knowledge about mental illness was included: '*I have very little knowledge about mental illness*'. As with the other statements, it required participants to indicate their level of agreement or disagreement. For this analysis, the five response categories were grouped into three, those agreeing (strongly agree/tend to agree), those disagreeing (disagree strongly/tend to disagree), and those who said 'neither agree nor disagree'. Figure 3I shows that there were different patterns of response between men and women, with men more likely to agree than disagree, while the reverse was true for women. Attitudes about knowledge of mental illness were associated with attitudes about prejudice and exclusion, and tolerance and support for community care, with similar results for both men and women, as shown in Figure 3J. Those who felt they were more knowledgeable, i.e. who disagreed that they knew little about mental illness, had considerably more positive views towards both prejudice and exclusion and tolerance and support for community care, compared with those who agreed (i.e. did not feel knowledgeable) or those who neither agreed nor disagreed.

Table 3.9, 3.10 Figures 3I, 3J

Figure 3I

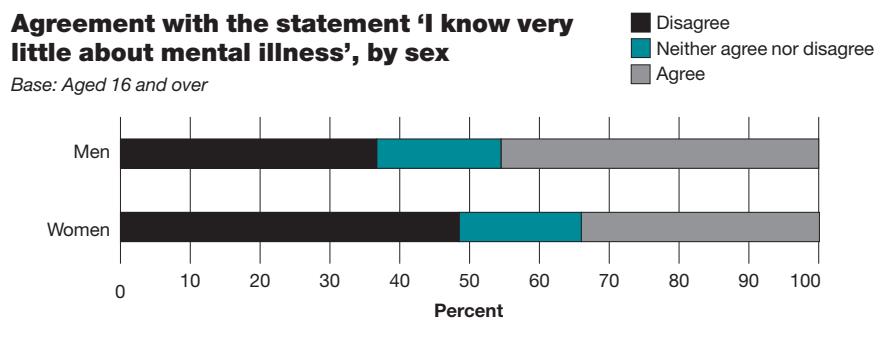
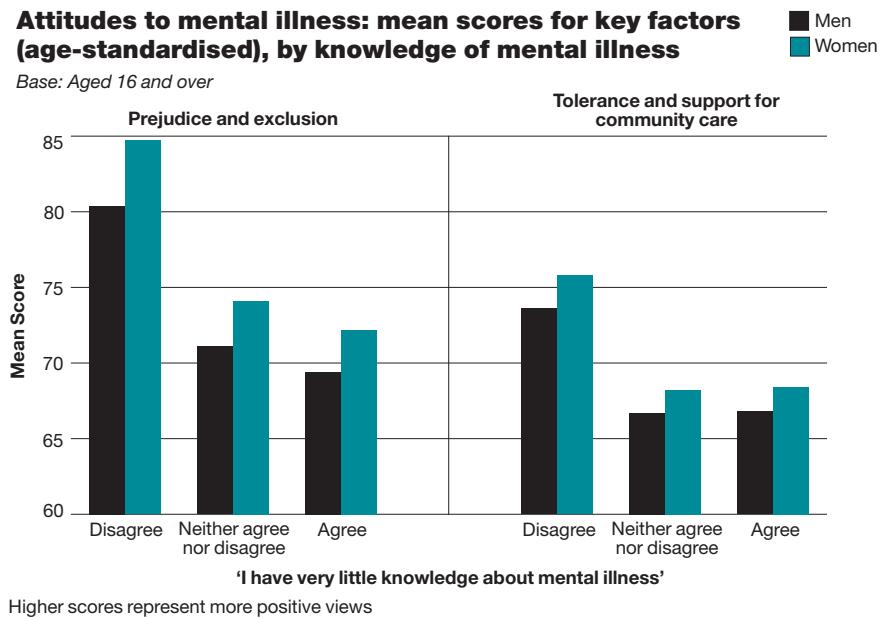


Figure 3J



3.3.9 Attitudes towards mental illness, by General Health Questionnaire score (GHQ-12)

Attitudes to mental illness were analysed by scores on the General Health Questionnaire (GHQ-12), which provides an indication of probable mental ill health (see Section 3.2.2 for more detail). There was no statistically significant variation by GHQ-12 score for either attitudes about prejudice and exclusion or tolerance and support for community care.

