

# Public attitudes, perceptions and understanding of mental health in Northern Ireland

March 2006



**Health**  
Promotion  
Agency

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<b>Contents</b>	<b>PAGE</b>
<b>List of figures</b> .....	3
<b>List of tables</b> .....	4
<b>Foreword</b> .....	5
<b>Introduction</b> .....	6
<b>Method</b> .....	9
<b>Results</b> .....	10
<b>What the public consider to be the major health problems in Northern Ireland</b> ..	10
<b>Awareness of mental health problems</b> .....	10
<b>Perceived prevalence of mental health problems</b> .....	11
<b>Personal experience of mental health problems</b> .....	12
<b>Stigma</b> .....	13
<b>Stigma score</b> .....	13
<b>Levels of stigma in Northern Ireland</b> .....	14
<b>Mental health literacy</b> .....	19
<b>Perceived control over physical and mental health</b> .....	19
<b>Lifestyle changes to improve health</b> .....	20
<b>Social networks</b> .....	22
<b>Knowledge of interventions</b> .....	24
<b>Identifying mental health problems</b> .....	29
<b>Recognising mental illness (schizophrenia and depression)</b> .....	30
<b>Views on the need for help</b> .....	31
<b>Views on the people likely to be helpful, harmful or neither</b> .....	31
<b>Views on the treatments likely to be helpful, harmful or neither</b> .....	32
<b>Views on recovery from mental illness</b> .....	34
<b>Help seeking</b> .....	36
<b>Who would we most likely turn to if we had a mental health problem?</b> .....	36
<b>Who would be your first point of professional contact?</b> .....	36
<b>Awareness of local mental health organisations</b> .....	37
<b>Discussion</b> .....	38
<b>References</b> .....	43
<b>Appendix</b> .....	45

# List of figures

## PAGE

Figure 1: Participants' views on the proportion of people in Northern Ireland who might have a mental health problem at some point in their lives .....	11
Figure 2: Participants who had personal experience of mental health problems, by gender .....	12
Figure 3: Difference in stigma score, taken from the scale of attitudes to mental health problems, by social class group .....	14
Figure 4: A comparison of the influence participants perceived people to have on their own physical and mental wellbeing .....	20
Figure 5: Lifestyle changes made by participants to improve health, even for a short time, by gender .....	22
Figure 6: Lifestyle changes made by participants to improve health, even for a short time, by social class .....	22
Figure 7: Frequency of seeing friends or relatives, by gender .....	23
Figure 8: Frequency of attendance at any social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender .....	23
Figure 9: The number of participants in each age group who accurately recognised the symptoms of Ann and Jane .....	31

# List of tables

PAGE

Table 1:	Participants' attitudes towards those with mental health problems .....	16
Table 2:	Attitudes towards those with mental health problems – comparing the HPA survey to findings from Scotland pre- and post-campaign .....	18
Table 3:	Ways in which participants tried to influence their health in the last year, by gender, age and social class .....	21
Table 4:	Participants who attend any social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender, age and social class .....	24
Table 5:	Participants' opinions on whether various treatments would be helpful, harmful or neither in treating mental health problems .....	26
Table 6:	Participants' opinions on whether various treatments would be helpful – comparison between those who have experienced mental health problems and those who have not .....	28
Table 7:	Who would be helpful for Ann and Jane? .....	32
Table 8:	What treatments would be helpful for Ann and Jane? .....	34
Table 9:	Participants' views on whether Ann and Jane will recover from their mental illness .....	35
Table 10:	Who the participants would most likely turn to if they thought they had a mental health problem .....	36

## Appendix

Table 11:	Comparison of the 2006 HPA survey and the 2001 census sample .....	45
Table 12:	Participants' views on what the major health problems are in Northern Ireland at present, by gender, age and social class (unprompted) .....	46
Table 13:	Participants' responses when asked to name known mental health problems, by gender, age and social class .....	47
Table 14:	Participants' personal experience of mental health problems, by gender, age and social class .....	48
Table 15 (a-v):	Participants' opinions on whether various people, both professional and non-professional, would be harmful, helpful or neither in treating schizophrenia and depression, by gender, age and social class .....	49-54
Table 16a:	How much influence participants thought people could have on their own physical wellbeing by the way they choose to live their lives, by gender, age and social class .....	55
Table 16b:	How much influence participants thought people could have on their own mental wellbeing by the way they choose to live their lives, by gender, age and social class .....	55
Table 17:	How often, on average, participants saw friends or relatives who did not live with them, by gender, age and social class .....	56
Table 18:	Frequency of participants' attendance at social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender, age and social class .....	56

# Foreword

The policy environment that supports mental health in Northern Ireland has never been more favourable; in January 2003 the DHSSPS published the *Promoting mental health strategy and action plan 2003–2008*, which outlines 30 actions under four key areas: policy development, improving knowledge and skills, increasing awareness and reducing discrimination and preventing suicide.<sup>1</sup>

More recently in October 2006 *Protect life – a shared vision, the Northern Ireland suicide prevention strategy and action plan 2006–2011* was published following extensive consultation.<sup>2</sup> The strategy recognises that in order to address this very complex and devastating problem, action should be twofold, ie a whole population approach, recognising that anyone could be at risk of suicide, and a targeted approach with specific actions relating to key priority groups identified as being most at risk.

Both of these regional strategies outline a need for a public information campaign to address mental health, challenge stigma and increase help seeking behaviours. In order to contribute to the implementation of these actions, the Health Promotion Agency for Northern Ireland (HPA) carried out research on the public's perception of mental health. It also recognised that a common language and shared definition of mental health is needed.

This research highlights that mental health is indeed a complex issue that requires a public mental health approach, that is, a population wide approach to understanding and addressing risk and protective factors for mental health and wellbeing.

This study is the first of its kind to be carried out in Northern Ireland and the findings outlined here will be of interest to you and your organisation. The HPA is delighted to be able to add to the growing body of knowledge in this very important area of public health and looks forward to working with a range of organisations in the development of initiatives to improve the mental health and wellbeing of our population.



Dr Brian Gaffney  
Chief Executive  
Health Promotion Agency for Northern Ireland

# Introduction

## Background

In July 2005, as a result of concern about an increase in the number of suicides, the Minister for Health, Social Services and Public Safety, Shaun Woodward MP, established a taskforce to develop a suicide prevention strategy for Northern Ireland. In March 2006, the Government published a consultation document *Protect life – a shared vision*, which was Northern Ireland's proposed suicide strategy. Following the consultation period in October 2006, the Government published *Protect life – a shared vision, the Northern Ireland suicide prevention strategy and action plan 2006–2011*.<sup>2</sup>

*Protect life* has two overarching objectives:

1. To strengthen the protective factors against the risk of suicide among the general population.
2. To reduce the risk of suicide and self-harm for those in society most at risk.

It also contains specific actions, one of which is *“by 2007 to develop and implement a suicide awareness information campaign which helps to de-stigmatise mental health and encourage help seeking behaviour”*.<sup>2</sup>

To support the planning of this campaign and, specifically, to aid the development of objectives for a general public mass media campaign in 2007, the HPA reviewed work carried out elsewhere around suicide prevention and interventions. The evidence shows that extensive media campaigns for suicide prevention are not common, largely due to fear of encouraging suicide imitation.

## Mental health

Mental health and wellbeing underpins all health and wellbeing and, as such, is a resource that needs to be protected and promoted. The positive dimension of mental health is stressed in the World Health Organization's (WHO) definition of health, as contained in its constitution: *“Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”*<sup>3</sup>

Mental health is seen to be more than the absence of mental illness. It is a positive sense of wellbeing whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing the competencies of individuals and communities and enabling them to achieve their self-determined goal.<sup>4</sup>

Our mental health influences how we think and feel about ourselves and others, and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events: having a baby, moving house, experiencing bereavement.<sup>5</sup>

Everyone has mental health needs, not just those who have been diagnosed as having a mental disorder. No group is immune to mental disorders, but the risk is higher among the poor, homeless, unemployed, people with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women and the neglected elderly. As a result, mental health problems affect society as a whole, and not just a small, isolated segment.

For all individuals, mental health and physical health are closely linked. As our understanding of this interdependent relationship between mental and physical health increases, it becomes more apparent that mental health is crucial to the overall wellbeing of individuals, societies and countries. Some research has

gone so far to say that mental health can be described as the underpinning of all health and wellbeing.<sup>6</sup> Unfortunately, though, in most parts of the world, mental health and mental disorders are not given anywhere near the same importance as physical health. Rather, they have been largely ignored or neglected.

A variety of terms are used to describe mental health problems. These include: mental disorder, mental ill health, mental illness, psychiatric illness, nervous breakdown, burnout, etc. Most people have limited understanding of mental health problems and attitudes prevail based on fear or embarrassment. Stigma refers to the negative stereotype beliefs and attitudes towards those experiencing mental health problems. Stigma can lead to people being labelled, devalued or set apart from others, and prevent them from accessing help, thereby hindering recovery.

## **Mental health and mental illness: points on a continuum**

“Mental health” and “mental illness” are not polar opposites but may be thought of as points on a continuum.<sup>7</sup> As explained, mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental illness, however, is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterised by alterations in thinking, mood or behaviour (or a combination of these) associated with distress and/or impaired functioning. For example, depression is a mental disorder largely marked by alterations in mood. Schizophrenia is characterised by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and the sense of self. Attention-deficit/hyperactivity disorder is a mental disorder largely marked by alterations in behaviour (over activity) and/or thinking (inability to concentrate).

## **Level of mental health problems in Northern Ireland**

In 2000, the Office for National Statistics (ONS) carried out a survey of psychiatric morbidity (mental ill health) of people aged 16 to 74 years in Great Britain.<sup>8</sup> Results showed that about one in six adults aged between 16 and 74 had a neurotic disorder, such as depression, anxiety or a phobia. Furthermore, according to the Mental Health Foundation, in the course of one year, one in four people will experience a mental health problem.<sup>9</sup> The Health and Social Wellbeing Survey showed people in Northern Ireland to be at greater risk of mental ill health than people in Scotland and England due to factors such as poverty and community conflict affecting people here more than elsewhere.<sup>10</sup>

Mental health problems have a huge emotional and significant economic cost. Suicide and self-harm alone have a substantial impact in terms of both lives lost and the resulting impact on families and the local community. Evidence also suggests that the cost of suicide and self-harm has a significant economic impact on Northern Ireland. For example, in 2004, the total estimated cost of suicide alone to NI was in the region of £202 million, which equates to £1.4 million per suicide.<sup>2</sup> self-harm is estimated to have cost £6.6 million in hospital costs, lost earnings and other lost output in the same year.<sup>2</sup>

Mental health problems are common; in the most recent Health and Social Wellbeing Survey in Northern Ireland (2001), 21% of respondents scored high in the GHQ12, which measures possible psychiatric morbidity.<sup>10,11,12</sup> The WHO estimates that there are one million suicides each year, representing 1.4% of the total global burden of disease.<sup>13</sup> In the last two decades, large increases in the rates of suicide among young people have been reported across most regions of the world. Suicide is the third biggest cause of years of life lost after cardiovascular diseases and cancer.<sup>14</sup> Northern Ireland has more suicides per 100,000 people (9.8) than England (8.6) and Wales but less than Scotland (15.9) and the Republic of Ireland (11.6).<sup>2</sup> However, within Northern Ireland there are stark regional variations, for example North and West Belfast have rates of

17.9 and 18.1.<sup>1</sup> In recent years, there have been around 150 suicides each year in Northern Ireland; 41% are single males and 22% are males aged between 25 and 34.<sup>2</sup>

There are multiple risk factors for suicide and typically, individuals who die by suicide experience more than one risk factor. Risk factors include depression, alcohol and drug misuse, personality disorder, hopelessness, low self-esteem, bereavement, break-up of a relationship, unemployment and social isolation. Mental illness (including substance misuse) can also play a role. While a vast majority of people with a mental illness will not die by suicide, research studies in Europe and the United States of America reported that up to 90% of individuals who died by suicide had some form of mental disorder.<sup>15</sup> In the UK, 50% of all suicide cases occur in current or formerly diagnosed psychiatric patients.<sup>13</sup> Non-compliance with treatment and loss of contact with services are reported to be common risk factors. Reducing the stigma associated with having a mental health problem, and encouragement for those at risk of suicide to seek help, are aspects that also need to be addressed.

To support the planning of this campaign and specifically to aid the development of objectives for a public information campaign in 2007, the HPA commissioned quantitative research with the public.

## **Aims of the survey**

The survey aims to examine the views and perceptions of adults in Northern Ireland with regard to mental health. The survey seeks to examine levels of mental health literacy, and explore stigma and attitudes around help seeking.

## **Main objectives**

To assess with the general public:

- Perception of the prevalence of mental health problems in Northern Ireland.
- Levels of mental health literacy, including
  - knowledge and beliefs about mental health problems that aid their recognition, management or prevention,
  - opinions on how much control we have over our own mental health.
- Help seeking behaviour: where to go, who to go to, self help, knowledge/beliefs about prevention or treatments.
- Levels of stigma: attitudes to those with mental health problems, beliefs about recovery.
- Experience of mental health problems (self report).
- Recent awareness of literature, information and advertising around mental health.
- Awareness of mental health organisations.

# Method

The Health Promotion Agency placed a set of questions on an omnibus survey in March 2006. The questionnaire was administered via face-to-face interviews carried out at 45 randomly selected sampling points throughout Northern Ireland.

## Sampling

The quota sampling technique was used and consisted of 1013 participants, of which 46% were male and 54% female. Table 11 in the Appendix provides a profile of our sample by gender, age and social class group. Those aged 16–24 accounted for 13% of the total sample, 25–34 made up 20%, 35–49 made up 30%, 50–64 made up 21% and those aged 65 and over accounted for 17%. Social class groups were categorised as ABC1, C2 and DE (based on occupation of chief income earner in household). The percentage sampled in each comprised: ABC1, 43%; C2, 21%; DE, 36%. Table 11 in the Appendix also provides a comparison between our survey and the Northern Ireland 2001 census data, and shows that our sample is representative of the adult population.

The interviewers used a questionnaire developed by the research team at the Health Promotion Agency. The questions were devised by the HPA research team or taken from previous surveys used to inform mental health campaigns in Scotland, England and Australia.

