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Time to Change Wales

time to change Wales
let's end mental health discrimination

amser i newid Cymru
rhown ddiwedd ar wahaniaethu ar sail iechyd meddwl

Attitudes towards Mental Illness Wales 2024

Evaluation Report

Opinion Research Services
September 2024

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Introduction

Background

1. Time to Change Wales (TtCW) is Wales' national campaign to end the stigma and discrimination faced by people with mental health problems in Wales. The ultimate goal is to improve attitudes and change behaviour towards mental health.
2. The campaign is funded by Welsh Government and delivered by Adferiad and Mind Cymru.
3. Time to Change England conducted a Mental Illness Attitude Survey annually within England between 2007 and 2020, with Mind taking over the responsibility for commissioning this survey since 2021. This has enabled a full analysis of changing attitudes over time and provided valuable comprehensive data. Hoping to benefit from previous learnings in the development and interpretation of the survey, TtCW decided to commission two waves of the (almost identical) Mental Illness Attitude Survey which were completed in Wales in 2018/19 and 2020/21.
4. The first phase of fieldwork was completed in December 2018 – January 2019 at the same time as corresponding research in England and used the same questionnaire. This was completed using a face-to-face interviewing methodology. The second phase of research was due in December 2020 – January 2021 using the same methodology. However, due to the global pandemic, research was initially delayed and then switched to a different methodology – a postal push-to-web approach was used since face-to-face interviewing was not possible at this time.
5. In 2024 TtCW commissioned a repeat of Mental Illness Attitudes Survey using the same postal push-to-web approach that was employed in 2020/21. The questionnaire remains mostly the same, but some questions have been replaced by those taken from the British Social Attitudes survey[1].

Fieldwork

6. TtCW commissioned Verian (previously Kantar) to conduct the fieldwork of the 2024 survey using the same push-to-web methodology that was employed in 2021. The fieldwork methodology and quotas were agreed between Kantar and TtCW with the intention of providing a broadly representative sample of adults in Wales. The methodology was also agreed between Kantar and TtCW.
7. The fieldwork was completed by Kantar in spring (April – May) 2024 and consists of 526 self-completion interviews with adults (aged 16+) living in Wales.
8. The sample was selected using a stratified random sampling method from the Royal Mail private address file (PAF). Letters sent to households provided information about the research and an explanation on how to complete an online survey or request a paper questionnaire. Those who completed the survey received a £10 voucher.
9. The methodology allowed more than one person per household to complete a survey with each letter containing up to a maximum of four logins per household. Addresses that Kantar's data supplier CACI predicted to contain only one adult were allocated two logins in the invitation letter, addresses predicted to contain two adults were allocated three logins, and other addresses were allocated four logins. The mean number of logins per address was c2.7. Although it is difficult to police the same person completing more than once, Kantar had checks in place during data processing to remove speeders who rush to complete the survey and data was checked for duplicates.

[1] https://natcen.ac.uk/british-social-attitudes

10. Verian processed the data and provided TtCW and Opinion Research Services (ORS) with a cleaned SPSS dataset. ORS conducted their own weighting to better match the Wales population and previous waves. They then created cross tabulations and other analysis to inform this report.

Identifying trends

11. An important purpose of commissioning repeat waves of research was to be able to measure any changes in attitude over time and in particular to identify whether levels of stigma and discrimination were declining. This report will therefore seek to highlight any trends since 2021 and 2019 both across the total sample and within sub-groups.

12. However, there are two important considerations when exploring these trends:

    - Changes to the methodology
      - Both the 2024 and 2021 survey were carried out using an online/push-to-web methodology, whereas the 2019 survey was carried out using a face-to face methodology.
    - The impact of the pandemic on awareness and attitudes.

13. The research methodology used does have an impact on results and different methodologies have different strengths and weaknesses. Face-to-face interviews will often get more complete data as the interviewer ensures every question is properly understood and answered in full. However, the presence of an interviewer can also impact responses with respondents, consciously or subconsciously, looking to please the interviewer as well as seem to be a 'good' person. Importantly face-to-face interviewers can persuade people to participate even if they are not interested in the topic and are too busy. A self-completion process may allow a respondent to be more 'honest,' and to spend more time considering their response to a particular question. However, there will be an element of self-selection as those who are interested in the topic, those with time to spare and those more comfortable with being online are all more likely to participate than other groups.

14. A change in methodology therefore means that any changes in attitude between 2024/2021 and 2019 could be real or could be a result of the methodological change. During this report we will discuss changes and trends in data based on the assumption that data is comparable, but the reader should be aware that the change in methodology may have caused or contributed to those changes.

15. The second challenge in writing this report is the impact of the pandemic both on mental health and on the public conversation around mental health. The potential impact on the nation's mental health of a national lockdown with a high number of people facing unemployment or job insecurity has been recognised. The issue has had significant coverage in the media including discussions around the need to focus on mental wellbeing. This is likely to have had much more of an impact on the 2021 survey, however it is likely that long-term effects of the pandemic and subsequent changes in society, particularly in terms of employment and healthcare, are still influencing the way people respond to questions around mental health.

16. An event such as a pandemic has the potential to create a step change in awareness or understanding of mental health, the challenge is to separate out cause and effect. Is an increase in the proportion of people knowing someone with a mental health illness due to an increase in the number of people ***experiencing*** mental distress, an increase in people being ***willing to talk*** about their mental health or an increased ***awareness*** amongst friends and family.

17. It is important to bear in mind that owing to the differences in methodology between 2019 and 2024 and the changes in circumstances since 2021 (in the midst of the pandemic), it is difficult to draw direct comparisons between 2024 and either of the previous two waves of the survey without considering the effects the changes may or may not have had, and whether one change may have more of an effect than the other.

Representativeness

18. As part of the wave 1 analysis and reporting it proved necessary to re-weight the sample data to increase representativeness within Wales. We used six weighting factors: Gender, Age, Welsh Index of Multiple Deprivation, Working Status, Ethnicity and Rural/Urban location. In order to enable the best possible analysis of trends this weighting approach was repeated for wave 2 and again for the 2024 survey.

19. The overall sample profile and weighting can be seen in Appendix 2.

Executive summary

20. The 2024 survey shows that attitudes towards, and tolerance of, mental illness show little sign of improvement and in some respects have declined since 2021. This is despite an increase in those claiming a personal experience and a significant increase in those recalling seeing advertising and campaign material aimed at reducing stigma and discrimination.

21. Attitudes (especially for those aged 16-34) and behaviours towards people with a mental illness, as well as mental health-related knowledge, have all fallen since 2021. Respondents also seem less comfortable discussing their mental health with friends and family, and less likely to visit their GP for help if they felt they had a mental health problem, than respondents from the 2019 or 2021 waves.

22. There are some findings which have remained consistent throughout this series of reports such as women showing more awareness, or over 65s being less open. There is some evidence that higher social grades are better informed and more accepting. Those with a personal experience either directly or indirectly are generally better informed and more accepting of mental health issues.

23. Overall, this report shows there is still a long way to go to eradicate mental health stigma, and it is clear that there is a need for continued mental health stigma work, particularly amongst those aged 65 or above, men and those in lower social grades.

24. It should be noted that this research does not explore self-stigma where an individual feels shame themselves which can potentially inhibit them from disclosing mental health difficulties due to fear of being discriminated against by others. Future waves of this study may wish to explore this issue.

Experience

25. One in five (20%) people had personally experienced a mental health issue, a significant increase from 2021 and 2019 (15% and13% respectively). Over four in five (81%) respondents knew of someone who had experienced a mental health issue at some point in the past, which is similar to 2021 (80%) but significantly more than in 2019 (68%).

26. Around three quarters (76%) had either had a personal experience at some point, or a recent experience (themselves, or through knowing someone who had experienced a mental health problem in the last year) to reflect on when considering their responses. This is a significant increase on the proportion who claimed this in 2021 (66%) and in 2019 (46%). While these results show a clear increase, we cannot know whether this is an increase in incidence rates or an increase in awareness amongst acquaintances.

27. These higher levels of experience raise questions as to why positive attitudes appear to have deteriorated over the last three years. The changes in the percentages around fear and tolerance is perhaps an indicator of a drop in trust towards community-based mental health schemes that may be a contributory factor in greater stigma. There has been widespread media coverage in recent months of crimes committed by people who had a mental illness and had either stopped taking medication or been unable to access help, and it is important to view the results in this context. However, as the survey did not investigate reasons behind attitudes, we cannot be sure what factors have driven the change and further research would be needed to ascertain this. There may be some benefit to a follow-up piece of qualitative research to further explore these drivers and potentially help shape future campaigns to reduce stigma and discrimination.

Attitudes including fear, tolerance and integration

28. This project used the previously developed tools of a CAMI score to measure attitudes, a MAKS score to measure knowledge and a RIBS score to measure intended behaviour. These scores, and how they are calculated is discussed and reported in more depth in the body of the report.

29. The CAMI score is developed from people's responses to twenty-seven statements designed to understand levels of fear, understanding and tolerance alongside attitudes to exclusion, integration and the provision of support services. The higher the score the more positive an individual's attitude to mental illness is. The raw CAMI score in 2024 was 108.9, which is significantly lower than the score in 2021 (113.71) and 2019 (112.97).

30. Sub-groups differences were explored which showed that those with personal experiences or knowledge of mental health problems tended to score more highly than those without such experiences. Socio-economic grade also had an impact with ABC1s receiving a significantly more positive score than C2DEs. These patterns largely reflect those found in 2019.

31. The 2024 survey also shows a widening of the gap between the attitudes of men and women, with the CAMI score for men now significantly lower than for women for the first time. This suggests that campaigns aimed at improving the attitudes of men towards mental illness have not yet had the desired impact and men should remain a key target group for future campaigns.

32. In addition to the overall score the individual attitude statements were divided in to 'fear and exclusion,' 'tolerance and understanding' 'integration' and 'causes' categories. There were some changes compared with 2021.

33. There was an increase in the proportion of people who agreed across six of the eight statements regarding fear. The statement seeing the largest increase was '*it is frightening to think of people with mental problems living in residential neighbourhoods*', with 15% of people agreeing with this compared with 7% in 2021 and 8% in 2019. Recent events involving people with mental illness that have had widespread media coverage may well have contributed to this change in attitude, although it should be remembered that fieldwork will have pre-dated some more recent events.

34. There was a negative change to six of the seven statements regarding tolerance bringing levels back to around the same as in 2019, though generally attitudes are still fairly understanding in this area overall.

35. There was also a significant negative change to seven of the nine statements regarding integration within the community, however, this group of statements attracted a wide range of attitudes. Four statements were agreed with by seven in ten or more respondents. Despite the significant drop in agreement with these statements when compared with 2021 and 2091, this reflects a generally positive attitude towards the right to live and work as an integrated part of the community, with women and those who have had personal experience of mental illness being more likely in general to agree.

36. However, the level of agreement with statements such as '*people with mental illness are far less of a danger than most people suppose*' (65%) '*residents have nothing to fear from people coming into their neighbourhood to obtain mental health services*' are lower (55%) and these have seen the largest falls in agreement (12 and 10 percentage points respectively) since 2021 adding support to the theory that people are now more fearful of the potential actions of those with mental health problems.

Knowledge

37. The MAKS score is developed from people's responses to six statements and relates to knowledge about mental health. The higher the score the better knowledge an individual had demonstrated. The raw MAKS score for the total sample was 22.6, which is a significant drop compared with 2021 (23.0).

38. When we explore MAKS scores by demographic groups we can see some changes within the patterns. Across the three waves, there has been some fluctuations in results by age for those aged under 65, however, trends do suggest a continued lower level of knowledge in the over 65s. There is a clear gender difference in 2024 with men scoring lower than women, a pattern also seen in 2019, but not in 2021. One unchanged feature across all three waves is that ABC1s have better knowledge than C2DEs.

39. Those who had seen or heard adverts scored significantly more highly on this knowledge metric when compared with the overall mean score. This always raises a question around cause and effect, does seeing the campaign increase knowledge or does better knowledge increase the propensity to notice and remember the campaign?

40. Three of the metrics included in the MAKS score show a significant fall in the proportion agreeing when compared with 2021. Notably there has been a fall in the proportion agreeing that psychotherapy (80% down from 86%) and medication (71% down from 76%) can be an effective treatment for people with mental health problems. Women are more likely to agree that medication can be an effective treatment.

41. Women are also more likely than men to agree that they would know how to advise a friend with a mental health problem to get professional help (64% vs 54%). This gender difference also existed in 2021 and 2019 though the proportion agreeing has dropped for both men and women in 2024.

42. Nine out of ten respondents recognised schizophrenia, bipolar disorder, and depression as mental illnesses. However, it is worth noting that the proportion recognising bipolar disorder as a mental illness has fallen compared with 2021 and is now in line with the 2019 result. Only 58% recognise drug addiction as a mental illness. This research does not explore where people gain their information about different mental health conditions, and it would be interesting to explore this further in order to identify the best ways to improve recognition. Time to Change Wales could seek to address this knowledge gap through portraying individuals with these conditions in future public campaigns.

Behaviour

43. The RIBS score is based on agreements with four statements and relates to living with, working with, living near to or continuing a relationship with somebody with a mental health problem. The higher the RIBS score the more appropriate that person's behaviour is. The raw RIBS score was 16.5, a significant decrease compared with 2021.

44. Despite falls in scores since 2021, the RIBS scores amongst the younger age groups remain higher than for the older age groups supporting findings elsewhere regarding improved understanding and awareness amongst the under 35 age group.

45. As previously, ABC1s remain significantly more willing to behave positively than C2DEs. In 2024 the RIBS score for men is significantly lower than for women, a difference which was not evident in 2021.

46. Considering the individual statements used to calculate the RIBS score, there has been a significant decrease in agreement with three of the four statements when compared with 2021, with an indicative (not significant) drop in agreement with being willing to live with someone with a mental health problem. This indicates that the positive change in behaviours seen in 2021 has not been sustained.

47. As with other metrics, ABC1s, and those with greater knowledge, either through personal experience or because of someone they know, generally resulted in significantly higher levels of agreement with these statements. Those aged under 35 are the most likely group to agree that they would be willing to live with someone with a mental health problem, while those 65+ are the least likely.

Talking about mental health

48. The questionnaire included a series of questions which explored people's openness in discussing their own mental health with a health professional, employers and friends and family. Following a substantial negative change between 2019 and 2021, the 2024 results remain broadly in line with those seen in 2021. The pandemic is no longer a day-to-day issue for most, but there is little to no sign of a return to 2019 levels. This might suggest that the pandemic has had long-lasting effects on people's willingness to discuss mental health issues, or it could indicate that research is needed to understand whether other factors are having an impact.

49. Only around three in five (62%) said they would be likely to ask their GP for help if they felt they had a mental health problem, while this is not a significant change since 2021 (66%), it now sits 18 percentage points lower than in 2019. The result for the over 65s has declined significantly by 22 percentage points compared with the previous wave. Such a fall, particularly amongst older people, is a clear concern, and while it seems highly likely that the pandemic was a factor in the initial change, other research may help to understand why results are not showing signs of recovery.

50. While there has been little change, those aged 16-34 remain significantly less likely to visit their GP to discuss a mental health problem and encouraging young people to visit the GP remains a key challenge.

51. In 2024 around half (49%) would feel comfortable having this discussion with friends or family, with just under a fifth (18%) feeling very comfortable. This result is similar to that seen in 2021, but remains significantly lower than in 2019, when over three in five (63%) stated they would be comfortable. Men, and C2DEs remain significantly less likely than women to feel comfortable talking about a mental health problem to a friend or family member. It is likely that the long-term effects of the pandemic have a significant part to play in these results, however it suggests that Time to Change Wales needs to continue to help to normalise discussions around mental health, particularly within family settings.

52. In 2024, only around three in ten (29%) would be comfortable having this discussion with their current or prospective employer, while six in ten would feel uncomfortable (60%). Following a significant fall between 2021 (23%) and 2019 (40%), the proportion who would feel comfortable having this discussion with their employer has recovered significantly since 2021, however it continues to remain below 2019 levels. Further, the proportion of over 65s saying they would feel comfortable talking to their employer about mental health has fallen with each wave. This is such a substantial change it seems that the pandemic, which has occurred between these two waves must have had some influence. This is an area which merits further attention and perhaps more research to understand the change in attitudes.

Treatment of those with mental health problems

53. Amongst those who knew somebody experiencing a mental health problem in the past twelve months, the majority agree they had been treated fairly or even more positively because of their illness. However, these figures are significantly lower across four of the scenarios (getting help for a physical problem, finding a job, keeping a job and in education) than in 2021.

54. The maintained increase in the number perceiving a person as being treated unfairly by mental health professionals since 2019 (from 4% to 15% in 2021 and 12% in 2024) is still a potential cause for concern. It is possible that accessing care has been made more difficult during the pandemic and lower levels of access or even a 'postcode lottery' level of access is being seen as unfair. Further research may be necessary to understand what has driven this increase.

Other attitudes to mental health

55. The 2024 questionnaire asked respondents to imagine three hypothetical scenarios where an employee applied for a promotion after spending repeated periods of time off work with a health condition – either depression, schizophrenia, or diabetes – which was now being controlled by medication.

56. Results suggested differing attitudes towards physical and mental health problems in the workplace. For all three of the conditions, a sizeable proportion felt that the person would be either 'much less' or 'slightly less likely' to receive the promotion than their colleagues. However, these proportions were higher for depression and schizophrenia (72% and 73%) than for diabetes (38%). Similarly, while more than half felt that somebody who had experienced time off with diabetes was 'just as likely' to be promoted as anyone else (53%), only small minorities felt this would be true for the employee with depression (17%) or schizophrenia (13%).

57. The 2024 questionnaire also asked a series of questions to gauge attitudes and awareness around schizophrenia. The results suggest that relatively few respondents feel that people with schizophrenia 'have themselves to blame', that 'they can pull themselves together', and that 'they are hard to talk to'. However, somewhat higher proportions feel people with schizophrenia may be 'a danger to others', be 'unpredictable', or 'feel differently to others'. This was particularly pronounced for those who had never had a mental health problem, and those in lower social grades.

58. A relatively high level of 'don't know' and middle ground/neutral responses given to several of these questions suggests some lack of understanding or awareness of the condition. This suggests there would be some benefit to a campaign to improve understanding of schizophrenia amongst the general public.

59. Finally, the questionnaire asked to what extent respondents would be willing or unwilling to have various social interactions or relationships with two hypothetical individuals, Gareth and Stephen, who have recently been displaying symptoms of schizophrenia and depression respectively.

60. Results showed there is still some stigma associated with these conditions, particularly with regards to closer relationships, and more so with schizophrenia than with depression. Most respondents would be willing to know Gareth or Stephen as workmates or social acquaintances, or to have them as friends, although they would generally be more willing to engage with Stephen (i.e. a person who had symptoms of depression), than with Gareth (i.e. one who showed symptoms of schizophrenia).

61. Respondents would be far less willing to let Gareth or Stephen provide childcare for somebody in their family (15% and 24% respectively) or have them marry into their family (35% and 46%). While two in three (67%) would be willing for Stephen to move next door to them, less than half (43%) felt this way about Gareth.

62. Women and those aged 16-34 were generally more willing to engage with Gareth and Stephen, although it is clear that there is still work to be done to reduce stigma towards mental illness amongst all sub-groups of the population, and particularly with regards to more serious mental health conditions such as schizophrenia.

Campaign awareness

63. Respondents were shown a number of campaign materials which had been used by TtCW since the 2021. Three in ten (30%) recalled the adverts and a further 27% remembered "similar" adverts, meaning that overall, over half (57%) recalled campaign adverts – significantly higher than 2021 (48%) and 2019 (35%). This increase is clearly a positive finding for the campaign and the steady growth suggests that awareness is building over time as the campaigns build on previous iterations.

64. As in previous waves, there was a lower level of recall amongst over 65s. Whilst this may be an ongoing cause for concern, it is positive to note a continued improvement in awareness among this group: just under half (48%) recalled adverts in 2024, compared with 35% and 20% respectively in previous waves.

65. Encouragingly, the level of recall among C2DEs, and those who do not have personal experience of a mental health problem have also increased significantly in 2024, narrowing the gap between sub-groups in these areas.

Attitudes to mental illness

66. The survey included twenty-seven statements on a range of attitudes towards mental illness. The statements have been previously developed by the Department of Health in England and build on a number of previous studies[2].

67. For each of the twenty-seven statements respondents were asked to give their opinion using a five-point scale from 'Agree Strongly' to 'Disagree Strongly'. The order in which respondents saw the statements was rotated to ensure there was no order effect on agreement levels.

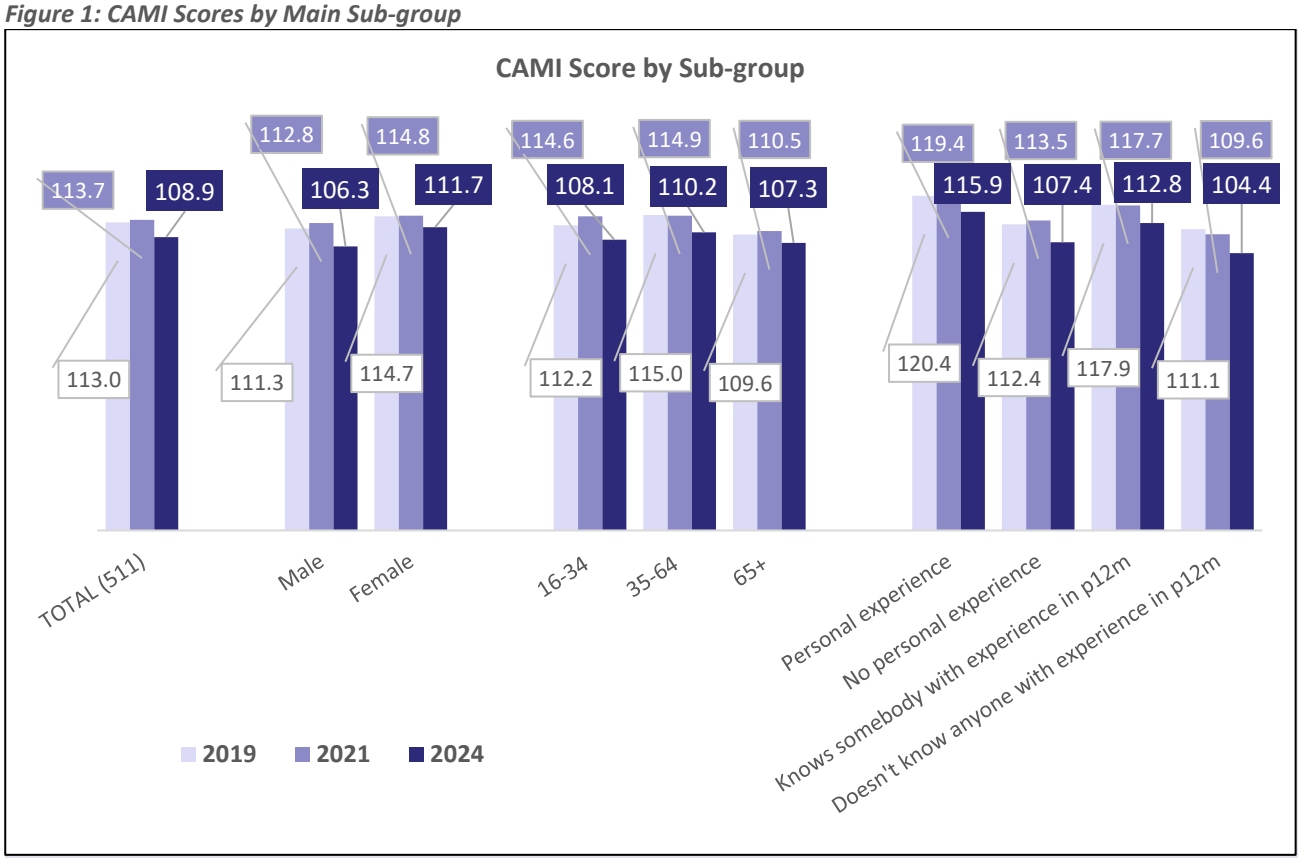
Community Attitudes to Mental Illness (CAMI) scores

68. An agreed approach to summarising and reporting this data has been developed which is referred to as the CAMI score. This is calculated by summing scores for each respondent across the various CAMI statements (by allocating a score of 5 to the most positive response, down to 1 for the least positive). More information on the process used to derive CAMI scores can be found in Appendix 4.

69. In this process, the higher the score the more positive the attitude of that person, or that sub-group of people is towards mental illness. The maximum score would be 135 (=27 x 5) and the minimum score would be 27 (=27 x 1).

70. Overall, the mean CAMI for Wales score was **108.9,** a decrease of 4.8 compared with 2021 and 4.1 compared with 2019**.** The drop in the score of 4.8 between 2021 and 2024 is statistically significant.

Figure 1: CAMI Scores by Main Sub-group



Base: All respondents (2019=511, 2021=851, 2024=526)

[2] M. Taylor, M. Dear, "Scaling Community Attitudes Toward the Mentally Ill" Schizophrenia Bulletin, 7(2), 1981, 225-240 (accessible via https://camiscale.com)

71. When we explored results by age in 2024, we saw that those aged 35-64 had a more positive attitude than both younger and older people; a similar pattern to that seen in the 2019 results, while the 2021 results showed all those aged under 65 having a significantly more positive attitude than the over 65s. There has been a significant decrease in the CAMI scores across all age groups in 2024, though more so in the 16-34 age group (6.5 score decrease) and less so in the 65+ age group (3.2 score decrease). This suggests that any potential increase in positive attitudes across younger people seen in 2021 was likely connected to the wider conversations around mental health during the pandemic, and this has not been sustained over the last three years.

72. The importance of experience can be clearly seen to have an impact on attitudes. Those with personal experience demonstrated a significantly more positive attitude when compared with all other groups, and those without personal experience significantly less positive (115.9 v 107.4). Exposure to somebody with personal experience also resulted in a more positive attitude. This pattern is unchanged since 2019.