Table 3.11

3.3.10 Attitudes towards mental illness, by experience of mental illness

In order to look into experience of mental illness, participants were presented with a list of mental illnesses and asked whether they had ever experienced any of them. A further question established whether they had ever been diagnosed with any of the illnesses they had experienced. For analysis in this chapter (and for Chapter 2), these diagnosed mental illnesses were grouped into four categories:

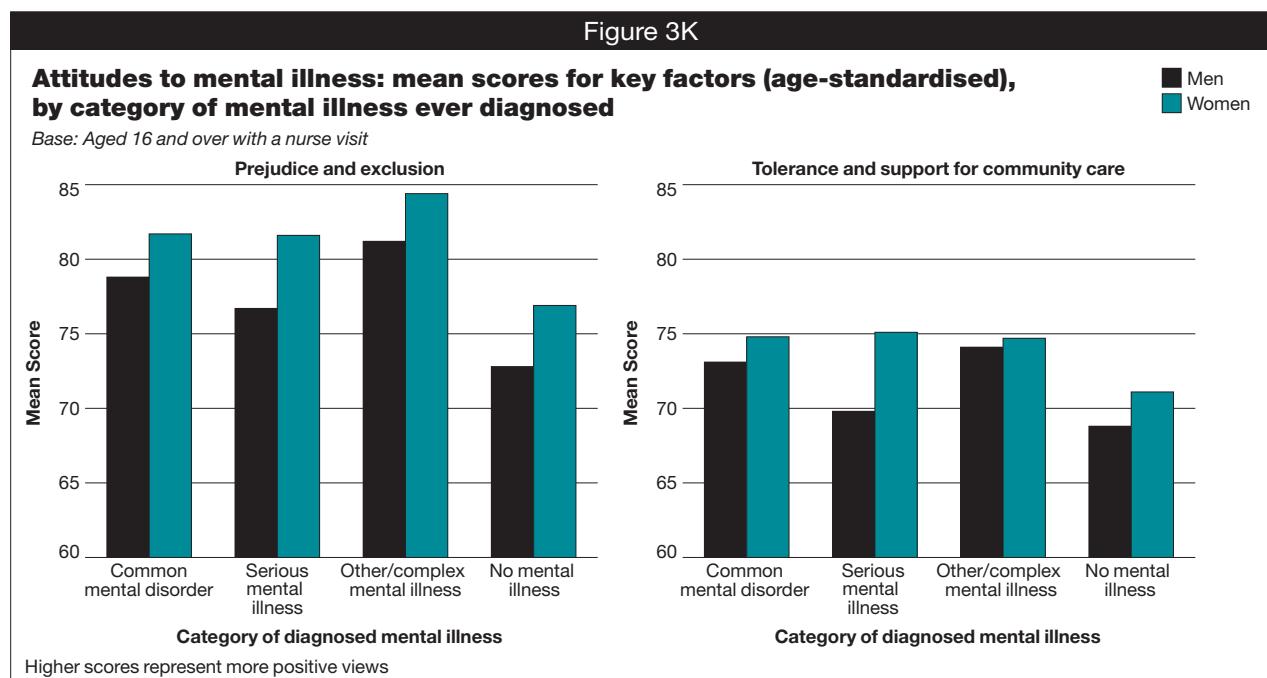
- common mental disorders
- serious mental illness
- other mental illness including complex disorders
- no diagnosed mental illness.

See Section 3.2.2 for more details of the conditions included in each category. A further category of alcohol or drug dependence was also identified, but the number of participants in this category was too small to be analysed separately. Just under a quarter of adults (24%) had been diagnosed with a common mental disorder, and fewer had been diagnosed with an illness in the other categories (4% with a serious mental illness and 2% with another

mental illness including complex conditions).²³ 56% of adults had never been diagnosed with a mental illness. This section looks at the association between experience of mental illness and attitudes towards prejudice and tolerance.

There was statistically significant variation for both prejudice and exclusion and tolerance and support for community care, by whether participants had ever been diagnosed with a mental illness. Participants who had been diagnosed with some form of mental illness had more positive attitudes towards both factors (they were less prejudiced and more tolerant) than those who had never been diagnosed, as shown in Figure 3K.

Table 3.12, Figure 3K



3.3.11 Attitudes towards mental illness by whether currently having counselling or therapy

All participants were asked whether they were currently in receipt of counselling or therapy for a mental, nervous or emotional problem, regardless of whether or not they had reported any diagnosis of current or previous mental illness. A list of possible types of counselling and therapy was presented;²⁴ some types, such as bereavement counselling (grouped with other types of counselling), might not be directly related to experience of a mental illness. 3% of adults reported that they were currently receiving counselling or therapy, and in fact, as reported in Chapter 2, the vast majority of these reported that they had ever been diagnosed with at least one mental illness (91% of men and 88% of women).