## Presentation of results

Tables and figures with percentage responses to each question have been added for illustration purposes. The overall base numbers are shown on the tables to indicate the number of respondents on which percentages were based. The majority of information for the survey has been presented in the form of percentages that have been rounded up to the nearest whole number. As a result of rounding, some column or row percentages may not equal 100% exactly. Each question contained in the survey has been analysed based on the participant's gender, age and socioeconomic status, of which respondents were grouped into five age bands (ie 16–24, 25–34, 35–49, 50–64 and 65+) and three for social class (ie ABC1, C2 and DE).

All survey results are subject to sampling variability, which means that observed differences between sub-groups may not always be statistically significant (ie they may have occurred by chance). Those differences that are statistically significant are reported and commented upon in this report.

Within the tables, the Chi Square statistical test has been used to report whether there are any associations between groups (ie gender, age, social class). Three levels of statistical significance are shown in the tables (ie \* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$ ). Where data from the survey are at least interval scaled, Analysis of Variance (ANOVA) or t tests have been employed to check for differences between sub groups.

Participants were informed that responses would be considered confidential when completing the questionnaire. Despite individual confidentiality being confirmed, it is important to note that when interpreting the findings of this survey, the sensitivity of the topic may or may not have influenced the participants in revealing personal information or experience of mental health.

# Results

## What the public consider to be the major health problems in Northern Ireland

To find out whether mental health is considered when people think of health concerns in our society, respondents were asked what they considered to be the major health problems in Northern Ireland at present (unprompted). In all, 54% of respondents correctly identified cancer, followed by heart disease (47%) (see Table 12 in the Appendix). There was no variation between males and females. However, older respondents were more likely to say heart disease, with those in social class DE less likely to say likewise.

There was little mention of any specific mental health issues although the next problem, stated by a minority of respondents, was alcohol abuse (16%), followed by obesity (11%), stroke (7%) and depression (7%). Other mental health problems were stated by less than 3% of respondents.

When prompted with a range of health problems, the proportion stating mental health conditions rose. For example, suicide was listed by 42% of respondents, compared to 3% unprompted. Four in 10 respondents (40%) said alcohol misuse, compared to 16% unprompted, while almost as many (39%) said depression, compared to 7% unprompted. Just under a quarter (24%) said anxiety, stress or pressure.

When asked which health problem the Government should address as a matter of priority, physical problems again came out on top – 61% said cancer and 42% said heart disease. However, these were followed by alcohol misuse (22%), suicide (21%) and depression (15%). There was little variation across gender, age or social class.

## Awareness of mental health problems

When respondents were asked what they considered to be the main mental health problem, 58% said depression, 8% said alcoholism, 6% said Alzheimer's Disease and 5% said severe stress. There was no variation across gender, age or social class.

Respondents were asked what mental health problems they had heard of (unprompted) (see Table 13 in the Appendix). The mental health problem cited most was depression (73%), followed by dementia/Alzheimer's Disease (36%), schizophrenia (31%), alcoholism (21%), nervous breakdown (13%) and anxiety disorder (11%). When analysed by gender, females were more likely than males to state depression (76% against 70%) ( $p < 0.05$ ) and Alzheimer's Disease (41% against 31%) ( $p < 0.001$ ). They were also more likely to state postnatal depression (7% against 2%) ( $p < 0.001$ ).

When analysed by age, depression was less likely to be stated by the youngest (16–24) and oldest (65+) age groups. In total, 64% of respondents in these age groups stated depression, compared to 76% or more in the other age groups ( $p < 0.01$ ).

Typically, awareness of Alzheimer's rose with age, with under a quarter (24%) of 16–24 year olds listing the disease, compared to 45% of those aged 65+ ( $p < 0.001$ ).

There was also a statistically significant difference between the age groups in relation to schizophrenia awareness, with those in the 25–34 age group (39%) most likely to state the condition and those in the 65+ age group (20%) least likely ( $p < 0.001$ ). The oldest age group were also less likely to state drug dependence – 3% compared to the 9% average across all the age groups ( $p < 0.01$ ).

When analysed by social class, those in the DE group (27%) were less likely to state Alzheimer's than those

in the other social class groups ( $p < 0.001$ ). ABC1s were more likely than the others to state schizophrenia (41% compared to 24% and 23%) ( $p < 0.001$ ), manic depression (12% compared to 7% and 7%) ( $p < 0.01$ ) and anxiety disorders (15% compared to 9% and 7%) ( $p < 0.01$ ).

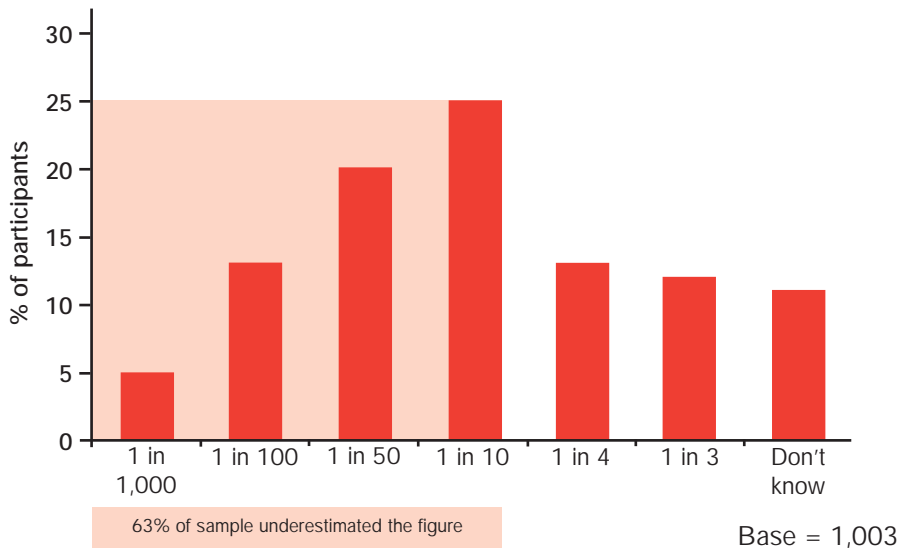
Taken collectively, these findings suggest that the youngest and oldest age groups are least aware of specific mental health problems, with females and ABC1s more likely than males and other social class groups to cite more problems.

## Perceived prevalence of mental health problems

Respondents were asked what proportion of people might have a mental health problem at some point in their lives. According to the Mental Health Foundation, this is estimated to be one in four during the course of one year (for a debate in the academic literature on this figure being an underestimate, see Stewart-Brown 2002).<sup>8,15</sup> Other figures estimate one in six adults have a neurotic disorder, such as depression, anxiety or a phobia.<sup>10</sup> At present, it is unclear what the figure is within Northern Ireland for the likelihood of developing a mental health problem at some point in a person's life.

If the figure is taken to be one in four, almost two thirds (63%) of the sample underestimated the problem (See Figure 1). Eighteen percent of respondents considerably underestimated the figure to be either 1 in 100 or 1 in 1000. A fifth of the sample (20%) estimated the figure to be 1 in 50, while one quarter (25%) said 1 in 10. Thirteen percent of respondents said one in four, 12% said one in three and 11% did not know. There was no significant difference across gender, age or social class.

**Figure 1: Participants' views on the proportion of people in Northern Ireland who might have a mental health problem at some point in their lives**



When these results were compared to other UK surveys, similar findings were observed. In 2003, a Department of Health survey (including England, Scotland and Wales) measured attitudes to mental illness in Great Britain.<sup>17</sup> Participants were asked what proportion of people in Great Britain they think might have a mental health problem at some point in their lives. The findings from this survey showed that participants generally underestimated the prevalence of mental health problems within the population. One quarter of respondents estimated 1 in 10, 38% estimated even less (1 in 50=14%, 1 in 100=15%, 1 in 1000=9%). Twelve percent estimated one in four and 9% higher than one in three. Sixteen percent of participants did not know.

More recently, in a survey conducted in Scotland, participants were asked to estimate the prevalence of mental health problems.<sup>6</sup> The question in the Scottish survey differed from the one we presented in our survey in that

participants were asked 'out of 100 people, how many do you think will have a mental health problem at some point in their lives?' The participants' mean average response was 48 people out of 100, clearly indicating a higher incidence rate than our survey. The range of responses to this question was as follows: 31% said between 1 and 30, 37% said between 31 and 60, 23% said between 61 and 90, 4% said between 91 and 100 and 5% did not answer.

As the phrasing of the question in the Scottish survey is different to our survey, direct comparisons are not possible. However, it can be suggested from the findings that the high estimates may in part be a result of recent advertising campaigns that have raised awareness within Scotland of how common mental health problems are.

## Personal experience of mental health problems

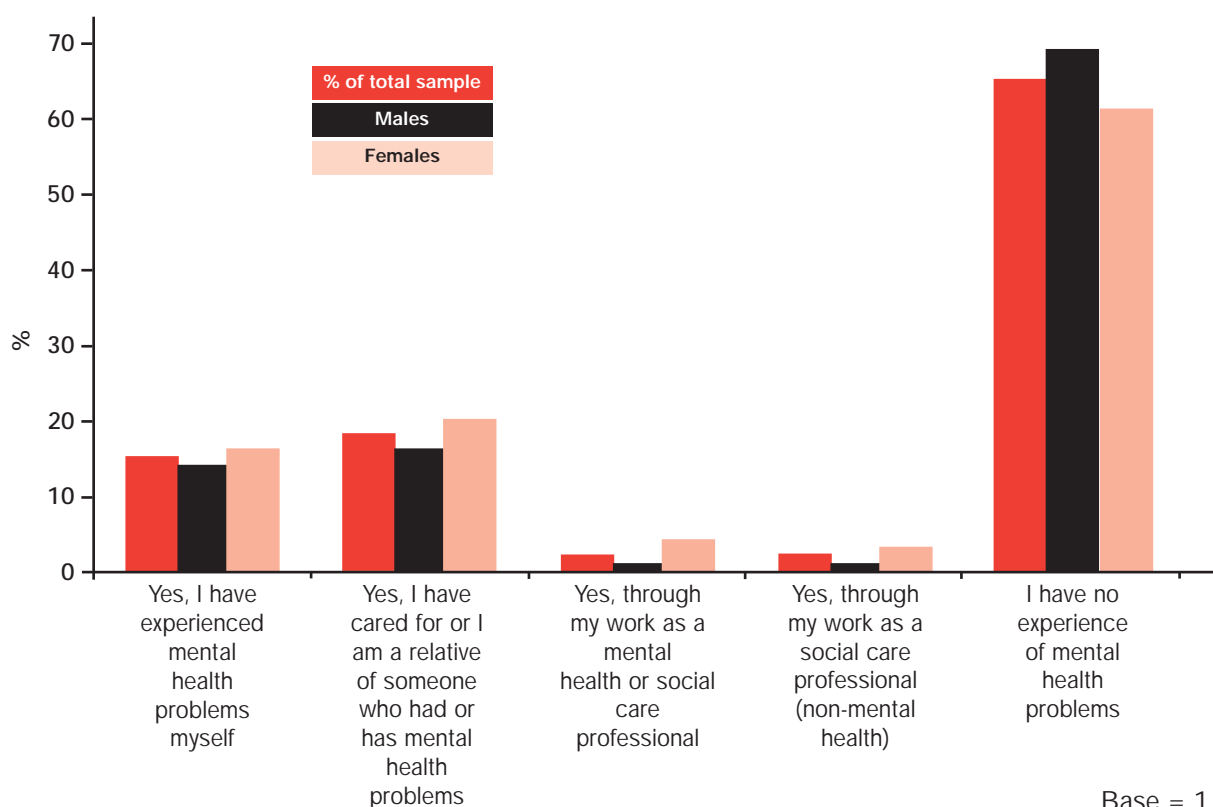
Participants were asked if they had any personal experience of mental health problems (see Figure 2 and Table 14 in the Appendix). Almost two thirds of the sample (65%) said no.

Just over one in seven (15%) said 'yes, I have experienced mental health problems myself'. This figure is below the one in four estimate for the population.<sup>9</sup> This is either due to respondents failing to recognise that they have experienced a mental health problem or, alternatively, being unwilling to report it.

Almost one in five (18%) answered 'yes, I have cared for or I am a relative of someone who had or has mental health problems'. Two percent responded 'yes, through my work as a mental health or social care professional' and 2% responded 'yes, through my work as a social care professional (non mental health)':

Males (69%) were significantly more likely than females (61%) to say they had no experience of mental health problems ( $p < 0.01$ ). In terms of age, the 16–24 year olds (80%) were most likely to say they had no such experience (either personally or through others) ( $p < 0.001$ ). They were followed by the 65+ (68%), 25–34 (65%), 35–49 (61%) and 50–64 (57%) age groups. The DE social class group (21%) were significantly more likely to say they had this personal experience when compared to the ABC1 (12%) and C2 (11%) groups ( $p < 0.001$ ).

**Figure 2: Participants who had personal experience of mental health problems, by gender**



# Stigma

It is possible that help seeking can be impeded by two factors – the failure to identify or articulate a problem and/or stigma. The formal definition of stigma is: *distinguishing mark of social disgrace, to 'stigmatise: to mark out or describe as something bad'*.<sup>18</sup>

Other countries, most notably Scotland (See me campaign) and New Zealand (Like Minds campaign) have tackled mental health problems and suicide by anti-stigma campaigns. The extent to which the Northern Ireland public stigmatise people with mental health problems was assessed through a series of questions. A scale of attitudes to mental health problems was calculated by summing the responses to nine separate statements. The scale consisted of four positive and five negative statements. The same scale was included in the Second national Scottish survey of public attitudes to mental health, mental wellbeing and mental health problems.<sup>6</sup>

The positive statements included: 'anyone can suffer from mental health problems', 'the majority of people with mental health problems recover', 'people with mental health problems should have the same rights as everyone else' and 'people are generally caring and sympathetic to people with mental health problems'. A value of 5 was allocated for 'disagree strongly', 4 for 'disagree slightly', 3 for 'neither agree nor disagree', 2 for 'agree slightly' and 1 for 'agree strongly'.