73. The gap between the attitudes of men and women has widened to 5.4 and is statistically significant for the first time (111.7 v 106.3). The CAMI score for men dropped significantly from 112.8 in 2021 to 106.3 in 2024, and while the CAMI score for women has also seen a significant decrease, the fall is less pronounced (from 114.8 in 2021 to 111.7 in 2024).

74. We explored other sub-group factors which are shown in Figure 2 . Those who were retired had a less positive attitude than other groups – this clearly correlates with the finding for those aged 65+.

75. Socio-economic grade also had an impact with ABC1s receiving a significantly more positive score when compared with all people, and C2DEs significantly less positive. We also explored Welsh Index of Multiple Deprivation (WIMD) however, the individual sample sizes are fairly small making significant differences difficult – and no significant differences across deprivation groups are evident in the 2024 results. In this report we will mainly use the grouped socio-economic grades to explore differences that are likely to be connected to income and circumstances.

76. In 2024, Black, Asian and other Ethnic minority respondents had a CAMI score of 101.7 compared with 109.4 for white respondents. However, the non-white sample was small with just twenty-three respondents making it difficult to draw conclusions.

77. When making comparisons with 2021 scores almost all groups have seen a significant decrease (with no group seeing an increase). In general, men, those aged 16-34, those who are working, those living in urban areas, those who are single, and those with no personal experience of mental illness all saw the largest drops in their CAMI scores. Conversely those aged 55+ and those who are retired saw no significant change.

78. Those living in urban locations have seen one of the largest significant decreases in their CAMI score (5.5 points) however, as seen in 2021, neither the CAMI score for those living in urban areas or the CAMI score for those living in rural areas is significantly different to the overall score.

Figure 2: CAMI scores by sub-groups

Factor	Sub-Group	2019	2021	2024
Working Status	Working	113.92	114.63	108.62
	Retired	109.80	110.56	107.95
	Non-working	114.55	115.29	110.48
Social Grade	ABC1	115.14	116.00	111.82
	C2DE	111.50	111.36	105.98
WIMD	1 Most deprived	111.90	113.36	108.48
	2	110.96	112.05	109.22
	3	112.61	113.70	108.04
	4	113.75	113.85	109.09
	5 Least deprived	115.28	115.72	109.51
Location	Rural	114.85	113.32	110.01
	Urban	112.01	113.90	108.36
Ethnicity	White	113.32	113.93	109.42
	Non-white	104.48	109.08	101.70
Welsh Speaking	Welsh speaking (fluent & non fluent)	115.27	114.38	109.19
	Not Welsh speaking (inc. learners)	112.40	113.55	108.89

79. A fuller summary of scores by sub-groups can be seen in Appendix 5.

Fear and exclusion of people with mental illness

80. In addition to the overall CAMI score, the twenty-seven statements have been sub-divided into four categories which look at attitudes in more detail. The first group of eight statements focus on fear and exclusion and are listed below. Six of these metrics (in bold) have seen a significant increase when compared with 2021:

- **It is frightening to think of people with mental problems living in residential neighbourhoods**
- Locating mental health facilities in a residential area downgrades the neighbourhood
- **Anyone with a history of mental problems should be excluded from taking public office**
- I would not want to live next door to someone who has been mentally ill
- **As soon as a person shows signs of a mental disturbance, they should be hospitalised[3]**
- **People with mental illness should not be given any responsibility**
- **A person would be foolish to marry someone who has suffered from mental illness, even though they seem fully recovered[4]**
- **People with mental illness are a burden on society.**

81. As can be seen in Figure 3, while the proportions agreeing with each statement remain low, some trends are starting to emerge across the three waves with some statements showing a gradual increase in agreement, while others that showed signs of improvement (lower levels of agreement) in 2021 are now showing significantly higher levels of agreement than in 2019.

[3] Wording updated for 2024 survey – previous wording: As soon as a person shows signs of a mental disturbance, **he** should be hospitalised

[4] Wording updated for 2024 survey – previous wording: **A woman** would be foolish to marry **a man** who has suffered from mental illness, even though **he** seems fully recovered.

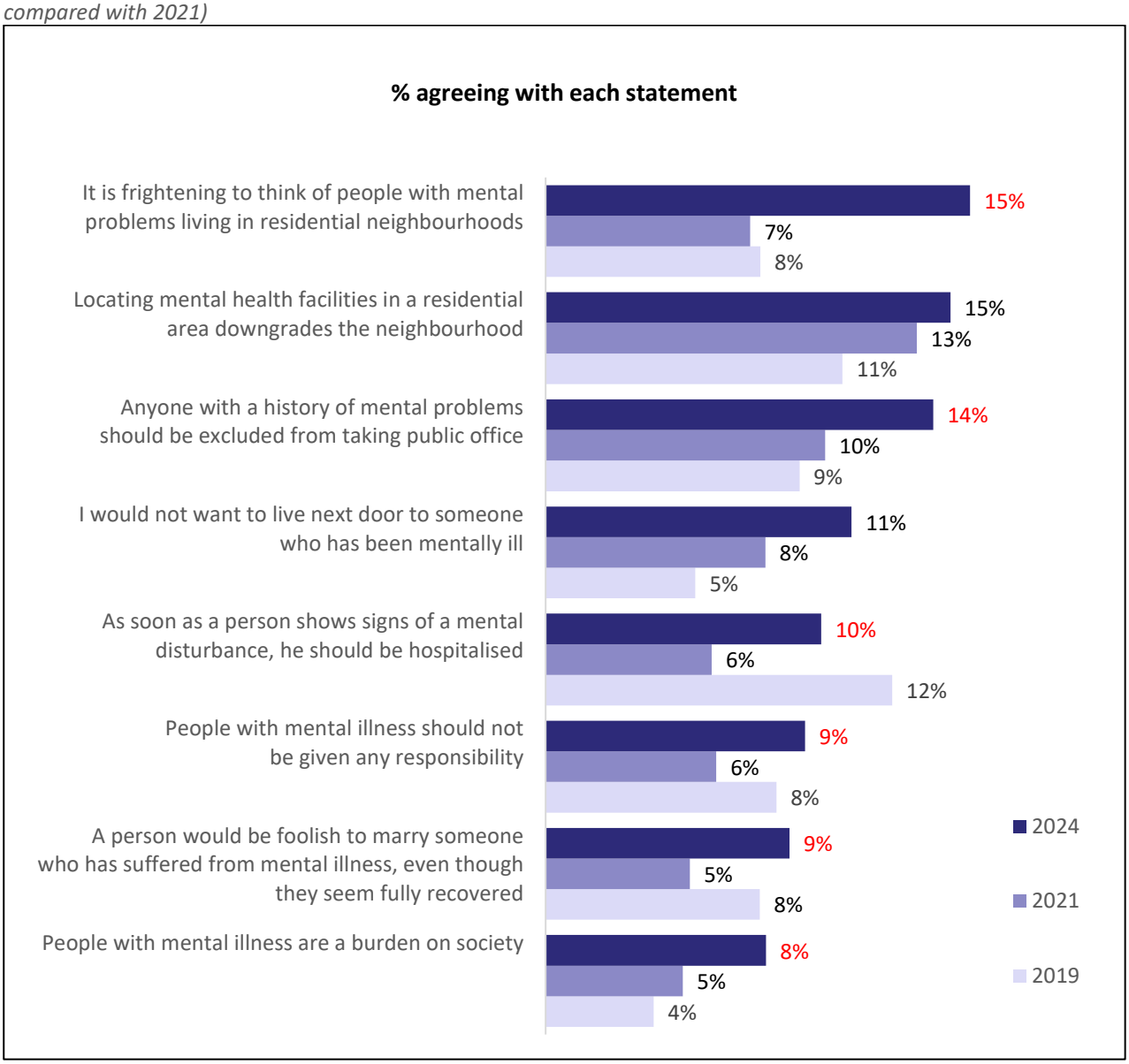
82. No statement showed a lower level of agreement when compared with 2021. The level of agreement has fallen for one statement (*as soon as a person shows signs of a mental disturbance, they should be hospitalised*) since 2019 (10% in 2024 vs 12% in 2019).

83. The statement with the largest increase in agreement is '*it is frightening to think of people with mental problems living in residential neighbourhoods*', with 15% of people agreeing with this compared with 7% in 2021 and 8% in 2019.

84. There were some sub-group differences across all these statements with women, ABC1s and younger people generally being less likely to agree. On almost all metrics experience reduced the propensity to agree. This has remained consistent with previous years.

85. Despite the overall increase in the proportion of respondents agreeing '*it is frightening to think of people with mental health problems living in residential neighbourhoods*' there were significant differences between subgroups, 20% of men, 20% of those who are a parent/guardian of a child under 18 and 17% of those who are married agreed with this statement, in each case significantly higher than their parallel group.

Figure 3: Level of Agreement with fear and exclusion statements *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511; 2021~851; 2-24~526)

Understanding and tolerance of mental illness

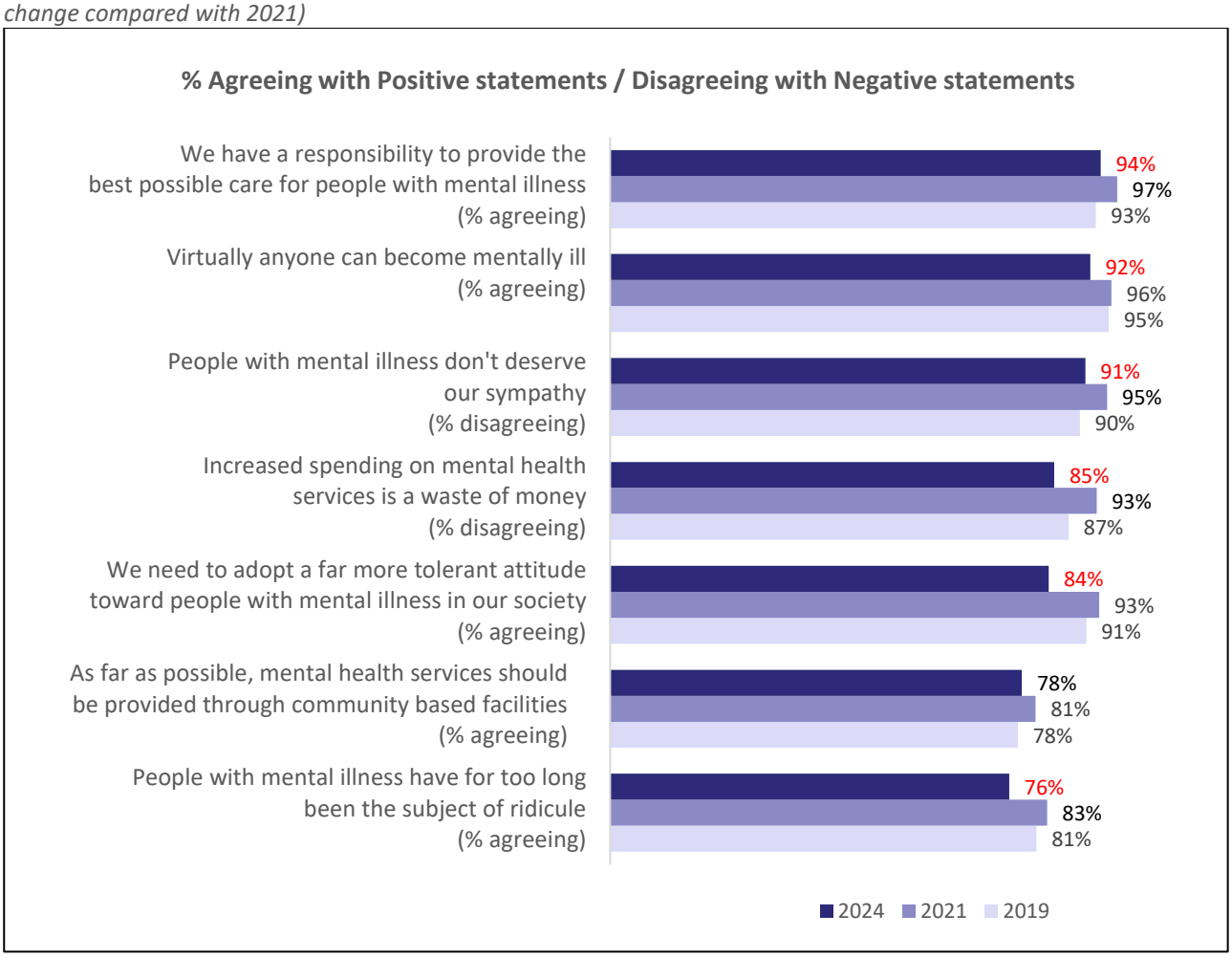
86. The second group of statements focus on understanding and tolerance and relate to the seven statements listed below. Two of these statements were framed in a negative way and therefore analysis and reporting focuses on the proportion disagreeing rather than agreeing with the statement.

87. Six of these metrics (in bold) have seen a significant decrease when compared with 2021:

- **We have a responsibility to provide the best possible care for people with mental illness**
- **Virtually anyone can become mentally ill**
- **People with mental illness don't deserve our sympathy (% disagreeing)**
- **Increased spending on mental health services is a waste of money (% disagreeing)**
- **We need to adopt a far more tolerant attitude toward people with mental illness in our society**
- As far as possible, mental health services should be provided through community-based facilities
- **People with mental illness have for too long been the subject of ridicule.**

88. Overall, attitudes are fairly understanding with more than nine in ten agreeing (or disagreeing with negative statements) with the first three statements, whilst more than eight in ten agreed with the next two statements, and more than three quarters agreed with the last two statements. However, there has been a significant drop in agreement across all but the last statement when compared with 2021, bringing levels back to the levels seen in 2019, or in some cases even lower.

Figure 4: Level of Agreement with understanding and tolerance statements *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

89. The statements that have seen the biggest drop in agreement since 2021 are '*we need to adopt a far more tolerant attitude towards people with mental illness in our society*' (a decrease of ten percentage points compared with 2021 and seven percentage points compared with 2019 – both significant), and '*people with mental illness have for too long been the subject of ridicule*' (a decrease of seven percentage points compared with 2021 and a decrease of five percentage points compared with 2019 – both significant).

90. Compared with all respondents, women were more likely to agree that people with mental illness have for too long have been the subject of ridicule, that we need to adopt a far more tolerant attitude, that virtually anyone can become mentally ill, and that we have a responsibility to provide the best possible care. They are also more likely to disagree that that spending on mental health services was a waste of money.

91. Those who had either experienced a mental health problem themselves or known someone who has within the last year are also more likely to agree with most of the positive statements and disagree with the negative statements.

92. Those who are retired are significantly more likely to believe that mental health services should be provided through community care.

Integration with the community

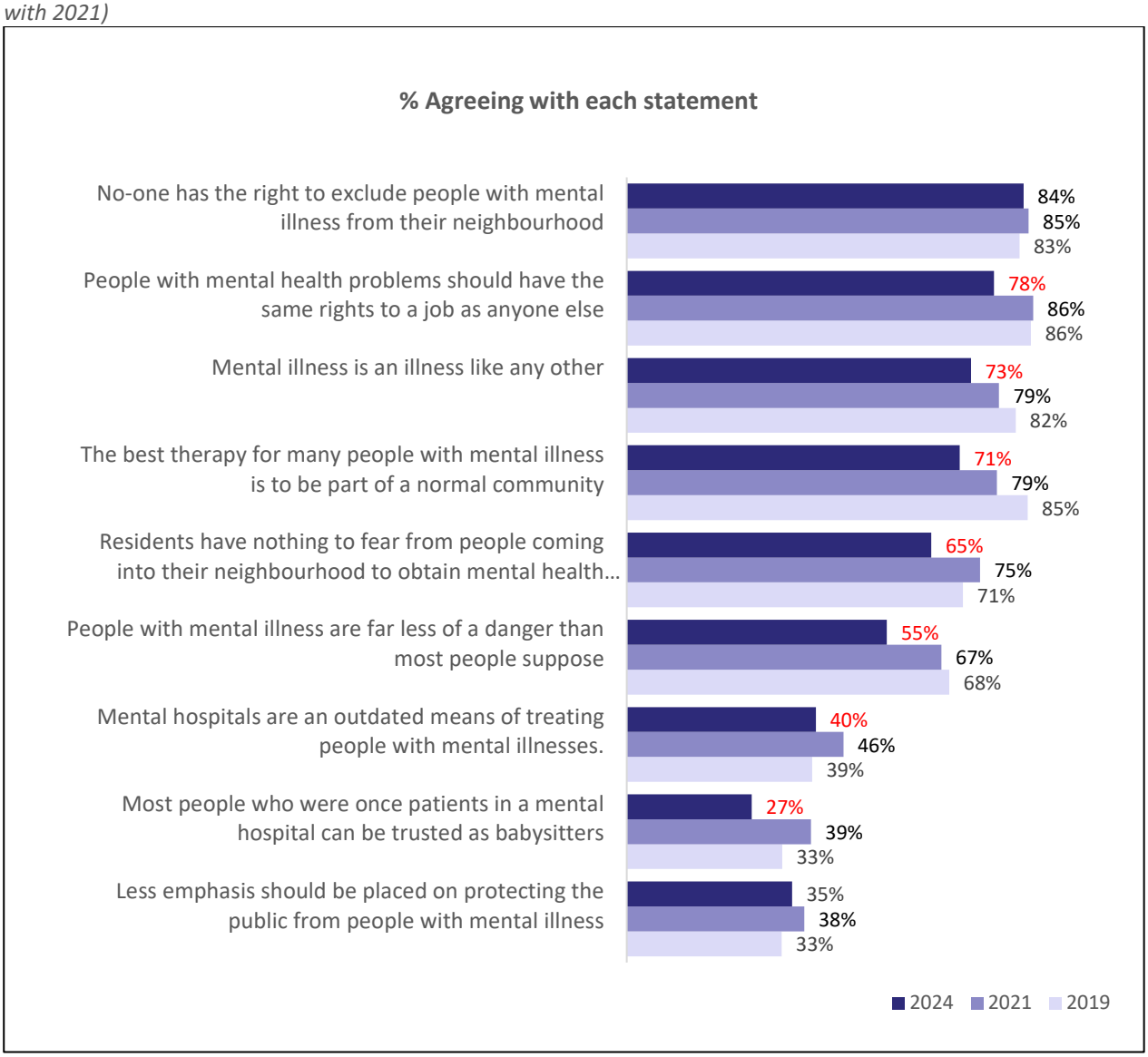
93. The next set of statements relate to integration within the community and includes the nine statements listed below. Seven of these metrics (in bold) have seen a significant decrease when compared with 2021:

- No-one has the right to exclude people with mental illness from their neighbourhood
- **People with mental health problems should have the same rights to a job as anyone else**
- **Mental illness is an illness like any other**
- **The best therapy for many people with mental illness is to be part of a normal community**
- **Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services**
- **People with mental illness are far less of a danger than most people suppose**
- **Mental hospitals are an outdated means of treating people with mental illnesses.**
- **Most people who were once patients in a mental hospital can be trusted as babysitters**[5]
- Less emphasis should be placed on protecting the public from people with mental illness.

94. This group of statements attracted a wide range of attitudes. The first four statements were agreed with by seven in ten or more respondents. This reflects a generally positive attitude towards the right to live and work as an integrated part of the community, with women and those who have had personal experience of mental illness being more likely in general to agree. However, three of these four statements have seen a significant decrease in the level of agreement when compared with both 2021 and 2019 results.

[5] Wording updated for 2024 survey – previous wording: Most **women** who were once patients in a mental hospital can be trusted as babysitters.

Figure 5: Level of Agreement with integration statements *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

95. There have also been significant changes in a negative direction for a further four statements. Notably, there has been a decrease of ten percentage points or more in the proportion of people who agree '*residents have nothing to fear from people coming into their neighbourhood to obtain mental health services*' (10 percentage points), '*people with mental illness are far less of a danger than most people suppose*' (12 percentage points) and '*most people who were once patients in a mental hospital can be trusted as babysitters*' (12 percentage points) suggesting that people are now more fearful of the potential actions of those with mental health problems. This is possibly driven by incidents involving people with mental illness reported in the news over recent years.

96. Sub-group analysis shows that again, women, those who have experienced a mental health problem themselves and those who know someone who has done in the last year are significantly more likely to agree with the statements about babysitters and those with mental illness being less of a danger than people suppose. However, the fall in agreement with these statements overall does not align with the increases seen across the three survey waves in the proportion of people saying that they have experienced a mental health problem themselves or have known someone who has had a mental health problem within the last year. This suggests that there are a wider range of factors involved in driving this change and would warrant further investigation.

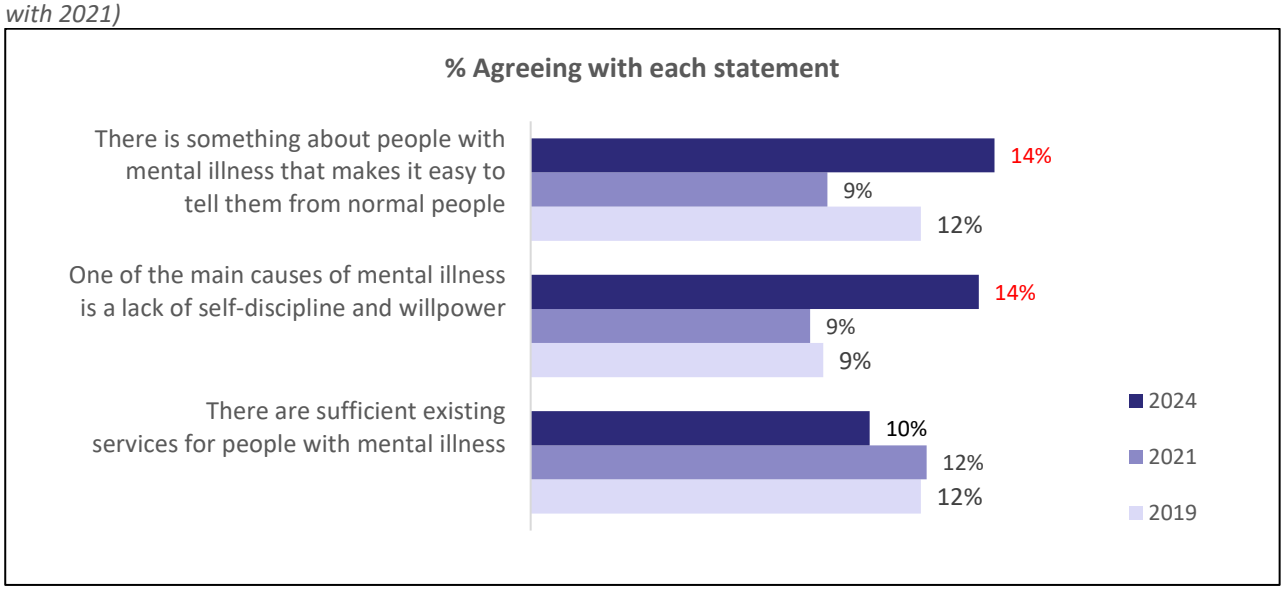
Causes of mental illness and the need for special services

97. Just three statements form the final group, and these are focused on the causes of mental illness and the need for special services. Two of these metrics (in bold) have seen a significant decrease when compared with 2021:

- **There is something about people with mental illness that makes it easy to tell them from normal people**
- **One of the main causes of mental illness is a lack of self-discipline and willpower**
- There are sufficient existing services for people with mental illness.

98. Just ten percent (12% in 2021 and 2019) consider that there are sufficient existing services for people with mental illness. This suggests there is a recognition that services can be over-stretched which is perhaps not surprising considering the wider discussions around mental health services in recent years. This belief is more prevalent amongst younger people (16-34: 18%; 35-64: 7%; 65+:8%) and those living in urban areas than those living in rural areas (13% v 5%). Given that those living in rural areas are likely to have to travel further to access mental health services it is not surprising that this group are less likely to feel current services are sufficient.

Figure 6: Level of Agreement with causes and services *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2021~851; 2019~511; 2024~526)

99. A relatively small proportion (14%) believe that people with a mental illness can be easily identified. This is a significant change from 2021 (9%) but not from 2019 (12%). The belief is more prevalent amongst men than women (19% v 9%) and C2DEs than ABC1s (20% v 9%).

100. There has also been a significant increase in the proportion who perceive mental illness as being related to a lack of discipline and willpower (14% in 2024 v 9% in both 2021 and 2019). This belief is more prevalent amongst men that women (18% v 10%) and those living in urban areas than those living in rural areas (18% v 6%).

101. These results indicate a lack of understanding mental illness, and the causes of mental illness, amongst men in particular; a trend that is apparent across all three survey waves.