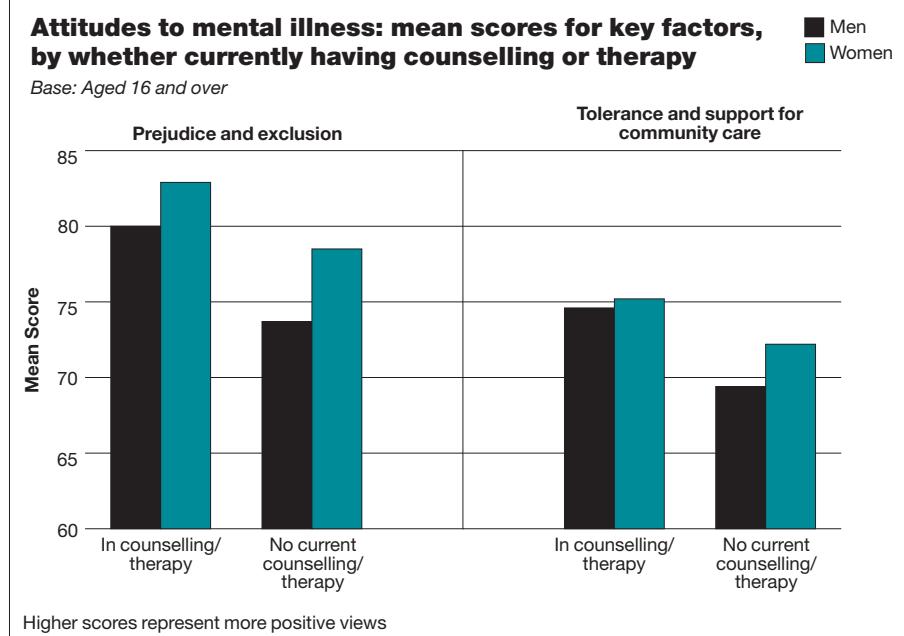
As is evident from Figure 3L, attitudes towards mental illness were related to whether a person was receiving any counselling or therapy, with statistically significant variation for both factors. Participants who were having counselling or therapy at the time of the interview had more positive attitudes than those who were not.

Table 3.13, Figure 3L

3.4 Discussion

The analyses in this chapter confirm that attitudes towards mental illness are associated with socio-demographic characteristics such as age, region, household income, level of deprivation, education and economic status.²⁵ Attitudes are also related to people's knowledge and experience of mental illness, as well as whether people are having counselling or therapy.

Figure 3L



Findings from the National Attitudes to Mental Illness survey show improvement in attitudes towards mental illness over the last decade.⁹ However, it is clear that differences remain between different demographic groups.

Overall, HSE 2014 results found that women held more tolerant and less prejudiced attitudes than men. Furthermore, views were more positive relating to the prejudice and exclusion factor than the factor relating to tolerance and support for community care. This may be a factor needing further emphasis in future campaigns and initiatives. Particular targets could include younger people, who showed lowest levels of tolerance and support for community care. Conversely, older people had less favourable views about prejudice and exclusion.

Higher levels of prejudice and exclusion and lower levels of tolerance and support for community care were also associated with economic factors. People living in households with lower incomes and in areas with higher levels of deprivation had lower scores on both factors, as did people with lower levels of educational qualifications. Retired people were least positive about prejudice and exclusion, while the unemployed had least positive views about tolerance and support for community care.

Exposure to, and knowledge about, mental illness were also associated with attitudes to mental illness. Those who had direct experience themselves, who knew others with mental illness, or who felt that they had some knowledge about it, had much more positive views than other participants. These results are consistent with research findings that interventions which do not confirm stereotypes, through education and/or contact with people with mental health problems, can be effective ways to reduce negative attitudes.^{26,27}

While participants with experience of mental illness held more positive views, it is still the case that some of them themselves felt prejudice and lack of tolerance towards mental illness. Previous research has found that stigma and discrimination lowers help-seeking among those with mental health problems.¹⁴ Holding negative attitudes and applying them to the self is known as self stigma or internalised stigma. However, even in the absence of this, anticipated discrimination may deter people from help-seeking.²⁸

The data reported in this chapter may be useful to policy makers and also may help inform the work of those organisations who are trying to reduce stigma and discrimination in relation to mental illness.