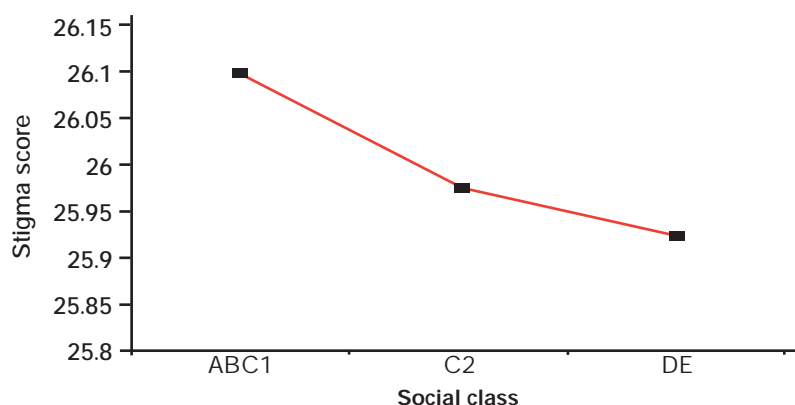
The negative statements included: 'if I was experiencing a mental health problem I would not want anyone knowing about it', 'I would find it hard to talk to someone with mental health problems', 'people with mental health problems are largely to blame for their own condition', 'the public should be better protected from people with mental health problems', and 'people with mental health problems are often dangerous'. A value of 1 was allocated for 'disagree strongly', 2 for 'disagree slightly', 3 for 'neither agree nor disagree', 4 for 'agree slightly' and 5 for 'agree strongly'.

## Stigma score

When responses were summed, a total value for the scale could potentially vary from 9 (least likely to stigmatise mental ill health) to 45 (most likely to stigmatise mental ill health). The actual variation in the present data was 9–41. The mean score was 25, with 13% of the sample on this mark. Ranked scores for all of the sample (n=729, completed all nine questions fully) data follows a normal distribution – that is, the majority of participants' scores lie within the bell shaped curve.

No statistically significant differences were found across gender or age but a statistically significant difference was observed across social class. Based on the mean attitudinal scores, the ABC1 group scored statistically significantly higher (26.09) on the attitudes scale than the C2 (25.97) ( $p < 0.01$ ) and DE groups (25.92) ( $p < 0.001$ ), while the C2 and DE groups did not differ statistically significantly from each other (See Figure 3).

**Figure 3: Difference in stigma score, taken from the scale of attitudes to mental health problems, by social class group**



## Levels of stigma in Northern Ireland

Participants' responses to each of the nine statements were analysed separately by gender, age and social class to provide a further breakdown of attitudes. Two additional statements that were not included in the previously outlined scale were also analysed. These were 'I am afraid of experiencing mental health problems myself in the future' and 'people with mental health problems should not be allowed to do important jobs such as doctors, nurses etc' (see Table 1). The results are presented below.

### Can anyone experience a mental health problem?

A large majority of respondents (98%) agreed that 'anyone can experience mental health problems'. No significant differences were observed across gender, age or social class. Forty six percent of respondents said they would be 'afraid of experiencing mental health problems themselves in the future'. There were no significant gender differences here but there were significant age and social class differences. The youngest age group were least likely to have this fear (36%), while those most likely to have such a fear were aged 50 to 64 (57%) ( $p < 0.01$ ). Respondents in social class group DE (57%) were more likely than those in the ABC1 (41%) and C2 groups (44%) to have this fear ( $p < 0.01$ ).

Eighty percent disagreed that those with mental health problems were largely to blame for their own condition. Those in the youngest and oldest age groups were less likely to disagree in this way, but more likely to say neither or don't know.

### Talking to someone with a mental health problem and the likelihood of participants disclosing to others that they have a mental health condition

When participants were presented with the statement 'I would find it hard to talk to someone with mental health problems', almost 7 in 10 (68%) disagreed either slightly or strongly, while 19% agreed. There were no significant differences across gender or social class. However, there was a significant age effect, the 16–24 (29%) and 65+ (22%) age groups agreed with the statement more than the others ( $p < 0.01$ ).

When participants replied to 'if I was experiencing mental health problems I wouldn't want people knowing about it', 54% agreed either slightly or strongly, while 28% disagreed either slightly or strongly. There were no differences across gender, age or social class.

The participants' response to the above two statements demonstrates that the majority are willing to talk to people who experience mental health problems. However, the view of over half the sample is that if they were experiencing mental health problems themselves, they would not want people knowing about it. This finding raises a complex issue in relation to supporting those with mental health problems. People reported a

willingness to talk to a person with mental health problems, which perhaps suggests that they want to be seen to be doing the right thing. However, what is more revealing is that if they themselves were the person with the mental health problem, they would not want to disclose it, suggesting stigma around the issue. Fear of disclosing a mental health problem may reduce the likelihood of the person seeking help.

### Rights and work responsibilities

Ninety one percent of respondents agreed that people with a mental health problem should have the same rights as anyone else. There was no variation across gender, age or social class. However, 46% of respondents also agreed with the statement 'people with mental health problems should not be allowed to do important jobs such as doctors, nurses etc'. Agreement with this statement varied with age and social class. Those of retirement age were most likely to agree (53% of 65+ year olds), while those aged 16–24 (41%) and 25–34 (37%) were least likely ( $p < 0.05$ ). Participants in the C2 group (42%) were less likely to agree than those in the ABC1 (46%) and DE groups (47%) ( $p < 0.05$ ).

### Fear and empathy

When participants were presented with the statement 'the public should be better protected from people with mental health problems,' 41% agreed either slightly or strongly, while 25% disagreed either slightly or strongly. There were no differences across gender, age or social class.

Forty three percent of respondents disagreed with the statement 'people with mental health problems are often dangerous'. Disagreement with this statement varied with gender and social class. Females (45%) were more likely to disagree than males (40%) ( $p = .05$ ), while the ABC1 group (51%) were more likely to disagree than the C2 (42%) and DE groups (34%) ( $p < 0.001$ ).

When participants were presented with the statement 'people are generally caring and sympathetic to those with mental health problems,' the response was split, with 44% agreeing slightly or strongly and 34% disagreeing slightly or strongly. There was a significant age difference as the 50–64 (47%) and 65+ (50%) age groups were more likely to agree slightly or strongly with the statement than the other age groups ( $p < 0.01$ ).

### Perception of recovery

Forty three percent of respondents believed that the majority of people with mental health problems recover. However, agreement with this statement varied with gender. Females (46%) were more likely to agree than males (38%) ( $p < 0.05$ ).

**Table 1: Participants' attitudes towards those with mental health problems**

	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know	Base
'If I was experiencing mental health problems I wouldn't want people knowing about it'	25	29	14	16	12	5	1,010
'Anyone can experience mental health problems'	68	30	1	0	0	1	1,009
'I would find it hard to talk to someone with mental health problems'	6	13	10	33	35	4	1,009
'I am afraid of experiencing mental health problems myself in the future'	17	29	18	14	15	7	1,004
'The majority of people with mental health problems recover'	10	33	24	13	5	16	1,009
'People with mental health problems should have the same rights as anyone else'	52	39	5	2	1	1	1,007
'People are generally caring and sympathetic to those with mental health problems'	14	30	17	22	12	5	1,007
'People with mental health problems are largely to blame for their own condition'	1	5	8	29	51	6	1,008
'People with mental health problems should not be allowed to do important jobs such as doctors, nurses etc'	20	26	19	13	12	11	1,009
'The public should be better protected from people with mental health problems'	14	27	27	15	10	7	1,008
'People with mental health problems are often dangerous'	5	22	26	25	18	5	1,009

### Attitudes in Northern Ireland compared to Scotland

In Table 2, the responses to similar statements in the Well? What do you think? (2002 and 2004) Scottish survey of public attitudes to mental health, wellbeing and mental health problems are presented.<sup>6,19</sup> The 2004 survey took place after the Scotland See me campaign launch in October 2002. These findings show a lot of similarities between Northern Ireland and Scotland and illustrate the complexity of attitudes towards mental health problems. For example, there is a common recognition that 'anyone can experience mental health

problems' and 'people with mental health problems should have the same rights as anyone else', indicated by a high percentage of people agreeing with the statements. However, the picture is less clear when we consider the proportion of participants who agreed with the statement associated with stigma 'if I was experiencing mental health problems I wouldn't want people knowing about it', indicating embarrassment at having mental health problems and desire to hide them from others. The figure for Northern Ireland (54%) was higher than the pre- and post-campaign figures for Scotland (50% and 45% respectively), which shows that our sample were even less willing to disclose that they have a mental health problem.

A higher proportion of respondents in the HPA survey than the Scottish pre-campaign survey (2002) agreed that the 'public should be better protected from people with mental health problems'.<sup>6,19</sup> However a lower proportion of respondents in the HPA survey agreed that 'people with mental health problems are often dangerous' when compared to the 2002 Scottish survey. This finding in Scotland had improved by 2004.<sup>6,19</sup> This suggests that the Scottish campaign may have led to a shift in opinion.

The latter statement suggests that people feel they are in danger when they are in the company of a person with a mental health problem. The responses to both statements offer a worrying insight into people's perceptions of those with mental health problems. Taken collectively, these views demonstrate that stigma towards those who experience mental health problems may have multiple consequences – the person with a mental health condition may not seek help and/or the public may be afraid to offer it.

There was a difference between responses to the statement 'the majority of people with mental health problems recover'. Participants in our sample (43%) were less likely to agree with this than in Scotland (50%). But worth noting is that this figure actually decreased in Scotland after the first See me campaign, so recovery is an aspect that should be highlighted in a campaign that focuses on mental illness.

Participants in Northern Ireland expressed similar views to those in the Scottish pre-campaign survey in response to the statements 'I would find it hard to talk to someone with mental health problems', 'people are generally caring and sympathetic to those with mental health problems' and 'people with mental health problems are largely to blame for their own condition'.

Overall, it seems that we in Northern Ireland are more positive when it comes to understanding the rights of someone with a mental health problem. However, we are less likely than people in Scotland to disclose that we have a mental health problem. In addition, fewer of us in Northern Ireland see the public as caring and sympathetic to those with mental health problems, and fewer of us believe those with a mental health problem are likely to recover.

**Table 2: Attitudes towards those with mental health problems – comparing the 2006 HPA survey to Scotland’s pre- and post-campaign survey findings**

	% Agreeing with the statement		
	HPA NI Survey 2006	Scotland 2002	Scotland 2004 post-campaign
'If I was experiencing mental health problems I wouldn't want people knowing about it'	54	50	45
'Anyone can experience mental health problems'	98	98	97
'I would find it hard to talk to someone with mental health problems'	19	20	15
'I am afraid of experiencing mental health problems myself in the future'	46	–	–
'The majority of people with mental health problems recover'	43	50	46
'People with mental health problems should have the same rights as anyone else'	91	88	88
'People are generally caring and sympathetic to those with mental health problems'	34	36	39
'People with mental health problems are largely to blame for their own condition'	6	7	6
'People with mental health problems should not be allowed to do important jobs such as doctors, nurses etc'	45	–	–
'The public should be better protected from people with mental health problems'	41	35	24
'People with mental health problems are often dangerous'	26	32	15

# Mental health literacy

Physical health literacy is defined as 'the ability to gain access to, understand, and use information in ways which promote and maintain good health'.<sup>20</sup> Examples include: learning first aid skills, knowledge of what a healthy diet is, knowledge of how to perform regular breast examinations, taking regular exercise or being able to access health information via a GP, book or the internet. Mental health literacy has been defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention'.<sup>21, 22</sup>

However, this definition restricts mental health literacy to a medical interpretation, one of identifying and managing illness. In essence, the definition of physical health literacy could equally be applied to mental health literacy, ie the ability to gain access to, understand and use information in ways that promote and maintain good MENTAL health.<sup>20</sup>

In comparison to the amount of information available to the public on physical health, mental health literacy has been neglected. With the high likelihood of a mental health problem occurring during a person's lifetime, it is important that the public are aware of the various mental health conditions, who can be contacted for help and what treatments are available. In addition, people should be aware that they themselves can control or influence their mental health, and should be informed, educated and equipped with the information and skills to do this.

To assess mental health literacy in Northern Ireland, participants were asked questions to gauge their understanding of promoting and protecting mental health, as well as their specific knowledge of mental health problems and the possible courses of action for prevention and treatment.

Participants were asked about the influence or control they think they can have over their mental health, as well as several questions about lifestyle changes they had tried to make to improve their health in general. More specifically, they were asked who they would go to for help if they had a mental health problem and what treatments they would consider helpful in treating mental health conditions.

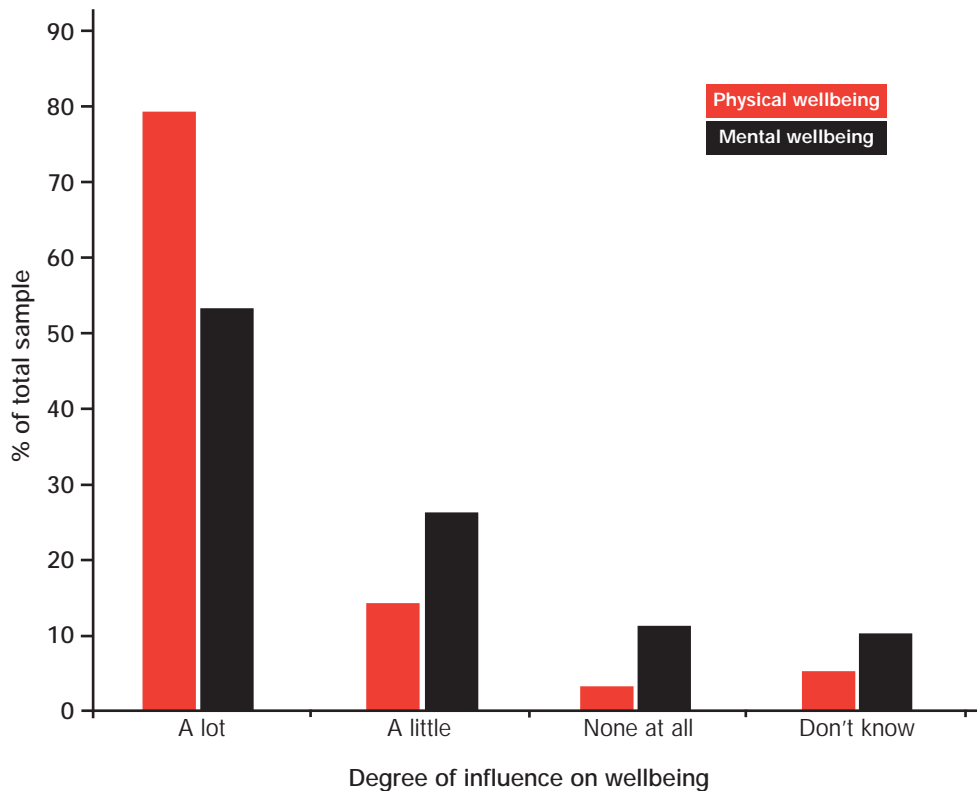
## Perceived control over physical and mental health

Respondents were asked how much influence they thought people could have on their own physical wellbeing by the way they choose to live their lives. The majority of respondents (93%) said a little or a lot of influence (see Figure 4 and Table 16a in the Appendix). Only 3% said no influence at all and 5% did not know. There were no differences across gender or age but there was a difference across social class, with 89% of the DE group saying a little or a lot, compared to 96% of the ABC1 group and 93% of the C2 group ( $p < 0.01$ ). The DE group (7%) also gave a higher proportion of 'don't know' responses than the ABC1 (3%) and C2 groups (4%).