Understanding of mental health

Mental health-related knowledge scale (MAKS)

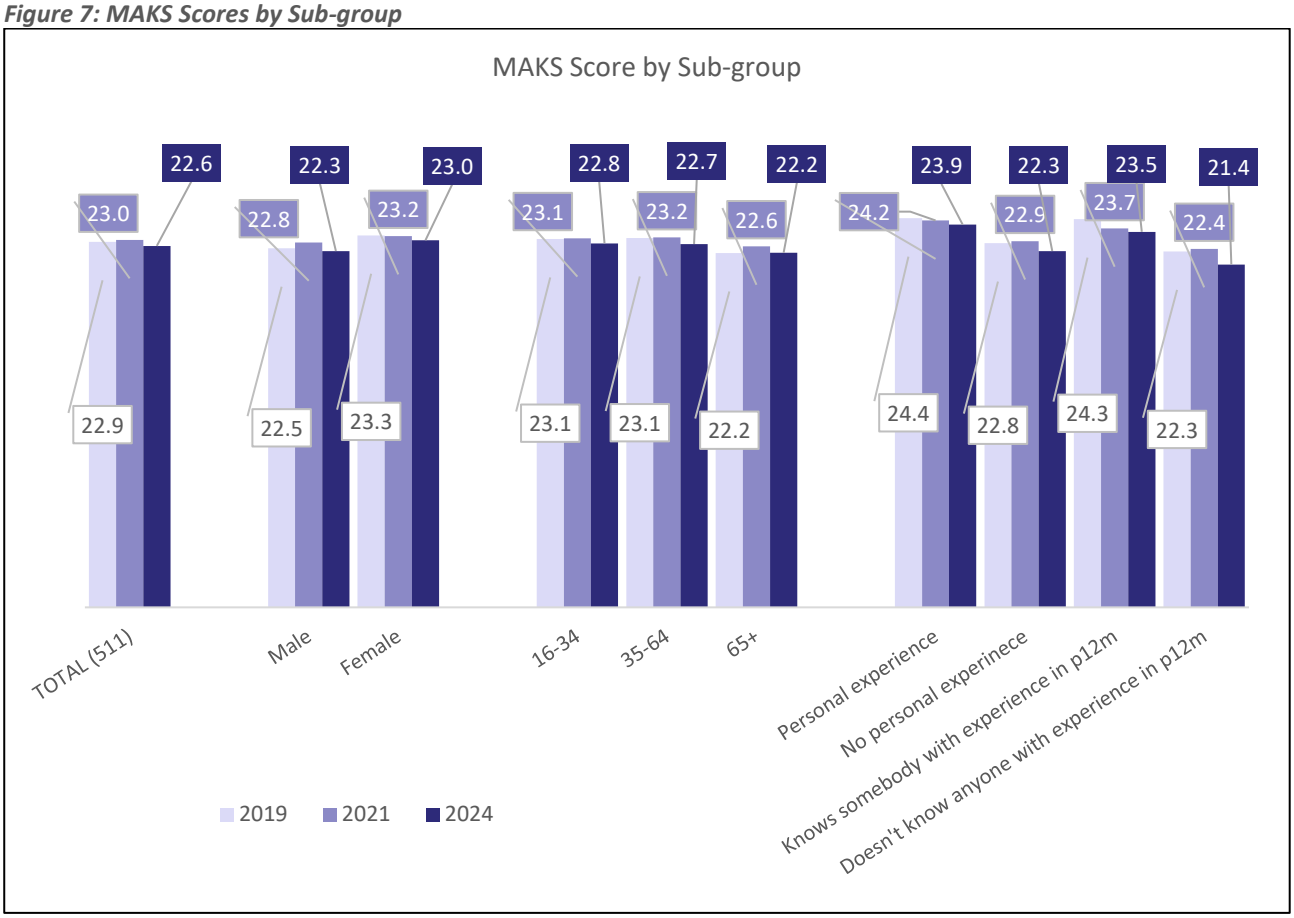
102. Respondents' knowledge of mental-health related issues was explored using a series of statements which have been developed by the Department of Health over recent years to provide a 'MAKS' score[6]. As with the CAMI score, respondents were asked to give their opinion on each statement using a five-point scale from 'Agree Strongly' to 'Disagree Strongly'. The order in which respondents saw the statements was rotated to ensure there was no order effect on agreement levels.

103. The MAKS score is calculated by summing scores for each respondent across six statements (relating to employment, advice-giving, treatment, support and recovery). More information on the process used to derive MAKS scores can be found in Appendix 4.

104. In this process, the higher the score the more knowledgeable the respondent, or sub-group of respondents are about mental illness. The maximum score would be 30 (=6 x 5) and the minimum score would be 6 (=6 x 1).

105. Overall, the mean MAKS score was **22.6** - a decrease of 0.4 compared with 2021 and 0.3 compared with 2019. The drop in score of between 2021 and 2024 is statistically significant.

Figure 7: MAKS Scores by Sub-group



Base: All respondents (2019=511, 2021=851, 2024=526)

[6] Evans-Lacko, S; Little K; Meltzer H; Rose D; Rhydderch D; Henderson C; Thornicroft G. Development and Psychometric Properties of the Mental Health Knowledge Schedule (MAKS) (Canadian Journal of Psychiatry 2010 Jul; 55, 440-448.)

106. In 2019 men scored significantly lower than women on this knowledge-based metric, however this significant difference was not present in 2021. In 2024 women again score significantly higher on this metric suggesting there is still a gender difference. There has been a slight decrease in score for both men and women since 2021, though neither difference is significant.

107. When the MAKS score is explored by age, those aged 25-34 score significantly higher compared to the overall mean score. In 2019 those under 65 scored significantly higher than over 65s and in 2021 only those aged 35 – 64 scored significantly higher than the over 65s. While it is difficult to identify a definite trend based on these results, it does suggest a continued lower level of knowledge in the over 65s and possibly in the knowledge of 16–24-year-olds when compared to 25–64-year-olds.

108. When we look by socio-economic groupings, we see the same pattern as in 2021 and 2019 with C2DEs scoring lower than ABC1s.

109. As before, exposure to mental health issues significantly increases knowledge whether that is through a personal experience of mental health issues or knowing somebody else with an issue.

110. Those who had seen or heard adverts scored significantly more highly on this knowledge metric when compared with the overall mean score. This always raises a question around cause and effect, does seeing the campaign increase knowledge or does better knowledge increase the propensity to notice and remember the campaign?

111. In terms of differences when compared with 2021 there are few significant changes, however the most notable are a drop from 23.44 to 22.16 for those in the least deprived WIMD group (5), a drop from 22.43 to 21.45 for those with have not known someone who has experienced a mental health problem in the last 12 months, and a drop from 22.92 to 22.30 for those who have had no personal experience of mental illness. There were no significant differences between 2021 and 2019 when considered by sub-groups.

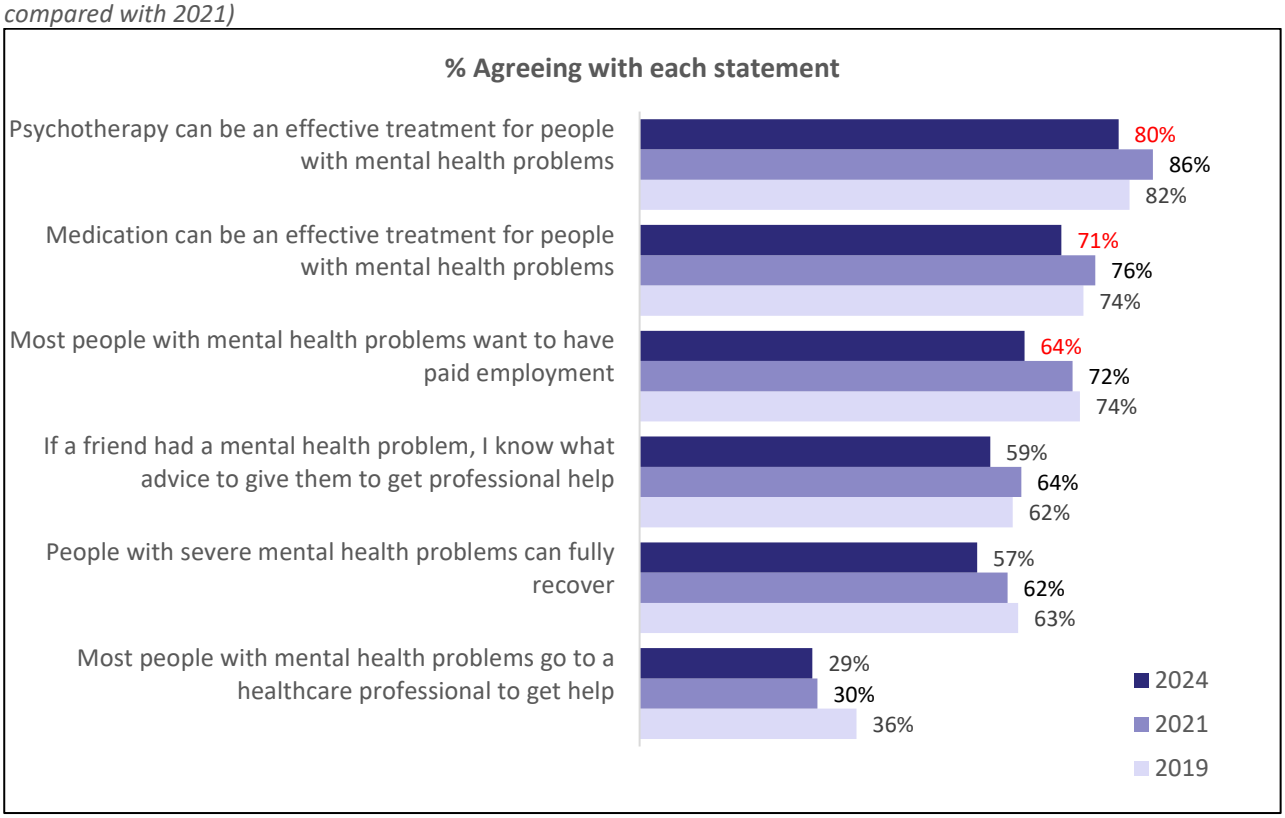
Figure 8: MAKS scores by sub-groups

Factor	Sub-Group	2019	2021	2024
Age	16-24	22.59	22.99	22.20
	25-34	23.47	23.19	23.38
	35-44	23.30	23.04	22.77
	45-54	23.32	23.28	22.87
	55-64	22.72	23.10	22.59
	65-74	23.02	22.64	22.20
	75+	20.97	22.52	22.18
Social Grade	ABC1	23.41	23.42	23.07
	C2DE	22.51	22.55	22.19
WIMD	Most deprived - 1	22.54	22.95	22.70
	2	22.53	22.57	23.09
	3	23.30	22.99	22.69
	4	22.48	23.05	22.41
	5	23.35	23.44	22.16
Campaign awareness	Seen or heard ads	23.75	23.60	23.07
	Seen or heard similar	23.71	23.66	22.62
	Not seen	22.34	22.55	22.32

112. The statements included in the MAKS score are shown below. Three of the metrics (in bold) show a significant fall in the proportion agreeing when compared with 2021:

- **Psychotherapy can be an effective treatment for people with mental health problems**
- **Medication can be an effective treatment for people with mental health problems**
- **Most people with mental health problems want to have paid employment**
- People with severe mental health problems can fully recover
- If a friend had a mental health problem, I know what advice to give them to get professional help
- Most people with mental health problems go to a healthcare professional to get help.

Figure 9: Proportions in agreement with each MAKS statement *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

113. Four fifths (80%) agreed with the statement that psychotherapy could be an effective treatment, whilst over seven in ten (71%) agreed that medication can be effective and over three fifths (64%) that most people want employment.

114. Notable changes since last year were significant falls in the proportion of people agreeing that psychotherapy (80% down from 86%) and medication (71% down from 76%) can be an effective treatment for people with mental health problems. As in 2021, women are more likely to agree that medication can be an effective treatment, however differences by social grade and age are no longer apparent.

115. There has also been a significant decrease (71% v 76% in 2021) in the proportion of people agreeing that most people with mental health problems want to have paid employment. The overall fall in agreement with this statement appears to be mainly driven by a large fall in agreement amongst older age groups (amongst those aged 65 or more agreement fell by 14 percentage points and for those who are retired agreement fell by 17 percentage points).

116. Agreement with the remaining three statements are lower than first three, with less than three in five agreeing they would know what advice to give to a friend with mental health problems (59%) and that people with severe mental health problems can never fully recover (57%), and less than three-in-ten

agreeing that most people with mental health problems go to a healthcare professional to get help (29%). However, knowledge and understanding in these areas is relatively static with all three metrics remaining in line with 2021 results, and only the final statement seeing a significant change compared with 2019.

117. In 2024 there are a number of differences by social grade with ABC1s more likely to agree people can make a full recovery (61% v 57% overall) and more likely to see medication as an effective treatment (77% v 71% overall), mirroring the 2021 results.

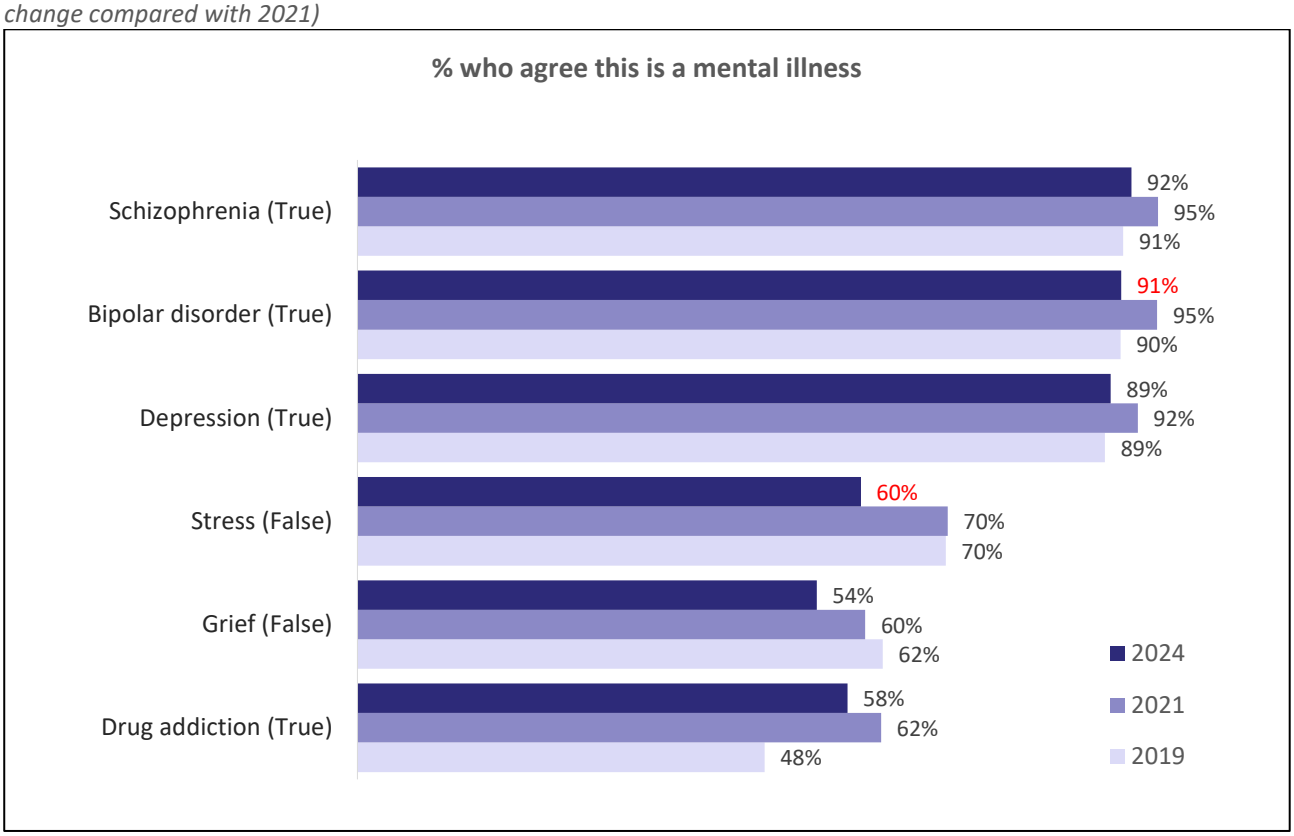
118. When looked at by gender, more than three fifths (64%) of women agreed that they would know how to advise a friend with a mental health problem to get professional help, whilst only 54% of men agreed. This gender difference also existed in 2021 and 2019 though the proportion agreeing has dropped for both men and women in 2024.

Identifying different types of mental illnesses

119. Respondents were asked whether they would agree that each of six named conditions were a type of mental illness. Schizophrenia, bipolar disorder, and depression were all identified as a mental illness by around nine out of ten. However, it is worth noting a significant decrease since 2021 (of 4 percentage points) in the proportion recognising bipolar disorder as a mental illness, bringing the result back in-line with the 2019 result. Our research does not enable us to identify why or how decreases in recognition have occurred but do suggest that some external factors have impacted awareness.

120. There has also been a significant decrease (60% vs 70% in 2021) in the proportion believing that stress is a mental illness. Again, it is difficult to ascertain the reason(s) for this change, however as stress is not generally considered to be a mental illness, it may suggest that some public perceptions are moving closer to those of health care professionals.

Figure 10: Proportions agreeing that each problem is a mental illness. *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

121. When we reviewed the data by social grade some differences emerged with ABC1s are significantly more likely to see schizophrenia (95% vs 89%) and bipolar disorder (95% vs 87%) as a mental illness compared with C2DEs.

122. Women were more likely than men to see stress (65% vs 55%) and drug addiction (66% vs 52%) as mental illnesses when compared to men.

Behaviour around mental health issues

Reported and Intended Behaviour scale (RIBS)

123. Intended behaviour was measured using the 'RIBS' scores. As with the previous scales reported, RIBS has been developed via previous academic research as providing a useful measurement tool. In this case, it relates to four statements relating to living with, working with, living nearby, and continuing a relationship with somebody with a mental health problem.

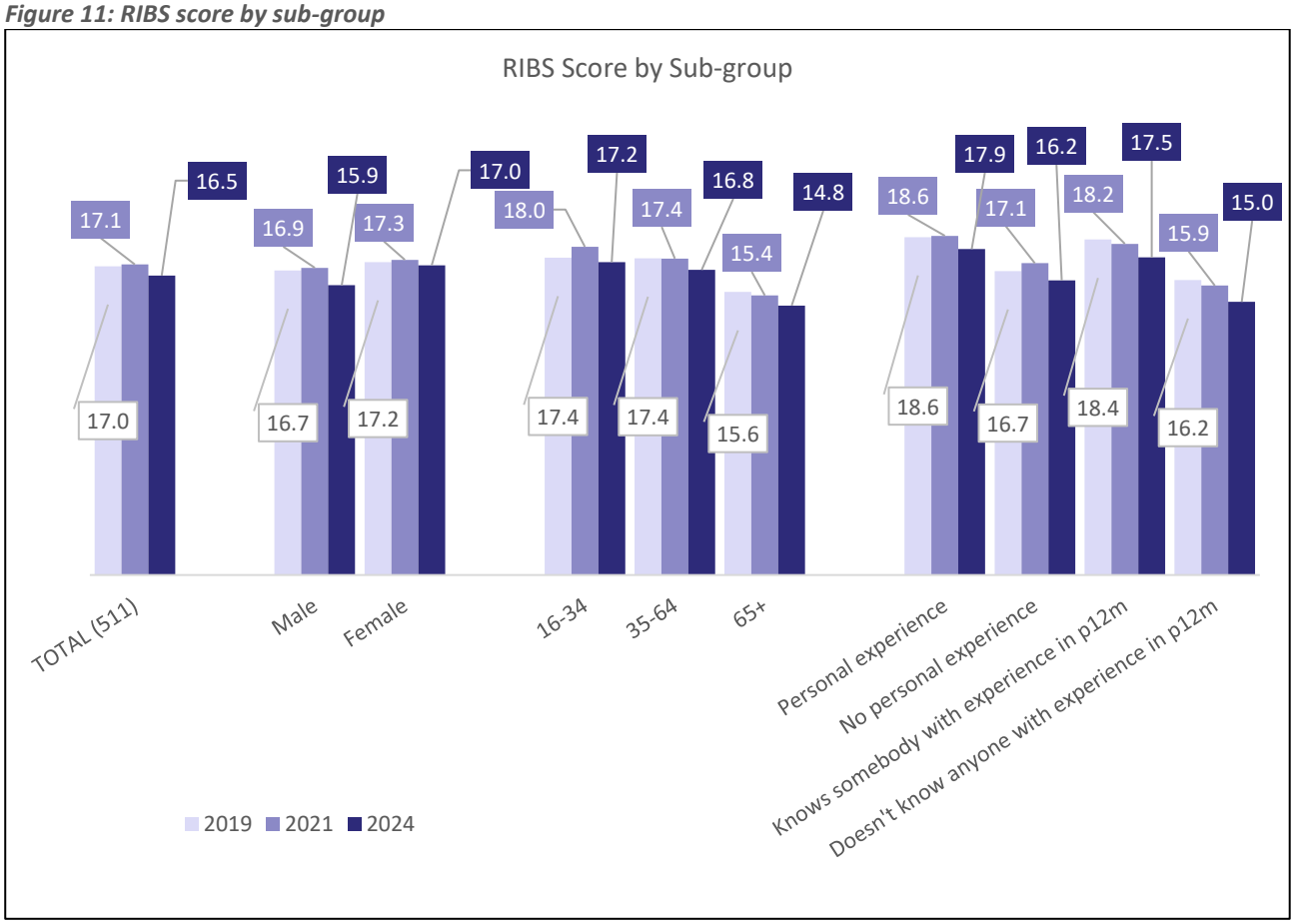
124. As before, for each of the questions respondents were asked to give their opinion using a five-point scale from 'Agree Strongly' to 'Disagree Strongly'. The order in which respondents saw the statements was rotated to ensure there was no order effect on agreement levels.

125. The overall score is calculated by adding the score for each question. A mean score for the total sample and various subgroups has been calculated. More information on the process used to derive RIBS scores can be found in Appendix 4.

126. In this process the higher the score the more appropriate the behaviour of the respondent, or sub-group of respondents would be. The maximum score would be 20 (=4 x 5) and the minimum score would be 4 (=4 x 1).

127. Overall, the mean RIBS score was **16.5,** a decrease of 0.6 compared with 2021 and of 0.5 compared with 2019. The drop in score between 2021 and 2024 is statistically significant.

Figure 11: RIBS score by sub-group



Base: All respondents (2019=511, 2021=851, 2024=526)

128. At a sub-group level there are several significant differences since 2021. In 2021 there was an increase in the scores amongst those who have no personal experience of a mental health problem when compared to 2019 which was seen to possibly indicate more positive behaviours amongst the wider population. However, in 2024 there has been a significant decrease in the scores amongst both those who have, and those who do not have personal experience of a mental health problem, though the drop is largest for those whose have no personal experience (from 17.1 to 16.2). And those with a personal experience (as well as those with indirect experience) still score significantly higher than those without as they did in both 2019 and 2021.

129. There is a clear correlation with age with scores falling for each age group, as also seen in 2021, however the only significant changes since 2021 are amongst those aged 16-34 (from 18.0 to 17.2) and those aged 35-64 years (from 17.4 to 16.8). The drop in scores for 16–34-year-olds is mainly driven by a drop in score for 16-24 year olds (from 18.2 to 17.1) and has brought the two younger age groups back to being more closely matched, as they were in 2019, however, the RIBS scores amongst the younger age groups remain higher than for the older age groups supporting findings elsewhere regarding improved understanding and awareness amongst the under 35 age group.

130. Another notable significant change since 2021 is a drop in the RIBS score for men (from 16.9 to 15.9) while there has been no significant change amongst women. The RIBS score for Men in 2024 is significantly lower than the overall score, while the RIBS score for women is significantly higher – this difference was not evident in 2021.

131. As in 2019 and 2021, ABC1s remain significantly more willing to behave positively, while C2DEs remain significantly less likely to do so (17.1 and 15.9 respectively).

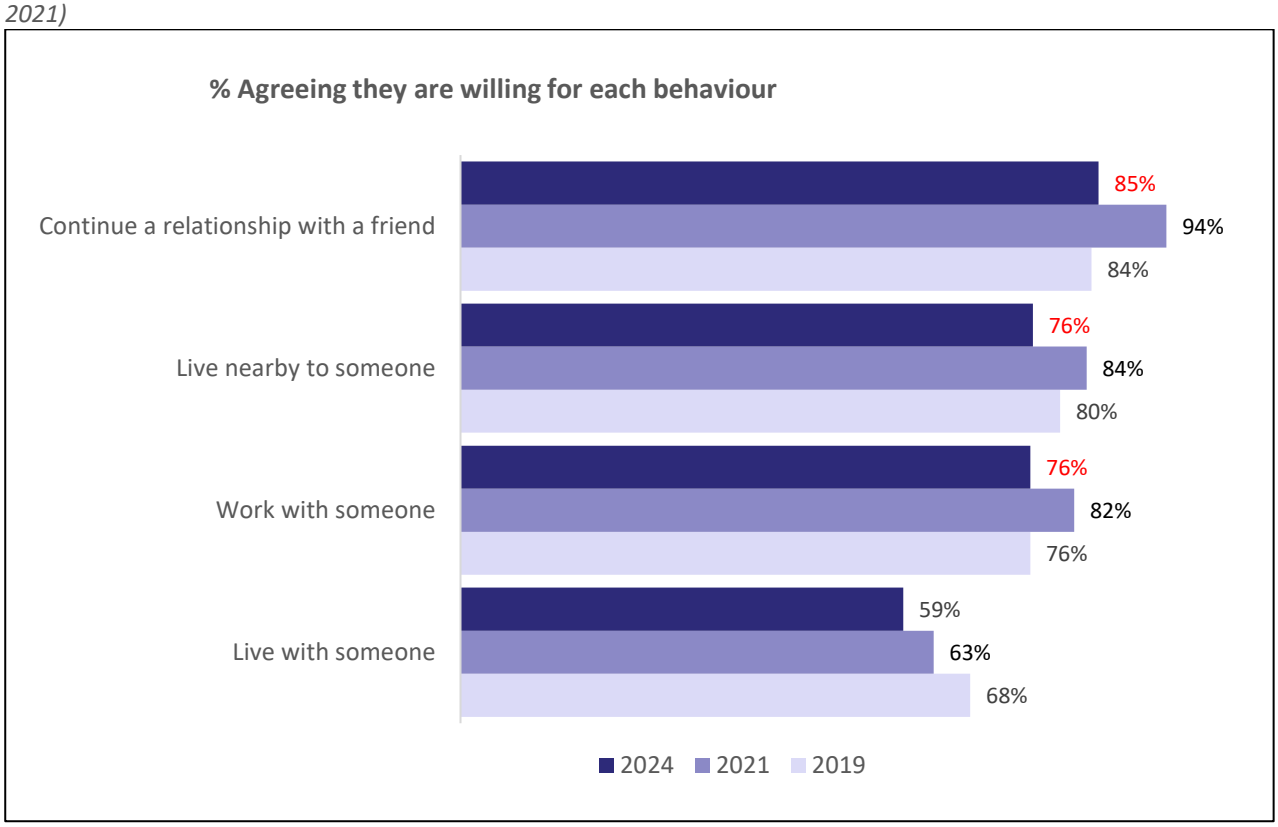
Figure 12: RIBS scores by sub-groups

Factor	Sub-Group	2019	2021	2024
Age	16-24	17.50	18.19	17.12
	25-34	17.38	17.91	17.25
	35-44	16.90	17.74	17.07
	45-54	18.07	17.68	16.65
	55-64	17.12	16.74	16.62
	65-74	16.13	15.90	15.36
	75+	14.73	14.67	14.16
Social Grade	ABC1	17.40	17.64	17.08
	C2DE	16.67	16.50	15.85
WIMD	Most deprived - 1	16.71	17.34	16.46
	2	16.92	16.78	16.73
	3	16.66	17.07	16.56
	4	16.75	17.03	16.42
	5	17.54	17.10	16.04
Campaign awareness	Seen or heard ads	17.53	17.45	16.99
	Seen or heard similar	17.33	17.83	16.77
	Not seen	16.69	16.69	16.00

132. The four questions used to calculate the RIBS score ask respondents whether "In the future they would be willing to…. Those in bold have fallen significantly since 2021:

- …**continue a relationship with a friend who had developed a mental health problem**
- **…live nearby to someone with a mental health problem**
- …**work with someone with a mental health problem**
- …live with someone with a mental health problem.