References and notes

- 1 World Health Organization. *The Way Forward*. Chapter 5 in *The World Health Report 2001 – Mental Health: New Understanding, New Hope*. WHO, 2001, p. 111.
www.who.int/whr/2001/en/whr01_ch5_en.pdf?ua=1
- 2 www.time-to-change.org.uk/
- 3 Department of Health. *2010 to 2015 government policy: mental health service reform*. DH, London, 2015.
www.gov.uk/government/publications/2010-to-2015-government-policy-mental-health-service-reform/2010-to-2015-government-policy-mental-health-service-reform
- 4 Department of Health. *Closing the Gap: Priorities for essential change in mental health*. DH, London, 2014.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-17_Feb_2014.pdf
- 5 World Health Organization. *Comprehensive mental health action plan 2013 – 2020*. WHO, 2013.
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1
- 6 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. *Psychiatric Morbidity Among Adults Living In Private Households 2000*. p32. The Stationery Office, London, 2001.
www.ons.gov.uk/ons/search/index.html?newquery=adult+psychiatric+morbidity+survey+2000
This study showed that in any one year 1 in 4 British adults experienced at least one mental disorder, and 1 in 6 experienced this at any given time.
- 7 McManus S, Meltzer H, Brugha T et al. *Adult psychiatric morbidity in England, 2007. Results of a household survey*. The Health and Social Care Information Centre, Leeds, 2009.
www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf
This study showed that 23% of adults in England experienced one of the mental conditions covered; reference periods varied depending on the condition, from experience in the last week to experience in the last year.
- 8 Corker E, Hamilton S, Henderson C et al. *Experiences of discrimination among people using mental health services in England 2008 – 2011*. The British Journal of Psychiatry 2013;**202**:s58-s63.
- 9 www.time-to-change.org.uk/sites/default/files/Attitudes_to_mental_illness_2014_report_final_0.pdf
- 10 TNS BMRC. *Attitudes to Mental Illness 2013 Research Report, Prepared for Time to Change*. TNS BMRC, London, 2014.
www.time-to-change.org.uk/sites/default/files/121168_Attitudes_to_mental_illness_2013_report.pdf
- 11 Evans-Lacko S, Malcolm E, West K et al. *Influence of Time to Change's social marketing interventions on stigma in England 2009-11*. British Journal of Psychiatry 2013;**202**(S55):s77-s88.
- 12 Before the factor analysis was undertaken, eligible cases for the analysis were identified. Any cases with more than three ‘don’t know’ answers across the 12 statements were excluded, and there were 6687 valid cases with at least 9 valid responses for analysis. Two-factor and three-factor analyses were run, with VARIMAX rotation. Three factors explained 52% of the total variance, while two factors explained 43%. A Cronbach’s Alpha reliability analysis was run for all derived factors. Due to the fact that Factor 1 had a statistically significantly higher reliability measure within a two-factor solution, and for consistency with previous findings, a two-factor solution was selected for this research.
- 13 Cronbach’s Alpha score for Factor 1 was 0.767; Cronbach’s Alpha score for Factor 2 was 0.668. The value of Cronbach’s Alpha varies from zero to 1, with scores above 0.6 constituting an appropriate degree of reliability.
- 14 Rusch N, Evans-Lacko S, Henderson C, Flach C, Thornicroft G. *Knowledge and Attitudes as Predictors of Intentions to Seek Help for and Disclose a Mental Illness*. Psychiatry Online.org, 2011, vol 62, no. 6.
- 15 Goldberg D, Williams PA. *User Guide to the General Health Questionnaire*. NFER-Nelson, Windsor, 1998.
- 16 Age-standardised data are discussed here, to allow comparisons between regions to exclude age-related effects. See the section in Section 3.2.2. about age-standardisation.
- 17 Not all households provide information about household income. 20% of adults lived in households that did not have any information about household income.
- 18 These proportions are based on all adults participating in the HSE 2014, table not shown.
- 19 This category includes those who are not actively seeking work, including those who are sick or disabled, or who are looking after the family or home.
- 20 These proportions are based on all adults participating in the HSE 2014, table not shown.
- 21 The proportion mentioning that they had themselves experienced mental illness at this question is very much lower than the proportion identified with mental illnesses in Chapter 2. The question examined here presents a very different context from the questions examined in Chapter 2, where people were presented with a list of conditions and asked which they had experienced. It is also possible that, when asked about the ‘person closest to you’ with a mental illness, many may not have thought to include themselves.
- 22 These proportions are based on all adults participating in the nurse visit (where these questions were asked) in HSE 2014; table not shown.
- 23 Prevalence of the different categories of mental illness are taken from Chapter 2, Table 2.1.

- 24 The types of counselling listed were:
- Counselling
 - Bereavement counselling
 - Cognitive behavioural therapy
 - Psychotherapy or psychoanalysis
 - Mindfulness therapy
 - Alcohol or drug counselling
 - Art, music or drama therapy
 - Social skills training
 - Couples or family therapy
 - Sex therapy
 - Another type of therapy.
- 25 Evans-Lacko S, Henderson C, Thornicroft G. *Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012*. British Journal of Psychiatry 2013;202(S55):s51-s57, 2013.
- 26 Mehta N, Clement S, Marcus E et al. *Systematic review of evidence for effective interventions to reduce mental health related stigma and discrimination: medium and long-term effectiveness*. British Journal of Psychiatry 2015;207:377-384.
- 27 Corrigan PW, Morris SB, Michaels PJ et al. *Challenging the public stigma of mental illness: a meta-analysis of outcome studies*. Psychiatr Serv. 2012;63(10):963-73.
- 28 Clement S, Schauman O, Graham T et al. *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies*. Psychol Med. 2015;45(1):11-27.