Participants were then asked how much influence they thought people could have on their own mental wellbeing by the way they choose to live their lives (see Figure 4 and Table 16b in the Appendix). In all, 79% said a little or a lot of influence. Of the rest, 11% said people have no influence and 10% did not know. Again, there were no differences across gender or age but there was a difference across social class, with 76% of the DE group saying a little or a lot of influence, compared to 81% of the ABC1 and C2 groups ( $p < 0.05$ ). The DE group (13%) also gave a higher proportion of 'none at all' responses than the ABC1 (10%) and C2 groups (9%).

Taken collectively, the results show that a higher percentage of participants believed they had more control over their physical wellbeing than their mental wellbeing. This is consistent with the view of Jorm et al, that the level of mental health literacy is lower than that of physical health literacy.<sup>21</sup> The results illustrate the need to increase the public's mental health literacy levels. This requires a focus on the public's perception of mental health and their awareness of protection, self-help and when and from whom professional help should be sought about a mental health problem.

**Figure 4: A comparison of the influence participants perceived people to have on their own physical and mental wellbeing**



## Lifestyle changes to improve health

To get an indication of how many people currently try to influence their mental health (and identify those groups who do not), we asked respondents whether, in the last year, they had tried to make any changes to their lifestyle in order to improve their health, even in the short term (see Table 3). As expected, most of the changes made were those that influence physical health, most notably dietary changes.

Almost half of the sample (49%) had tried to eat more fruit and vegetables, while just under 4 in 10 (38%) had cut down on fatty foods. Equal proportions (27%) had tried to lose weight or had started walking. A quarter of respondents (25%) had taken up a regular physical activity and a quarter (25%) had also tried to reduce stress levels. Nearly as many (23%) had tried to get out and see friends more and 17% had talked to people about things that were bothering them. Slightly fewer (15%) had tried to reduce their alcohol consumption and 14% had attempted to give up smoking. Almost 1 in 10 had tried relaxation techniques (8%).

Females were more likely than males to make lifestyle changes that would benefit both their physical and mental health. For example, they were more likely than males to eat more fruit and vegetables (56% compared to 40%) ( $p < 0.001$ ), cut down on fatty foods (43% compared to 32%) ( $p < 0.001$ ), try to lose weight (35% compared to 19%) ( $p < 0.001$ ) and start walking for pleasure or to get to work (31% compared to 21%) ( $p < 0.001$ ) (see Figure 5).

The 16–24 (19%) and 65+ (17%) age groups were least likely to try to reduce levels of stress when compared to the other groups ( $p < 0.05$ ). Those aged 50 and over (10% of 50–64 year olds and 6% of 65+ year olds) were least likely to lower their alcohol consumption ( $p < 0.001$ ). Participants aged 16–24 (5%) and 65+ (3%) were least likely to try some relaxation techniques, while all the other age groups were at the same level (10%) ( $p < 0.05$ ).

### Who are likely to try activities that may help mental health?

With regard to activities that may promote mental health (although the proportion of all respondents doing these activities was comparatively low), females were more likely than males to go out and see friends more often (26% compared to 19%) ( $p < 0.01$ ), talk to people about things that were bothering them (22% compared to 12%) ( $p < 0.001$ ) and try some relaxation techniques (10% compared to 6%) ( $p < 0.05$ ). Males were more likely than females to reduce their alcohol consumption (17% compared to 13%) ( $p < 0.05$ ). There were no differences between males and females in relation to taking up regular physical activity, trying to reduce stress levels and attempting to give up smoking.

On the other hand, the ABC1 group (28%) were most likely to try to reduce stress levels when compared to the C2 (22%) and DE groups (22%) ( $p < 0.05$ ). The ABC1 group (11%) were also most likely to try relaxation techniques when compared to the C2 (8%) and DE groups (5%) ( $p < 0.05$ ) (see Figure 6).

**Table 3: Ways in which participants tried to influence their health in the last year, by gender, age and social class**

	% of total	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Tried to eat more fruit and vegetables	49	40	56***	39	53	51	49	45	55	46	42***	1,013
Cut down on fatty foods	38	32	43***	38	39	34	39	39	42	39	32**	1,013
Tried to lose weight	27	19	35***	25	32	34	28	13***	31	26	24*	1,013
Started walking (for pleasure or to work)	27	21	31***	20	30	28	29	23	28	30	24	1,013
Took up a regular physical activity	25	24	27	33	37	25	21	12***	30	26	20**	1,013
Tried to reduce stress levels	25	24	25	19	28	28	26	17*	28	22	22*	1,013
Tried to get out and see friends more	23	19	26**	28	24	19	24	23	25	18	23	1,013
None of these	21	26	17**	27	15	19	22	29**	17	24	26**	1,013
Talked to people about things that were bothering me	17	12	22***	20	22	16	18	11	18	15	18	1,013
Reduced the amount of alcohol I drink	15	17	13*	18	21	17	10	6***	14	17	14	1,013
Tried to give up smoking	14	14	14	18	18	15	12	5**	9	15	18***	1,013
Tried some relaxation techniques	8	6	10*	5	10	10	10	3*	11	8	5*	1,013
Other	2	1	2	1	2	1	2	3	1	1	2	1,013

Figure 5: Lifestyle changes made by participants to improve health, even for a short time, by gender

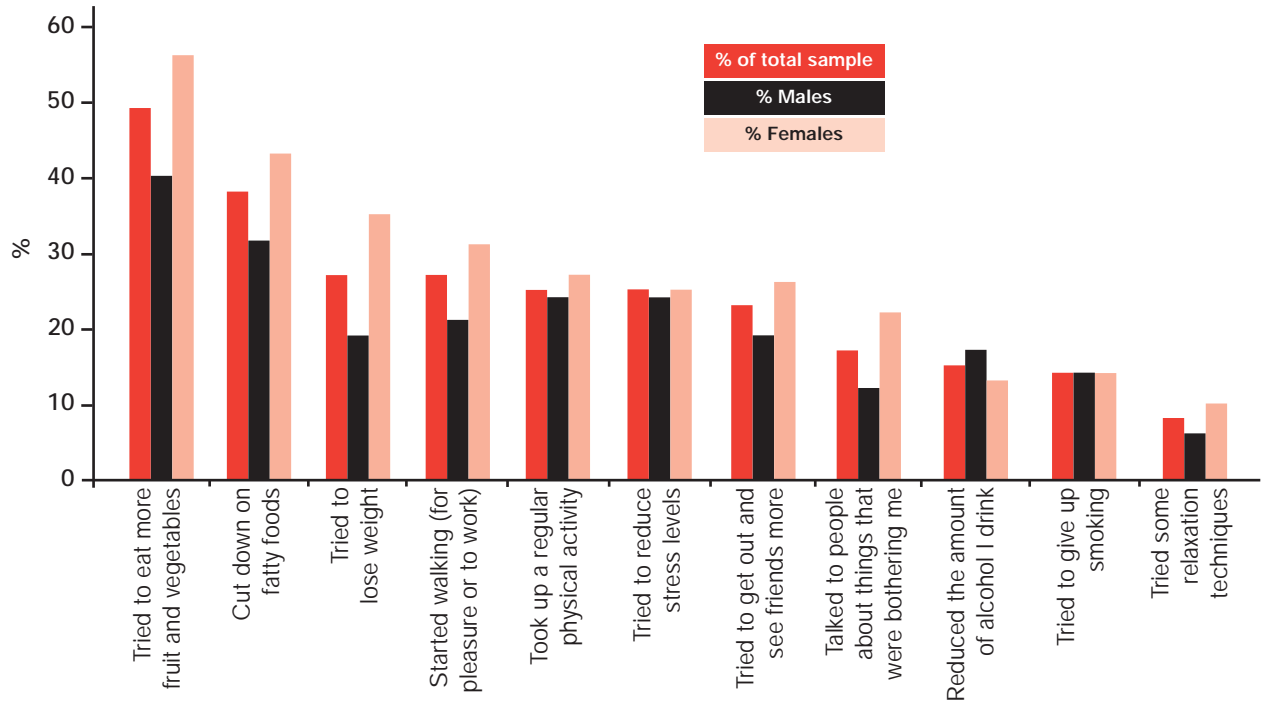
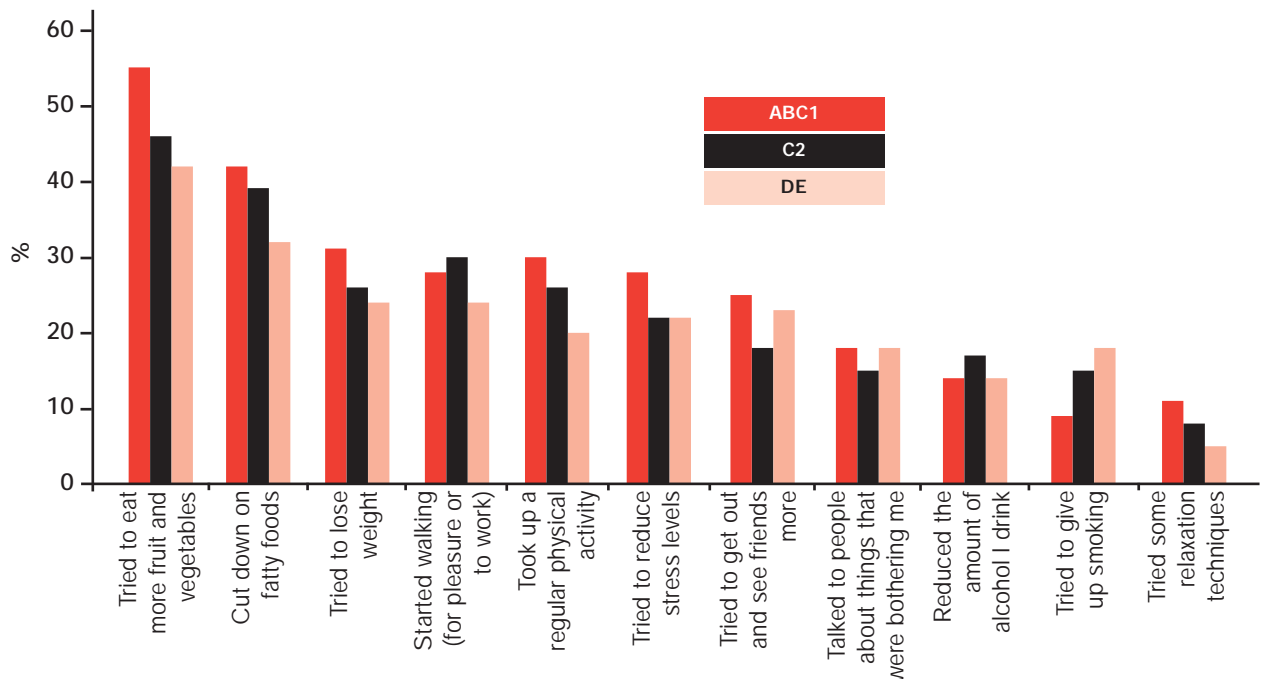


Figure 6: Lifestyle changes made by participants to improve health, even for a short time, by social class



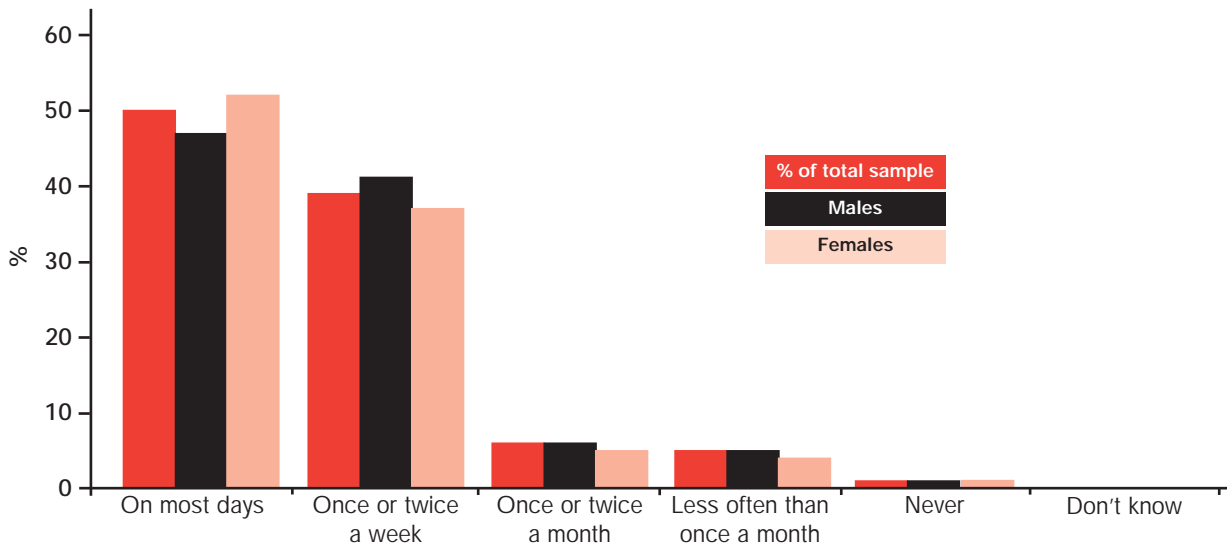
## Social networks

Establishing and maintaining social networks through a partner, family or friends can help protect against mental health problems. Having few close friends or relatives has been associated with a greater likelihood to report psychotic symptoms.<sup>23</sup> Furthermore, social isolation may play a part in the development of psychotic symptoms. Some elderly people who have had little social contact (ie visited once a month or less) have taken their own lives, in marked contrast to a control group who were repeatedly visited more than once a week.<sup>24</sup> Characteristics such as being unmarried or living alone are more common among those with depression who later die by suicide than those who do not.