Figure 13: Level of agreement with each behaviour *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

133. The majority (more than three quarters) would be willing to do each of the above with the lowest level of agreement being to live with someone with a mental health problem (59%). However, there has been a significant drop in the level of agreement with the top three statements, with an indicative (not significant) drop in agreement with being willing to live with someone with a mental health problem. This indicates that the positive change in behaviours seen in 2021 has not been sustained.

134.

135. Figure 14 shows the percentage agreeing with each statement by subgroup.

136. Differences by social grade exist for each of these metrics with ABC1s being more likely to agree than C2DEs in each case.

137. The differences by age are also notable. For all statements the over 65s are significantly less likely to agree than those under 65. In the case of the final statement – living with someone - there is an even stronger correlation with age with 16 - 34 the most likely age group to agree (72%), though 35 – 64s (63%) are more likely to agree than over 65s (34%).

138. Those with greater knowledge, either through personal experience or because of someone they know, resulted in significantly higher levels of agreement with each statement, with the exception of 'work with' where the difference is not significant for those with/without personal experience.

Figure 14: Levels of agreement by various sub-group

Factor	Sub-Group	% Agree Strongly or Slightly			
		Friend	Live nearby	Work	Live with
TOTAL		85	76	76	59
Gender	Male	81	72	69	56
	Female	90	82	84	64
Age	16-34	84	80	82	72
	35-64	89	81	82	63
	65+	79	62	56	34
Working Status	Working	87	79	83	63
	Retired	78	61	57	38
	Non-working	89	88	83	74
Social Grade	ABC1	89	83	86	67
	C2DE	81	70	67	53
Personal experience	Had personal experience	95	87	84	76
	Not had personal experience	84	76	76	56
Known someone	Known someone	92	85	84	72
	Not known someone	79	68	64	38

Talking about mental health

139. The questionnaire included a series of questions which explored people's openness in discussing their own mental health with a health professional, employers and friends and family.

140. In 2021, this topic showed the most substantial changes compared with 2019. This corresponded with other research[7] conducted by Time to Change Wales in 2020 which found that people were reluctant to discuss a mental health problem openly (along with other problems) as they were worried about being a burden when the pandemic was at its height and people generally had so many issues to deal with. There were also accounts of people having difficulty accessing mental health support and getting through to GPs.

141. In 2024, however, the results are broadly in line with those seen in 2021. The pandemic is no longer a day-to-day issue for most, but there is little to no sign of a recovery towards 2019 levels. This might suggest that the pandemic has had long-lasting effects on people's willingness to discuss mental health issues, or it could indicate that research is needed to understand whether other factors are having an impact.

With a GP

As can be seen in

142. Figure 15, in 2019 four out of five respondents (80%) said they would be likely to ask their GP for help if they felt they had a mental health problem. In 2021 this fell significantly to just two in three (66%) and the result in 2024 has declined by a further four percentage points (62%), though the difference between 2024 and 2021 is not significant. Such a fall is a clear concern, and while it seems highly likely that the pandemic was a factor in the initial change, other research may help to understand why results are not showing signs of recovery.

143. The significant fall in likelihood of visiting the GP between 2019 and 2021 seemed to affect every sub-group, with the exception of the over 65s where there was no change. In 2024, however, the result for the over 65s has declined significantly by 22 percentage points compared to the previous wave (65% vs 86%).

144. In spite of this significant fall among over 65s, younger people aged 16-34 remain significantly less likely to visit the GP than those in older age groups.

145. The result for women has decreased, albeit not significantly, since 2021 (67% vs 72%), meaning that while the proportion of women who say they would be likely to visit the GP is still higher than for men (67% vs 58%), the difference is no longer significant.

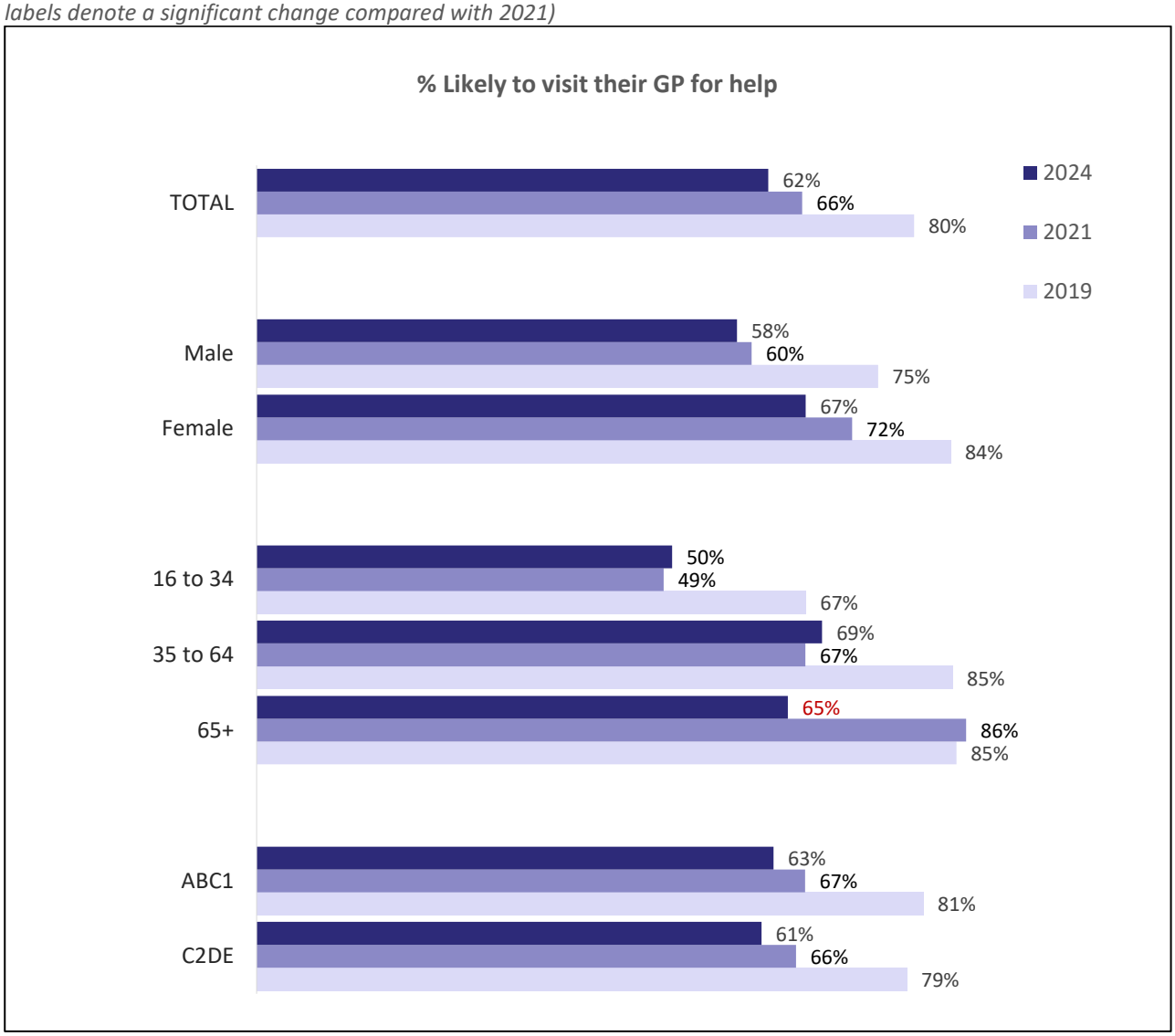
146. These sub-group differences are interesting and warrant exploration. For example, is the reduced willingness to talk to their GP amongst over 65s, and continued lower levels of willingness in the under 65s connected to a fall in visiting GPs for any issue? Does the indicative gender difference reflect a wider habit with women more likely to visit their GP and discuss their physical health than men rather than being a difference related purely to mental health?

147. Across all three waves, there are no real differences by social grade.

148. Amongst those who had experienced a mental health problem just over half (56%) had spoken to a GP or family doctor in the past 12 months.

[7] This includes an online survey TtCW conducted in summer 2020 and the Time to Talk Day opinion poll. Both highlighted an increase in self-stigma and difficulties or a reluctance to access support networks.

Figure 15: Proportion very/quite likely to ask GP for help if they felt they had a mental health problem *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

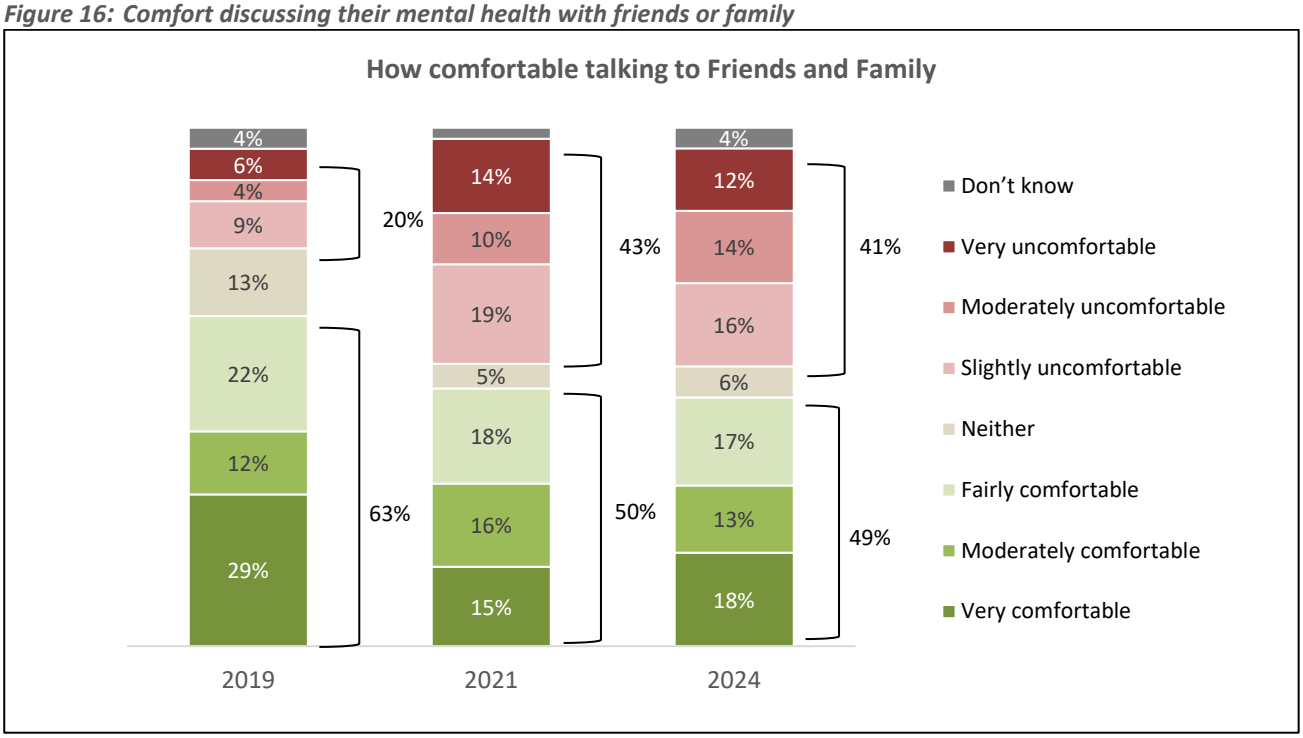
With friends and family

149. Respondents were asked how comfortable they would be talking to a friend or family member about their mental health. Figure 16 shows their answers using a 7-point scale from 'Very comfortable' to 'Very uncomfortable'.

150. In 2024 around half (49%) would feel comfortable having this discussion, with just under a fifth (18%) feeling very comfortable. This result is similar to that seen in 2021, when half (50%) were comfortable, with 15% being very comfortable. The latest results therefore remain significantly lower than in 2019, when over three in five (63%) stated they would be comfortable, suggesting there is still much work to be done in helping people to normalise discussions around mental health.

151. In 2024, more than two in five (41%) would be uncomfortable discussing their mental health with friends and family, which is similar to 2021 (43%) and remains more than twice as many as in 2019 (20%).

Figure 16: Comfort discussing their mental health with friends or family



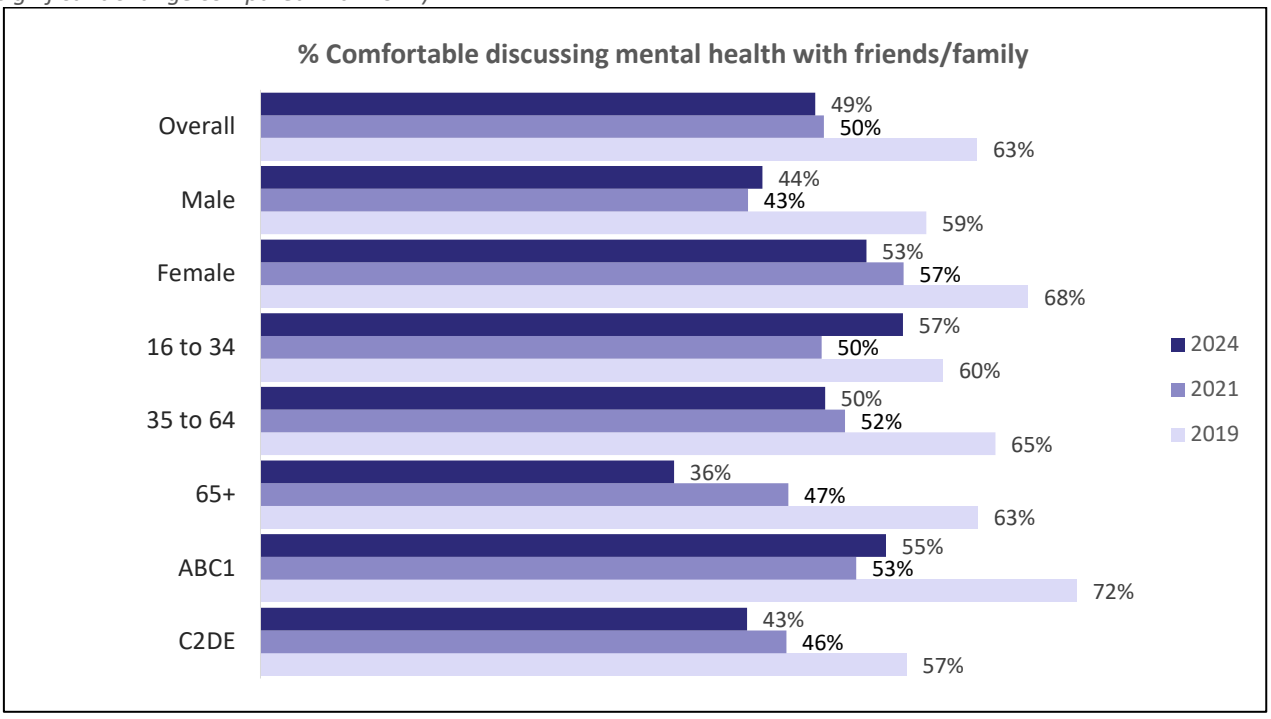
Base: All respondents (2019~511, 2021~851, 2024~526)

152. Men remain significantly less likely than women to feel comfortable talking about a mental health problem to a friend or family member (44% v. 53%) although the difference is not quite as pronounced as in 2021.

153. Compared with the previous wave, higher proportions of younger people would be comfortable, and fewer older people would be comfortable talking to family or friends about a mental health problem – however, neither change is statistically significant compared with 2021.

154. ABC1s remain significantly more likely to be comfortable than C2DEs.

Figure 17: Comfortable talking about mental health to a friend/family member *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

With a current or prospective employer

155. Respondents were also asked how comfortable they would be talking to a current or prospective employer about their mental health.

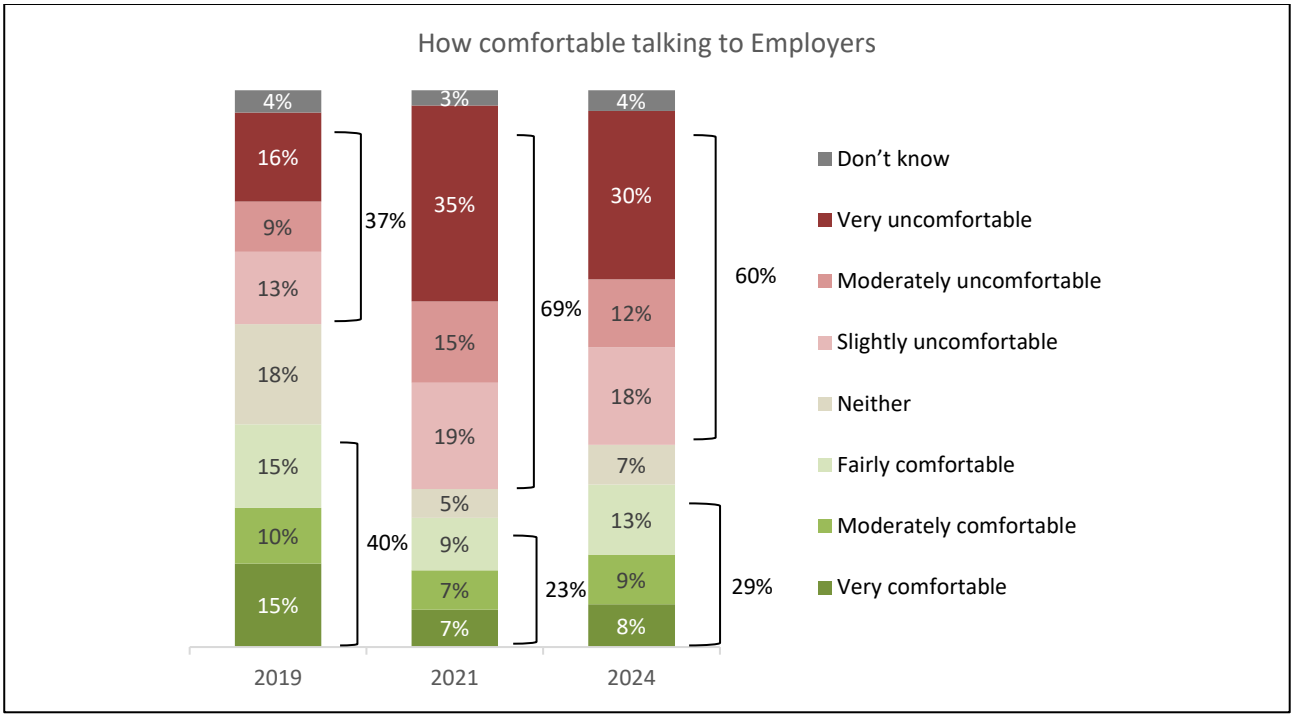
156. In 2024, only around three in ten (29%) would be comfortable having this discussion with their employer. On the other hand, three in five would feel uncomfortable (60%) and three in ten would feel very uncomfortable (30%).

157. Between 2019 and 2021, and despite the considerable conversation around employee wellbeing during the pandemic, there was a significant increase in the proportion of people who would feel uncomfortable discussing their mental health with an employer. Almost seven in ten (69%), said they would be uncomfortable doing this in 2021, compared with an overall figure of 37% in 2019.

158. The proportion who would feel comfortable having this discussion with their employer has therefore increased significantly since 2021, however it continues to remain below 2019 levels.

159. This is such a substantial change so it seems that the pandemic, which has occurred between the first two waves must have had some influence, and that the influence of the pandemic is still being felt. More research would be needed to understand the driver of this change. It is possible that with many people fearing for their jobs they are less likely to wish to discuss any weakness with an employer, or maybe more respondents have had a personal experience of having, or trying to have such a conversation, or maybe the experience of remote working (which has remained common for many since the pandemic) has simply made such conversations more difficult to initiate.

Figure 18: Comfortable discussing their mental health with Employer



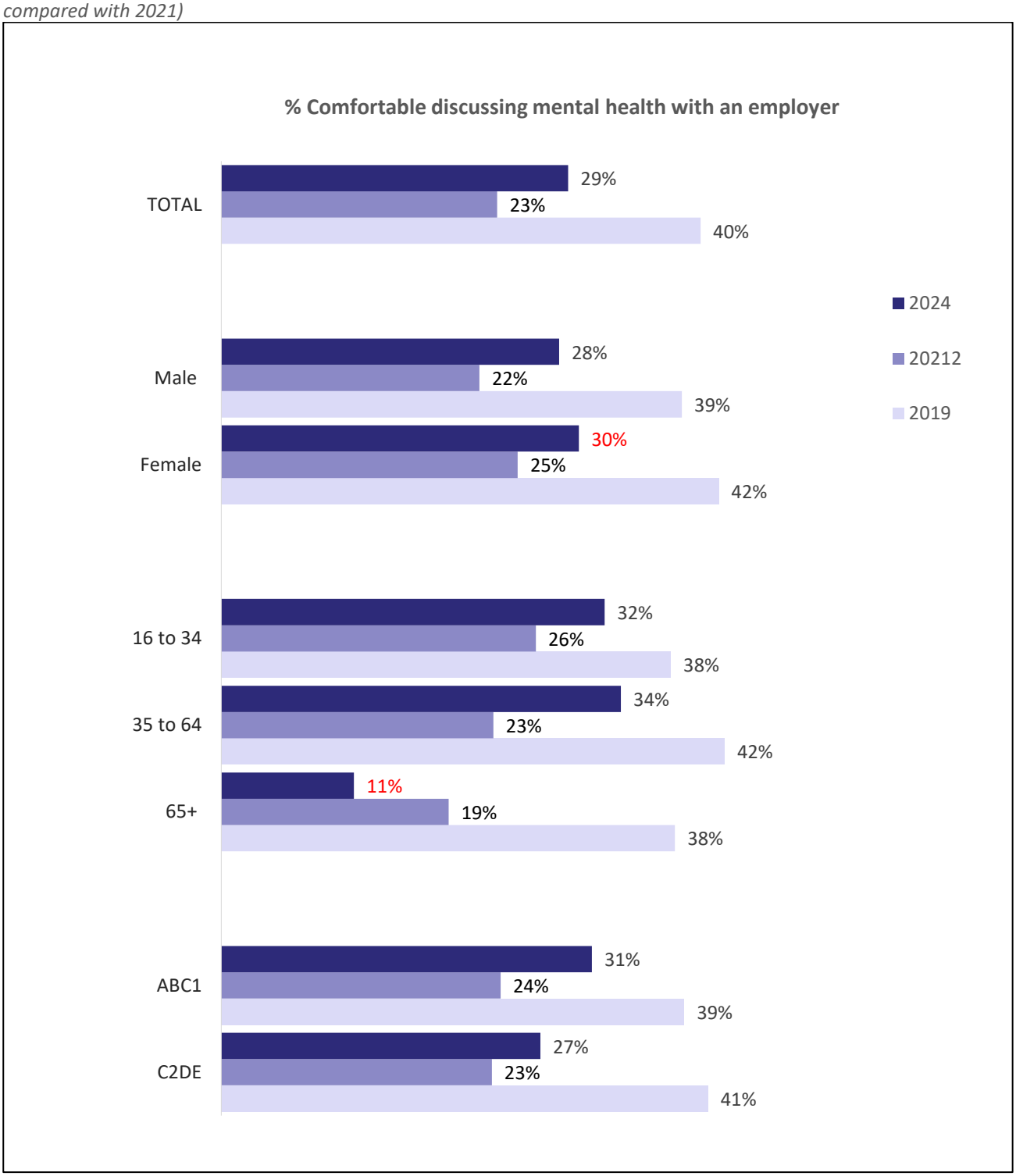
Base: Excludes those who said "not applicable"

160. The proportion feeling comfortable had fallen significantly across all sub-groups in 2021, but the 2024 results show a trend of recovery, although the only significant increase is amongst 35-64-year-olds. This change removes the previously seen correlation with younger groups being the most comfortable discussing mental health, and instead reflects the pattern seen in 2019 when those aged 35 – 64 were also the most comfortable.

161. It is also notable that while the 16-34- and 35–64- age groups have both seen a recovery since 2021, the proportion of over 65s saying they would feel comfortable talking to their employer about mental

health has fallen with each wave, and now sits 27 percentage points lower than in 2019 and is significantly lower compared with both other age groups. This warrants further research to understand why the older age group now feels less comfortable than previously.

Figure 19: Comfortable talking about mental health to an Employer *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

Experience of mental health problems

162. In order to better understand attitudes to mental health, the survey included a number of questions which explored personal experiences and the extent to which respondents had either experienced mental health problems or currently know people with a mental health problem.

