Public Health England

Attitudes to mental health problems and mental wellbeing

Findings from the 2015 British Social Attitudes survey

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Summary

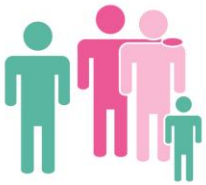
This paper presents new findings on attitudes to mental wellbeing and mental health problems. Levels of life satisfaction are high, and most people have positive attitudes towards improving their own mental wellbeing. However, there are varying levels of acceptance of those with mental health problems, and perceptions of prejudice towards people with these conditions are still widespread.

Most people are confident they know what it means to have good mental wellbeing. People are aware of different factors that impact on their mental wellbeing and the things they can do to improve it.

Two-thirds spend at least "quite a lot" of time thinking about their own mental wellbeing, and a majority feel they know what to do to improve their mental wellbeing and have the time to do so.

65% spend at least quite a lot of time thinking about their mental wellbeing

Spending time with friends and family, going for a walk or getting fresh air, and getting more sleep are widely regarded by people as activities which help them feel more positive.



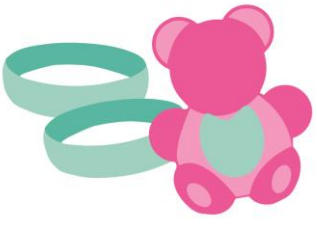
76% spending time with friends and family

63% going for a walk or getting fresh air

54% getting more sleep

Levels of acceptance are higher for a person with depression than schizophrenia. Perceptions of workplace prejudice have improved over time, but the view that someone with a mental health problem would be just as likely to be promoted as anyone else is still only held by a minority.

The public is more accepting of a person with depression than someone with schizophrenia. People are less willing to interact with someone with either depression or schizophrenia in more personal settings, such as marrying into the family or providing childcare.



Perceptions of workplace prejudice have improved over time, with more people feeling that someone with mental health problems would stand an equal chance of promotion compared with 15 years ago. However, this view is still only held by a minority, while a far larger proportion say the employee would be much less likely to be promoted. The reverse is true when we ask about an employee with diabetes.

People who have personal experience of mental health problems, or who know someone close to them who has had such problems, express lower levels of prejudice.

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Introduction

In 2015 Public Health England (PHE) commissioned sets of questions on NatCen's British Social Attitudes survey (BSA) to measure public attitudes to four subject areas - alcohol, obesity, dementia and mental wellbeing.

This paper presents analysis of the results of the questions about mental health problems and mental wellbeing. It covers two main themes - knowledge and awareness about mental wellbeing and stigma associated with mental health problems.

The survey included 40 questions about mental health; the stigma questions had previously been included on either BSA or the Scottish Social Attitudes (SSA) survey, BSA's sister survey. The rest of the questions, including the questions about mental wellbeing, were developed through a process of questionnaire design and piloting.

Carried out annually since 1983,[1] BSA is an authoritative source of data on the views of the British public. It uses a random probability sampling methodology to yield a representative sample of adults aged 18+ living in private households in Britain. The majority of questions are asked by an interviewer face-to-face in the form of a Computer Assisted Personal Interview (CAPI), while a smaller number are answered by respondents in a self-completion booklet. Questions relating to mental health were included in both sections of the survey.

Data collection was carried out between July and November 2015 and the overall response rate was 51%. The achieved sample for the face-to-face questions on mental health was 2140; the achieved sample for the self-completion questions was 1812. The data have been weighted to account for non-response bias and calibrated to match the population profile on the basis of age, sex and region.[2] All differences described in the text (between different groups of people) are statistically significant at the 95% level or above, unless otherwise specified.

Wider context

One in four people in the UK experience a mental health problem each year (Health and Social Care Information Centre, 2009). As well as affecting those individuals, this has wider impacts on healthcare and the economy. The government's mental health strategy (Department of Health, 2011) sets out objectives for improving both mental wellbeing in the population and public understanding of mental health. Two of the strategy's aims are to ensure that individuals look after their own mental health better and to challenge stigma and negative attitudes.