Our survey included a question to establish how often respondents see friends or relatives who are not living with them. We also asked whether they regularly attend any social or leisure events (ie leisure centre, sports clubs, church group or community centre) and whether they are in employment or education where it is likely they will socialise with people on a daily basis.

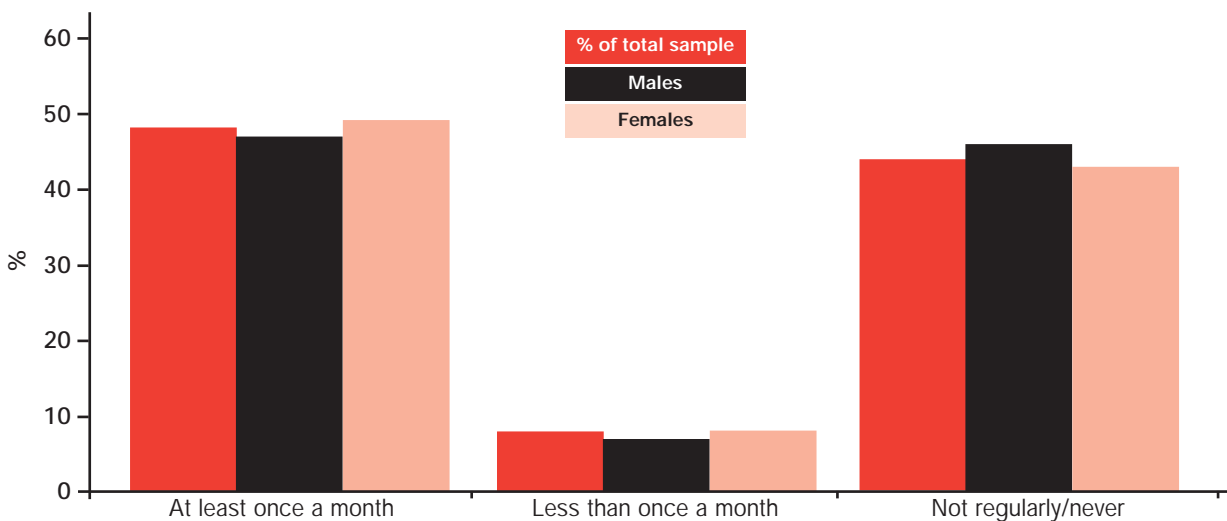
When participants were asked how often, on average, they see friends or relatives who are not living with them, half the sample (50%) said most days, while almost 4 in 10 (39%) said once or twice a week. Of the rest, 6% said once or twice a month, 5% said less than once a month and 1% said never (see Figure 7). There were no significant differences across gender, age or social class (see Table 17 in the Appendix).

**Figure 7: Frequency of seeing friends or relatives, by gender**



When participants were asked if they regularly attend any social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), almost half the sample (48%) said at least once a month. Of the rest, 8% said less than once a month and 44% said not regularly/never. There was no significant gender difference (see Figure 8).

**Figure 8: Frequency of attendance at any social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender**



A significant difference was observed across the age groups (see Table 4). The 16–24 year olds (61%) were most likely to attend social or leisure events or facilities at least once a month, while the 50–64 year olds (42%) were least likely ( $p<0.05$ ).

There was also a significant difference between social classes, with the ABC1 group (58%) most likely to attend social or leisure events or facilities at least once a month. Less than half of the C2 group (48%) and less than 4 in 10 (36%) of the DE group were likely to do the same ( $p<0.001$ ). This trend was further confirmed by the proportion in each social group who didn't attend regularly or never at all.

**Table 4: Participants who attend any social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender, age and social class**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Yes, at least once a month	48	47	49	61	56	44	42	44*	58	48	36***	1,011
Yes, less than once a month	8	7	8	4	8	9	8	7	9	7	7	1,011
Not regularly/never	44	46	43	36	36	47	50	49	34	45	57	1,011
Don't know	0	0	0	0	1	0	0	1	1	0	0	1,011

## Knowledge of interventions

Participants were presented with a list of activities that can influence mental health, some of which could be considered 'prevention' activities, such as being physically active. Others were medical treatments, such as being prescribed with antidepressants. For each option, the participants were asked to consider if it would be helpful, harmful or neither in looking after your mental health.

The highest proportion of respondents (94%) said getting out and about more would be a helpful activity in looking after mental health (see Table 5). There were no significant differences across gender, age or social class. This was followed by becoming more physically active, such as playing more sport, or doing a lot more walking or gardening (86%). Females (90%) were more likely than males (86%) ( $p<0.05$ ) to say this was helpful but there were no significant differences across age or social class. In selecting preventative measures ahead of medical interventions, participants may be indicating their preference for preventative activities as a form of treatment. It may also indicate their preference for 'easy' access treatments, where they would not have to ask someone for help.

Almost 8 in 10 respondents (78%) said counselling would be helpful. Females (81%) were more likely than males (74%) to have this view ( $p<0.01$ ). More than 7 in 10 respondents (71%) said relaxation, stress management, meditation or yoga courses would be helpful. Again, females (77%) were more likely than males (64%) to have this view. Those in the oldest age group, 65+ (59%), were least likely to consider these techniques helpful ( $p<0.01$ ) and most likely to say they didn't know (11%) ( $p<0.01$ ). Almost 7 in 10 respondents (68%) thought reading about people with similar problems and how they dealt with them would help. Females (73%) were more likely than males (63%) to have this view ( $p<0.01$ ), while those aged 25–34 (75%) were more likely than the other age groups to say likewise ( $p<0.05$ ).

Over half the sample (55%) highlighted cutting out alcohol altogether, while slightly fewer (54%) said consulting a book about the problem would be helpful. Those in the DE social class group (49%) were least likely to agree with the latter ( $p < 0.001$ ). Over half the sample (53%) also said psychotherapy would be helpful, while more than 4 in 10 (44%) said consulting a website about the problem would be beneficial. However, those aged 65+ (22%) ( $p < 0.001$ ) and those in the DE group (39%) ( $p < 0.001$ ) were least likely to agree that this was helpful. Going on a special diet or avoiding certain foods was considered helpful by 42% of participants, although the C2 social class group (36%) were least likely to agree ( $p < 0.05$ ). Forty two percent of respondents also thought antidepressants would help – the DE group (49%) were more likely than the ABC1 (40%) and C2 groups (33%) to say this ( $p < 0.01$ ).

Four in 10 participants (40%) said vitamins, tonics or herbal medicines would be helpful, while almost as many (39%) said likewise about consulting an expert using email or the web. Those aged 65+ (24%) were least likely to see the benefits of this and most likely to say they didn't know (42%) ( $p < 0.001$ ). Participants in the DE social class group (31%) were also most likely to say they didn't know ( $p < 0.001$ ). Other options that respondents considered helpful included being admitted to a psychiatric ward in a hospital (35%), receiving cognitive behavioural therapy (33%), or having an occasional alcoholic drink to relax (31%).

When asked what treatments they thought may be harmful for mental health, the highest proportion (29%) of respondents said vitamins, tonics or herbal medicines. This was followed by: painkillers such as codeine, aspirin or Panadol (25%), going on a special diet or avoiding certain foods (22%), hypnosis (18%), having an occasional alcoholic drink to relax (17%), cutting down on alcohol (16%), cutting out alcohol altogether (16%) (see Table 5).

As for those treatments that respondents did not know to be either helpful or harmful, the highest proportion selected: cognitive behavioural therapy (37%), hypnosis (30%), electro-convulsive therapy (ECT) (27%), antipsychotics (25%), consulting an expert using email or the web (24%).

**Table 5: Participants' opinions on whether various treatments would be helpful, harmful or neither in treating mental health problems**

	Helpful %	Harmful %	Neither %	Depends %	Don't know %	Base
Getting out and about more	94	3	0	2	1	1,009
Becoming more physically active, such as playing more sport, or doing a lot more walking or gardening	86	3	0	7	4	1,010
Counselling	78	6	1	9	5	1,009
Attending courses on relaxation, stress management, meditation or yoga	71	14	1	8	6	1,010
Reading about people with similar problems and how they have dealt with them	68	12	6	8	6	1,011
Cutting out alcohol altogether	55	16	3	16	10	1,009
Consulting a book that gives information about the problem	54	13	10	12	11	1,008
Psychotherapy	53	13	2	13	18	1,005
Consulting a website that gives information about the problem	44	13	9	13	21	1,007
Going on a special diet or avoiding certain foods	42	22	3	17	17	1,000
Antidepressants	42	10	26	18	4	1,007
Vitamins, tonics or herbal medicines	40	29	7	12	12	1,004
Consulting an expert about your problem using email or the web	39	14	9	14	24	1,008
Being admitted to a psychiatric ward in a hospital	35	9	16	28	12	1,009
Cognitive behavioural therapy	33	12	2	16	37	1,008
Having an occasional alcoholic drink to relax	31	17	23	18	10	1,001
Tranquillisers such as valium	23	11	36	20	11	1,008
Electro-convulsive therapy (ECT)	19	8	23	22	27	1,004
Antipsychotics	19	13	27	16	25	1,000
Sleeping pills	16	14	43	19	9	1,010
Hypnosis	15	18	18	20	30	1,004
Painkillers such as codeine, aspirin or Panadol	12	25	39	12	13	1,004

### Personal experience

To assess whether personal experience of mental health problems affects an individual's perception of interventions or treatments, the above responses were analysed in more detail (see Table 6). The findings illustrate that many treatments were considered helpful by more people who have such personal experience than people who have not. The treatments in question include: counselling; courses on relaxation, stress management, meditation or yoga; reading about people with similar problems and how they have dealt with them; cutting out alcohol altogether; consulting a book about the problem; psychotherapy; antidepressants; consulting an expert about your problem using email or the web; being admitted to a psychiatric ward in a hospital; having an occasional alcoholic drink to relax; electro-convulsive therapy (ECT); antipsychotics; sleeping pills; hypnosis.

The six treatments that brought about the biggest difference in opinion between those who had experienced mental health problems and those who had not are: antidepressants (21 percentage point difference); consulting a book about the problem (11 percentage point difference); reading about people with similar problems and how they have dealt with them (10 percentage point difference); psychotherapy (10 percentage point difference); cognitive behavioural therapy (9 percentage point difference); going on a special diet or avoiding certain foods (9 percentage point difference). Those with experience of mental health problems viewed each of these six treatments more favourably than those without such experience.

**Table 6: Participants' opinions on whether various treatments would be helpful – comparison between those who have experienced mental health problems and those who have not**

	Considered helpful (%)	
	Have experienced mental health problems	Have not experienced mental health problems
Getting out and about more	94	94
Becoming more physically active, such as playing more sport, or doing a lot more walking or gardening	88	89
Counselling	84	77
Attending courses on relaxation, stress management, meditation or yoga	76	70
Reading about people with similar problems and how they have dealt with them	77	67
Cutting out alcohol altogether	63	54
Consulting a book that gives information about the problem	63	52
Psychotherapy	62	52
Consulting a website that gives information about the problem	45	44
Going on a special diet or avoiding certain foods	41	42
Antidepressants	60	39
Vitamins, tonics or herbal medicines	39	41
Consulting an expert about your problem using email or the web	41	39
Being admitted to a psychiatric ward in a hospital	40	34
Cognitive behavioural therapy	34	33
Having an occasional alcoholic drink to relax	37	30
Tranquillisers such as valium	33	33
Electro-convulsive therapy (ECT)	23	19
Antipsychotics	23	19
Sleeping pills	20	15
Hypnosis	18	14
Painkillers such as codeine, aspirin or Panadol	13	12

## Identifying mental health problems

Participants were asked questions to assess whether they could accurately recognise a mental health problem. Respondents were presented with a case study illustrating the feelings or behaviour of a person who is experiencing a mental health problem. They were then asked if they thought the person needed help. If they agreed that help was needed, they were asked who they believed could help the person and what treatment would be helpful. Questions were asked to try to establish the respondents' perceptions of recovery for each person.

Two case studies were used in the questionnaire. These were adapted from a study assessing public recognition of mental disorders in Australia (see also Link, Phelan, Bresnahan, Stueve and Pescosolido 1999).<sup>21,25</sup> Case study one was shown to half the sample and described a woman, Ann, with the symptoms of schizophrenia. The second case study was shown to the rest of the sample and described the symptoms of Jane, who was suffering from depression. The descriptions of schizophrenia and depression met the criteria outlined in ICD–10 and DSM–IV, two classification systems used by clinicians for assessing and diagnosing mental disorders. The case studies are presented below. Two female characters were used (rather than one male and one female) to keep responses consistent, as participants' answers could vary depending on the gender of the person in the case study.

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

*2. Jane is 30 years old. She has been feeling unusually sad or miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Jane doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day to day tasks seem too much for her. This has come to the attention of Jane's boss, who is concerned about her lowered productivity.*

After reading the case study, a series of questions were asked to establish whether participants could:

- accurately recognise the problem described;
- decide if the person with the problem needed help, and who could provide it;
- decide what treatment would be helpful for the person.

Questions were also asked to establish perceptions about recovery, ie:

- the likelihood of the person being able to participate in family life in the future;
- whether the person is likely to go back to work;
- whether the person can develop close relationships;
- whether the person can live an ordinary life;
- whether the person is likely to do something violent to themselves or others.

## Recognising mental illness (schizophrenia and depression)

### Ann (schizophrenia)

When, without being prompted, participants were asked what if anything is wrong with Ann, 43% of the sample (base=509) identified schizophrenia, 33% said depression, 11% said 'mental illness' and 8% said nervous breakdown. Other responses included: stress (3%), 'psychological emotional' problems (5%) and 'a problem' (4%).

There was no difference between males and females for accurately recognising that Ann had schizophrenia. However, there was an age difference as the youngest and oldest age groups were less likely than the others to recognise the symptoms of schizophrenia (60% of 25–34 year olds, 46% of 35–49 and 50–64 year olds, 30% of 16–24 year olds and 25% of 65+ year olds accurately recognised Ann's symptoms) ( $p < 0.001$ ) (see Figure 9).

There was also a significant social class difference. The ABC1 group (50%) were more likely than the C2 group (42%) to accurately recognise Ann's schizophrenia, while those in the DE group (35%) were least likely to identify the symptoms ( $p < 0.05$ ). In relation to those participants who incorrectly thought Ann had depression, no significant social class differences were observed.

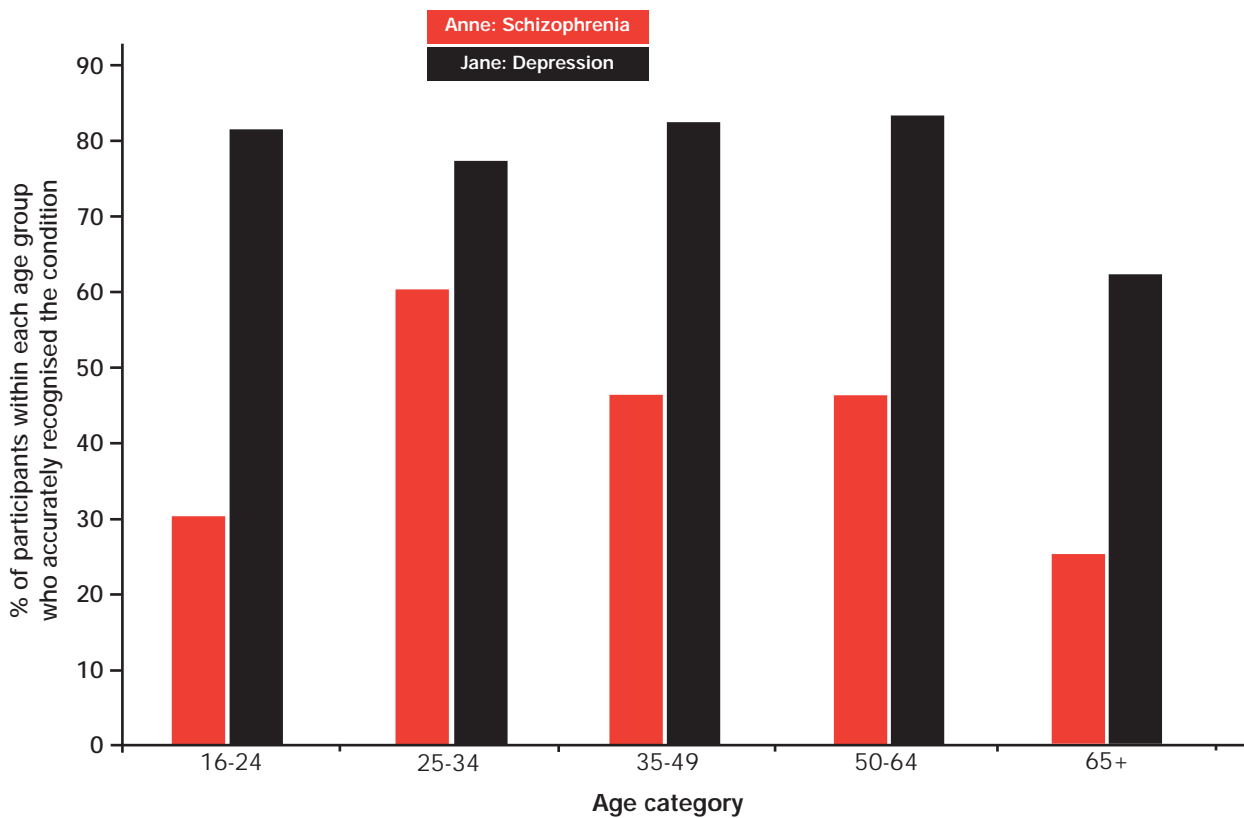
### Jane (depression)

When, without being prompted, participants were asked what if anything is wrong with Jane, just over three quarters of the sample (77%) (base= 504) accurately recognised the symptoms of depression. Twelve percent believed she had stress and 6% said she had 'a problem'. Females (81%) were significantly more likely than males (73%) ( $p < 0.05$ ) to accurately identify Jane's condition. There was a significant age difference, with the 65+ age group (62%) least likely to recognise Jane's depression when compared to the 16–24 (81%), 25–34 (77%), 35–49 (82%) and 50–64 (83%) age groups ( $p < 0.01$ ) (see Figure 9). No significant social class differences were observed.

### Ann (schizophrenia) and Jane (depression)

Participants were more likely to accurately recognise Jane's symptoms of depression (77%) than Ann's symptoms of schizophrenia (43%). It was interesting to note that some participants mislabelled schizophrenia as depression. This finding may have been a result of depression being diagnosed more frequently than schizophrenia in Northern Ireland, or simply a result of the term 'depression' being used more often and known more extensively.

**Figure 9: The number of participants in each age group who accurately recognised the symptoms of Ann and Jane**



## Views on the need for help

Participants were asked 'do you think Ann/Jane needs professional help?' More than 9 in 10 (96%) said yes, Ann (schizophrenia) needs professional help, 1% said no, she does not and 3% did not know. No differences were observed across gender or social class.

In Jane's case (depression), 93% said yes, she needs professional help, 2% said no, she does not and 4% did not know. Females (96%) were significantly more likely than males (90%) to say yes ( $p < 0.05$ ). Males (7%) were more likely than females (2%) to say they did not know. No differences were observed across social class.

## Views on the people likely to be helpful, harmful or neither

A list of people and their occupations (some professional, some not) was presented to participants. They were then asked whether the people on the list would be a help to Ann or Jane. The three people considered most helpful for Ann and Jane were a family doctor (94% Ann, 94% Jane), a psychiatrist (93%, 90%) and a counsellor (87%, 86%) (see Table 7). Other contacts considered helpful included a psychologist (82%, 77%), a close family friend (75%, 79%), a social worker (66%, 63%), a member of the clergy (60%, 58%), a telephone counselling service (59%, 61%), an alternative or complementary therapist (38%, 44%), or a chemist or pharmacist (32%, 35%). The final option was 'to deal with the problem on her own' (6%, 6%).

**Table 7: Who would be helpful for Ann and Jane?**

	Ann (schizophrenia)			Jane (depression)		
	% of total sample (Base)	% Male	% Female	% of total sample (Base)	% Male	% Female
Family doctor or GP	94 (506)	95	94	94 (500)	91	96
Psychiatrist	93 (503)	91	94	90 (497)	88	91
Counsellor	87 (499)	87	87	86 (499)	84	89
Psychologist	82 (485)	83	81	77 (486)	74	80
Close family friend	75 (505)	73	76	79 (496)	76	81
Social worker	66 (501)	64	68	63 (498)	62	64
Clergy	60 (502)	59	61	58 (496)	53	61
Contact a telephone counselling service	59 (495)	55	64	61 (496)	57	64
Alternative or complementary therapist	38 (488)	36	40	44 (487)	38	50*
Chemist or pharmacist	32 (499)	32	32	35 (494)	36	34
Deal with problem on her own	6 (499)	5	7	6 (496)	6	6

Participants were also asked to select from the list those people it would be harmful for Ann (schizophrenia) to contact. To 'deal with the problem on her own' was considered harmful by almost 7 in 10 respondents (69%). An alternative or complementary therapist (12%) and a chemist (10%) were considered the next most harmful (see Table 15 (a-k) in the Appendix).

Participants who received the Jane (depression) case study were also asked to select those people it would be harmful for her to contact. To 'deal with the problem on her own' was considered harmful by more than 6 in 10 respondents (62%). A chemist (9%) and an alternative or complementary therapist (9%) were considered the next most harmful. Contacting a telephone counselling service was considered harmful by almost as many participants (8%) (see Table 15 (l-v) in the Appendix).

Participants were then asked to select those people it would be 'neither helpful nor harmful' for Ann (schizophrenia) or Jane (depression) to contact. Responses were similar in both cases – the top three were a chemist or pharmacist (58% Ann, 57% Jane), an alternative or complementary therapist (51% Ann, 47% Jane) and the clergy (35% Ann, 38% Jane). See Table 15 (a–v) in the Appendix for a complete list.

## Views on the treatments likely to be helpful, harmful or neither

Lists of different treatments were presented to participants. They were then asked to indicate how helpful, harmful or otherwise they considered the treatments to be for Ann and Jane. The treatments included suitable medication such as antidepressants, as well as inappropriate medication such as antibiotics. A considerable

number of participants suggested that antibiotics would be helpful for both Ann (9%) and Jane (12%). This suggests that these respondents either could not diagnose a mental health problem, or had a poor knowledge of common medical treatments.

### Ann (schizophrenia)

For treating the symptoms of schizophrenia, respondents said the following would be helpful: antidepressants (65%), antipsychotics (41%), tranquillisers such as valium (39%), vitamins, minerals, tonics or herbal medicines (37%), sleeping pills (26%), painkillers such as codeine, aspirin or Panadol (11%) and antibiotics (9%) (see Table 8). Females were significantly more likely to recommend the use of antidepressants (70%) than males (59%) ( $p < 0.05$ ). There were no other significant gender differences.

There were, however, significant differences across social class in relation to using antipsychotics, antibiotics, or painkillers such as codeine, aspirin or Panadol for treating schizophrenia. The ABC1 group (47%) were more likely to view antipsychotics as helpful than the C2 (39%) and DE groups (35%) ( $p < 0.05$ ). The opposite trend was observed in relation to the use of painkillers such as codeine, aspirin or Panadol, with the C2 (14%) and DE (16%) groups more likely to consider them helpful than the ABC1 group (6%) ( $p < 0.05$ ). A similar trend to this was observed in response to antibiotics, with the C2 (12%) and DE (13%) groups both more likely than the ABC1 group (5%) to say they were helpful ( $p < 0.01$ ).

Participants were also asked what treatments they would consider harmful for Ann. Sleeping pills (43%) got the largest response, followed by painkillers (37%), tranquillisers (37%), antibiotics (34%), antipsychotics (20%), antidepressants (18%) and vitamins, minerals, tonics or herbal medicines (10%).

Participants were then asked what treatments they would consider neither helpful nor harmful for Ann. The highest proportion of respondents (57%) said antibiotics. This was followed by vitamins, minerals, tonics or herbal medicines (53%), painkillers (52%), antipsychotics (39%), sleeping pills (31%), tranquillisers (24%) and antidepressants (18%).

### Jane (depression)

For treating the symptoms of depression, respondents said the following would be helpful: antidepressants (69%), vitamins, minerals, tonics or herbal medicines (46%), tranquillisers such as valium (32%), sleeping pills (29%), antipsychotics (25%), painkillers such as codeine, aspirin or Panadol (13%) and antibiotics (12%) (see Table 8). There were no significant gender differences.

Participants aged 65+ (51%) were least likely to say antidepressants were an effective treatment when compared to other age groups. The proportion of people who agreed that antidepressants would be effective ranged from 71%–74% ( $p < 0.05$ ). There were no other significant age differences.

In relation to social class, 18% of the DE group said painkillers such as codeine, aspirin or Panadol would be helpful, significantly more than the ABC1 (11%) and C2 (9%) groups ( $p < 0.05$ ). However, the number of participants who considered painkillers helpful was relatively small in comparison to the size of the sample. There were no other significant differences between groups.

### Participants were also asked what treatments they would consider harmful for Jane.

Tranquillisers (43%) got the largest response, followed by sleeping pills (42%), painkillers (38%), antibiotics (37%), antipsychotics (32%), antidepressants (19%) and vitamins, minerals, tonics or herbal medicines (10%).

Participants were then asked what treatments they would consider neither helpful nor harmful for Jane. Again, the highest proportion of respondents (52%) said antibiotics. This was followed by painkillers (49%), vitamins, minerals, tonics or herbal medicines (44%), antipsychotics (43%), sleeping pills (29%), tranquillisers (24%) and antidepressants (12%).

**Table 8: What treatments would be helpful for Ann and Jane?**

	Ann (schizophrenia)			Jane (depression)		
	% of total sample (Base)	% Male	% Female	% of total sample (Base)	% Male	% Female
Antidepressants	65 (494)	59	70*	69 (493)	66	71
Antipsychotics	41 (458)	41	41	25 (463)	26	24
Tranquillisers such as valium	39 (495)	37	40	32 (489)	32	33
Vitamins, minerals, tonics or herbal medicines	37 (497)	37	37	46 (494)	47	46
Sleeping pills	26 (501)	23	29	29 (495)	30	28
Painkillers such as codeine, aspirin or Panadol	11 (500)	11	11	13 (496)	13	13
Antibiotics	9 (497)	9	9	12 (494)	13	11

## Views on recovery from mental illness

Participants were asked for their views on the likelihood of Ann (schizophrenia) and Jane (depression) recovering from their illnesses. They also gave their views on the likelihood of either woman being able to participate in family life at Christmas, going back to work within a year, developing close relationships, living an ordinary life in the future, or doing something violent to themselves or others (see Table 9). For every possibility presented, respondents were inclined to believe that the person experiencing depression, Jane, was more likely to recover than Ann, who was experiencing schizophrenia.

When participants were asked how likely is it that Ann will participate in family life at Christmas, half the sample (50%) said fairly or very likely. Just over a fifth (22%) said fairly or very unlikely. Of the rest, 13% said neither likely nor unlikely and 16% did not know. When participants were asked how likely is it that Jane will participate in family life at Christmas, 67% said fairly or very likely, a figure which is higher than the response for Ann. Just 10% of participants said it was fairly or very unlikely. An equal proportion (10%) said neither likely nor unlikely and 14% did not know.

**Table 9: Participants' views on whether Ann and Jane will recover from their mental illness**

	Likely (fairly or very)		Neither likely nor unlikely		Unlikely (fairly or very)		Don't know	
	Ann	Jane	Ann	Jane	Ann	Jane	Ann	Jane
Participate in family life at Christmas	50	67	13	10	22	10	16	14
Go back to work within a year	42	65	13	12	29	8	16	15
Develop close relationships	45	62	16	14	25	11	15	13
Live an ordinary life in the future	66	80	11	8	13	4	11	8
Do something harmful or violent to herself	40	21	20	23	24	37	17	19
Do something harmful or violent to others	24	14	22	21	33	46	21	19

When asked whether Ann (schizophrenia) will go back to work within a year, slightly more than 4 in 10 participants (42%) said fairly or very likely. More than one quarter of participants (29%) said fairly or very unlikely. Of the rest, 13% said neither likely nor unlikely and 16% did not know. When asked whether Jane (depression) will go back to work within a year, almost two thirds of participants (65%) said fairly or very likely, 8% said fairly or very unlikely, 12% said neither likely nor unlikely and 15% did not know.

Almost half the respondents (45%) said it was fairly or very likely that Ann will develop close relationships. However, one quarter of participants (25%) said this was fairly or very unlikely. Of the rest, 16% said it was neither likely nor unlikely and 15% did not know. When participants were asked the same question in relation to Jane, 62% said fairly or very likely, 11% said fairly or very unlikely, 14% said neither likely nor unlikely and 13% did not know.

When asked whether Ann will live an ordinary life in the future, two thirds of the sample (66%) said fairly or very likely. Of the rest, 13% said fairly or very unlikely, 11% said neither likely nor unlikely and 11% did not know. In relation to Jane, 8 in 10 participants (80%) said fairly or very likely, 4% said fairly or very unlikely, 8% said neither likely nor unlikely and 8% did not know.

Responses to each of the four possibilities (the likelihood of Ann/Jane being able to participate in family life after Christmas, going back to work within a year, developing a close relationship and living an ordinary life in the future) were summed to give an overall mean score for participants' opinions on whether Ann (mean=11) and Jane (mean=9) are likely to recover. A lower mean score indicates a greater likelihood of recovery. The respondents believed that Jane (depression) was statistically significantly more likely than Ann (schizophrenia) to recover ( $t=8.04$ ,  $df=719$ ,  $p<0.001$ ).

When asked whether Ann will do something harmful or violent to herself, 40% of participants said this was fairly or very likely. Almost one quarter (24%) said it was fairly or very unlikely, 20% said it was neither likely nor unlikely and 17% did not know. When asked the same question in relation to Jane, 21% said fairly or very likely, 37% said fairly or very unlikely, 23% said neither likely nor unlikely and 19% did not know.

When asked whether Ann will do something harmful or violent to others, 24% said this was fairly or very likely, 33% said fairly or very unlikely, 22% said neither likely nor unlikely and 21% did not know. When asked the same question in relation to Jane, 14% said fairly or very likely, 46% said fairly or very unlikely, 21% said neither likely nor unlikely and 19% did not know.

# Help seeking

## Who would we most likely turn to if we had a mental health problem?

Respondents were asked who they would most likely turn to if they themselves thought they had a mental health problem. Almost 7 in 10 (67%) said they would turn to their GP. Of the rest, 11% would turn to their husband/wife/partner, 7% to a close family friend and 5% to their mother. A small minority (2%) said they wouldn't know who to turn to (see Table 10). The remaining participants said they would turn to either a psychiatrist, counsellor, sister, daughter or member of the clergy (minister or priest). Respondents were unlikely to contact a telephone counselling service, psychologist, father, brother, social worker, telephone helpline or alternative/complementary practitioner. It is interesting to note the reluctance to talk to male family members.

Females (68%) were slightly more likely than males (66%) to say they would turn to their GP; however, this difference was not significant. There was an age difference, with 16–24 (53%) and 25–34 year olds (58%) less likely to say they would turn to their GP than the older groups, 35–49 (68%), 50–64 (74%) and 65+ (79%) ( $p < 0.01$ ). No social class difference was observed.

The high proportion (67%) who said they would most likely turn to their GP need to be considered in context. By this stage of the questionnaire, respondents may have been thinking in terms of a severe illness. If this question was asked again in a different context, it is possible that more respondents would name non-professional friends or family members rather than their GP. This is currently being explored in qualitative research commissioned by the HPA.

**Table 10: Who the participants would most likely turn to if they thought they had a mental health problem**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	Base
GP	67	66	68	53	58	68	74	79	1007
Husband/wife/partner	11	13	9	3	16	13	12	5	1007
Close family friend	7	8	7	12	10	7	4	6	1007
Mother	5	4	7	20	8	3	1	1	1007
Don't know	2	3	1	5	2	1	1	2	1007

## Who would be your first point of professional contact?

Respondents were then asked who would be their first point of professional contact if they thought they had a mental health problem. In total, 92% of participants said their GP, 2% said a counsellor or psychiatrist, and 1% said a psychologist, member of the clergy, helpline or that they did not know. There were no significant differences across gender or social class. There was a significant difference in the age of respondents who would contact a GP, with 16–24 year olds being least likely (86%) and 65+ year olds being most likely (97%) ( $p < 0.001$ ).

## Awareness of local mental health organisations

Participants were asked whether they had heard of any organisations that help people with mental health issues. Just under half the sample said yes (48%), the rest said no (52%). There were no significant gender differences. Again, the youngest and oldest age groups were less aware of mental health organisations. The 16–24 (65%) and 65+ age groups (66%) had a significantly greater proportion who did not know of any, while the other age groups had between 44% and 49% who said the same ( $p < 0.001$ ).

The organisations most frequently named were Samaritans (21%), Action Mental Health (8%), Childline (8%) and Praxis (7%). The Northern Ireland Association of Mental Health (4%), AWARE Defeat Depression (3%) and Carers and Users Support Enterprise (C.A.U.S.E) (1%) were also mentioned.

# Discussion

This mental health literacy and stigma survey aimed to provide some insight into the public's perception of mental health. It is possible that help seeking can be made more difficult by two factors – the failure to identify or articulate a problem, and stigma. The survey sought to examine the public's knowledge and beliefs about mental health, and the attitudes that may contribute to stigma. It also set out to determine whether people are aware of how they can access help if they themselves, or a friend, develop a mental health problem. In addition, it aimed to find out whether people feel they can influence their own mental health, and whether they can recognise the symptoms of a mental health problem.

## Understanding mental health as a health issue

When participants were asked to consider what the major health problems are in Northern Ireland they initially associated the question with physical health, citing heart disease and cancer. However, when prompted with examples of mental health problems, participants reconsidered their response to take into account mental health conditions. This is an indication that people do not perceive mental health problems as a health issue to the same degree as physical health conditions.

When participants were asked how much influence or control they feel they have over their physical and mental health, a higher percentage of respondents said they had more control over their physical health. This suggests a lack of awareness that people can proactively improve and protect their mental health. This was further evidenced when respondents were asked about recent lifestyle changes they had made to improve their health. It was clear that some participants had made positive lifestyle changes, but the majority of these were changes that would impact on physical health, such as improved nutrition or trying to lose weight. Few changes were made to proactively improve mental health, although almost a quarter (23%) had tried to get out and see friends more, and 17% had talked to people about things that were bothering them. These positive lifestyle changes, although not shared by the majority of the sample, indicate some progress in people looking after their mental health. However, the mental health lifestyle changes tended to be made by females and those in the ABC1 social class group.

The respondents' focus on physical health rather than mental health is not surprising after many years of media campaigns giving advice on how to prevent cancer and heart disease, which encouraged people to stop smoking, moderate alcohol consumption, increase physical activity and improve their nutrition. This is consistent with the findings of Jorm et al, who conducted a survey in Australia that also showed the level of mental health literacy was lower than that of physical health literacy.<sup>22</sup> These findings illustrate the need to increase the public's mental health literacy, with a focus on raising awareness and understanding of mental health as an issue, and as something we can protect and improve just like our physical health.

## Perceived prevalence of mental health problems

An exact figure for the number of people who develop a mental health problem at some point in their lives is not available, but it has been estimated that one in four UK adults experience at least one diagnosable mental health problem in any one year.<sup>9</sup> The most recent Health and Social Wellbeing Survey in Northern Ireland (2001) (HSWB) reported that one in five (21%) respondents achieved a score (GHQ12) that indicated possible psychiatric morbidity (mental ill health). Taking the UK measure of one in four as a benchmark, 63% of our participants underestimated the prevalence of mental health problems.

This underestimate in the survey indicates that the population is not aware of the extent of mental health problems in our communities. This lack of awareness could be due to two factors: either people do not recognise a mental health problem when experiencing it themselves or in others, because they lack

knowledge about the issue (mental health literacy); or there may be a general reluctance to acknowledge mental health conditions because of stigma.

## Awareness of mental health disorders

Our survey findings around knowledge and treatments would suggest that the level of mental health literacy is poor and varies by personal characteristics. Respondents were probed on their knowledge of mental health problems and were asked to list some. As expected, depression was the main condition cited (73%) followed by schizophrenia (31%). However, females were more likely than males (76% versus 70%) to be aware of depression and there was a considerable variation among the age groups, with the youngest and oldest age groups being least aware of specific problems such as depression. The ABC1 group was also more likely than the other social class groups to be able to cite a number of specific mental health problems (ie dementia/Alzheimer's Disease, schizophrenia and drug dependence).

## Reported experience of mental health problems

When asked directly about their own experience of mental health problems, just over one in seven (15%) respondents said 'yes, I have experienced mental health problems myself'. This is fewer than the estimated figures of one in five (HSWB) or one in four (ONS) of the population. Again, this is due to respondents either failing to recognise that they have experienced a mental health problem, or being unwilling to report it due to stigma.

Interestingly the youngest and oldest age groups, and males in particular, were least likely to say they had any personal experience of mental health problems (either themselves or through others). Only 9% of 16–24 year olds and 8% of 65+ year olds said they had experienced mental health problems themselves, despite these groups having 21% and 18% prevalence levels, respectively, for psychiatric morbidity (mental ill health).<sup>10</sup> This would suggest that either stigma, or the inability to recognise the problem, is a factor for these groups in particular.

People in the DE social class group are more likely to experience mental health problems than those in the other social class groups and our findings show that they are also more likely to admit it. One in five of them (21%) said they had experience of mental health problems. However, personal experience of mental health problems is highly underreported for the ABC1 (12%) and C2 (11%) groups in our survey, again possibly due to stigma.

## Stigma

Stigma is considered a major barrier to help seeking.<sup>25</sup> Participants' responses to each of the attitude statements relating to stigma demonstrated the complexity of assessing attitudes towards mental health problems. For example, there was a common recognition that anyone can experience mental health problems (98%) and that people with mental health problems should have the same rights as anyone else (91%). However, the picture wasn't as clear when other statements were presented.

Fewer participants reported a willingness to talk to a person with mental health problems (68%), and more importantly, over half the sample (55%) admitted that they would not want to disclose their own mental health problem. This confirms stigma around the issue, which is actually at a higher level in Northern Ireland than it was in Scotland prior to the 'See me' campaign.<sup>19</sup>

A stigma score was allocated to each respondent according to their answers to the set of stigma statements.

While there was no significant variation in stigma score across age and gender, there appears to be a statistical variation between the social class groups. Although they score not much higher, the ABC1 group scored statistically significantly higher (26.09) than the C2 (25.97) ( $p < 0.01$ ) and DE groups (25.92) ( $p < 0.001$ ) (see Figure 3). This also correlates with the findings that this group underreported personal experience of mental health problems.

We cannot conclude from one set of questions that the ABC1 group is more likely than the other social class groups to stigmatise mental health problems; it is possible that they may have been more honest in their responses. But this, coupled with the finding that they substantially underreported their personal experience of mental health problems, suggests that it could be the case.

Generally speaking, we tend to assume that increased knowledge about an issue or group of people should decrease prejudice, so it would appear unusual that the group with the higher mental health literacy should be the group most likely to stigmatise the issue. However, if this is the case, it is a warning that an anti-stigma campaign based solely on imparting knowledge about mental health problems may not be effective in encouraging help seeking. This is supported by evaluation findings from New Zealand's 'Like Minds Like Mine' campaign. These show that this approach was effective in reducing the stigma towards depression, but has actually increased the stigma towards more serious mental illnesses, specifically schizophrenia.<sup>27</sup>

Findings from our survey would also suggest that the public considers some mental health problems more serious or frightening than others. Respondents believed that the character in the depression case study, Jane, was more likely than Ann, (schizophrenia), to recover ( $p < 0.001$ ). Respondents also believed the person with schizophrenia was more likely to do something harmful or violent to others. Collectively, these findings demonstrate that stigma based on fear may prevent a person with mental health problems disclosing that fact and seeking help. Moreover, this fear of people who are experiencing mental health problems may, in turn, prevent others from offering help.

It may also be the case that people do not seek help, or offer help, because they cannot identify a problem until it becomes severe, or are not clear about what help is available, or how they can offer help.

## Recognising that help is needed

Respondents were asked about help seeking if they themselves were experiencing a mental health problem. They were also asked about help seeking with regard to the case studies, featuring depression and schizophrenia. This also revealed some differences between what people think others should do and what they would actually do themselves.

The majority of respondents thought that both Ann (schizophrenia) (96%) and Jane (depression) (93%) needed help. With regard to schizophrenia, agreement that help was needed was consistent across age, gender and social class. However, in relation to depression, males were less likely to recognise it, and more uncertain as to whether a person with it needs help.

When participants were asked who could help Ann or Jane, the top answers were a GP and psychiatrist. However, a high proportion of respondents also said a member of the clergy (60% Ann, 58% Jane) or a telephone counselling service (59%, 61%), would be helpful. More than 6 in 10 said it would be harmful for Ann or Jane to 'deal with the problem on her own' (69% Ann, 62% Jane).

When respondents were asked to whom they would most likely turn if they had a mental health problem, surprisingly, family or close friends were not the immediate response. Nearly 7 in 10 respondents (67%) said their GP. This was followed by their husband/wife/partner for only 1 in 10 (11%), then a close family friend (7%).

It is possible that by this stage of the questionnaire, respondents were thinking in a medical context and 'GP' seemed the correct answer to give. Or it is possible that embarrassment would cause people to confide in their GP before a family member. It would be interesting to ask this question in a different context, to see if non-professional help would be sought first. This again needs further research. It is also interesting to note the reluctance to talk to male family members and friends, which may indicate a perceived lack of sympathy from male friends and relatives. In addition, despite respondents saying that Ann or Jane would benefit from talking to the clergy or ringing a telephone counselling service, they appear reluctant to do the same themselves. Less than 1% said they would do either.

When participants were asked who would be their first point of professional contact if they had a mental health problem, again the majority (92%) said their GP. It is worth noting once more that participants may have given a 'correct' answer rather than a realistic answer. For example, there was no gender difference, despite men being less likely than women to attend a GP for any reason.

These findings would suggest that people know they should contact their GP in the event of a mental health problem, but do not indicate that they would actually do it. This raises the question: when are people likely to contact their GP? Is it likely to be when the first symptoms of mental health problems are recognised (which depends on people being able to recognise symptoms in the first place), or is it likely to be later, when symptoms have already spiralled and the problem has become more severe? Untreated, mental health problems can worsen, and a delay in contacting a professional for help could hinder recovery. More research is required to explore the point at which people seek help. Further studies are also needed to see whether people recognise the symptoms of mental health problems and whether more information on these is required.

It is worth noting that 16–24 year olds were least likely to say they would contact their GP. To aid the development of information campaigns for this age group, it would be helpful to examine and address young people's reluctance to go to their GP for help. It would also be of value to ensure that GPs are aware of the reluctance among this important and vulnerable age group and that they seek to address this issue themselves.

These findings would suggest that campaigns need to not only target people who are at risk of suffering mental health problems, but also GPs and 'significant others' – those closely connected to people who are at risk of experiencing mental health problems (eg mothers, partners).

This information was obtained to help develop several required actions outlined in the *Protect life* strategy, specifically an information campaign that will help to destigmatise mental health and encourage help seeking behaviour.<sup>12</sup> It is hoped that this will, in the long term, contribute to suicide prevention in Northern Ireland.

It is obvious that there is a contradiction between what people know they should do or how they should behave, and what they actually do. This contradiction is most likely due to stigma. But the problem is circular. Ignorance of the issue leads to stigma, but stigma prevents the issue being talked about in a way that will improve knowledge. Both together lead to people not knowing they can take care of their mental health, not knowing when to seek help, or not actually seeking help when help is needed.

The cycle could be broken by an effective programme of public information. However, delivering an effective mental health message to the public, one that takes into account all the points discussed, is quite a complex and challenging task given the sensitivity of the issue. What should be the main messages or call to action? Who should be targeted, and how do we best communicate with these target groups?

It may not be timely to try to reduce stigma just by challenging attitudes. Recent qualitative research undertaken by the HPA has shown that people in Northern Ireland currently have a low and strongly negative understanding of what the term mental health actually means, taking it to refer only to severe mental illness or learning disability. The public needs to be educated about mental health as an issue, but communicating

knowledge alone will not remove the stigma. Public information needs to be twofold, reducing stigma and communicating knowledge at the same time.

Neither is it timely just to tell people to seek help, as the findings of this survey suggest that people are unaware of the symptoms of mental health problems. Also, that would not address the stigma around help seeking.

It would seem that a phased approach is necessary, beginning with a campaign that would enable the public to discuss mental health openly as an issue. This could be tackled by presenting mental health as a state of health that everyone has, that can be both positive and negative, and that can be influenced and controlled just like our physical health. Once the public has a greater understanding and more open attitude towards mental health, then the task of encouraging self help, and the more difficult task of encouraging help seeking, can be tackled. This should be carried out in an innovative way and targeted at the key groups of people that most need it, as well as those that support them.

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# Appendix

Table 11: Comparison of the 2006 HPA survey and the 2001 census sample

	% HPA survey (2006)	% Census (2001)
<b>Gender</b>		
Male	46 (n=471)	48
Female	54 (n=542)	52
<b>Age</b>		
16–24	13 (n=132)	16
25–34	20 (n=198)	19
35–49	30 (n=302)	27
50–64	21 (n=214)	20
65+	17 (n=167)	17
<b>Social class</b>		
ABC1	43 (n=438)	47
C2	21 (n=213)	21
DE	36 (n=362)	32

**Table 12: Participants' views on what the major health problems are in Northern Ireland at present, by gender, age and social class (unprompted)**

Health problem	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Cancer	54	52	55	49	55	53	56	55	53	55	54	1,013
Heart disease	47	47	46	30	44	48	53	52***	52	52	37***	1,013
Alcohol misuse	16	18	14	16	16	17	16	13	16	15	16	1,013
Obesity	11	11	10	14	12	11	9	6	14	6	9**	1,013
Depression	7	6	8	4	7	9	7	7	8	6	26	1,013
Stroke	7	8	6	4	6	6	10	8	7	7	6	1,013
Diabetes	4	3	5	5	4	5	3	6	6	2	3*	1,013
Asthma	3	3	4	4	4	4	1	3	2	3	4	1,013
Suicide	3	3	3	5	4	3	2	2	3	3	3	1,013
Dementia/Alzheimer's Disease	2	1	3*	1	2	2	1	5*	3	2	1	1,013
Accidents	2	2	2	4	4	1	1	0***	2	2	2	1,013
Anxiety/stress/pressure	2	1	2	2	1	2	2	3	2	3	1	1,013
Schizophrenia/psychosis	1	.4	1	1	1	1	0	1	1	1	1	1,013
Self-harm	.4	1	.2	2	1	.3	0	0	1	1	0	1,013
Manic depression (Bipolar affective disorder)	.1	0	.1	1	0	0	0	0	.2	.2	0	1,013
Other	11	12	11	13	7	13	10	13	12	9	11	1,013
Don't know	5	5	4	12	6	2	3	2***	4	5	5	1,013

**Table 13: Participants' responses when asked to name known mental health problems, by gender, age and social class**

Health problem	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Nervous breakdown	13	15	12	14	14	16	14	8	13	15	14	1,013
Drug dependence	9	11	8	13	10	13	7	3**	11	10	7	1,013
Personality disorder	3	3	2	3	4	4	1	2	3	3	2	1,013
Alcoholism	21	23	19	23	22	24	19	16	21	22	21	1,013
Depression	73	70	76*	64	76	77	77	64**	71	75	74	1,013
Manic depression (Bipolar affective disorder)	9	7	11	8	9	12	8	5	12	7	7**	1,013
Postnatal depression	4	2	7***	3	6	6	2	2*	4	7	3***	1,013
Eating disorder/anorexia, bulimia	5	4	5	6	5	5	4	2	5	7	3	1,013
Severe stress	9	9	8	3	11	9	10	8	10	9	7	1,013
Post traumatic stress disorder	2	2	2	4	2	3	1	1	3	2	1	1,013
Panic attacks/disorder	7	6	7	7	10	8	5	2*	6	6	7	1,013
Obsessive compulsive disorder	2	3	2	5	3	3	1	1	2	4	2	1,013
Anxiety disorder	11	12	10	8	11	13	15	5*	15	9	7**	1,013
Phobias (eg agoraphobia)	2	2	2	1	4	3	1	1*	3	2	1	1,013
Dementia/Alzheimer's Disease	36	31	41***	24	31	35	43	45***	43	39	27***	1,013
Psychosis	2	2	2	3	4	1	3	1	3	3	1	1,013
Schizophrenia	31	29	33	30	40	34	28	20***	41	24	23***	1,013
Self-harm	6	6	6	8	5	8	3	5	6	6	6	1,013
Don't know	6	7	4	11	4	4	4	8*	5	6	6	1,013

**Table 14: Participants' personal experience of mental health problems, by gender, age and social class**

Personal experience	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Yes, I have experienced mental health problems myself	15	14	16	9	15	17	22	8***	12	11	21***	1,013
Yes, I have cared for or I am a relative of someone who had or has mental health problems	18	16	20	11	17	20	18	22	19	18	17	1,013
Yes, through my work as a mental health or social care professional	2	1	4*	1	3	4	1	2	4	1	1**	1,013
Yes, through my work as a social care professional (non-mental health)	2	1	3*	1	1	3	3	2	4	1	1*	1,013
I have no experience of mental health problems	65	69	61**	80	65	61	57	68***	66	70	61	1,013
Other	2	2	2	1	3	3	3	1	3	4	1*	1,013

**Table 15 (a-v): Participants' opinions on whether various people, both professional and non-professional, would be harmful, helpful or neither in treating schizophrenia and depression, by gender, age and social class (a-k represents Ann – schizophrenia; l-v represents Jane – depression).**

**a. Family doctor or general practitioner**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	2	2	2	4	1	2	1	0	1	3	2	506
Helpful	94	95	94	94	95	95	93	93	94	93	95	506
Neither	4	4	5	1	4	3	6	8	5	5	3	506

**b. Chemist or pharmacist**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	10	11	10	12	10	10	12	8	12	9	9	499
Helpful	32	32	32	25	33	34	27	41	30	34	34	499
Neither	58	57	58	64	57	57	60	51	59	57	58	499

**c. Counsellor**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	1	2	1	1	0	2	2	1	1	2	2	499
Helpful	87	87	87	90	85	87	87	86	88	86	85	499
Neither	12	11	12	9	15	11	12	13	11	12	13	499

**d. Social worker**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	4	6	3	7	2	5	3	4	5	3	4	501
Helpful	66	64	68	59	65	67	68	68	65	67	67	501
Neither	30	31	30	33	33	28	30	29	30	31	29	501

e. Telephone counselling service

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	6	6	5	7	3	5	7	5	9	2	4	172
Helpful	59	55	64	49	70	59	58	58	54	70	60	172
Neither	35	40	31	44	26	36	35	37	38	28	37	172

p≤.01 socioeconomic status

f. Psychiatrist

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	2	2	2	0	2	1	3	3	2	0	2	503
Helpful	93	91	94	93	92	91	94	95	94	95	90	503
Neither	5	7	4	7	6	7	4	3	4	5	8	503

g. Psychologist

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	2	3	1	0	1	3	2	3	1	3	2	485
Helpful	82	83	81	84	77	79	82	90	85	84	76	485
Neither	16	15	18	16	22	18	16	8	13	13	22	485

h. Close family friend

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	5	5	5	3	4	6	4	6	6	6	3	505
Helpful	75	73	76	73	76	74	70	82	75	73	75	505
Neither	21	22	19	25	20	20	25	12	19	21	22	505

**i. Alternative or complementary therapist (eg acupuncture, homeopathy, reflexology)**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	12	11	12	10	15	10	12	12	13	11	11	488
Helpful	38	36	40	30	49	39	31	39	40	35	37	488
Neither	51	54	49	59	36	51	57	49	48	54	53	488

**j. Clergy**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	5	6	5	7	3	6	6	4	5	7	5	502
Helpful	60	59	61	46	62	56	61	75	60	58	60	502
Neither	35	36	34	47	35	38	33	21	35	34	35	502

**k. Deal with the problem on her own**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	69	68	70	59	63	70	76	73	77	63	63	499
Helpful	6	5	7	3	7	7	2	11	7	5	6	499
Neither	25	27	24	38	30	23	23	16	17	32	31	499

p<.05 age

**(l-v represents Jane – depression)**

**l. Family doctor or general practitioner**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	1	2	0	0	3	1	1	0	1	0	2	500
Helpful	94	91	96	97	92	95	91	94	94	95	92	500
Neither	5	7	4	3	6	4	8	6	5	5	6	500

**m. Chemist or pharmacist**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	9	11	7	3	11	9	8	9	7	10	9	494
Helpful	35	36	34	36	31	35	42	32	35	34	36	494
Neither	57	54	59	61	59	56	50	60	58	56	55	494

**n. Counsellor**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	3	4	2	3	2	1	6	2	1	2	6	499
Helpful	86	84	89	84	85	93	78	87	89	88	83	499
Neither	11	13	9	13	13	5	16	11	10	11	12	499

**o. Social worker**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	5	4	6	2	7	3	4	7	5	4	5	498
Helpful	63	62	64	63	55	68	66	58	61	65	63	498
Neither	33	35	31	36	39	29	30	35	34	31	32	498

**p. Telephone counselling service**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	8	8	7	8	7	6	8	10	8	3	10	496
Helpful	61	57	64	54	65	68	60	48	64	63	56	496
Neither	32	34	29	38	28	26	31	42	28	34	34	496

**q. Psychiatrist**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	2	3	2	2	5	2	0	1	2	2	2	497
Helpful	90	88	91	93	85	91	89	92	91	87	91	497
Neither	8	10	7	5	10	7	12	7	7	12	8	497

**r. Clinical psychologist**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	3	4	2	5	5	3	0	3	3	3	3	486
Helpful	77	74	80	76	70	79	81	77	79	75	75	486
Neither	20	22	19	19	25	18	19	21	18	22	22	486

**s. Close family friend**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	4	5	4	5	5	3	5	4	4	5	4	496
Helpful	79	76	81	79	74	81	80	77	81	76	77	496
Neither	17	19	16	16	21	15	14	20	15	19	18	496

**t. Alternative or complementary therapist (eg acupuncture, homeopathy, reflexology)**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	9	11	7	13	8	5	10	13	7	6	12	487
Helpful	44	38	50	44	50	43	50	33	46	51	38	487
Neither	47	52	43	43	43	53	41	54	47	44	50	487

p≤.05 gender

**u. Clergy**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	5	5	5	5	6	5	4	5	6	7	3	496
Helpful	58	53	61	45	55	56	66	63	58	59	56	496
Neither	38	42	34	50	39	39	30	33	37	34	40	496

**v. Deal with the problem on her own**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
Harmful	62	58	66	65	62	60	67	59	67	59	59	496
Helpful	6	6	6	5	6	7	6	6	6	5	8	496
Neither	32	36	28	31	32	32	27	35	28	37	34	496

**Table 16a: How much influence participants thought people could have on their own physical wellbeing by the way they choose to live their lives, by gender, age and social class**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
A lot	79	78	80	82	80	78	83	71	83	81	73	1,010
A little	14	15	13	13	10	15	13	19	13	12	16	1,010
None at all	3	2	3	2	5	3	1	2	1	3	4	1,010
Don't know	5	5	5	3	6	4	4	8	3	4	7	1,010

p≤.05 socioeconomic status

**Table 16b: How much influence participants thought people could have on their own mental wellbeing by the way they choose to live their lives, by gender, age and social class**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
A lot	53	52	55	49	56	54	58	48	57	58	46	1,009
A little	26	26	25	28	25	26	24	27	24	23	30	1,009
None at all	11	12	10	10	11	12	10	11	10	9	13	1,009
Don't know	10	10	10	14	9	9	8	13	9	11	11	1,009

p≤.05 socioeconomic status

**Table 17: How often, on average, participants saw friends or relatives who did not live with them, by gender, age and social class**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
On most days	50	47	52	63	51	48	43	51	44	54	55	1,010
Once or twice a week	39	41	37	30	39	40	47	35	43	38	34	1,010
Once or twice a month	6	6	5	5	6	5	5	8	7	6	5	1,010
Less often than once a month	5	5	4	1	5	6	5	5	6	3	5	1,010
Never	1	1	1	1	0	1	0	1	0	1	1	1,010
Don't know	0	0	0	0	0	0	0	1	0	0	0	1,010

p≤.05 age

**Table 18: Frequency of participants' attendance at social or leisure events or facilities (eg leisure centre, sports clubs, church group or community centre), by gender, age and social class**

	% of total sample	% Male	% Female	Age 16-24	Age 25-34	Age 35-49	Age 50-64	Age 65+	ABC1	C2	DE	Base
At least once a month	48	47	49	61	56	44	42	44	58	48	36	1,011
Less than once a month	8	7	8	4	8	9	8	7	9	7	7	1,011
Not regularly/never	44	46	43	36	36	47	50	49	34	45	57	1,011
Don't know	0	0	0	0	1	0	0	1	1	0	0	1,011

p≤.05 age

p≤.001 socioeconomic status



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