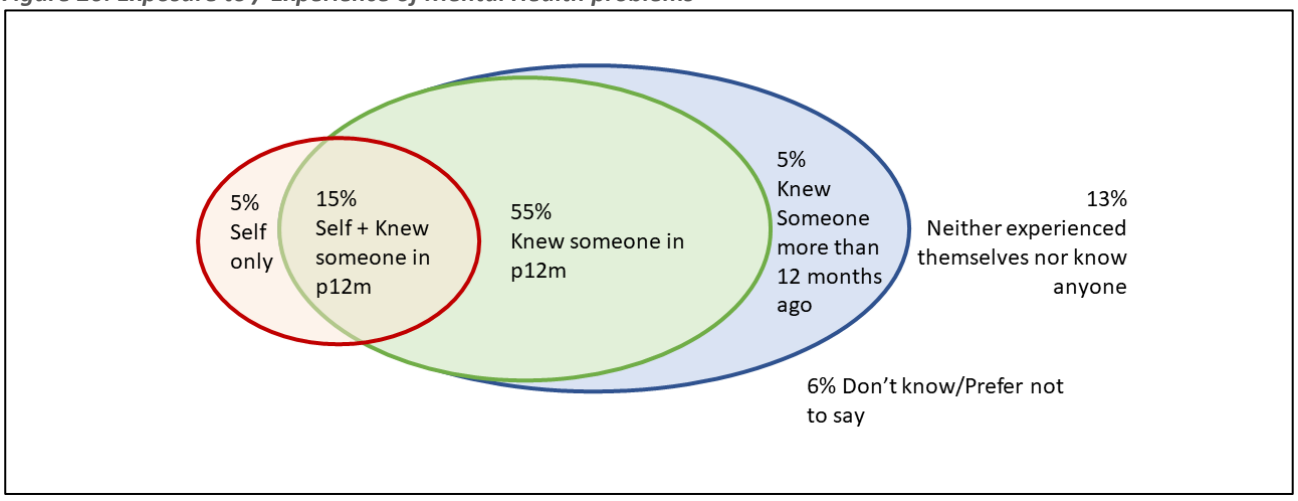
163. The Venn diagram (Figure 20) below aims to summarise the extent of exposure to, or experience of, mental health problems. [8]

164. In 2024 over four in five (81%) respondents knew of someone who had experienced a mental health issue at some point – this is in-line with 2021 (80%) but still significantly higher than in 2019 (68%). Around three quarters (76%) had either had an experience themselves or knew of someone with an experience during the last 12 months which is significantly higher than in both 2021 (66%) and 2019 (46%). While these results show a clear increase in recent experience, we cannot know whether this is an increase in incidence rates (especially considering the impact of the pandemic and methodology changes) or an increase in awareness amongst acquaintances.

165. A fifth (20%) per cent of people said that they had a personal experience, a significant increase from 15% in 2021 and 12% in 2019. Most of these also knew somebody else who had experienced a mental health problem. In this context it may be worth considering the impact of the methodology on the data collected with 2019 data collected as part of a face-to-face interview and 2021 and 2024 entirely self-completion. It could possibly suggest a reduction in stigma, particularly self-stigma, however further survey waves using the same methodology would be needed before it would be possible to identify whether this a definite trend.

166. Whilst we cannot be sure what drove the 2021 change, it is likely that the higher proportion in 2019 saying they knew nobody who had experienced a mental health problem was inflated by the methodology, i.e. where an interviewer has not directly offered a 'prefer not to say' option, respondents were less likely to give this as a response, and perhaps therefore, if they were unsure or uncomfortable, more likely to say they did not know anyone.

Figure 20: Exposure to / Experience of Mental Health problems



Base: All respondents (526). Prefer not to say/Don't know included as a valid option.

[8] This diagram is based on the responses from Q10 'Who is the person closest to you who has or has had some kind of mental illness' and Q19 'Has any adult aged 16 or over that you know had a mental health problem over the last twelve months, excluding yourself?'. 'Prefer not to say' and 'Don't know' are included as valid options. Please note that this was not the case for this diagram in the 2019 and 2021 report, however the 2019 and 2021 figures in the commentary above include 'Prefer not to say/Don't Know' as valid options and are therefore directly comparable with 2024 figures.

Close personal experiences

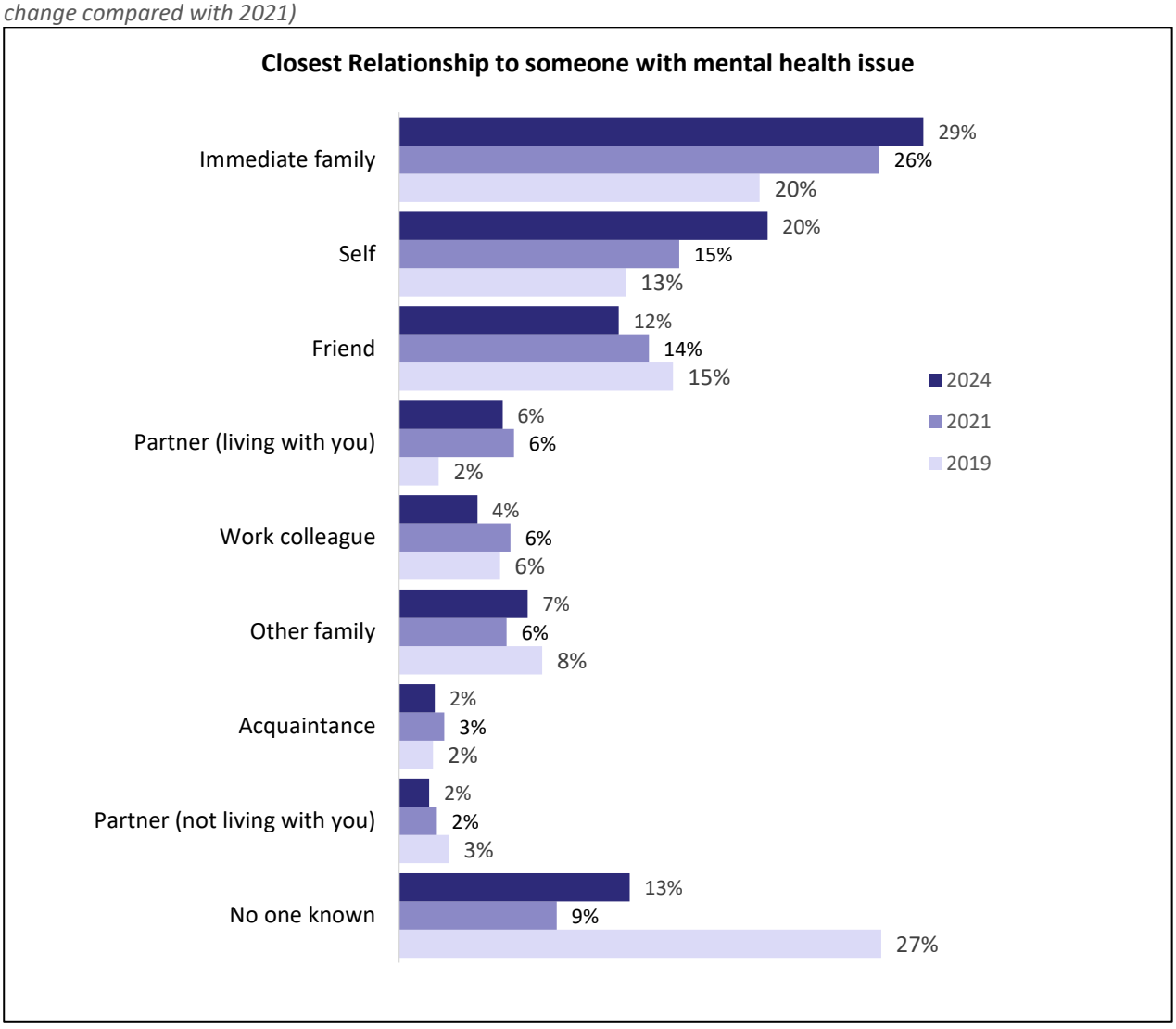
167. Initially respondents were asked about their closest experience of some form of mental illness at any time in the past. Figure 21 shows the 2024 data is broadly in-line with 2021, though there some small increases amongst some groups.

168. The proportion of people saying they have experienced a personal mental health issue has seen a significant increase since 2021, and a small, but not significant increase between 2019 and 2021. The proportion of those saying someone in their immediate family has had a mental health issue has also increased in both 2021 and 2024 (though these are not statistically significant), indicating an upward trend.

169. There are some slight falls in other categories, however these should be seen in the context that they were asked about their *closest* experiences and so an increase in immediate family will almost inevitably reduce the proportion mentioning some more distant relationships.

170. The largest difference compared with 2019 is the fall in the number of people stating that they were not aware of any experiences. This fell from nearly three in ten (27%) in 2019 to just around one in ten (9%) in 2021. The 2024 data shows a small, but not significant increase to 13%, but is still significantly below that seen in 2019. This is a notable finding and is very likely to have been impacted in some way by the pandemic and wider discussions of mental health.

Figure 21: Proximity of relationship to person with mental health issue *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526). Prefer not to say/Don't know included as a valid option.

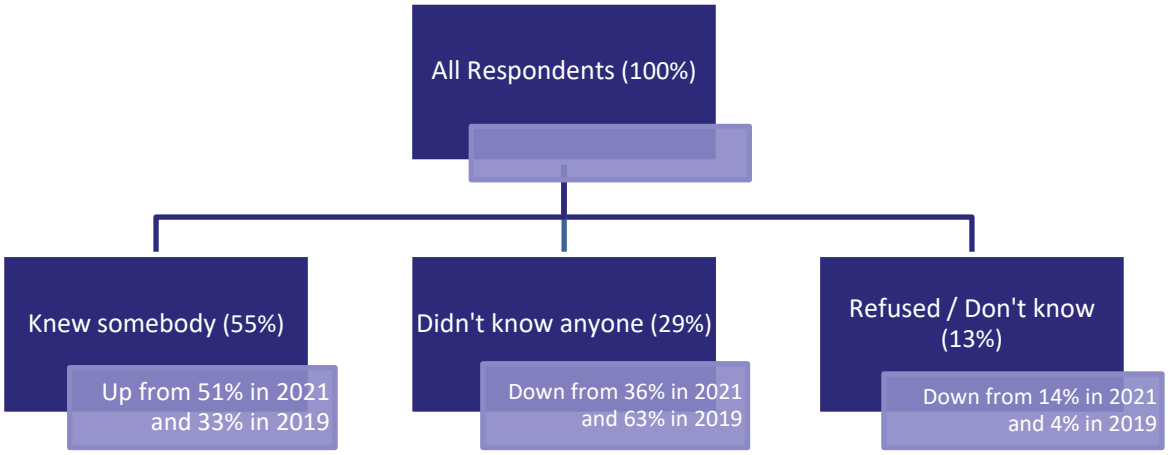
Half have known someone with an issue during the last year

171. Respondents were then asked to think only about experiences during the past year.

172. Over half (55%) said that they know at least one adult who has had a mental health problem in the last 12 months (excluding themselves), which is broadly in-line with 2021 (51%) but significantly higher than 2019 (33%). There is also a significant decrease in the proportion who said they didn't know anyone when compared with 2021 and 2019 (29% vs 37% and 63% respectively).

173. The largest change seen is between 2021 and 2019 in the proportion of those saying they do not know anyone. As discussed above, this is likely at least partly driven by the change in methodology with less respondents giving a 'prefer not to say' response in 2019. However, the fall between 2021 and 2024 in those saying they don't know anyone, cannot be explained by methodology and suggests other factors are involved, warranting further exploration.

Figure 22: Levels of Experience during past year



Base: All respondents (526). *Prefer not to say/Don't know included as a valid option.*

174. Analysis by subgroup shows some encouraging changes suggesting increased awareness amongst subgroups that had previously been significantly lower compared with their counterparts.

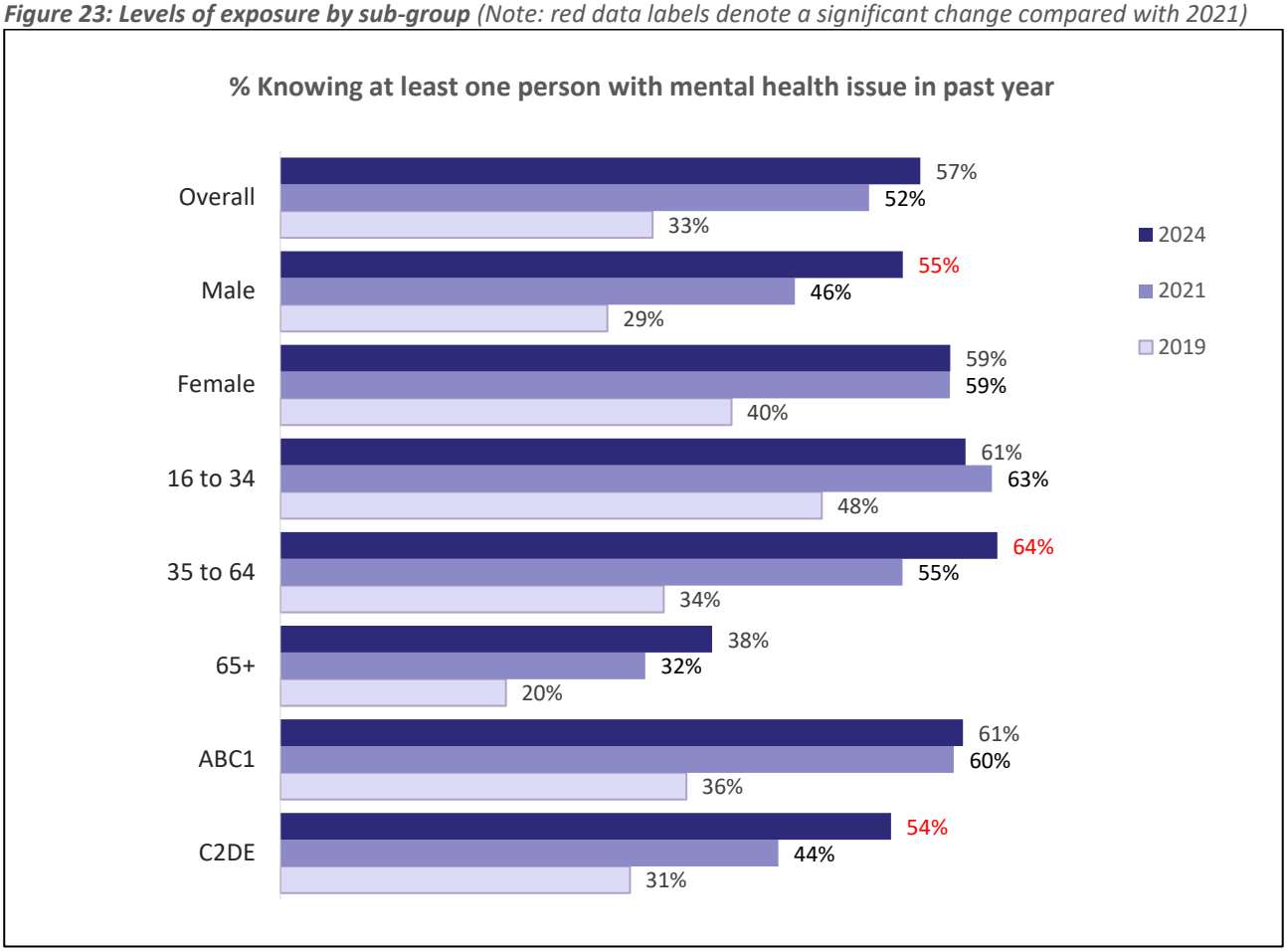
175. The previously identified gap between men and women has narrowed with women no longer significantly more likely to say they know someone with a mental health problem in the past year. This appears to have been driven by a significant increase in the proportion of men who say that they know someone with a mental health problem in the past year, without a similar increase evident amongst women. This is a possible reflection on recent targeted Time to Change Wales campaigns[9] promoting men's mental health which may be helping to close the gender gap on talking about the mental health.

176. There has also been a significant increase in the proportion of those aged 35-54 saying they know at least one person with a mental health problem in the past year removing the correlation seen in 2021 with younger people (aged under 25) being the most likely to know someone. However, those aged 65+ were the least likely to know someone in both 2021 and 2024.

177. Further, an increase in the proportion of those in the C2DE social grade group saying they know at least one person with a mental health problem within the past year closes the gap between the ABC1 and the C2DE groups.

[9] This includes a specific men's campaign called Talking Is A Lifeline in Phase 3 2018-2021.

Figure 23: Levels of exposure by sub-group *(Note: red data labels denote a significant change compared with 2021)*



Base: All respondents (2019~511, 2021~851, 2024~526)

Perception of how person with mental health issue was treated

178. Those respondents who knew somebody who had experienced a mental health problem in the past twelve months were asked whether the person they knew has been treated fairly, unfairly, or more positively in various scenarios, as a result of the problems they were experiencing.

179. The first chart overleaf looks at primarily professional relationships including accessing work and healthcare in 2019 and 2021 and 2024.

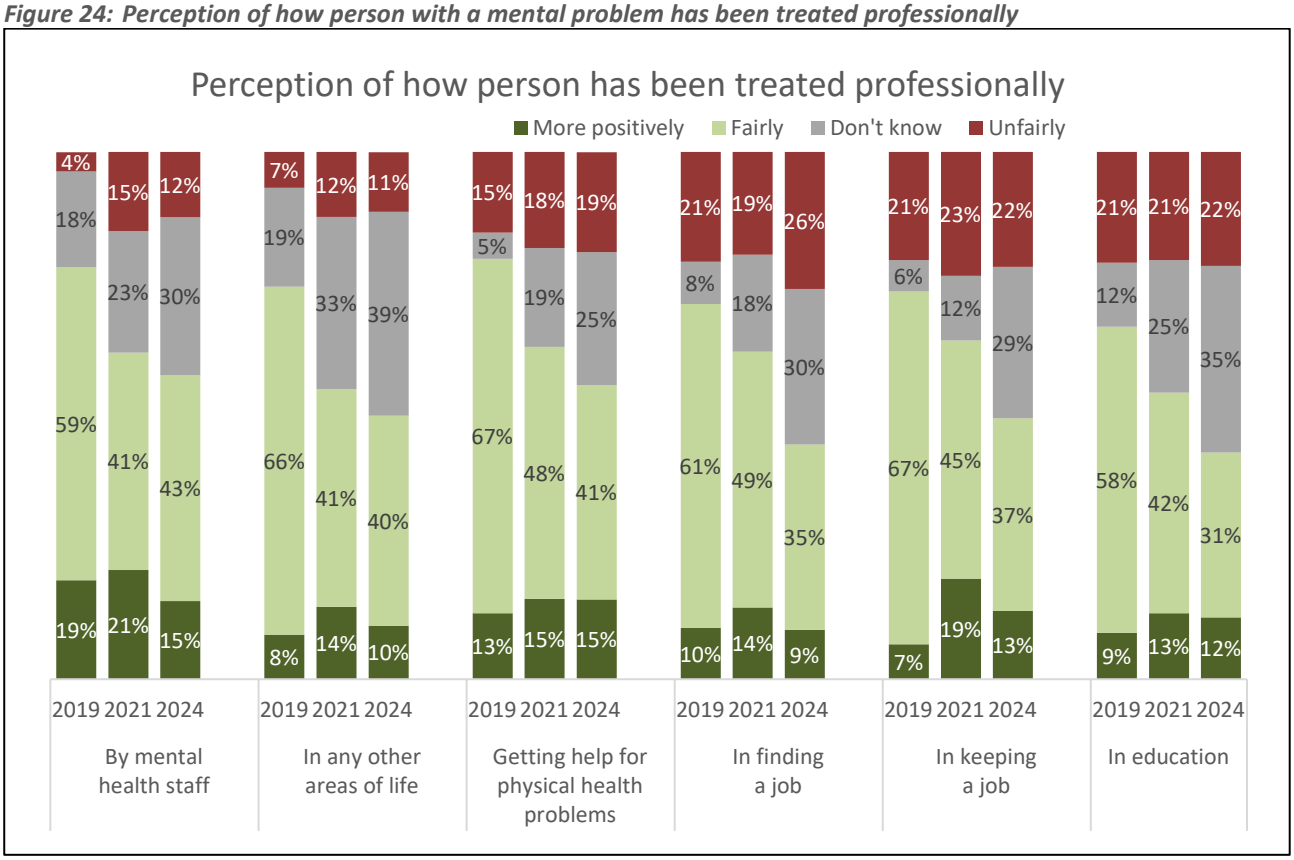
180. Overall, at least two out of five (with most more than half) agreed that the person had been treated either fairly or in a more positive way, in each of the scenarios listed. However, these figures are lower across all, and significantly lower across four of the scenarios (getting help for a physical problem, finding a job, keeping a job and in education) than in 2021. All are significantly lower when compared with 2019.

181. However, this appears to be driven more by an increase in the proportion saying 'don't know' across all scenarios as opposed to an increase in the proportion saying they felt the person they knew with a mental health problem was treated unfairly. Further research may help to understand why respondents found it more difficult to give an answer to these questions than previously.

182. The only scenario where there has been a significant increase in this proportion saying 'unfairly' since 2021 is in finding a job (26% vs 19%). It is interesting to note that there is no such increase in the proportion who feel the person they know with a mental health problem was treated unfairly in keeping a job, though there has been a significant decrease in those saying they were treated more positively or fairly.

183. The maintained increase in the number perceiving a person as being treated unfairly by mental health professionals since 2019 (from 4% to 15% in 2021 and 12% in 2024) is still a potential cause for concern. It is possible that care has been made more difficult during the pandemic and lower levels of access to care is being seen as unfair. Further research may be necessary to understand what has driven this increase.

Figure 24: Perception of how person with a mental problem has been treated professionally



Base: All respondents who know another adult who has had a mental health problem in the last 12 months (NB: Base sizes vary due to the exclusion of 'not applicable' categories)

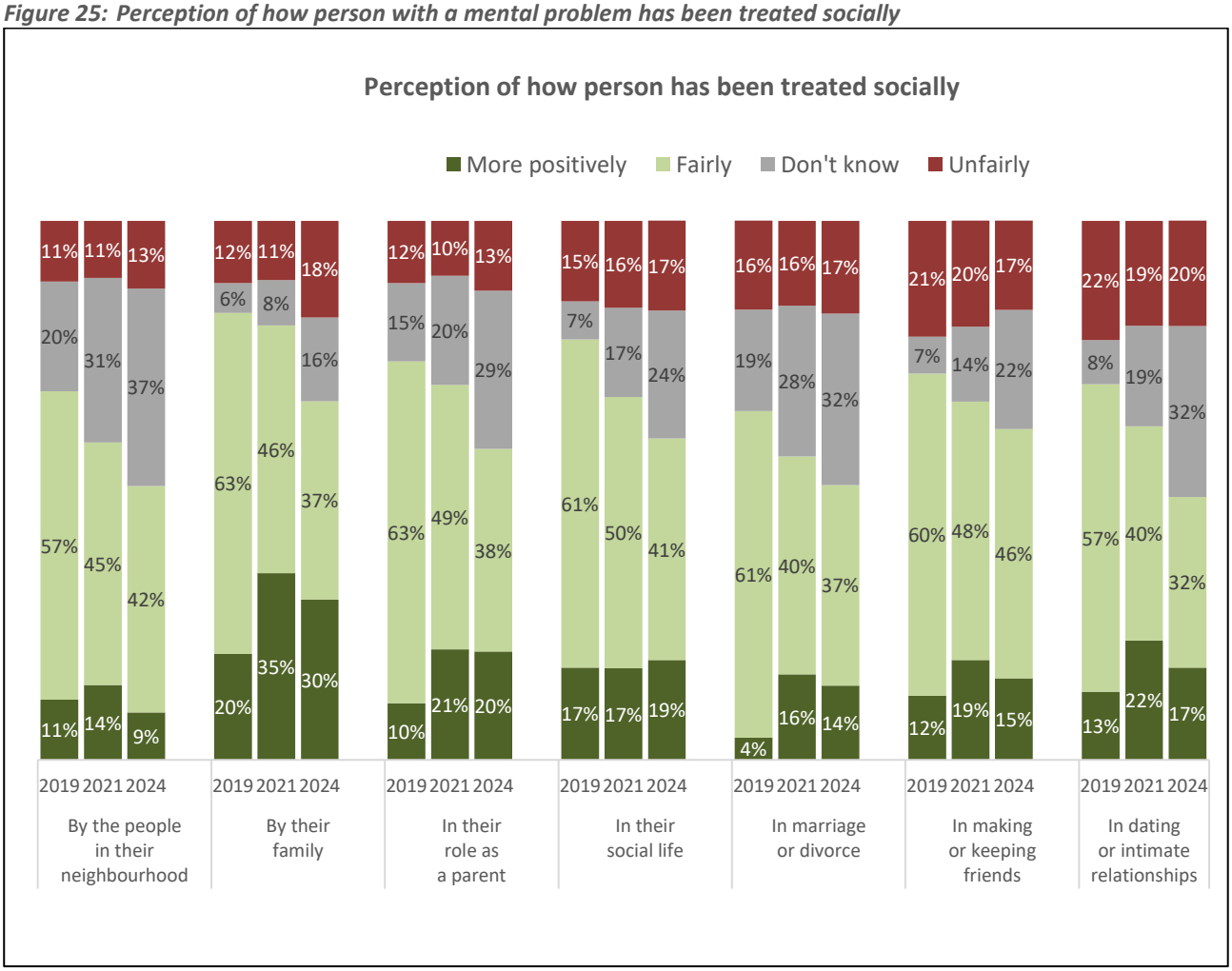
184. A similar trend can be seen on the metrics which refer to more personal relationships, whereby there has been a decrease since 2021 in the proportion believing they are treated fairly or more positively across all scenarios, and a significant decrease across five of the seven scenarios shown in the following chart (by people in their neighbourhood, by family, in their role as a parent, in their social life, in dating or intimate relationships).

185. Again, there has been a significant increase in the proportion saying 'don't know' across all but one scenario (in marriage or divorce), whilst generally the proportion believing the person they know with a mental health problem was treated unfairly has remained consistent since 2021.

186. The only scenario where there has been a significant increase in this proportion saying 'unfairly' since 2021 is in how they were treated by family (18% vs 11%). For this scenario there has also been a significant fall from 81% in 2021 to 67% in 2024 in the proportion saying they were treated fairly or more positively. This is particularly concerning, given the important role family plays in the lives of most people.

187. Overall, the results from these questions on the treatment of those with mental health problems suggests more work needs to be done to continue previously seen improvements in understanding of mental illness. The results suggest that it would be particularly beneficial for Time to Change Wales to conduct some specific work with families as well as with health services.

Figure 25: Perception of how person with a mental problem has been treated socially



Base: All respondents who know another adult who has had a mental health problem in the last 12 months
(NB: Base sizes vary due to the exclusion of 'not applicable' categories)

Other attitudes to mental health

188. The remaining sections of the questionnaire asked further questions aimed at understanding respondents' attitudes to and understanding of mental health issues. These questions were all asked for the first time in 2024.