Public messages that encourage good mental health, such as the Five Ways to Wellbeing (these are Connect**,** Be Active**,** Take Notice**,** Keep Learning and Give),[3] draw on evidence-based strategies about the steps individuals can take to improve mental wellbeing (Government Office for Science, 2008). Our

[1] Apart from in 1988 and 1992 when its core funding was used to fund the British Election Study series.
[2] www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-33/technical-details.aspx
[3] www.fivewaystowellbeing.org/

questions on this subject, discussed in the first section of this paper, draw on the concepts on which these initiatives are based.

Recent government policy has prioritised reducing the stigma associated with mental health problems. A 2014 Department of Health (DH) report included a priority action to stamp out discrimination in order to "help millions of people affected by mental health problems to fulfil their potential as active and equal citizens" (DH, 2014:33). In 2016 an independent report into mental health recognised the stigma and marginalisation faced by people with mental health problems. The report calls for an integrated physical and mental health approach, promoting good mental health and preventing poor mental health, and sees ending stigma as "vital" (Mental Health Taskforce, 2016:17). The second section of this paper explores levels of prejudice towards people with mental health problems.

Experience of mental health problems

24% have personal experience of mental health problem(s)

In order to better understand people's attitudes and knowledge about mental wellbeing and mental health problems, it is useful to be able to distinguish between those who have experienced mental health problems and those who have not. To do this, we asked respondents if they (or someone close to them) had ever been diagnosed with any of a list of specific mental health conditions (the full list is at the end of the paper). A quarter (24%) have personal experience of mental health problem(s), while six in 10 (59%) know someone close to them who has had a diagnosis.[4]

Table 1 shows that personal experience is significantly associated with a number of socio-demographic variables; women (27% compared with 22% of men), younger/middle age groups (26-29% of 18-64 year olds compared with 11% of those aged 75+), people from a White ethnic group (26% compared with 13% of those from a Black Minority Ethnic group) and those living in the two most deprived area quintiles[5] (28% compared with 20-21% of those in the three least deprived quintiles) report higher levels of mental health problems.

[4] This is in line with other research; the latest Health Survey for England reported 26% of adults aged 16+ ever having a mental health condition, with higher rates among women, middle age groups and those living in more deprived areas (Bridges, 2015).

[5] We used the Index of Multiple Deprivation to assign each respondent with a local area deprivation score. For the purpose of this analysis, scores were then assigned to quintiles. The Index of Multiple Deprivation 2010 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score at the small area level in England.

Table 1 Personal experience of previous diagnosis with any of the mental health problems (shown on the list) and associated socio-demographic factors

		Yes	No	*Weighted base*	*Unweighted base*
All	%	24	75	*2149*	*2140*
Sex					
Male	%	22	78	*1011*	*912*
Female	%	27	73	*1138*	*1228*
Age					
18-24	%	26	73	*255*	*147*
25-34	%	26	73	*363*	*313*
35-44	%	29	71	*350*	*363*
45-54	%	26	74	*398*	*391*
55-64	%	28	72	*306*	*341*
65-74	%	19	81	*284*	*333*
75+	%	11	88	*191*	*247*
Ethnic group					
White	%	26	74	*1877*	*1916*
Black Minority Ethnic	%	13	87	*267*	*220*
IMD quintile					
0.53->8.49 [least deprived]	%	21	79	*374*	*390*
8.49->13.79	%	20	80	*363*	*364*
13.79->21.35	%	21	78	*331*	*337*
21.35->34.17	%	28	72	*383*	*381*
34.17->87.80 [most deprived]	%	28	72	*406*	*391*
Life satisfaction score					
0-4	%	45	55	*155*	*164*
5-6	%	38	62	*316*	*333*
7-8	%	22	78	*1032*	*1012*
9-10 (Very high)	%	17	83	*641*	*625*

Variables are shown in the table where we found significant differences between subgroups in the proportions saying "Yes"; knowing someone with a mental health condition was also significant but not shown; there were no non-significant variables in our analysis.

In addition to collecting data on experience of mental health problems, we also asked "overall, how satisfied are you with your life nowadays?" with answers given on an 11-point scale, ranging from 0 "not at all" to 10 "completely". Responses are skewed towards the top of the scale: just 7% have a low score (0-4) and 15% a middle score (5-6); half (48%) have a moderately high score (7-8) and 30% a very high score (9-10).[6] Scores are significantly associated with personal experience of a mental health problem: those with experience of a mental health problem are less likely to have a "very high" score (20% compared with 33% of those without personal experience). However, this relationship is not likely to have a straightforward interpretation, as the personal experience question asks whether the respondent has "ever" had a mental health problem, while we measure life satisfaction "nowadays".

[6] This is an ONS harmonized question, one of a set that measure wellbeing. The preamble says the question is about "your feelings on aspects of your life". Latest ONS (2014) figures are similar: 29% had a "very high" score; 77% had a moderate/high (7-10) score.

Mental wellbeing

The 2015 survey included questions to measure public knowledge and awareness of mental wellbeing as well as perceptions of the different factors that impact on mental wellbeing and steps that can be taken to improve it.

Knowledge and awareness

91% are very or quite confident that they know what it means to have good mental wellbeing

We asked respondents - without giving any definition – "how confident are you that you know what it means to have good mental wellbeing?" The vast majority (91%) say they are "very" or "quite" confident (responses are evenly split between the two categories, with 45% saying "very" confident). Just 2% say they are "not at all confident".

To ensure that respondents answered subsequent questions on the basis of the same understanding of mental wellbeing, we provided this definition:

> ***The next set of questions are about 'mental wellbeing'. By this I mean how someone is feeling and how well they deal with the normal ups and downs of everyday life. Having good mental wellbeing includes:***
> - ***feeling positive,***
> - ***enjoying daily activities,***
> - ***getting on well with other people,***
> - ***being able to make decisions,***
> - ***and dealing with change or uncertainty.***

While most people feel they know what mental wellbeing means, we were also interested in establishing whether it is a relevant or important idea for them. To do this we asked respondents how much time they spend thinking "about your own mental wellbeing". Two-thirds (65%) do think mental wellbeing is important – at least in terms of spending time thinking about it. A quarter say they do this "a great deal" and a 40% say "quite a lot". Just 6% say "not at all".

Table 2 Time reported spent thinking about own mental wellbeing

		A great deal	Quite a lot	Not very much	Not at all	*Weighted base*	*Un-weighted base*
All	%	26	40	29	6	*2149*	*2140*
Ethnic group							
White	%	25	39	30	6	*1877*	*1916*
Black Minority Ethnic	%	36	40	19	4	*267*	*220*
Personal experience of mental health problem							
Yes	%	34	43	20	3	*526*	*549*
No	%	23	39	32	6	*1615*	*1583*
Life satisfaction score							
0-4	%	37	35	20	7	*155*	*164*
5-6	%	31	38	27	4	*316*	*333*
7-8	%	23	43	29	4	*1032*	*1012*
9-10 (Very high)	%	25	36	30	9	*641*	*625*

Variables are shown in the table where we found significant differences between subgroups in the proportions selecting either "a great deal" or "quite a lot"; non-significant variables (not shown) are age, sex, local area deprivation, knowing someone who has had a mental health problem.

People who have personal experience of a mental health problem, and those with lower life satisfaction scores are more likely to say they spend a "great deal" or "quite a lot" of time thinking about their own mental wellbeing. This is also the case for those from a Black Minority Ethnic group, despite the fact that this group reported lower levels of mental health problems.

Views about improving mental wellbeing

We measured three different aspects of the extent to which people feel they can improve their mental wellbeing by asking respondents whether they agreed or disagreed with the following statements:

> ***The things that affect my mental wellbeing are out of my control***
>
> ***I know what to do to improve my mental wellbeing***
>
> ***I don't have time to spend looking after my mental wellbeing***

72% agree they know what to do to improve their mental wellbeing

Overall, most people express positive attitudes about improving their mental wellbeing. A majority (72%) agree they know what to do to improve their mental wellbeing (just 8% disagree). Sixty per cent disagree that they "don't have time" for looking after their mental wellbeing,[7] while the same proportion (60%) disagree that the "things that affect my mental wellbeing are out of my control" (and just 13% agree with each statement).[8]

Attitudes vary among different groups in relation to feeling that they have control over the things that affect mental wellbeing. For example, 21% of

[7] Meanwhile, when we asked whether people "don't have time" for "looking after their physical health and fitness", a similar proportion (66%) disagree.
[8] While in each case the majority view was positive, only relatively small proportions felt this *strongly* (between 12% and 16% for each statement).

those with personal experience of mental health problem(s) agree that the things that affect mental wellbeing are out of their control, compared with 11% of those without such experience. Similarly, 29% of those with a low satisfaction score (0-4) agree they don't have control over these things, compared with 8% of those with a very high score (9-10). Those in more deprived areas are also more likely to think this compared with those in the least deprived areas.

As we have seen, although a majority (72%) feel they *personally* know what to do to improve their mental wellbeing, only 36% agree that most people "know what to do to keep themselves mentally healthy". This disparity may indicate some personal uncertainty or lack of knowledge – as people may be more likely to 'own up' to a lack of knowledge or understanding for other people, rather than in relation to themselves. The 36% who agree that most people know what to do to keep mentally healthy is just half the proportion (70%) who say the same in relation to whether most people know how to keep "physically healthy".

Factors thought to affect and improve mental wellbeing

We asked respondents which things (from a list) they think have the biggest, second biggest and third biggest effect on their mental wellbeing. The column on the far right of Table 3 shows the combined responses from these three questions, while data on the "biggest effect" is presented in the column to the left.

Relationships with family and friends and jobs or work-life balance are most commonly chosen as having the biggest effect on mental wellbeing

Public views on the factors that have the biggest effect on mental wellbeing are very mixed; relationships with family and friends and jobs or work-life balance are the two most popular factors, but are each only chosen by around one in five. Three further factors are chosen by one in ten or more: the amount and quality of sleep; finances; and the amount of time relaxing or having time out.

Combined responses (in the right hand column) reveal a similar mix of answers, with the top five factors being the same as in the column showing the "biggest effect". At least one in ten respondents selected each of: exercise; the amount of time spent outdoors; my home; and how much say I have in decisions, as having the first, second or third biggest effect on their mental wellbeing.

Table 3 Which, if any, do you think has the biggest effect on your mental wellbeing?

	% say biggest effect	% say 1st, 2nd or 3rd biggest effect*
My relationships with family and friends	21	54
My job or work-life balance	20	42
The amount or quality of sleep I get	14	39
My finances	12	36
The amount of time I spend relaxing / having time out	10	30
How much exercise I do	7	23
The amount of time I spend outdoors	5	16
My home	2	15
How much say I have in decisions that affect me	2	13
What or how much I eat or drink	1	8
The neighbourhood I live in	1	7
How much involvement I have in local groups or activities	1	4
Other	1	2
Weighted base	*2149*	*2149*
Unweighted base	*2140*	*2140*

**Responses sum to more than 100% as this combines data from three separate questions*

We then asked people which activities or behaviours "help you feel more positive or deal better with everyday life",[9] with those respondents who provided more than one answer being asked which was the "best thing for helping". Table 4 presents the activities and behaviours identified as the "best" (or only) thing that helps (column on the left), together with the combined responses for all the options mentioned by respondents (column on the right). The top half of the table shows answer options categorised in terms of the 'Five Ways' concepts[10]. The bottom half of the table shows answer options which are outside the 'Five Ways' framework.

76% say spending time with family and friends helps them feel more positive

The factors which people feel are the best (or only) thing that helps are similar to those which they report have the biggest effect on their mental wellbeing: spending time with family and friends was most commonly chosen, while getting more sleep is one of the top four choices. Other things that are seen as helping by one in ten or more are going for a walk or getting fresh air and going to the gym or taking another form of exercise. The three most popular answers are either in the 'connect' or 'physical/be active' categories, while the fourth most popular (getting more sleep) is outside the Five Ways framework.

When we look at all things mentioned, the top four choices are still important, being selected by at least three in ten, but this is also the case for at least one option from each of the other categories. These include spending time on hobbies, eating healthy food, making plans/setting goals, spending time helping others and taking time to think things through. These responses give quite a different picture compared to the predominance of 'connect' and 'physical/be active' activities seen when we asked about the 'best/only' activity. It is worth noting that some of the popular activities/behaviours are outside the Five Ways framework, including getting more sleep, eating healthy food and making plans and setting goals.

[9] The preamble explained "Here is a list of things that people might do which make them feel more positive or help them deal better with the ups and downs of everyday life."
[10] See www.fivewaystowellbeing.org/.

Table 4 Activities / behaviours which help people feel more positive or deal better with everyday life

% who choose…	Best/only thing that helps	All things that help*
Activities aligned with the 'Five ways to wellbeing'		
Connect		
Spend time with family and friends	34	76
Be involved in local groups, clubs or activities	1	20
Physical/Be Active		
Go for a walk or get some fresh air	17	63
Go to the gym or take some other form of exercise	10	36
Give/Keep Learning		
Spend time on hobbies like music, art, reading or crosswords	6	49
Spend time helping other people	3	31
Learn new things	1	27
Take notice		
Taking time to think things through	4	30
Activities outside the 'Five ways' framework		
Consumption		
Eat healthy food	3	44
Eat comfort food	1	15
Have an alcoholic drink	1	15
Seek help		
Make plans and set goals	4	35
Read information, self-help or motivational books	1	13
Seek advice or help from a professional	1	11
Other		
Get more sleep	9	54
Go shopping	2	19
Other	1	2
None of these	-	1
Weighted base	*2149*	*2149*
Unweighted base	*2140*	*2140*

**Responses sum to more than 100% as respondents could choose multiple options.*

Answer options are presented in conceptual order (and within each category in prevalence order); the showcard used in the interview listed the options in a different order, with no category headings.

There is no consistent pattern of relationships with socio-demographic factors across the different types of activities.[11] In general, age, sex and ethnic group are more frequently associated with the answers than our other background variables (local area deprivation is not significant for any of the categories tested). And, in contrast to many of the more attitudinal questions, having personal experience of a mental health problem is not key.

The small significant differences between subgroups of the population which we have found may, in fact, reflect different levels of engagement with activities across the different groups.[12] Women are more likely than men to choose spending time with family or friends (39% compared with 30%), while

[11] Significance tests were carried out on responses to the "best/only" activities.

[12] Respondents are logically likely to identify activities and behaviours which they engage in already – for example people who go to the gym more often may be more likely to identify this as something which helps their mental wellbeing.

men are more likely than women to say going to the gym (13% compared with 8%). Age and ethnic group are also significantly related to going to the gym (25-54 year olds and those from a White ethnic group were more likely than other groups to choose this).

Stigma associated with mental health problems

In the second part of this paper, we explore the extent to which those with mental health problems face discrimination and/or acceptance. Our questions focus on people with depression and schizophrenia, as previous work suggests that attitudes towards these two types of mental health problem might be quite different (see for example Reid et al., 2014).

Mental health problems in everyday life

To assess how the public feel about interacting with people with mental health problems in everyday life, we described two different people and asked how willing the respondent would be to interact with them in a range of situations:

Scenario 1 – Andy (schizophrenia symptoms):[13]

> ***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.***

Scenario 2 – Stephen (depression symptoms):

> ***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.***

People are less willing to interact with someone with either depression or schizophrenia in more personal settings such as marrying into the family

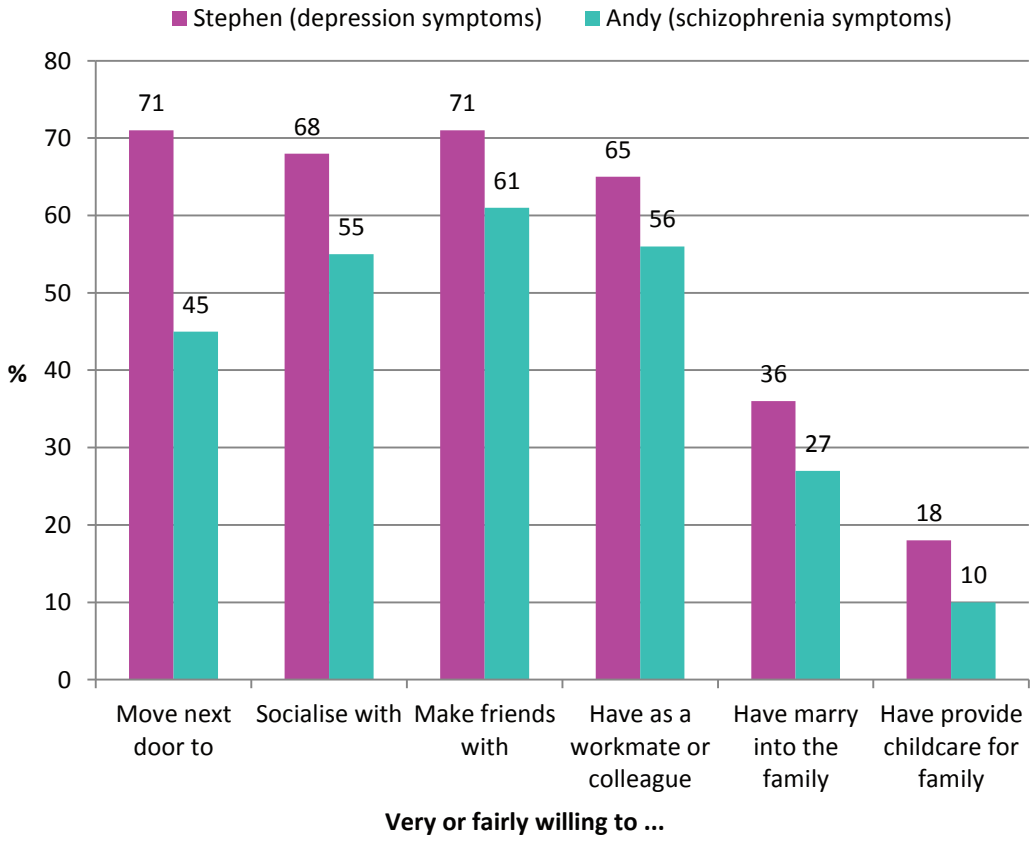
As shown in Chart 1 around seven in 10 say they are willing to move next door to Stephen, make friends with him or spend time socialising with him. Slightly fewer say they are willing to have him as a workmate or colleague. But there is a marked difference when we ask about more personal settings: only 36% are willing to have him marry into the family and only 18% would have him provide childcare for someone in their family.

While the overall pattern is largely the same, in most situations there are lower levels of acceptance (of around 8-13 percentage points) for Andy (schizophrenia) compared with Stephen (depression). This difference is more

[13] The scenarios did not use the words 'depression' or 'schizophrenia' to encourage people to respond to the description of the *behaviour* rather than a label. In fact, the Scottish Social Attitudes survey carried out an experiment to test for the effect of using these labels in the question text, and found that naming the conditions resulted in few differences to responses (Reid et al., 2014: 55).

pronounced for people's willingness to move next door – with a gap of 26 percentage points between the proportions willing to do this in relation to Stephen, compared with Andy. For both depression and schizophrenia, there tend to be higher levels of tolerance among those who have personal experience of mental health problems.

Chart 1 Willingness to interact with a person with depression/schizophrenia symptoms in everyday settings



Weighted base: 2149
Unweighted base: 2140

Workplace prejudice

To measure attitudes and perceptions of prejudice in the workplace, we asked two questions about the promotion prospects of employees with different health problems (depression, schizophrenia and diabetes). Diabetes was included to allow a comparison of perceptions of a mental health condition with those of a physical health condition. First, we asked:

> ***Suppose an employee applied for a promotion. He has had repeated periods off work because of [depression, schizophrenia or diabetes] but this has been under control for a year or so through medication. Do you think he would be just as likely as anyone else to be promoted, slightly less likely to be promoted, or, much less likely to be promoted?***

Responses to the first of these questions are shown in the '2015' column of Table 5, alongside data for three earlier survey years when these questions were asked. Four key findings stand out. First, in general, perceived prejudice

is higher for employees with mental health problems, compared with those who have diabetes. Second, people are more likely to think that an employee with depression would be treated fairly than an employee with schizophrenia (mirroring the lower level of stigma already seen for people with depression).

Third, it is worth noting that, even for an employee with diabetes, only 56% feel they would be "just as likely" to be promoted, while a sizeable minority think this is less likely. This finding suggests that, in order to assess perceived prejudice against those with mental health conditions, it is important to consider attitudes towards people with health problems more generally. In this case, as some people also feel that a person who has had time off work for diabetes would not have equal promotion prospects, it is the *gap* between responses to this question and responses to questions about depression and schizophrenia which reveals the stigma associated with mental health problems.

Perceptions of prejudice have reduced over time, especially in relation to depression and schizophrenia

Finally, the time series data show, that for each of the health problems, perceptions of prejudice have reduced over time. The changes are most marked for depression and schizophrenia, but are also evident for diabetes[14].

Table 5 Perceptions of workplace prejudice, 2000, 2003, 2006 and 2015

Views on promotion prospects	2000	2003	2006	2015
Depression				
% just as likely as anyone else to be promoted	8	9	13	17
% much less likely	41	46	36	35
Schizophrenia				
% just as likely as anyone else to be promoted	3	4	6	8
% much less likely	68	64	59	56
Diabetes				
% just as likely as anyone else to be promoted	48	51	54	56
% much less likely	7	9	7	7
Weighted base	*3426*	*2284*	*2151*	*2149*
Unweighted base	*3426*	*2293*	*2143*	*2140*

The follow-up question asked whether the employee's medical history *should* make a difference – in other words, asking for the respondent's own view:[15]

> ***And what do you think should happen? Should his medical history make a difference or not?***

Only small proportions express the most prejudiced attitude that a medical history of any of these health problems "definitely should" make a difference to chances of getting a promotion at work (8% say this for depression and diabetes, while 15% say this about schizophrenia). However, when we

[14] This mirrors findings from the Attitudes to Mental Illness survey, which also saw a reduction in prejudice in recent years. See www.time-to-change.org.uk/sites/default/files/Attitudes_to_mental_illness_2014_report_final_0.pdf.

[15] This is a technique that helps us measure something potentially socially unacceptable, i.e. prejudice, by framing it in terms of what others think, before asking for the respondent's own views. The first question 'normalises' the prejudiced response, making it more comfortable for the respondent to 'admit' that they feel the same.

combine responses for “definitely should” and “probably should” we find sizeable proportions – virtually half for schizophrenia – think this (see the first row of Table 6).

At the other end of the spectrum, the most tolerant response – that medical history “definitely shouldn’t make a difference” – is given by only a quarter (27%) for someone with depression and 17% for someone with schizophrenia (while 43% say the same about someone with diabetes). Again, mental health problems are seen as more problematic than a physical health problem.

Table 6 Views on whether medical history should make a difference to the promotion prospects of those with different health conditions

	Depression	Schizophrenia	Diabetes	*Weighted base*	*Un-weighted base*
All					
% say definitely/probably should	36	46	24	*2149*	*2140*
% say definitely should not	27	17	43	*2149*	*2140*
% say definitely/probably should					
Sex					
Male	42	51	26	*1011*	*912*
Female	30	42	21	*1138*	*1228*
Age					
18-24	28	36	15	*255*	*147*
25-34	35	40	27	*363*	*313*
35-44	32	43	18	*350*	*363*
45-54	38	47	28	*398*	*391*
55-64	35	49	24	*306*	*341*
65-74	38	53	23	*284*	*333*
75+	49	62	32	*191*	*247*
Ethnic group					
White	34	45	23	*1877*	*1916*
Black Minority Ethnic	47	56	28	*267*	*220*
Personal experience of mental health problem					
Yes	28	40	18	*526*	*549*
No	39	49	25	*1615*	*1583*
Knows someone who has had mental health problem					
Yes	32	42	20	*1268*	*1252*
No	42	53	29	*870*	*878*

Variables are shown in the table where we found significant differences between subgroups in the proportions saying medical history “definitely” or “probably should” make a difference for depression and schizophrenia. Non-significant variables (not shown) are local area deprivation and life satisfaction scores.

The remaining rows of Table 6 show subgroup breakdowns for these questions. Respondents who have experienced mental health problems, or who know someone close to them who has, express lower levels of mental health prejudice. The same is true for women, younger people and those from

a White ethnic group. We find similar relationships for the question about diabetes.[16]

Conclusions

The BSA 2015 findings reveal two fairly distinct pictures of public attitudes to mental health. On the one hand, the majority have high levels of awareness of 'mental wellbeing' as a concept, and most have positive attitudes towards improving their own mental wellbeing. A majority feel they have control over factors that impact on their mental wellbeing and people report a range of different steps they can take which help to improve it. Mental wellbeing is a relatively new area of attitudinal research, and it will be fascinating to revisit this in future, to see whether public knowledge changes over time, especially with regard to specific areas targeted by public health initiatives which aim to help people improve their mental wellbeing by taking active steps.

On the other hand, in spite of the relatively high prevalence of mental health problems in the population as a whole, there is evidence of fairly widespread negative attitudes towards people with mental health problems. Specifically, there is lower acceptance of a person with schizophrenia compared with a person with depression; while people are not very willing to interact with people with either condition in more personal settings. In a workplace context, only small minorities think that depression or schizophrenia would not be detrimental to an employee's promotion prospects (whereas more than half say the same about diabetes).

Of course views vary between different subgroups, and we have noted the significance of socio-demographic characteristics such as age, sex, ethnic group and local area deprivation. For example, some groups (including those who have personal experience of mental health problem(s) and those from more deprived areas) are more likely than others to agree that the things that affect mental wellbeing are out of their control.

Many of these socio-demographic characteristics, in turn, are related to reported experience of mental health problems, which suggests that a fruitful next step would be to use regression analysis to explore these relationships more fully. Certainly attitudes to mental wellbeing and mental health problems are strongly related to a person's own experiences and knowledge of mental health problems. This might imply that increasing knowledge and awareness among the wider population could help tackle prejudice (though this is undoubtedly an over-simplification of a complex issue). In any case, there is still more to be done to meet government aims of stamping out stigma associated with mental health problems.

[16] Ethnic group was not significantly related to views about diabetes.

Notes

Experience of mental health problems

We collected experience of mental health problems by asking respondents if they (or someone close to them) had been diagnosed with any of the following: 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, Other mental health problem. The full question text can be found in the appendix.

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