Treatment in the workplace

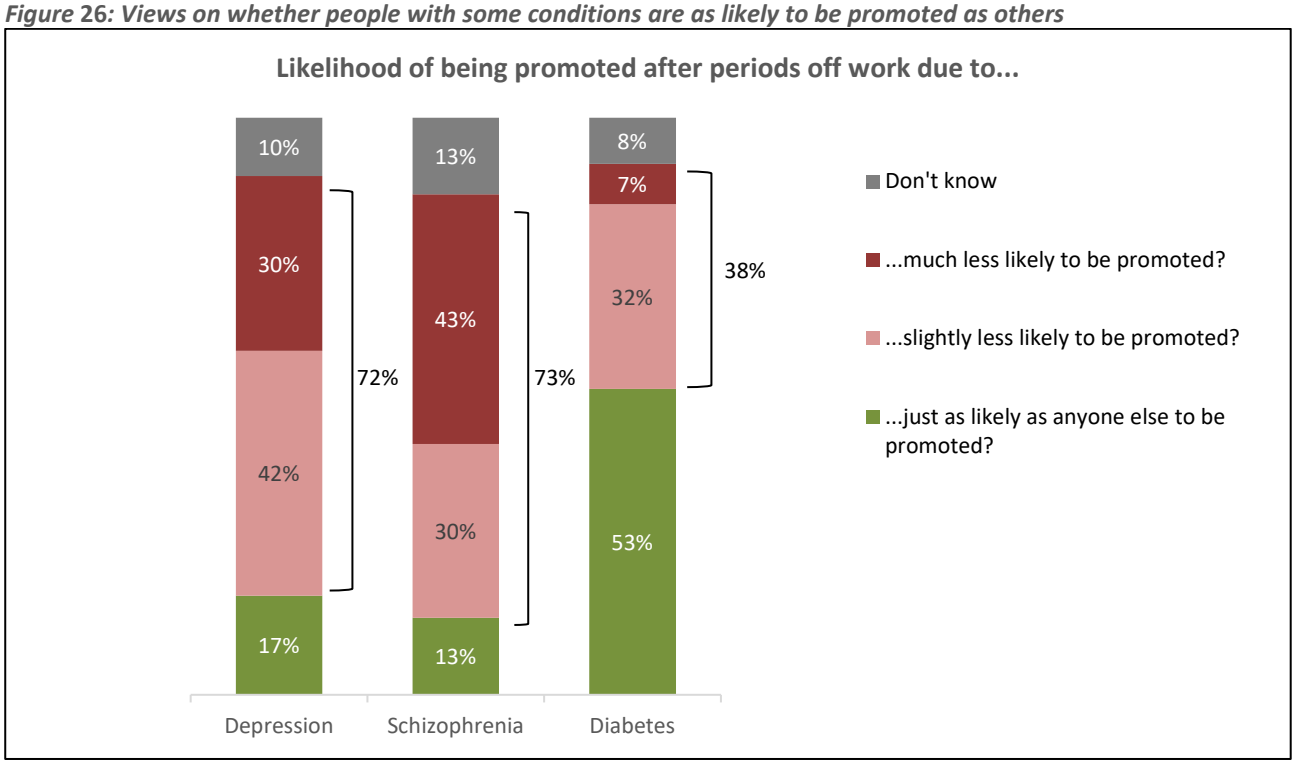
189. The 2024 questionnaire asked respondents to imagine three hypothetical scenarios where an employee applied for a promotion after spending repeated periods of time off work with a health condition – either depression, schizophrenia, or diabetes – which was now being controlled by medication. Respondents were asked whether they felt the employee would be 'just as likely', 'slightly less likely' or 'much less likely' to be promoted compared to anyone else in the organisation.

190. For all three of the conditions, a sizeable proportion felt that the person would be either 'much less' or 'slightly less likely' to receive the promotion than their colleagues. However, these proportions were higher for depression and schizophrenia (72% and 73%) than for diabetes (38%).

191. Similarly, while more than half felt that somebody who had experienced time off with diabetes was 'just as likely' to be promoted as anyone else (53%), only small minorities felt this would be true for the employee with depression (17%) or schizophrenia (13%).

192. This suggests that many would expect a person who had been absent from work with a mental health issue to be treated differently at work compared to somebody who had absent due to a physical condition.

Figure 26: Views on whether people with some conditions are as likely to be promoted as others



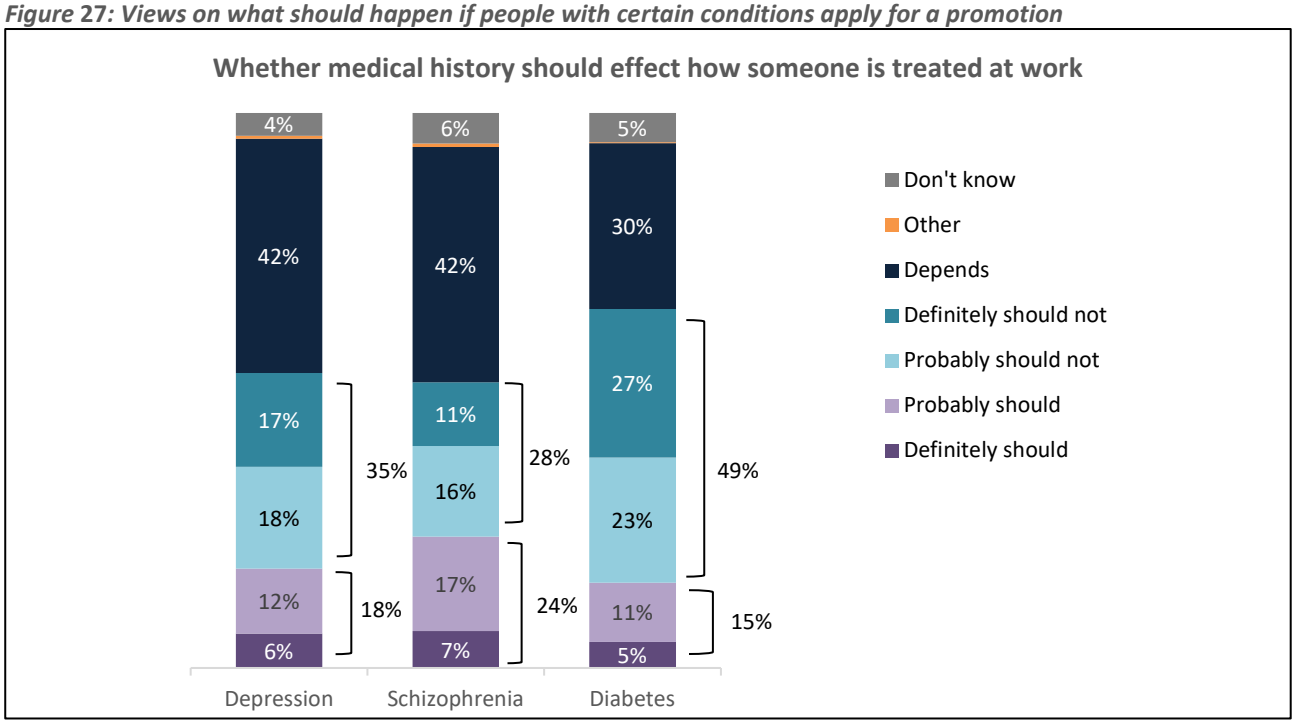
Base: All respondents (2024~526)

193. Respondents were then asked what should happen in these scenarios, specifically whether the person's medical history ought to make a difference when making the decision about whether to give them the job.

194. In each case, the most common response was that it would depend on the specifics of the job or type of work, and whether the condition would be likely to affect this. This was particularly true for depression and schizophrenia, where 42% were of this view, while for diabetes the result was 30%.

195. However, respondents were more likely to state that medical history should not make a difference for the person with diabetes (49%), than they were for the person with depression (35%) or schizophrenia (28%).

Figure 27: Views on what should happen if people with certain conditions apply for a promotion



Base: All respondents (2024~526)

196. For all three of the conditions in the scenarios, ABC1s were more likely than C2DEs to say that medical history should not make a difference.

197. Younger people were also somewhat less likely than older ages to feel that medical history would need to be taken into account.

Schizophrenia

198. The 2024 questionnaire also asked a series of questions to gauge attitudes and awareness around schizophrenia. Respondents were presented a series of questions and asked to give their opinion based on scale of 1 through to 5. For example, the first of these asked whether people with schizophrenia are a danger to others, where 1 on the scale equals "a danger to others" and 5 equals "not a danger to others".

199. The results suggest that relatively few respondents feel that people with schizophrenia 'have themselves to blame', that 'they can pull themselves together', and that 'they are hard to talk to'.

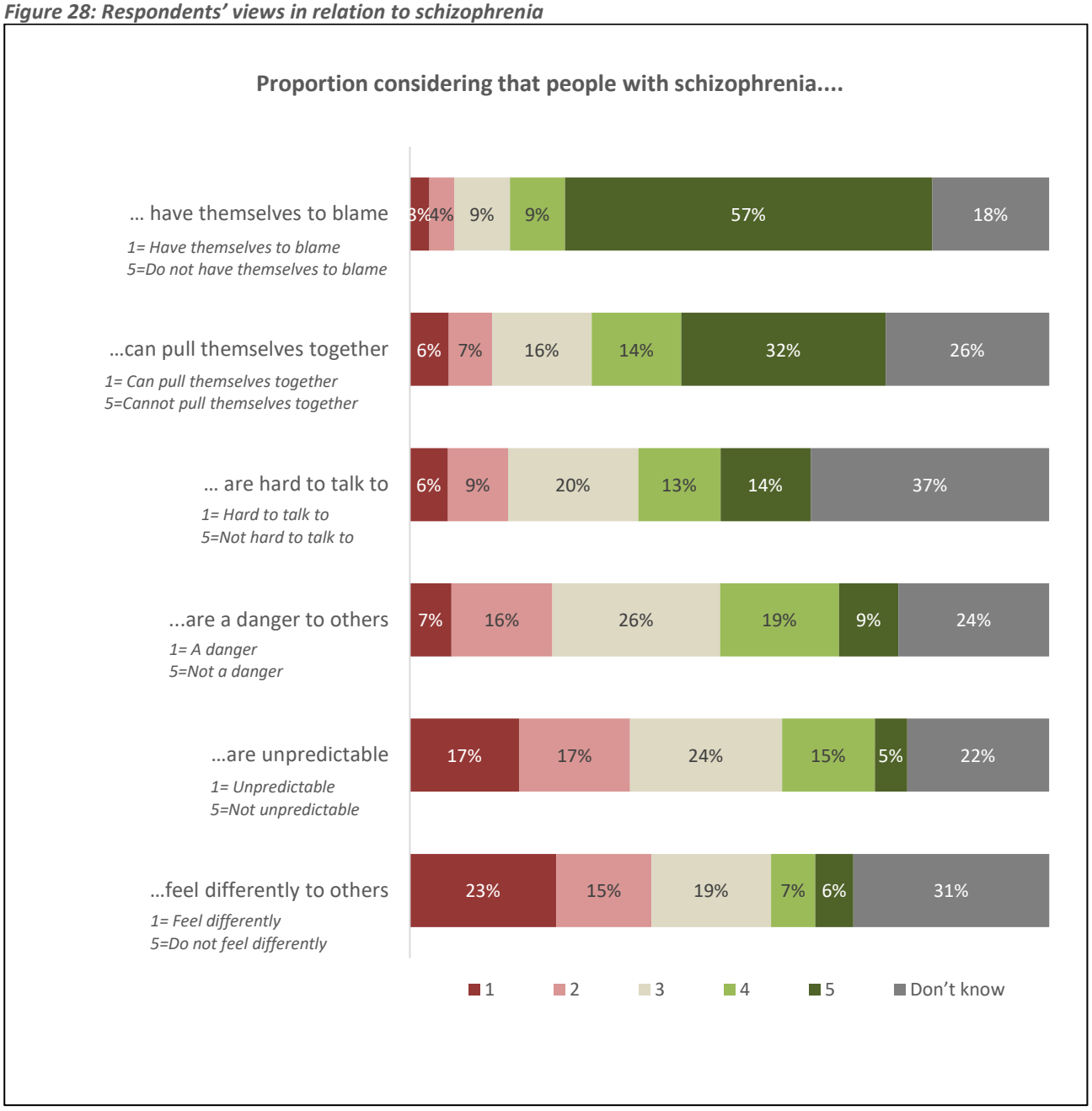
200. Somewhat higher proportions feel people with schizophrenia may be 'a danger to others', be 'unpredictable', or 'feel differently to others'. It is particularly worth noting that almost a quarter of respondents (23%) gave the 'strongest' response of '1' to indicate that people with schizophrenia feel 'differently to others', and nearly a fifth (17%) did so when asked if people with schizophrenia are 'unpredictable'.

201. However, it is also worth noting fairly sizeable proportions giving 'don't know' answers or choosing the middle ground option (i.e. '3') on the 1 to 5 scale. When combined, these two options account for

nearly half or more of all answers to the questions about whether people with schizophrenia are 'hard to talk to', are 'a danger to others', 'feel differently to other people', and are 'unpredictable'.

202. This suggests many respondents recognise that they might lack some understanding or awareness of the condition, and that there may be scope to improve knowledge of schizophrenia among the general public, perhaps via an awareness campaign or similar.

Figure 28: Respondents' views in relation to schizophrenia



Base: All respondents (2024~526)

203. Those who have never had a mental health problem were significantly more likely to give a response of '1' when asked about people with schizophrenia being a danger to others, unpredictable, and harder to talk to.

204. In terms of social grade, C2DEs were significantly more likely than ABC1s to answer '1' when asked if people with schizophrenia are unpredictable and have themselves to blame.

Gareth and Stephen

205. Finally, the questionnaire described two hypothetical individuals, Gareth and Stephen, who have recently been displaying symptoms of schizophrenia and depression respectively (although the questionnaire did not use these terms, only the descriptions provided below).

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

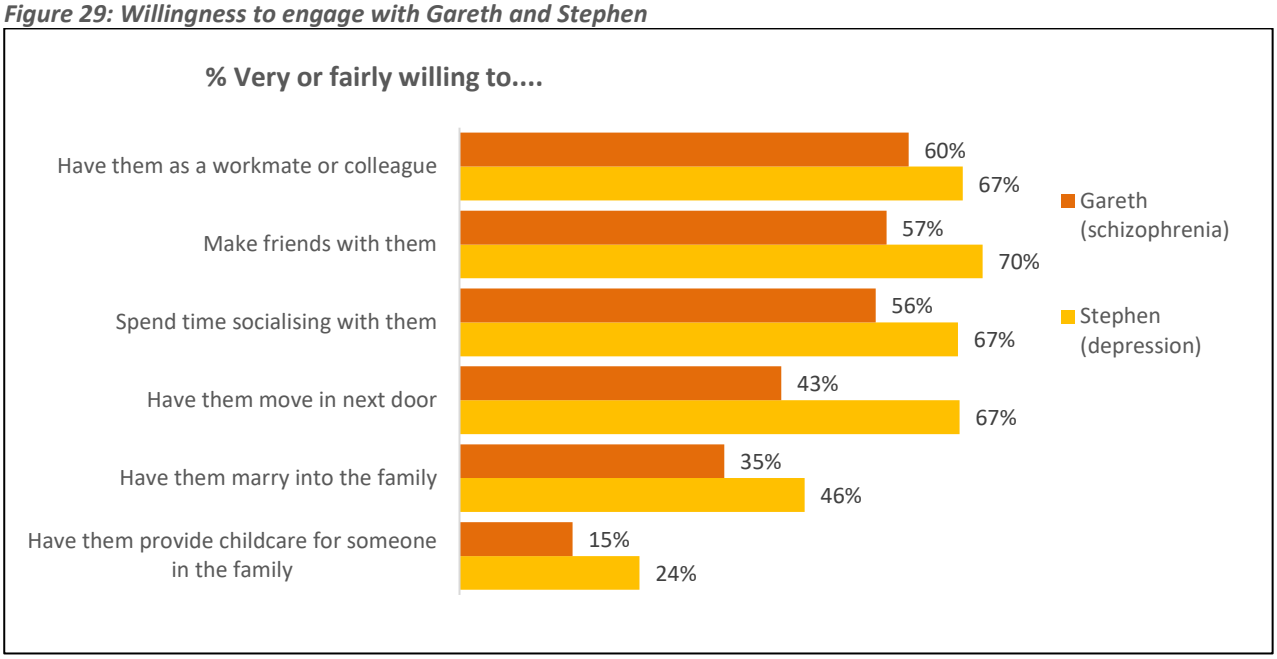
> *"Stephen has been feeling really down for about six months and his family have noticed that he hasn't been himself. He doesn't enjoy things the way he normally would. He wakes up early in the morning with a flat heavy feeling that stays with him all day long. He has to force himself to get through the day, and even the smallest things seem hard to do. He finds it hard to concentrate on anything and has no energy".*

206. Respondents were then asked to what extent they would be willing or unwilling to have various social interactions or relationships with Gareth and Stephen.

207. As shown in the chart below, most respondents would be willing to know Gareth or Stephen as workmates or social acquaintances, or to have them as friends, although they would generally be more willing to engage with Stephen (i.e. a person who had symptoms of depression), than with Gareth (i.e. one who showed symptoms of schizophrenia).

208. Respondents would be far less willing to let Gareth or Stephen provide childcare for somebody in their family (15% and 24% respectively) or have them marry into their family (35% and 46%). While two in three (67%) would be willing for Stephen to move next door to them, less than half (43%) felt this way about Gareth.

Figure 29: Willingness to engage with Gareth and Stephen



Base: All respondents (2024~526)

209. There were some significant differences by gender. For example, females would be significantly more likely to be willing to have Gareth as a workmate or as a friend. They would also be more willing to have Stephen marry into their family, spend time socialising with him, and to have him live next door to them.

210. There were also some significant differences in terms of age, with 16-34s generally being more willing than over 65s to engage with Gareth and Stephen.

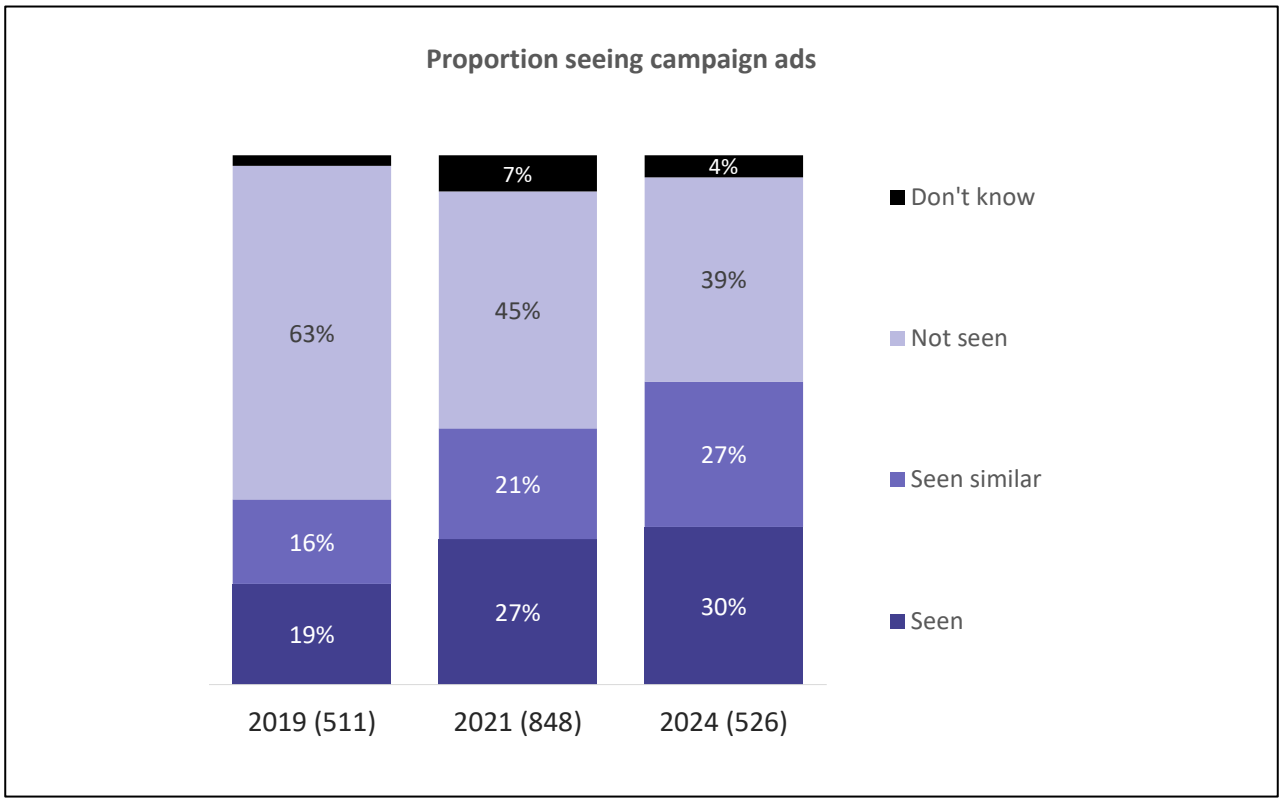
Campaign awareness

211. In order to explore the impact and recall of mental health-related campaigns respondents were shown some screen shots of mental health-related adverts that have appeared on television, radio, magazines or on the web. The full range of images shown can be seen in Appendix 6.

212. In 2024 three in ten (30%) recalled the adverts and a further 27% remembered "similar" adverts, meaning that overall, over half (57%) recalled campaign adverts – significantly higher than 2021 (48%) and 2019 (35%). This increase is clearly a positive finding for the campaign.

213. As in previous waves, there was a lower level of recall amongst over 65s. Whilst this may be an ongoing cause for concern, it is positive to note a continued improvement in awareness among this group: just under half (48%) recalled adverts in 2024, compared with 35% in 2021 and only 20% in 2019.

Figure 30: Proportion seeing ads



Base: All respondents (2019=511, 2021=851, 2024=526)

214. Looked at by sub-groups the highest levels of recall of campaign materials are amongst 16-34s, females, and those who have had a personal experience of a mental health problem or known somebody with one.

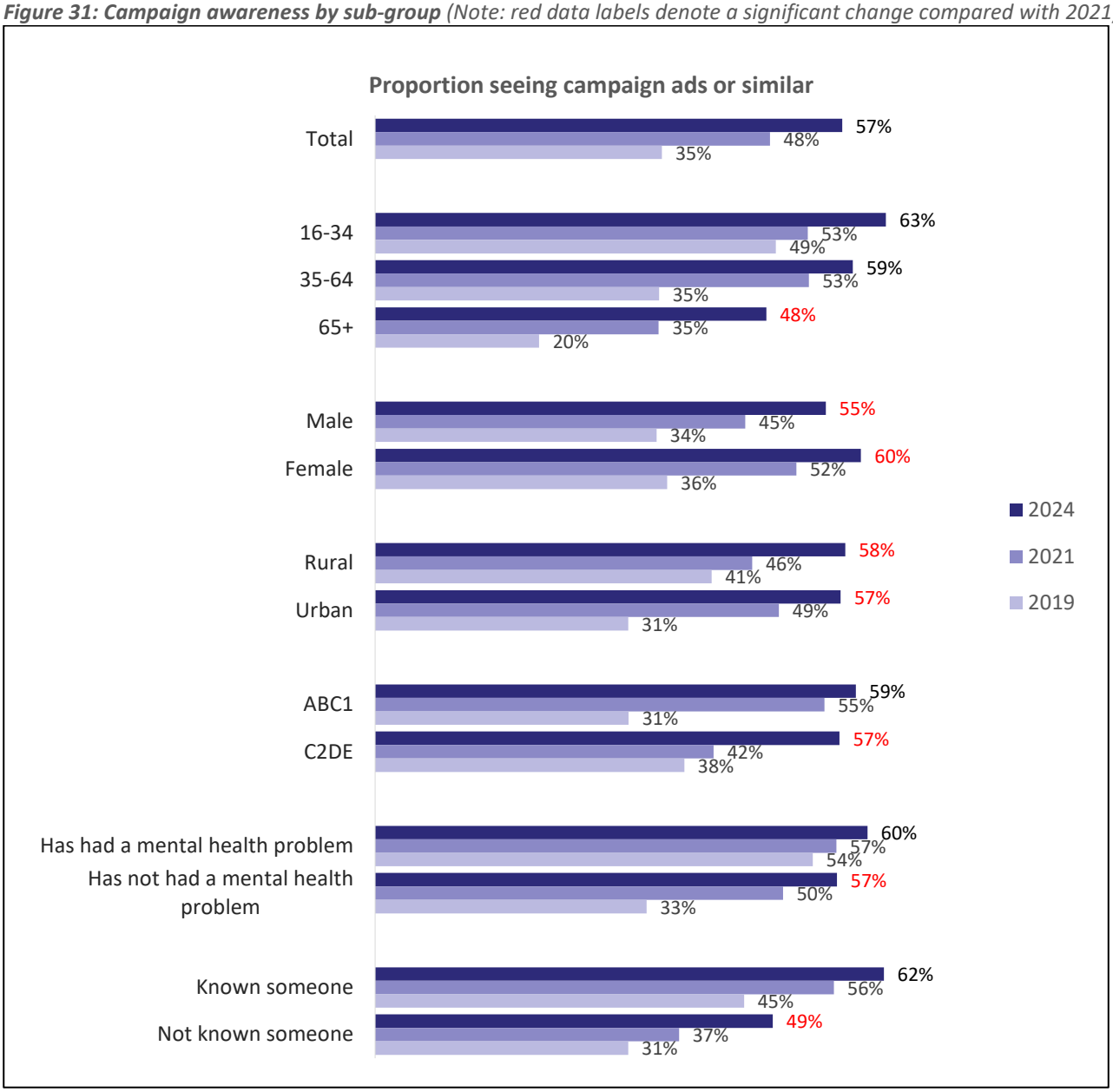
215. There have been indicative increases across all age groups in 2024, although only the change among over 65s can be said to be statistically significant. However, the level of recall among over 65s is still significantly lower than among other age groups.

216. In 2024, the proportions of males and females seeing campaign materials have both seen significant increases, while there were also significant increases in both urban and rural areas.

217. In 2021, ABC1s were significantly more likely to recall seeing ads than C2DEs. However, the level of recall among C2DEs has increased significantly in 2024, and there is now little difference between ABC1s (59%) and C2DEs (57%).

218. There have also been significant increases in recalling adverts among those in who do not have personal experience of a mental health problem, and there is no statistically significant difference in 2024 between those who have had a mental health problem (60%) and those who have not (57%).

Figure 31: Campaign awareness by sub-group *(Note: red data labels denote a significant change compared with 2021)*

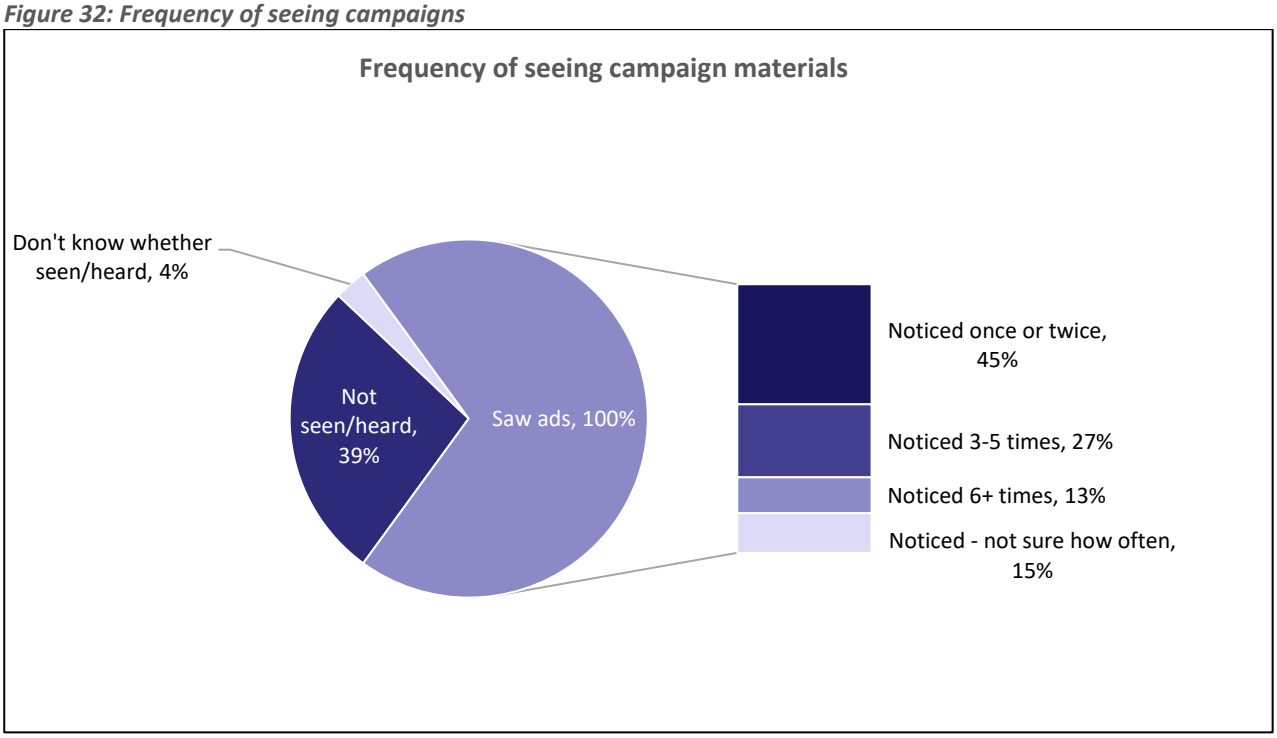


Base: All respondents (2019~511, 2021~851, 2024~526)

219. Those that had seen campaign adverts were asked how often they had seen them. Over four in five (45%) of all respondents had noticed once or twice but more than a tenth (13%) thought they had seen adverts six times or more.

220. The number of times (if any) that respondents have seen or heard relevant advertising is summarised overleaf.

Figure 32: Frequency of seeing campaigns



Base: All respondents (2024~526)

Appendices

Appendix 1 – List of figures

Appendix 2 - Interpretation of the data

Graphics are used in this report to support understanding of the data.

Charts show the proportions (percentages) of respondents making relevant responses. Where possible, the colours of the charts have been standardised with a 'traffic light' system in which:

- Green shades represent positive responses
- Beige and purple/blue shades represent neither positive nor negative responses
- Red shades represent negative responses
- The bolder shades are used to highlight responses at the 'extremes', for example, very satisfied or very dissatisfied

Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of 'don't know' categories, or multiple answers. Throughout the volume an asterisk (*) denotes any value less than half a per cent.

Generally, 'don't know' is included as a valid response in the charts. In some cases, 'prefer not to say' is also included as a valid response; where this is the case this has been noted.

Not all responses are necessarily included in charts.

In the report we have highlighted differences which are statistically significant. Data labels on charts that are coloured red indicate that the 2024 result is significantly different when compared with the 2021. Due to the rounding of individual percentages shown on the charts, in some cases the percentage difference reported in the text commentary may be one per cent higher or lower than the apparent difference shown on the corresponding chart.

Statistical testing takes into account the fact that there may be some variability between the sample of people that were interviewed and the whole population. Apparent differences in the data may not be considered to be statistically significant.

In order to test whether apparent differences over time or between sub-groups are statistically significant statistical tests are applied. These consider the sizes of the samples that are being compared and the level of confidence we need to have in our testing. In line with standard social research practice, we have used a 95% confidence level. In other words, we can be 95% certain that the difference has not occurred by chance.

To calculate statistical significance the following steps are taken:

1. The expected/required difference between the results (their sample means or proportions) is calculated. This is how much we expect the observed difference between two groups to vary due to sampling error. To do this we calculate a margin of error or confidence interval for the difference (using a z score of 1.96 assuming a confidence level of 95%). The margin of error will define the range around the observed difference where the true difference in the population is expected to lie.
2. The observed difference between the two results is calculated by subtracting one from the other.
3. If the observed difference is the same as or larger than the expected/required difference, then we can be 95% confident that the difference is statistically significant.

Appendix 3 – Weighting and respondent profile

Kantar conducted the interviewing and sampling for all three waves of this research. In 2019 and 2021 the fieldwork was conducted concurrently with fieldwork in England.

As this Wales report looked at only a sub sample of those interviewed in 2019 and 2021 it was established that the sample was not sufficiently representative for Wales only analysis. In 2019 following some discussion with Time to Change Wales it was decided to re-weight the data to ensure a more representative sample by location and WIMD classification. The impact of weighting can be seen in the table below.

2019 Sample Profile

Sub-groups	Target Population (Wales)	Actual Interviews		Applying ORS Weighting	
	%	Count	%	n	%
Male 16-24	7.2%	29	5.7%	36.0	7.0%
Male 25-34	7.7%	30	5.9%	39.0	7.6%
Male 35-44	6.8%	24	4.7%	41.5	8.1%
Male 45-54	8.2%	26	5.1%	41.6	8.1%
Male 55-64	7.5%	40	7.8%	42.3	8.3%
Male 65-74	6.8%	45	8.8%	35.1	6.9%
Male 75+	4.8%	36	7.0%	20.9	4.1%
Female 16-24	6.6%	26	5.1%	28.9	5.7%
Female 25-34	7.5%	43	8.4%	32.9	6.4%
Female 35-44	7.0%	40	7.8%	34.9	6.8%
Female 45-54	8.6%	34	6.7%	50.9	10.0%
Female 55-64	7.9%	37	7.2%	41.6	8.1%
Female 65-74	7.1%	53	10.4%	35.9	7.0%
Female 75+	6.4%	48	9.4%	29.4	5.8%
TOTAL	**100.0%**	**511**	**100.0%**	**511.0**	**100.0%**
Working	56.6%	190	37.2%	286.9	56.1%
Retired	25.3%	193	37.8%	131.7	25.8%
Otherwise not working	18.1%	128	25.0%	92.3	18.1%
TOTAL	**100.0%**	**511**	**100.0%**	**511**	**100.0%**
White	96.1%	484	94.7%	490.8	96.0%
Non-white	3.9%	27	5.3%	20.2	4.0%
TOTAL	**100.0%**	**511**	**100.0%**	**511**	**100.0%**
Rural	33.1%	215	42.2%	168.9	33.1%
Urban	66.9%	295	57.8%	341.2	66.9%
TOTAL	**100.0%**	**510**	**100.0%**	**510**	**100.0%**
1 Most deprived	8.6%	80	15.7%	43.5	8.5%
2	9.7%	53	10.4%	50.3	9.9%
3	10.1%	58	11.4%	60.3	11.8%
4	10.1%	41	8.0%	56.2	11.0%
5	10.5%	63	12.4%	49.4	9.7%
6	10.0%	69	13.5%	42.9	8.4%
7	10.2%	47	9.2%	44.1	8.6%
8	10.3%	16	3.1%	35.5	7.0%
9	10.0%	40	7.8%	59.2	11.6%
10 Least deprived	10.6%	43	8.4%	68.8	13.5%
TOTAL	**100.0%**	**510**	**100.0%**	**510**	**100.0%**

2021 Sample Profile

To maximise comparison a similar target weighting was used in 2021.

The self-completion methodology – cannot include a quota and therefore weighting is needed to correct for higher levels of participation by some sub-groups to ensure a more representative picture.

Sub-groups	Target Population (Wales)	Actual Interviews		Applying ORS Weighting	
	%	Count	%	n	%
Male 16-24	7.2%	33	3.9%	57.4	7.1%
Male 25-34	7.7%	47	5.5%	66.1	8.1%
Male 35-44	6.8%	47	5.5%	58.3	7.2%
Male 45-54	8.2%	39	4.6%	71.6	8.8%
Male 55-64	7.5%	37	4.3%	62.3	7.7%
Male 65-74	6.8%	60	7.1%	50.2	6.2%
Male 75+	4.8%	40	4.7%	34.0	4.2%
Female 16-24	6.6%	68	5.1%	44.6	5.5%
Female 25-34	7.5%	104	8.4%	63.7	7.8%
Female 35-44	7.0%	66	7.8%	60.3	7.4%
Female 45-54	8.6%	72	6.7%	74.9	9.2%
Female 55-64	7.9%	83	7.2%	66.1	8.1%
Female 65-74	7.1%	63	10.4%	50.6	6.2%
Female 75+	6.4%	54	9.4%	44.5	5.5%
TOTAL	**100.0%**	**813**	**100.0%**	**813**	**100.0%**
Working	56.6%	431	50.6%	480.7	56.5%
Retired	25.3%	261	30.7%	216.9	25.5%
Otherwise not working	18.1%	159	18.7%	153.3	18.0%
TOTAL	**100.0%**	**851**	**100.0%**	**851**	**100.0%**
White	96.1%	821	97.4%	821	97.4%
Non-white	3.9%	22	2.6%	22	2.6%
TOTAL	**100.0%**	**843**	**100.0%**	**843**	**100.0%**
Rural	33.1%	251	29.5%	281.7	33.1%
Urban	66.9%	600	70.5%	569.3	66.9%
TOTAL	**100.0%**	**851**	**100.0%**	**510**	**100.0%**
1 Most deprived	8.6%	91	10.7%	87.7	10.3%
2	9.7%	92	10.8%	85.3	10.0%
3	10.1%	76	8.9%	75.1	8.8%
4	10.1%	89	10.5%	89.4	10.5%
5	10.5%	83	9.8%	85.4	10.0%
6	10.0%	75	8.8%	76.0	8.9%
7	10.2%	82	9.6%	86.7	10.2%
8	10.3%	110	12.9%	111.9	13.2%
9	10.0%	66	7.8%	72.3	8.5%
10 Least deprived	10.6%	87	10.2%	81.2	9.5%
TOTAL	**100.0%**	**851**	**100.0%**	**851**	**100.0%**

2024 Sample Profile

To maximise comparison a similar target weighting was used in 2024.

The self-completion methodology – cannot include a quota and therefore weighting is needed to correct for higher levels of participation by some sub-groups to ensure a more representative picture.

Sub-groups	Target Population (Wales)	Actual Interviews		Applying ORS Weighting	
	%	Count	%	n	%
Male 16-24	6.60%	25	4.84%	44.5	8.61%
Male 25-34	7.32%	22	4.26%	36.2	7.02%
Male 35-44	6.88%	39	7.56%	34.6	6.70%
Male 45-54	7.64%	36	6.98%	37.0	7.17%
Male 55-64	8.06%	37	7.17%	40.4	7.83%
Male 65-74	6.80%	34	6.59%	32.0	6.20%
Male 75+	5.15%	23	4.46%	24.0	4.65%
Female 16-24	6.26%	33	6.40%	36.1	7.00%
Female 25-34	7.63%	47	9.11%	40.6	7.86%
Female 35-44	7.24%	59	11.43%	37.9	7.34%
Female 45-54	8.06%	39	7.56%	44.1	8.55%
Female 55-64	8.44%	51	9.88%	44.1	8.55%
Female 65-74	7.23%	45	8.72%	33.0	6.39%
Female 75+	6.69%	26	5.04%	31.7	6.14%
TOTAL	**100.00%**	**516**	**100.00%**	**516**	**100.00%**
Working	51.88%	306	58.29%	270.549	51.53%
Retired	24.68%	142	27.05%	133.121	25.35%
Otherwise not working	23.44%	77	14.67%	121.381	23.12%
TOTAL	**100.00%**	**525**	**100.00%**	**525**	**100.00%**
White	94.63%	487	95.49%	484.403	94.65%
Non-white	5.37%	23	4.51%	27.3702	5.35%
TOTAL	**100.00%**	**510**	**100.00%**	**512**	**100.00%**
Rural	33.38%	160	30.42%	175.6	33.38%
Urban	66.62%	366	69.58%	350.4	66.62%
TOTAL	**100.00%**	**526**	**100.00%**	**526**	**100.00%**
1 Most deprived	8.56%	55	10.46%	53.3	10.13%
2	9.81%	55	10.46%	54.8	10.43%
3	9.99%	57	10.84%	52.4	9.97%
4	10.04%	73	13.88%	70.4	13.39%
5	10.45%	41	7.79%	42.4	8.06%
6	10.15%	42	7.98%	41.7	7.93%
7	9.95%	51	9.70%	55.4	10.53%
8	10.42%	48	9.13%	50.3	9.57%
9	9.99%	62	11.79%	64.4	12.24%
10 Least deprived	10.64%	42	7.98%	40.8	7.76%
TOTAL	**100.00%**	**526**	**100.00%**	**526**	**100.00%**

Weighting factors are:

Gender Age interlocking
WIMD
Rural/Urban
Working Status
Ethnic Group
NOTE: weights were capped at 5 and reapportioned

Appendix 4 – Calculation of scores (CAMI, MAKS, RIBS)

To calculate CAMI Score

Twenty-seven questions are used
Q1_1 to Q1_27 are the source scores
Total score is calculated by adding response values for these questions.
Strongly agree should be given score of 5
Don't know was coded as neutral – score of 3
Some of the question scores were reverse coded to reflect direction of response

The SPSS file had coded these questions with strongly agree as "1" and Don't know as "6"
Therefore, recoded into new variables and used these new variables to calculate a final MAKS score

To calculate RIBS Score

Four questions are used
Q7_1 to Q7_4
Are the source scores
Total score is calculated by adding response values for these questions.
Strongly agree should be given score of 5
Don't know was coded as neutral – score of 3
The SPSS file had coded these questions with strongly agree as "1" and Don't know as "6"
Therefore, recoded into new variables and used these new variables to calculate a final RIBS score

To calculate MAKS Score

Six questions are used
Q8_1 to Q8_6
Are the source scores
Total score is calculated by adding response values for these questions.
Strongly agree should be given score of 5
Don't know was coded as neutral – score of 3
Q8_6 is reverse coded to reflect direction of response

The SPSS file had coded these questions with strongly agree as "1" and Don't know as "6"
Therefore, recoded into new variables and used these new variables to calculate a final MAKS score

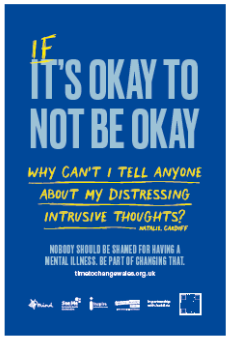
Appendix 5 – Summary of scores by sub-group

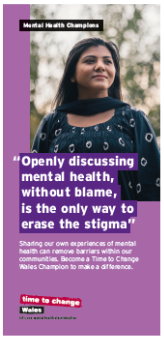
Sub- Group		2019 Base Size	2021 Base size	2024 Base Size	2019 CAMI Score	2021 CAMI Score	2024 CAMI Score
TOTAL	Total	511	851	526	112.97	113.71	108.91
Gender	Male	230	313	216	111.28	112.77	106.26
	Female	281	523	300	114.68	114.82	111.65
Age (Grouped)	16-34	128	258	132	112.18	114.64	108.12
	35-64	201	350	264	115.03	114.89	110.19
	65+	182	220	129	109.59	110.52	107.29
Working Status	Working	190	431	306	113.92	114.63	108.62
	Retired	193	261	142	109.80	110.56	107.95
	Otherwise not working	128	159	77	114.55	115.29	110.48
Ethnicity	White	484	821	487	113.32	113.93	109.42
	Non-white	27	22	23	104.48	109.08	101.7
Location	Rural	215	251	160	114.85	113.32	110.01
	Urban	295	600	366	112.01	113.90	108.36
Welsh Speaking	Yes	109	162	94	115.27	114.38	109.19
	No	402	688	421	112.40	113.55	108.89
Marital Status	Married	243	506	317	113.44	113.65	108.92
	Sep/Wid/div	125	119	68	110.36	112.04	110.36
	Single	143	226	138	113.68	114.62	108.3
Welsh Index of Multiple Deprivation	Most deprived - 1	133	183	110	111.90	113.36	108.48
	2	99	165	130	110.96	112.05	109.22
	3	132	158	83	112.61	113.70	108.04
	4	63	192	99	113.75	113.85	109.09
	Least deprived - 5	83	153	104	115.28	115.72	109.51
Social Grade (grouped)	ABC1	180	426	274	115.14	116.00	111.82
	C2DE	331	420	242	111.50	111.36	105.98
Personal Experience of mental health problem	Yes	69	138	108	120.38	119.35	115.94
	No	418	611	384	112.40	113.53	107.44
Known someone with mental health problem in past year	Yes	160	436	287	117.88	117.71	112.79
	No	335	307	156	111.08	109.63	104.38
Parent / Guardian of child under 18	No	382	667	362	112.44	113.84	108.98
	Yes	129	182	152	114.26	113.56	108.99
Campaign Awareness	Yes - seen/heard ads	101	228	161	116.31	115.54	110.83
	Yes - seen/heard similar ads	75	180	143	112.96	115.25	109.01
	No - Not seen/heard	326	379	202	111.88	112.76	107.95

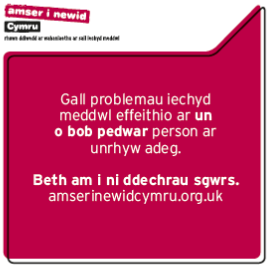
	Sub- Group	2019 Base Size	2021 Base Size	2024 Base Size	2019 MAKS Score	2021 MAKS Score	2024 MAKS Score
TOTAL	Total	511	851	526	22.87	22.99	22.62
Gender	Male	230	313	216	22.47	22.84	22.30
	Female	281	523	300	23.28	23.24	22.97
Age (Grouped)	16-34	128	258	132	23.05	23.10	22.78
	35-64	201	350	264	23.11	23.15	22.74
	65+	182	220	129	22.17	22.59	22.19
Working Status	Working	190	431	306	23.23	23.19	22.72
	Retired	193	261	142	22.12	22.58	22.22
	Otherwise not working	128	159	77	22.84	22.96	22.85
Ethnicity	White	484	821	487	22.89	23.04	22.70
	Non-white	27	22	23	22.48	22.38	22.21
Location	Rural	215	251	160	23.33	22.83	22.34
	Urban	295	600	366	22.64	23.07	22.76
Welsh Speaking	Yes	109	162	94	23.30	23.08	22.82
	No	402	688	421	22.77	22.97	22.61
Marital Status	Married	243	506	317	23.16	23.09	22.60
	Sep/Wid/div	125	119	68	21.76	22.88	22.42
	Single	143	226	138	23.01	22.84	22.78
Welsh Index of Multiple Deprivation	Most deprived - 1	133	183	110	22.54	22.95	22.70
	2	99	165	130	22.53	22.57	23.09
	3	132	158	83	23.30	22.99	22.69
	4	63	192	99	22.48	23.05	22.41
	Least deprived - 5	83	153	104	23.35	23.44	22.15
Social Grade (grouped)	ABC1	180	426	274	23.41	23.42	23.07
	C2DE	331	420	242	22.51	22.55	22.19
Personal Experience of mental health problem	Yes	69	138	108	24.35	24.21	23.95
	No	418	611	384	22.79	22.92	22.30
Known Someone with mental health problem in past year	Yes	160	436	287	24.29	23.72	23.50
	No	335	307	156	22.27	22.43	21.45
Parent / Guardian of child under 18	No	382	667	362	22.64	23.04	22.62
	Yes	129	182	152	23.43	22.86	22.73
Campaign Awareness	Yes - seen/heard ads	101	228	161	23.75	23.60	23.07
	Yes - seen/heard similar ads	75	180	143	23.71	23.66	22.62
	No - Not seen/heard	326	379	202	22.34	22.55	22.32

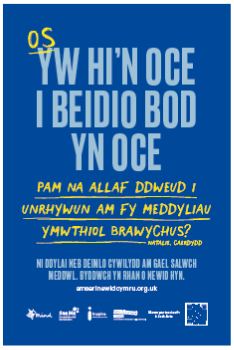
	Sub- Group	2019 Base Size	2021 Base Size	2024 Base Size	2019 RIBS Score	2021 RIBS Score	2024 RIBS Score
TOTAL	Total	511	851	526	16.97	17.06	16.45
Gender	Male	230	313	216	16.74	16.88	15.92
	Female	281	523	300	17.20	17.32	17.02
Age (Grouped)	16-34	128	258	132	17.43	18.04	17.19
	35-64	201	350	264	17.40	17.39	16.77
	65+	182	220	129	15.55	15.36	14.81
Working Status	Working	190	431	306	17.36	17.49	16.69
	Retired	193	261	142	15.82	15.49	15.01
	Otherwise not working	128	159	77	17.40	17.95	17.46
Ethnicity	White	484	821	487	17.07	17.11	16.54
	Non-white	27	22	23	14.54	15.52	15.78
Location	Rural	215	251	160	17.18	17.02	16.42
	Urban	295	600	366	16.86	17.09	16.46
Welsh Speaking	Yes	109	162	94	18.04	17.25	16.83
	No	402	688	421	16.70	17.02	16.35
Marital Status	Married	243	506	317	17.22	17.12	16.51
	Sep/Wid/div	125	119	68	15.72	15.66	15.76
	Single	143	226	138	17.25	17.60	16.64
Welsh Index of Multiple Deprivation	Most deprived - 1	133	183	110	16.71	17.34	16.46
	2	99	165	130	16.92	16.78	16.73
	3	132	158	83	16.66	17.07	16.56
	4	63	192	99	16.75	17.03	16.42
	Least deprived - 5	83	153	104	17.54	17.10	16.04
Social Grade (grouped)	ABC1	180	426	274	17.40	17.64	17.08
	C2DE	331	420	242	16.67	16.50	15.85
Personal Experience of mental health problem	Yes	69	138	108	18.57	18.64	17.91
	No	418	611	384	16.70	17.13	16.19
Known Someone with mental health problem in past year	Yes	160	436	287	18.43	18.20	17.45
	No	335	307	156	16.20	15.90	15.01
Parent / Guardian of child under 18	No	382	667	362	16.73	16.92	16.21
	Yes	129	182	152	17.54	17.66	17.14
Campaign Awareness	Yes - seen/heard ads	101	228	161	17.53	17.45	16.99
	Yes - seen/heard similar ads	75	180	143	17.33	17.83	16.77
	No - Not seen/heard	326	379	202	16.69	16.69	16.00

Appendix 6 – Campaign materials



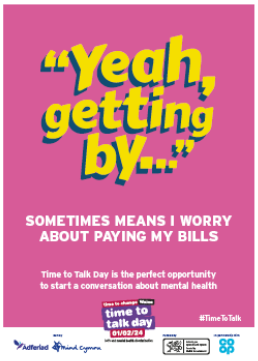


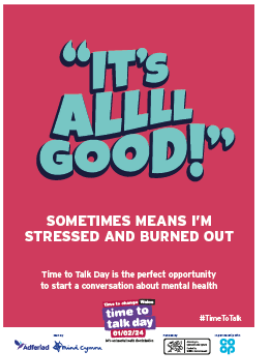





Gyda'n gilydd, byddwn ni'n rhoi diwedd ar stigma iechyd meddwl
Together, we will end mental health stigma


"NOT TOOOO BAD"
SOMETIMES MEANS I FEEL LOST AND ALONE
Time to Talk Day is the perfect opportunity to start a conversation about mental health
#TimeToTalk

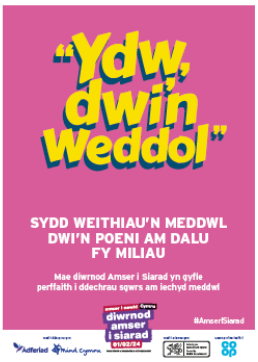

"Yeah, getting by..."
SOMETIMES MEANS I WORRY ABOUT PAYING MY BILLS
Time to Talk Day is the perfect opportunity to start a conversation about mental health
#TimeToTalk


"IT's ALLLL GOOD!"
SOMETIMES MEANS I'M STRESSED AND BURNED OUT
Time to Talk Day is the perfect opportunity to start a conversation about mental health
#TimeToTalk


Together, we will end mental health stigma
Mental health stigma can be a barrier for those seeking support. We're here to change that. Join our movement to make a difference.


Gyda'n gilydd, byddwn ni'n rhoi diwedd ar stigma iechyd meddwl
Together, we will end mental health stigma


"Helo, sut hwyl?"
SYDD WEITHIAU'N MEDDWL DWI YMA OS WYT TI EISIAU SIARAD
Mae diwrnod Amser i Siarad yn gyfle perffaith i ddechrau sgwrs am iechyd meddwl
#AmserISiarad


"Ydw, dwin weddol"
SYDD WEITHIAU'N MEDDWL DWI'N POENI AM DALU FY MILIAU
Mae diwrnod Amser i Siarad yn gyfle perffaith i ddechrau sgwrs am iechyd meddwl
#AmserISiarad


"POPETH YN DDAA"
SYDD WEITHIAU'N MEDDWL DWI O DAN STRAEN AC YN GORWNEUD PETHAU
Mae diwrnod Amser i Siarad yn gyfle perffaith i ddechrau sgwrs am iechyd meddwl
#AmserISiarad


Gyda'n gilydd, byddwn ni'n rhoi diwedd ar stigma iechyd meddwl

Appendix 7 – Letter and questionnaire

time to change Wales
let's end mental health discrimination

The Resident(s)
Address Line 1
Address Line 2
Address Line 3
Postcode

This is an invitation to take part in a survey for Time to Change Wales about mental health and attitudes towards mental illness.

Your contribution will help mental health charities to track changes over time and to plan their activities and support. The survey findings will be shared with funders and policymakers, so it is important we obtain views from as many different people as possible.

Each person who completes the survey will receive a **£10 gift voucher** to thank them for their time.

It's easy to take part. Simply go to **www.xxxxx.com** and log in using one of the reference number and password details provided below. Each set of login details can only be used once. Up to four people aged 16 and over can take part in your household, we have provided 3 logins below but if you need more, please contact us using the email address at the bottom of this letter.

Login 1	Login 2	Login 3
Ref No: xxxxxx	**Ref No: xxxxx**	**Ref No: xxxxx**
Password: xxxxxx	**Password: xxxx**	**Password: xxxxx**

The closing date for the survey is **Monday 13th May 2024.**

The survey can be completed on a laptop, tablet, or smartphone. If you are unable to complete the survey online and require a paper version of the questionnaire, please use the contact details provided in the box below.

I hope you enjoy the opportunity to express your thoughts and opinions.

Yours faithfully,
Lowri Wyn Jones
Time to Change Wales Programme Manager

This study is being carried out on behalf of Time to Change Wales by Verian, an independent social research organisation. If you would like to contact us about the study or if you require a postal version of the questionnaire, please contact Verian via the email address below.
mentalhealthsurvey@veriangroup.com

time to change Wales
let's end mental health discrimination

Verian | Attitudes towards Mental illness Wales 2024

13 February 2024

Content

Q056 – Merit_Voucher:

Q001 - Welsh_language_select: **Single coded**

Not back

Which language would you like to do the survey in?

Normal

1	English
2	Welsh

Q003 - Survey_Intro: **Text**

Not back

Hi there! This survey is conducted by Verian on behalf of Time to Change Wales.
We are going to ask you about your opinions on mental illness. It will take up to 15 minutes.

Time to Change Wales have been tracking attitudes to mental health among the general public for many years to see how opinion has changed. This survey uses some questions that were developed in the late 1970s, and which have been widely used in many surveys since then. The phrases used in these questions may seem outdated but it is important for us to use the same questions, without updating the wording, to allow us to measure genuine change over time.

Mental health problems range from common problems, such as depression and anxiety, to rarer problems such as schizophrenia and bipolar disorder.

If possible, please complete the survey in one sitting, since you will be unable to access it at a later time.
If you have any questions or wish to review the privacy policy during the survey, please click the 3 bars in the bottom left hand corner of the screen

Q004 - Consent_Text: **Text**

Not back

This survey includes some questions about your mental health as it helps our analysis to understand how people's own mental health affects their views of others. If there are any questions you do not wish to answer there is a 'Prefer not to say' option at every question.

Q005 - Q1: Opinions **Matrix**

Not back | Number of rows: 27 | Number of columns: 6

First, we would like to ask you about some opinions which other people hold about mental illness and would like you to tell us how much you agree or disagree with each one...

Rows: Random | Columns: Normal

Rendered as Dynamic Grid

		Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know *Fixed *Exclusive	Prefer not to say *Fixed
		1	2	3	4	5	999	99
1. One of the main causes of mental illness is a lack of self-discipline and will-power	1	❍	❍	❍	❍	❍	❍	❍
2. There is something about people with mental illness that makes it easy to tell them from normal people	2	❍	❍	❍	❍	❍	❍	❍
3. As soon as a person shows signs of mental disturbance, they should be hospitalized	3	❍	❍	❍	❍	❍	❍	❍
4. Mental illness is an illness like any other	4	❍	❍	❍	❍	❍	❍	❍
5. Less emphasis should be placed on protecting the public from people with mental illness	5	❍	❍	❍	❍	❍	❍	❍
6. Mental hospitals are an outdated means of treating people with mental illness	6	❍	❍	❍	❍	❍	❍	❍
7. Virtually anyone can become mentally ill	7	❍	❍	❍	❍	❍	❍	❍
8. People with mental illness have for too long been the subject of ridicule	8	❍	❍	❍	❍	❍	❍	❍
9. We need to adopt a far more tolerant attitude toward people with mental illness in our society	9	❍	❍	❍	❍	❍	❍	❍
10. We have a responsibility to provide the best possible care for people with mental illness	10	❍	❍	❍	❍	❍	❍	❍
11. People with mental illness don't deserve our sympathy	11	❍	❍	❍	❍	❍	❍	❍
12. People with mental illness are a burden on society	12	❍	❍	❍	❍	❍	❍	❍
13. Increased spending on mental health services is a waste of money	13	❍	❍	❍	❍	❍	❍	❍
14. There are sufficient existing services for people with mental illness	14	❍	❍	❍	❍	❍	❍	❍
15. People with mental illness should not be given any responsibility	15	❍	❍	❍	❍	❍	❍	❍
16. A person would be foolish to marry someone who has suffered from mental illness, even though they seem fully recovered	16	❍	❍	❍	❍	❍	❍	❍
17. I would not want to live next door to someone who has been mentally ill	17	❍	❍	❍	❍	❍	❍	❍
18. Anyone with a history of mental problems should be excluded from taking public office	18	❍	❍	❍	❍	❍	❍	❍
19. No-one has the right to exclude people with mental illness from their neighbourhood	19	❍	❍	❍	❍	❍	❍	❍
20. People with mental illness are far less of a danger than most people suppose	20	❍	❍	❍	❍	❍	❍	❍
21. Most people who were once patients in a mental hospital can be trusted as babysitters	21	❍	❍	❍	❍	❍	❍	❍

22. The best therapy for many people with mental illness is to be part of a normal community	22	❍	❍	❍	❍	❍	❍	❍	
23. As far as possible, mental health services should be provided through community based facilities	23	❍	❍	❍	❍	❍	❍	❍	
24. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	24	❍	❍	❍	❍	❍	❍	❍	
25. It is frightening to think of people with mental problems living in residential neighbourhoods	25	❍	❍	❍	❍	❍	❍	❍	
26. Locating mental health facilities in a residential area downgrades the neighbourhood	26	❍	❍	❍	❍	❍	❍	❍	
27. People with mental health problems should have the same rights to a job as anyone else	27	❍	❍	❍	❍	❍	❍	❍	

Q006 - Intro_2: **Text**

Not back

For the next few questions, we will ask about your experiences and views in relation to people who have mental health problems. By this, we mean people who have been seen by healthcare staff for a mental health problem.

We use the phrase 'mental health problems', as many people have told us this feels helpful for them. Or you may feel that terms such as 'mental illness' or 'mental health issues' describe your experiences better, or are easier to explain to other people in your life.

Q007 - Q3: **Single coded**

Not back

Are you currently living with, or have you ever lived with, someone with a mental health problem?

Normal

1	Yes
2	No
3	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q008 - Q4: **Single coded**

Not back

Are you currently working, or have you ever worked, with someone with a mental health problem?

Normal

1	Yes
2	No
3	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q009 - Q5: **Single coded**

Not back

Do you currently, or have you ever, had a neighbour with a mental health problem?

Normal

1	Yes
2	No
3	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q010 - Q6: **Single coded**

Not back

Do you currently have, or have you ever had, a close friend with a mental health problem?

Normal

1	Yes
2	No
3	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q011 - Q7: **Matrix**

Not back | Number of rows: 4 | Number of columns: 6

The following statements are about any future relationships you may experience with people with mental health problems. Please tell us how much you agree or disagree with each one.

Rows: Normal | Columns: Normal

Rendered as Dynamic Grid

		Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know **Fixed *Exclusive*	Prefer not to say **Fixed*
		1	2	3	4	5	999	99
1. In the future, I would be willing to live with someone with a mental health problem	1	❍	❍	❍	❍	❍	❍	❍
2. In the future, I would be willing to work with someone with a mental health problem	2	❍	❍	❍	❍	❍	❍	❍
3. In the future, I would be willing to live nearby to someone with a mental health problem	3	❍	❍	❍	❍	❍	❍	❍
4. In the future, I would be willing to continue a relationship with a friend who developed a mental health problem	4	❍	❍	❍	❍	❍	❍	❍

Q012 - Q8: **Matrix**

Not back | Number of rows: 6 | Number of columns: 6

How much you agree or disagree with the following statements about mental health problems, again that is conditions for which an individual would be seen by healthcare staff.

Rows: Random | Columns: Normal

Rendered as Dynamic Grid

		Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know *Fixed *Exclusive	Prefer not to say *Fixed
		1	2	3	4	5	999	99
1. Most people with mental health problems want to have paid employment	1	❍	❍	❍	❍	❍	❍	❍
2. If a friend had a mental health problem, I know what advice to give them to get professional help	2	❍	❍	❍	❍	❍	❍	❍
3. Medication can be an effective treatment for people with mental health problems	3	❍	❍	❍	❍	❍	❍	❍
4. Psychotherapy (e.g., talking therapy or counselling) can be an effective treatment for people with mental health problems	4	❍	❍	❍	❍	❍	❍	❍
5. People with severe mental health problems can fully recover	5	❍	❍	❍	❍	❍	❍	❍
6. Most people with mental health problems go to a healthcare professional to get help	6	❍	❍	❍	❍	❍	❍	❍

Q013 - Q9: **Matrix**

Not back | Number of rows: 6 | Number of columns: 6

To what extent you agree or disagree that each of the following conditions is a type of mental illness.

Rows: Random | Columns: Normal

Rendered as Dynamic Grid

		Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know *Fixed *Exclusive	Prefer not to say *Fixed
		1	2	3	4	5	999	99
1. Depression	1	❍	❍	❍	❍	❍	❍	❍
2. Stress	2	❍	❍	❍	❍	❍	❍	❍
3. Schizophrenia	3	❍	❍	❍	❍	❍	❍	❍
4. Bipolar disorder (manic-depression)	4	❍	❍	❍	❍	❍	❍	❍
5. Drug addiction	5	❍	❍	❍	❍	❍	❍	❍
6. Grief	6	❍	❍	❍	❍	❍	❍	❍

Q014 - Q10: **Single coded**

Not back

Who is the person closest to you who has or has had some kind of mental illness ?

Normal

1	Immediate family (spouse\child\sister\brother\parent etc)
2	Partner (living with you)
3	Partner (not living with you)
4	Other family (uncle\aunt\cousin\grand parent etc)
5	Friend
6	Acquaintance
7	Work colleague
8	Self
9	Other (please specify) **Open *Fixed*
10	No-one known **Fixed*
11	Prefer not to say **Fixed*

Q015 - Q12: **Single coded**

Not back

If you felt that you had a mental health problem, how likely would you be to go to your GP for help?

Normal

1	Very likely
2	Quite likely
3	Neither likely nor unlikely
4	Quite unlikely
5	Very unlikely
6	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q016 - Q13: **Single coded**

Not back

In general, how comfortable would you feel talking to a friend or family member about your mental health, for example telling them you have a mental health diagnosis and how it affects you?

Normal

1	Very uncomfortable
2	Moderately uncomfortable
3	Slightly uncomfortable
4	Neither comfortable nor uncomfortable
5	Fairly comfortable
6	Moderately comfortable
7	Very comfortable
8	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q017 - Q14: **Single coded**

Not back

In general, how comfortable would you feel talking to a current or prospective employer about your mental health, for example telling them you have a mental health diagnosis and how it affects you?

Normal

1	Very uncomfortable
2	Moderately uncomfortable
3	Slightly uncomfortable
4	Neither comfortable nor uncomfortable
5	Fairly comfortable
6	Moderately comfortable
7	Very comfortable
8	Not applicable **Fixed*
9	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Images: **Text**

Not back

Please take your time to look at the different adverts that have appeared on television, radio, magazines or on the web.

Please click on each image to ensure you have reviewed all adverts before you carry on to the next question.

Q019 - Q17: **Single coded**

Not back

Thinking about the images you have seen…

Have you seen or heard any of this advertising, or similar during the last year?

Normal

1	Yes - seen or heard some of these ads
2	Yes - seen or heard similar ads
3	No - Not seen
999	Don't know **Fixed *Exclusive*

Ask only if **Q019 - Q17**,1,2

Q020 - Q18: **Single coded**

Not back

How many times, have you seen or heard ANY of the advertising in the pictures before today?

Please answer as best you can even if it is just an estimate.

Normal

1	Once or twice
2	Three to five times
3	Six times or more
999	Don't know **Fixed *Exclusive*

Q021 - Q19 **Single coded**

Not back

Has any adult aged 16 or over that you know had a mental health problem over the last twelve months, excluding yourself?

This is only if you definitely know they have a mental health problem, not speculative

Normal

1	Yes
2	No
999	Don't know **Fixed *Exclusive*
997	Prefer not to say **Fixed *Exclusive*

Intro_4: **Text**

Not back

In the next part of the survey, we will ask you about whether people have treated this person unfairly because of their mental health problems, and also about whether they have been treated more positively because of them. We are interested in how people have reacted to this person as a result of their mental health problems.

We would like you to think about situations that have occurred in the last 12 months specifically. If you don't know whether this person was treated any differently in a particular situation, you have the option to say so.

Ask only if **Q19**,1

Q032 - Q26: **Matrix**

Not back | Number of rows: 13 | Number of columns: 6

As a result of their mental health problem, how has this person been treated…

Rows: Normal | Columns: Normal

Rendered as Dynamic Grid

	Unfairly	Fairly	More positively	Not applicable	Don't know **Fixed *Exclusive*	Prefer not to say **Fixed *Exclusive*
In making or keeping friends	❍	❍	❍	❍	❍	❍
By the people in their neighbourhood	❍	❍	❍	❍	❍	❍
In dating or intimate relationships, including treatment by spouse or co-habiting partner	❍	❍	❍	❍	❍	❍
In education	❍	❍	❍	❍	❍	❍
In marriage or divorce	❍	❍	❍	❍	❍	❍
By their family	❍	❍	❍	❍	❍	❍
In finding a job	❍	❍	❍	❍	❍	❍
In keeping a job	❍	❍	❍	❍	❍	❍
In their social life	❍	❍	❍	❍	❍	❍
When getting help for physical health problems	❍	❍	❍	❍	❍	❍
By mental health staff	❍	❍	❍	❍	❍	❍
In their role as a parent	❍	❍	❍	❍	❍	❍
In any other areas of life	❍	❍	❍	❍	❍	❍

Ask only if **Q014 - Q10**,8

Q041 - Q33: **Single coded**

Not back

In the past 12 months, have you spoken to a GP or family doctor on your own behalf, either in person or by telephone about being anxious or depressed or a mental, nervous, or emotional problem?

Do not include telephone calls to the NHS 111 service

Normal

1	Yes
2	No
3	Prefer not to say **Fixed*
999	Don't know **Fixed *Exclusive*

Q065 - PrDepres: **Single coded**

Not back

Suppose an employee applied for a promotion. They have had repeated periods off work because of depression but this has been under control for a year or so through medication. Do you think they would be ...

Select ONE answer only

Normal

1	...just as likely as anyone else to be promoted?
2	...slightly less likely to be promoted?
3	...much less likely to be promoted?
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q066 - ShdDep: **Single coded**

Not back

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

Normal

1	Definitely should
2	Probably should
3	Probably should not
4	Definitely should not
5	Depends on the job / type of work / depends on whether it would affect his / her job
996	Other, namely... **Open *Fixed*
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q067 - PrSchiz: **Single coded**

Not back

Suppose an employee applied for a promotion. They have had repeated periods off work because of schizophrenia but this has been under control for a year or so through medication. Do you think they would be ...

Select ONE answer only

Normal

1	...just as likely as anyone else to be promoted?
2	...slightly less likely to be promoted?
3	...much less likely to be promoted?
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q068 - ShdSchiz: **Single coded**

Not back

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

Normal

1	Definitely should
2	Probably should
3	Probably should not
4	Definitely should not
5	Depends on the job / type of work / depends on whether it would affect his / her job
996	Other, namely... **Open *Fixed*
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q075_1 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia are a danger to others or not a danger to others?

Please use 5-point scale to indicate your answer
1 = A danger to others, 5 = Not a danger to others

Q075_2 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia are unpredictable or not unpredictable?

Please use 5-point scale to indicate your answer
1 = Unpredictable, 5 = Not unpredictable

Q075_3 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia are hard to talk to or not hard to talk to?

Please use 5-point scale to indicate your answer
1 = Hard to talk to, 5 = Not hard to talk to

Q075_4 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia feel differently to others or do not feel differently to others?

Please use 5-point scale to indicate your answer
1 = Feel differently to others, 5 = Do not feel differently to others

Q075_5 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia have themselves to blame or do not have themselves to blame?

Please use 5-point scale to indicate your answer
1 = Have themselves to blame, 5 = Do not have themselves to blame

Q075_6 - BehSchiz: **Left-right slider**

In your opinion, do you think that people with Schizophrenia can pull themselves together or can't pull themselves together?

Please use 5-point scale to indicate your answer
1 = Can pull themselves together, 5 = Can't pull themselves together

Q069 - PrDiab: **Single coded**

Not back

Suppose an employee applied for a promotion. They have had repeated periods off work because of diabetes but this has been under control for a year or so through medication. Do you think they would be ...

Select ONE answer only

Normal

1	...just as likely as anyone else to be promoted?
2	...slightly less likely to be promoted?
3	...much less likely to be promoted?
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q070 - ShdDiab: **Single coded**

Not back

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

Normal

1	Definitely should
2	Probably should
3	Probably should not
4	Definitely should not
5	Depends on the job / type of work / depends on whether it would affect his / her job
996	Other, namely... **Open *Fixed*
999	Don't know **Fixed *Exclusive*
99	Prefer not to say **Fixed*

Q071 - MHInt2b: **Text**

Not back

Please consider the following scenario and then answer the questions that follow about this person...

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

Q072 - MHV1b: **Matrix**

Not back | Number of rows: 6 | Number of columns: 7

And now we would like you to think about how willing, or unwilling, you would be to ...

Rows: Normal | Columns: Rotated

Rendered as Dynamic Grid

		Very willing	Fairly willing	Neither willing nor unwilling	Fairly unwilling	Very unwilling	Don't know *Fixed *Exclusive	Prefer not to say *Fixed
		1	2	3	4	5	999	99
.. move next door to Gareth?	1	❍	❍	❍	❍	❍	❍	❍
... spend time socialising with Gareth?	2	❍	❍	❍	❍	❍	❍	❍
... make friends with Gareth?	3	❍	❍	❍	❍	❍	❍	❍
... have Gareth as a workmate or colleague?	4	❍	❍	❍	❍	❍	❍	❍
... have Gareth marry into the family?	5	❍	❍	❍	❍	❍	❍	❍
... have Gareth provide childcare for someone in your family (for example babysitting or child minding)?	6	❍	❍	❍	❍	❍	❍	❍

Q073 - MHInt3b: **Text**

Not back

The following scenario describes a different person. Now please consider this scenario and then answer the questions that follow about this person...

Stephen has been feeling really down for about six months and his family have noticed that he hasn't been himself. He doesn't enjoy things the way he normally would. He wakes up early in the morning with a flat heavy feeling that stays with him all day long. He has to force himself to get through the day, and even the smallest things seem hard to do. He finds it hard to concentrate on anything and has no energy.

Q074 - MHV2b: **Matrix**

Not back | Number of rows: 6 | Number of columns: 7

And now we would like you to think about how willing, or unwilling, you would be to ...

Rows: Normal | Columns: Rotated

Rendered as Dynamic Grid

		Very willing	Fairly willing	Neither willing nor unwilling	Fairly unwilling	Very unwilling	Don't know *Fixed *Exclusive	Prefer not to say *Fixed
		1	2	3	4	5	999	99
.. move next door to Stephen?	1	❍	❍	❍	❍	❍	❍	❍
... spend time socialising with Stephen?	2	❍	❍	❍	❍	❍	❍	❍
... make friends with Stephen?	3	❍	❍	❍	❍	❍	❍	❍
... have Stephen as a workmate or colleague?	4	❍	❍	❍	❍	❍	❍	❍
... have Stephen marry into the family?	5	❍	❍	❍	❍	❍	❍	❍
... have Stephen provide childcare for someone in your family (for example babysitting or child minding)?	6	❍	❍	❍	❍	❍	❍	❍

B001 - SexDemogsEnd_INTRO: Demographics **Begin block**

Q043 - SexDemogs_INTRO: **Text**

Not back

We just have a few final questions about you to make sure we're talking to a representative sample...

Q044 - Age: **Single coded**

Not back

Which of the following age groups are you in?

Please pick one option only.

Normal

1	Under 16	➔ GO TO SCREEN OUT
2	16-17	
3	18-24	
4	25-34	
5	35-44	
6	45-54	
7	55-64	
8	65-74	
9	75-84	
10	85 and above	

Q045 - Gender: Gender **Single coded**

Not back

What best describes your gender?

Normal

1	Male
2	Female
96	I don't identify as either **Fixed*
97	Prefer not to answer **Fixed*

Q046 - emp: Employment Status **Single coded**

Not back

Which of the following best describes you?

Normal

1	Full-time paid work (30+ hours per week)
2	Part-time paid work (8-29 hours per week)
3	Part-time paid work (under 8 hours per week)
4	Retired
5	Still at school
6	In full time higher education
7	Unemployed (seeking work)
8	Not in paid employment (not seeking work)

Q047 - Social_Status: Social Status & UK SEC **Single coded**

Not back

Which of the following groups does the Chief Income Earner in your household belong to...

The person in the household with the largest income is the Chief Income Earner, however this income is obtained

If the Chief Income Earner is retired and has an occupational pension, please select according to the previous occupation

If the Chief Income Earner is not in paid employment and has been out of work for less than 6 months, please select according to previous occupation

Normal

1	Semi or unskilled manual worker (e.g. manual jobs that require no special training or qualifications, manual workers, apprentices to be skilled trades, caretaker, cleaner, nursery school assistant, park keeper, non-HGV driver, shop assistant etc)
2	Skilled manual worker (e.g. skilled bricklayer, carpenter, plumber, painter, bus/ambulance driver, HGV driver, unqualified assistant teacher, AA patrolman, pub/bar worker, etc)
3	Supervisory or clerical/junior managerial/professional/administrator (e.g. office worker, student doctor, foreman with 25+ employees, salesperson, student teachers, etc)
4	Intermediate managerial/professional/administrative (e.g. newly qualified (under 3 years) doctor, solicitor, board director small organisation, middle manager in large organisation, principle officer in civil service/local government, etc)
5	Higher managerial/professional/administrative (e.g. established doctor, solicitor, board director in large organisation (200+ employees, top level civil servant/public service employee), headmaster/mistress, etc)
6	Student
7	Retired and living on state pension only
8	Unemployed (for over 6 months) or not working due to long term sickness

Q048 - MaritalStatus: Marital Status **Single coded**

Not back

Are you...?

Normal

1	Single
2	Married\Civil Partnership
3	Living as a couple
4	Widowed
5	Divorced
6	Separated

Q049 - Ethnicity_UK: Ethnicity - UK — **Single coded**

Not back

Which ethnic group would you describe yourself as?

Normal

1	British/English Welsh/Scottish/Northern Irish
2	White Irish
3	Other White background
4	White & Black Caribbean
5	White & Black African
6	White and Asian
7	Asian/Asian British
8	Indian
9	Pakistani
10	Bangladeshi
11	Chinese
12	Other Asian background
13	African
14	Caribbean
15	Other Black/African/Caribbean
96	Other **Fixed*
97	Prefer not to say **Fixed *Exclusive*

QYi: — **Single coded**

Not back

Are you the parent or guardian of any children aged under 18?

Normal

1	Yes parent
2	Yes guardian
3	No
997	Prefer not to say **Fixed *Exclusive*

QY: — **Single coded**

Not back

How would you describe your ability to speak Welsh?

Normal

1	Speak Welsh fluently
2	Speak Welsh, but not fluent
3	Learning Welsh
4	Do not speak Welsh

B001 - SexDemogsEnd_INTRO: Demographics — **End block**

Q056 – Merit_Voucher: **Text**

Not back

Thank you for taking part.

As an appreciation for completing the Attitudes to Mental Health Survey, ~~Kantar Public~~ Verian would like to give you a £10 Love2Shop gift voucher. We would like to send you a copy of your voucher (along with instructions) via email.

Please confirm your email address below and we will send you an email within the next 3-4 working days, containing your unique voucher code, and instructions for redeeming it, so you can claim it on receipt of the email.

Your email address will be kept confidential and will not be used for any marketing purposes. Email addresses will be collected and processed in line with Verian's privacy policy.

1. I would like to provide my email address

Please confirm your email address below:

2. I do not wish to provide an email address
3. I do not have an email address

If you do not wish to provide your email address or do not have an email address, we can send you your gift voucher by post. Note that vouchers sent by post will take up to 3 weeks to receive. Would you like to receive your voucher in the post?

1.Yes

2.No

4. I do not wish to claim a voucher/would prefer to donate my incentive to charity

If you would prefer to donate your incentive payment to charity, please indicate which one of the charities listed below you would prefer to donate to

1. UNICEF

2. SPECIAL OLYMPICS

3. NATIONAL TRUST

4. No charity

Q57 – Survey_Submission: