HSC Public Health Agency

Report 2: Mental health-related stigma

Mental Health Survey 2023/24

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Improving your health and wellbeing

Executive summary

The Public Health Agency developed the Mental Health Survey 2023/24 to support work undertaken for the Mental Health Strategy [1] and the Protect Life 2 strategy [2]. The strategies aim to promote mental wellbeing and reduce suicide prevalence in Northern Ireland (NI), respectively. This paper presents findings relating to the prevention of mental ill health among the NI general population.

A telephone survey was conducted in Spring 2023 with a nationally representative sample of 1,009 adults aged 18 years and above in the Northern Ireland general population. Participants were surveyed about a range of issues relating to the topics of mental health and suicide prevention. Findings included in this paper focus on attitudes to mental wellbeing and ill health, experience of mental ill health, behaviours that promote wellbeing, and coping with challenges to mental wellbeing.

Key findings:

- Awareness of public stigma and help-seeking stigma were midrange indicating stigma was neither high nor low among participants. Although, there were outliers for help-seeking stigma indicating some polarisation.
- Stigma was high for approximately 1 in 10 participants – 9% agreeing to all items for awareness of public stigma and 10% of those displaying stigmatising help-seeking attitudes to five out of ten items.

- Stigma was lowest among those aged 65+ years for awareness of public stigma and help-seeking stigma.
- Help-seeking stigma was highest among those in socioeconomic groups C2DE and those who reported having a mental ill health at some point.
- Awareness of public stigma and help-seeking stigma are associated with negative mental health-related attitudes, coping styles and behaviours to protect mental wellbeing.

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1. Background

The Mental Health Survey 2023/24 was undertaken to support the work conducted by the Public Health Agency to address Actions 1 and 2 of the Mental Health Strategy and the Protect Life 2 strategy. The survey aims to further understanding of the knowledge, attitudes and behaviours of the general population in Northern Ireland in relation to mental health and suicide. This paper presents findings on the prevention of mental ill health.

1.1. Mental health in Northern Ireland

Everyone has mental health and your mental health can be either good or poor, just like your physical health. Mental health influences how we think and feel about ourselves and others, and how we interpret and react to events. It affects our capacity to learn, communicate, manage interpersonal relationships, and influences our ability to cope with life events and transition periods.

Good mental health is referred to as mental wellbeing which the World Health Organization (WHO) define as 'a state of wellbeing in which an individual can realise his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community" [3].

When mental health declines, mental ill health can occur. Mental ill health occurs when an individual feels they cannot cope with the challenges they face and this impacts their cognitive, emotional and/or social abilities. Mental ill health may resolve in time or as a person's situation changes but mental ill health can also progress to mental illness. Mental illnesses refer to conditions that are clinically diagnosed by a medical professional and are defined by WHO [3] as:

> *"a broad range of problems with different symptoms. They are generally characterised by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia".*

Mental ill health and illness affects our society as a whole and no individual or group is immune to experiencing mental ill health and/or illness. However, the risk of mental ill health and/or illness is increased with other factors such as inequality, poverty, chronic physical ill health, minority group status, exposure to war, conflict and violence etc. Individuals who experience mental ill health are also vulnerable to disability, mortality, stigma and discrimination, and social exclusion [4].

It is important to understand that recovery from mental ill health and/or illness is possible, as is emphasised by the WHO [3]. Furthermore, an individual can have a diagnosed mental illness and also have good mental wellbeing. For example, an individual can be diagnosed with schizophrenia which is successfully treated with medication which means they are able to continue with their normal routines and are able to cope with challenges they face.

Understanding among the general population has increased with regards to mental health ill health and illness. However, negative attitudes prevail based on embarrassment, fear and stigma. This can impact a person's willingness to open up about their experience of mental ill health and/or illness and often prevents people from accessing help which ultimately can hinder recovery.

Whilst there is a scarcity of robust mental health statistics available in Northern Ireland [5], the Health Survey Northern Ireland [6] has consistently indicated that approximately 20%[a] of the general population have potential psychiatric morbidity based on symptoms reported in the

[a] This trend has remained stable over time with the exception of an increase in 2020/21 to 27% of the population. However, caution is advised in interpreting this change as there were methodological changes implemented due to COVID-19 restrictions that may have impacted this.

preceding four weeks. Although, the trend increased in 2020/21 to 27%. Potential psychiatric morbidity is higher among females compared to males (22% vs 18%, respectively for 2023/24). Furthermore, Bunting et al (2012) estimated the lifetime prevalence of a mental disorder among the NI general population was 39.1% [7].

The Health Survey NI also provided an indication on the population's mental wellbeing with the latest survey data being available for 2018/19. As with potential psychiatric morbidity, a consistent trend was observed from 2020/11 to 2018/19 with mental wellbeing scores on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBs) [8] averaging approximately 51 out of a total score of 70. This indicates good mental wellbeing on average. Since the latest date of available data for the NI population, cut offs have since been established for WEMWBs which provide more detailed interpretation of findings. Therefore, in future population-based surveys, we may have a better understanding of mental wellbeing among the NI population and this will be re-established via the NI Heath Survey from 2024/25.

1.1.1. Suicide in Northern Ireland

Suicide results from a complex interplay between biological, psychological, social and environmental factors. Globally, suicide rates have increased over the last 45 years by 60% with approximately 10.6 suicide deaths per 100,000 population in 2016 [9]. Suicide represents 1.5% of the total global burden of disease. When someone takes their own life, their friends, families and communities are affected. This means that suicide has a wide impact with substantial human and financial cost. It is important to remember that suicide is not inevitable – it is preventable and this makes suicide prevention a key priority for public health. The Government's over-arching message continues to be that one death by suicide is one too many and there is a firm commitment to reduce death by suicide.

Crude suicide rates in Northern Ireland were 12.3 deaths per 100,000 population in 2022 with the rate of death three times higher for males than females (19.2 vs 5.7 deaths per 100,000 population, respectively) [10]. Why individuals take their own lives is unknown. However, there are a wide range of factors at the individual, community and societal level that are associated with increased risk of suicide. Risk factors include (but are not limited to) age, gender, history of suicidal behaviour, suicide bereavement, chronic illness, mental disorders, alcohol and substance misuse, hopelessness, financial instability, stressful life events, interpersonal conflict, war and conflict, violence, trauma, abuse, sexuality, personality traits, high risk occupations, discrimination, criminality, deprivation and inequality, access to means etc. However, there are also a wide range of protective factors which include (but are not limited to) effective coping strategies, resilience, self-esteem, financial stability, strong interpersonal connections, religiosity and cultural beliefs, conflict resolution skills, help-seeking, access to services, effective clinical care etc.

It is estimated that suicide impacts on at least six other individuals and for 2022, this would equate to approximately 1,218 individuals bereaved by suicide [11]. The impact of suicide on those bereaved is vast and can impact on individuals' physical, psychological and social lives. These impacts include confusion, loss of sleep/insomnia, lack of energy, numbness, nightmares, feelings of unreality, loss of control, fear, blame, anger, guilt, social isolation, stigma, unemployment, anxiety, depression, homelessness etc [12, 13, 14].

1.1.2. Policy context

There are a number of policies focussed on improving the mental health and wellbeing of people in Northern Ireland which also contribute to reductions in suicide and self-harm [15, 16, 17].

Protect Life 2 [2] is Northern Ireland's strategy for preventing suicide and self-harm. Launched in 2019, the Strategy aims to reduce deaths by suicide by 10% by 2024 and to ensure support and prevention services for suicide are delivered to communities most at risk. PL2 includes a ten-point action plan including objective 4 which aims to *"enhance community capacity to prevent and respond to suicidal behaviour within local communities"*.

The Mental Health Strategy [1] for Northern Ireland was launched in 2021 and has 35 actions that aim to improve mental wellbeing for the whole population. The PHA has been tasked with Actions 1 and 2 of the Strategy which centre around improving the publics' awareness and understanding of mental health, mental ill health, reducing stigma, and mental health promotion across the life course.

Suicide prevention also features in a range of other policies, including:

- Making Life Better – A Whole System Framework for Public Health 2013-2023;
- Health and Wellbeing 2026: Delivering Together;
- New Strategic Direction for Alcohol and Drugs (NSD) Phase 2 2011-2016;
- Health and Social Care Commissioning Plan and Indicators of Performance Direction 2019–20;
- PHA Corporate Plan 2017-2021;
- Bamford Action Plan 2012-2015; and the Interdepartmental Action Plan[b].

1.2. Stigma

Stigma is a complex, multifaceted phenomenon for which there is no agreed definition [18]. Vogel & Wade (2009) define stigma as "*society's rejection of a person due to certain behaviours of physical appearances that are deemed unacceptable, dangerous and/or frightening*". Attributes that may be the focus of stigma include mental illness, ethnicity, drug misuse and/or physical disability [19]. Mental health stigma interacts with other forms of stigma (eg ethnicity, age, disability, sexuality) which may result in greater impacts for the individual [20].

It is generally accepted that stigma comprises of knowledge, attitudes, feelings, beliefs and behaviours [18]. While research has typically focused on attitudes [21], stigma comprises a complex interplay between these four components. Negative knowledge, attitudes and beliefs can result in discriminating behaviours that devalue individuals living with mental illness [22].

Individuals with mental ill health report experiencing stigma in the form of unfair treatment and/or discrimination (social distancing) and/or see or hear others experiencing stigma [23]. Individuals with mental ill health internalise stigma (ie self-stigma) which leads to a transformation in their identity whereby they take on societal views of them being undesirable or unacceptable and devalues their sense of self, reducing their self-esteem or self-worth [24].

The impact of stigma is wide-reaching and includes social, economic, psychological consequences [19, 25]. Stigma reduces self-esteem, impedes interpersonal relationships, seeking help for both mental and physical ill health, integration in the workplace or education, reduces access to housing, increases vulnerability to future mental ill health, reduces income and can lead to experiencing poverty, increases contact with criminal justice, being pressurised into making unwanted decisions/actions, decreases social connectedness. Ultimately, stigma prevents recovery from mental ill health, impacts the individual's quality of life and reduces life expectancy [18, 26, 27, 28, 29, 20]. Stigma is viewed as a key barrier to individuals seeking help with individuals avoiding help-seeking in order to maintain positive self-perceptions [30, 31, 24, 22].

[b] NB: these are the most up-to-date policies that are currently in place.

It is important to note that while the impacts of stigma are vast and significant, not everyone with mental ill health will experience stigma. Ewens et al. (2022) [29] found that people living with mental ill health also reported positive experiences in their relationships, in entertainment and mass media where mental ill health is positively portrayed, and positive experiences in culture and religious/spiritual settings.

1.3. The Mental Health Survey 2023/24

The Mental Health Survey 2023/24 was undertaken to gain insight into the knowledge, attitudes and behaviours of the general population in Northern Ireland in relation to mental health and suicide. The objectives are:

1. To assess current mental health literacy and attitudes among the NI general population;
2. To provide an indication of mental wellbeing and ill health among the general population that does not duplicate measures collected via other means (eg Health Survey NI);
3. To determine the steps taken by the general population in Northern Ireland to prevention mental ill health;
4. To examine attitudes and behaviours regarding help-seeking for mental ill health and suicide and evaluate satisfaction with help received, where relevant;
5. To explore mental health-related stigma among the general population;
6. To ascertain readiness to intervene with individuals experiencing mental health problems and/or suicidal crisis.

This paper focuses on the stigma in relation to mental ill health among the general population and therefore addresses objective 5. Furthermore, objective 6 is addressed via the psychosocial assessment of the Self-Stigma of Mental Illness and Self-Stigma of Seeking Help scales.

2. Evaluation approach

A telephone survey was conducted of the general population in Northern Ireland between May and June 2023, with 1,009 adults (aged 18+ years) participating. The sample was statistically representative of the general population based on Census 2011 data for gender, age, socioeconomic status, and local government district. Fifty-one percent of the sample were female (n=517). The survey took approximately 20 minutes to complete and topics were guided by the Mental Health and Protect Life 2 strategies which included the following:

- Attitudes to mental health, mental ill health and suicide
- Stigma against help-seeking
- Self-stigma
- General help-seeking behaviours
- Personal experience of mental ill health
- Looking after one's own mental health and coping
- Intervening when concerned about someone
- Awareness of mental health and suicide prevention training.

2.1. Measures

The Mental Health Survey 2023/24 incorporated a number of standardised scales to measure the topics identified. All scales have been psychometrically tested and are shown to be reliable and valid.

Attitudes Towards Suicide (ATTS) [32] is a 20-item 5-point Likert scale used to measure attitudes towards suicide and has been validated for use among the general population. The scale is widely used and has been used by the European Alliance Against Depression [33]. While the scale includes ten subscales, the psychometric properties of the scale do not replicate across studies [34]. The Public Health Agency included the scale in a survey conducted in 2022/23 examining attitudes towards suicide. The psychometric properties of the scale were tested for use among the general population in Northern Ireland. Subscales identified in this analysis were included in this survey which were *Suicide Prevention* (2-items) and *Suicidal behaviour as attention-seeking* (2-items).

The Brief COPE [35] is a 28-item 4-point Likert scale designed to measure the ways in which people respond to stress. The scale includes 14 subscales of which five were included in this survey: active coping (2-items), self-distraction (2-items), instrumental social support (2-items), substance use (2-items) and emotional support (2-items).

The Self-Stigma of Seeking Help Scale (SSOSH) [36] is a 10-item 5-point Likert scale designed to measure self-stigma of seeking psychological help. This is a potentially important barrier to seeking help. This is the first of two stigma-related scales that were used in this survey.

The Self-Stigma of Mental Illness Scale Short Form (SSMIS-SF) [37] is a 20-item Likert scale that measures internalised stigma and self-stigma against mental illness. It consists of four subscales: awareness, agreement, application and harm to self-esteem and is designed for use among people living with mental illness. However, the Awareness subscale measures awareness of public stigma and items are similar to public stigma scales. Items are phrased '*I think the public believes that most people with mental illness are…to blame for their problems/are unpredictable/will not recover or get better/are dangerous/are unable to take care of themselves*'. Given the brevity of the awareness subscale, the current survey tested the use of the subscale among the general population.

The Five Ways to Wellbeing scale was developed for inclusion in the European Social Survey 2012[3] and includes: connect, be active, take notice, keep learning and give. Responses to items on the scale can indicate participation in each of the measures and cumulative participation calculated.

The General Help-Seeking Questionnaire [38] was developed to measure help-seeking intentions. The original scale consisted of 20-items asking who you would seek help from if you and a personal or emotional problem (10-items) or if experiencing suicidal thoughts (10-items). Responses are rated on a 7-point Likert scale ranging 1 ‘extremely unlikely’ to 7 ‘extremely likely’. As the scale measures help-seeking intentions, it was adapted for the current survey as a measure of help-seeking behaviour.

In addition to the standardised scales, the Mental Health Survey 2023/24 asked participants about their experience of mental ill health, intervening when concerned about someone, and awareness of mental health and/or suicide prevention training programmes.

NB: The findings from the survey will be addressed through a series of papers that focus on topics. Therefore, not all measures are discussed in one paper.

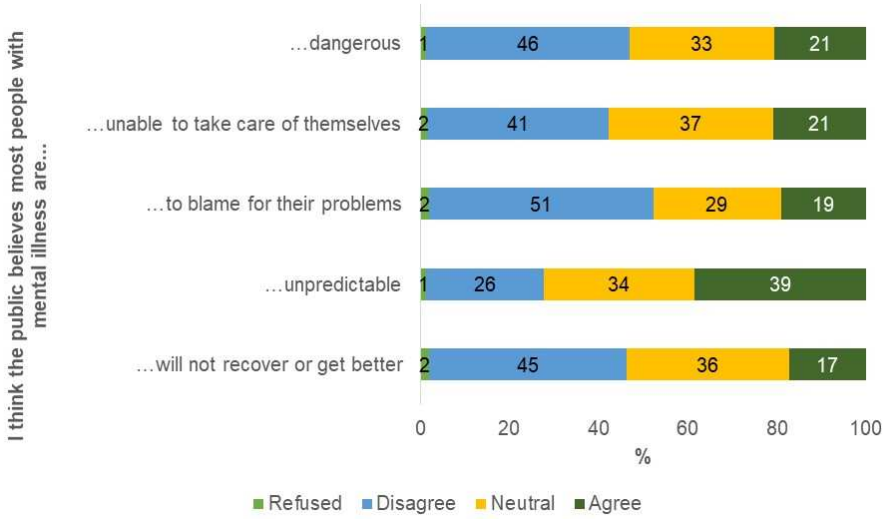
[3] See Home | European Social Survey

3. Findings

3.1. Awareness subscale of the Self-Stigma of Mental Illness Scale (SSMIS-SF)

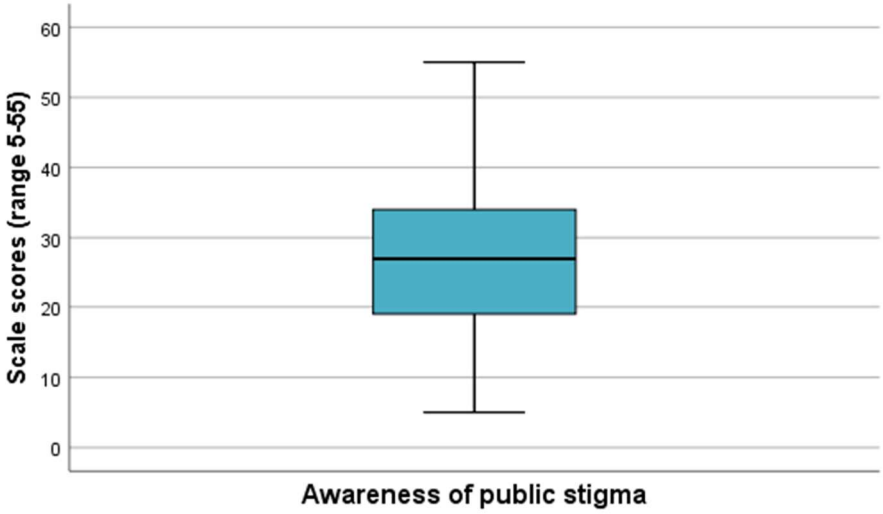
The Awareness subscale of the Self-Stigma of Mental Illness Scale (SSMIS) measures public stigma consisted of five items with ratings from fully disagree to fully agree to each of the five statements and frequencies are presented in Figure 1. Approximately one in five believe that most people view people with mental illness as dangerous (21%), unable to take care of themselves (21%), to blame for their problems (19%) and will not recover or get better (17%). However, nearly two in five believe that most people believe that people with mental illness are unpredictable (39%).

Figure 1: Frequencies for items on the Awareness subscale of the SSMIS (n=1,009)



Responses to the five items were summed to give an overall score for public stigma awareness and this score was used to examine differences between key demographic groups. The boxplot in Figure 2 shows the distribution of scores on the scale. Higher scores indicate higher levels of stigma. The average score for the full sample was 26.1 (range 5–55) which fell approximately at the mid-range of the scale.

Figure 2: Boxplot for SSMIS Scores (n=998)

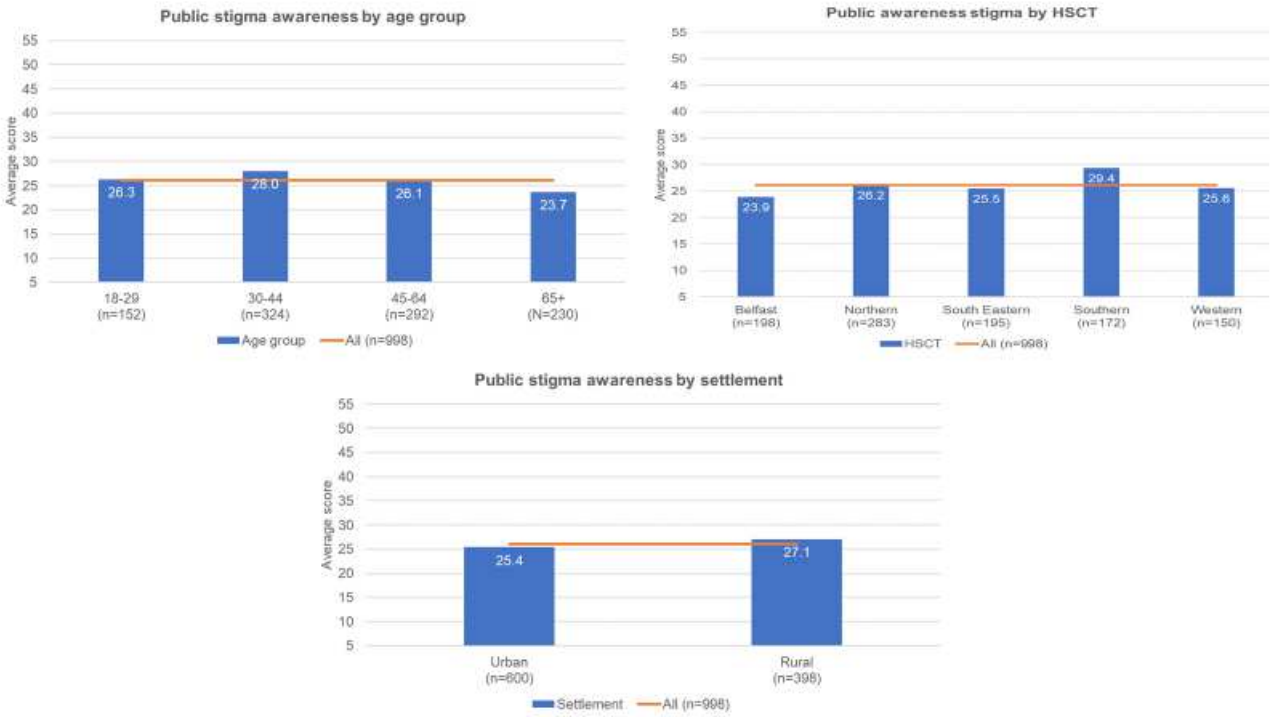


ANOVAs were undertaken to compare awareness of public stigma between key demographic groups and significant findings (see Table 2 for full detail).

Public stigma awareness was significantly (Figure 3):

- lower among those aged 65 years and above compared to all other age groups (M=23.7; 18–29, M=26.3; 30–44, M=28.0; 45–64, M=26.1; p≤.001);
- higher among those living in the SHSCT area compared to all other Trust areas (M=29.4; BHSCT, M=23.9; NHSCT, M=26.2; SEHSCT, M=25.5; WHSCT, M=25.6; p≤.001); and
- higher among those living in rural compared to urban areas (M=27.1 vs M=25.4, respectively; p≤.01).

Figure 3: Awareness of public stigma by age group, HSCT and settlement (n=998)



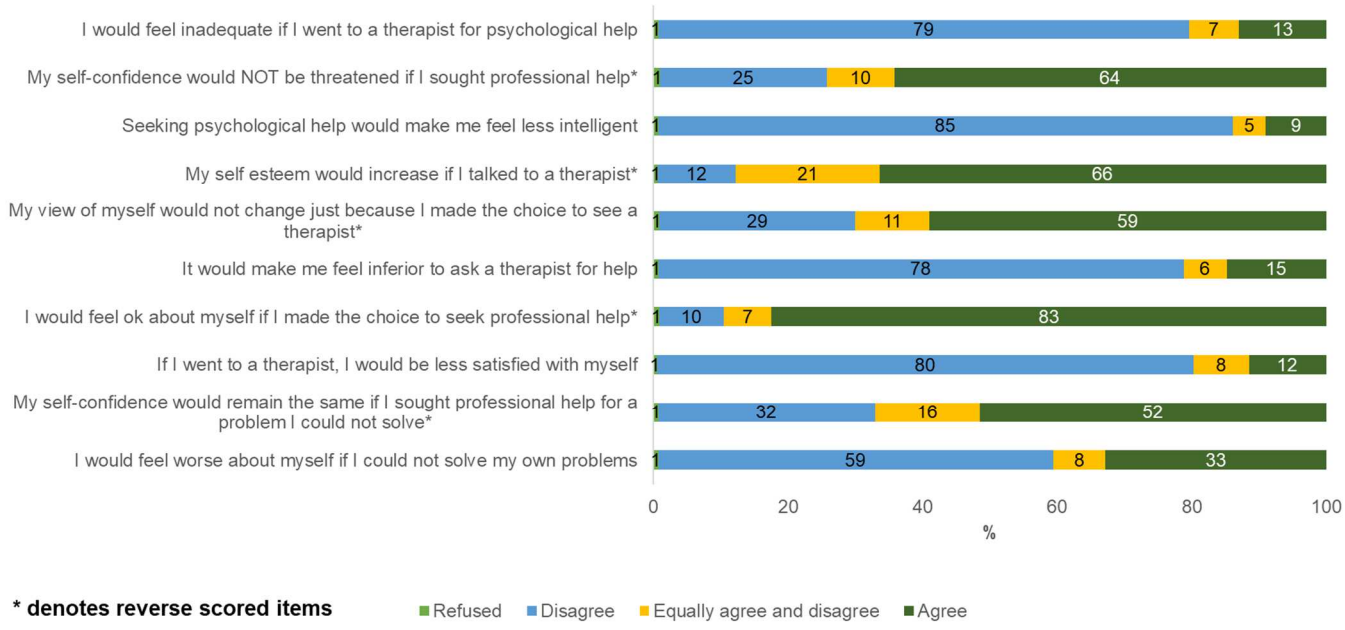
There were no significant associations between awareness of public stigma and gender, socioeconomic status, disability status, deprivation quintile, working in HSC, working in mental health and/or suicide prevention, or whether participants had experienced a mental health problem themselves (see Table 2 for full details).

Those who agreed to at least four of the five items were categorised as having high awareness of public stigma. This equated to 9% of survey participants.

3.2. The Self-Stigma of Seeking Help Scale (SSOSH)

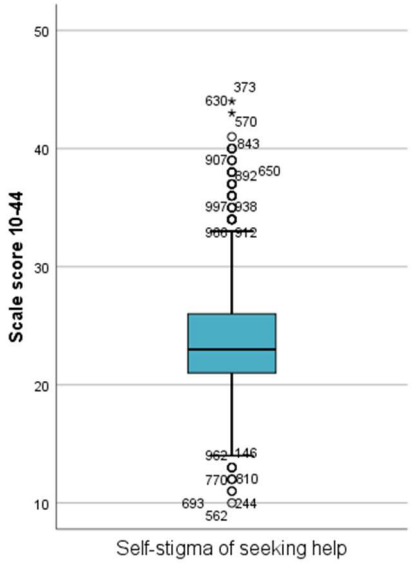
The Self-Stigma of Seeking Help Scale (SSOSH) consists of 10 items and the frequencies are presented in Figure 4. The frequencies on the 10-items included in the scale suggest that the majority of participants do not hold stigmatising views towards help-seeking. For instance, 85% disagreed that they would feel less intelligent if they sought psychological help, 83% agreed that they would feel ok about themselves if they were to seek professional help. The pattern of agreeing or disagreeing to items in ways that suggest non-stigmatising views were held across all 10 items.

Figure 4: Frequencies for itemson the Self-Stigma of Seeking Help Scale (n=1,009)



Responses to all 10 items on the SSOSH were summed if participants answered all 10 items, giving an overall score ranging 10 to 44. Higher scores were associated with higher levels of stigma. The average score on the scale was 24.0 which was approximately mid-range of the scale. However, the boxplot shows a significant number of outliers at both ends of the scale (Figure 5). This means that there were some polarised views with some holding highly stigmatising views of help-seeking and some who did not hold stigmatising views.

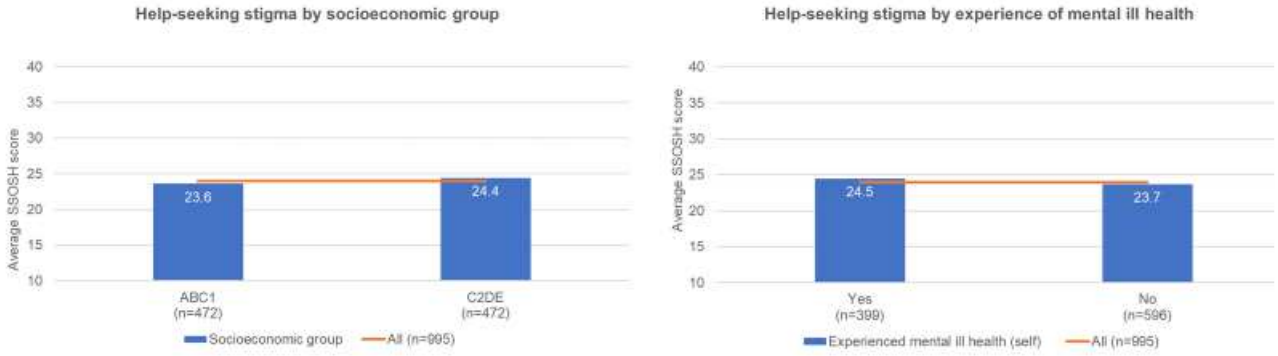
Figure 5: Boxplot for SSOSH scores (n=995)



Significant associations for help-seeking stigma are as follows (Figure 6):

- help-seeking stigma was higher among those in C2DE socioeconomic groups (C2DEs, M=24.4 vs ABC1s, M=23.6; p≤.05); and
- those who had experienced a mental health problem themselves at some point had higher help-seeking stigma compared to those who had never experienced a mental health problem (M=24.5 vs M=23.7; p≤.01).

Figure 6: Help-seeking stigma scores by age group, socioeconomic group and experience of mental ill health (n=998)



There were no significant associations between help-seeking stigma and gender, age group, HSCT, disability status, settlement, deprivation quintile, working in HSC or working in mental health and/or suicide prevention (see Table 3 for full details).

Those who held strong help-seeking stigmatising were identified if they responded to at least 5 out of the 10 scale items in ways that indicated help-seeking stigma. For example, those who agreed that they would feel inadequate and/or those who disagreed that their self-confidence would not be threatened by seeking psychological help etc.

One in ten (10%) were identified as having strong help-seeking stigmatising views. Having strong help-seeking stigmatising views was not associated with any of the key demographic variables, indicating the proportion holding strong stigmatising views was equivalent throughout demographic groups (see Table 4 for full details).

3.3. Stigma, attitudes & behaviour

Scores on the two stigma scales were correlated with scores on attitudinal scales to explore the relationship between awareness of public stigma, help-seeking stigma and attitudes towards suicide prevention, coping styles, intervening behaviours and participation in activities to improve mental wellbeing (see Table 1). Significant findings were as follows:

- Findings indicated a small positive correlation between awareness of public stigma and attitudes to mental health. Higher awareness of public stigma was associated with greater agreement that there is nothing you can do to protect your mental health.

- Small positive correlations were also found between of help-seeking stigma and attitudes to mental health. Higher degrees of help-seeking stigma was associated with agreement that there is nothing you can do to protect your mental health but also that your mental health can be looked after just like your physical health.

- There was a small positive correlation between dismissal of suicidal behaviour and stigma of help-seeking behaviour: increased help-seeking stigma was associated with increases in attitudes that dismiss suicidal behaviour;

- There was a small negative correlation between viewing suicide as preventable and stigma of help-seeking behaviour: increased help-seeking stigma was associated with views that suicide is not preventable;

- Active coping had a small positive correlation with awareness of public stigma and a small negative correlation with help-seeking stigma: increased active coping was associated with higher awareness of public stigma and decreased active coping was associated with increased help-seeking stigma;

- There was a small positive correlation between self-distraction and awareness of public stigma: as self-distraction increased so did awareness of public stigma;

- There was a small negative correlation between instrumental social support and help-seeking stigma: as instrumental social support decreased, help-seeking stigma increased;

- There was a small negative correlation between emotional support and help-seeking stigma: as emotional support decreased, help-seeking stigma increased;

- Awareness of pubic stigma and help-seeking stigma were higher among those who did not engage in all five measures of wellbeing;

- There was a negative correlation between willingness to intervene in someone considering suicide and awareness of public stigma: decreases in willingness to intervene were associated with increases in awareness of public stigma;

- Awareness of public stigma was significantly higher among those who had intervened with someone they were concerned were engaging in self-harming behaviours, those who had intervened when they were concerned about someone's alcohol use and among those who had intervened when they were concerned about someone's drug use.

Table 1: Relationship between stigma, attitudes and behaviours

	Self-stigma of mental illness		Self-stigma of seeking help	
Attitudes towards mental health				
Your mental health can be looked after just like your physical health	ρ=-.032	ns.	ρ=.154	p≤.001
There is nothing you can do to protect your mental health	ρ=.078	p≤.01	ρ= -.166	p≤.001
Attitudes towards suicide prevention				
Dismissing suicidal behaviour (higher scores indicating higher dismissal)	ρ= .030	ns.	ρ= .161	p≤.001
Suicide as preventable (higher scores indicating higher prevention)	ρ= .045	ns.	ρ= –.115;	p≤.001
Coping styles				
Active coping	r= .104	p≤.01	r= –.086	p≤.05
Self-distraction	r= .084	p≤.05	r= –.021	ns.
Instrumental social support	r= –.016	ns.	r= –.127	p≤.001
Substance use	ρ= .059	ns.	ρ= .043	ns.
Emotional support	ρ= .076	ns.	ρ= –.127	p≤.001
Engaging in all five measures of wellbeing	Yes, M=25.2 No, M=27.7	p≤.001	Yes, M=23.6 No, M=24.5	p≤.05
Intervening				
Willingness to intervene	ρ= –.133	p≤.001	ρ= –.067	ns.
Actual intervening behaviour when concerned…				
…about someone's mental health	Yes, M=26.9 No, M=25.8	ns.	Yes, M=24.1 No, M=24.8	ns.
…someone is thinking of suicide	Yes, M=27.1 No, M=26.4	ns.	Yes, M=24.4 No, M=23.7	ns.

…about someone self-harming	Yes, M=27.6 No, M=25.9	p≤.05	Yes, M=24.5 No, M=23.7	ns.
…about someone's alcohol use	Yes, M=27.7 No, M=25.7	p≤.05	Yes, M=24.3 No, M=23.9	ns.
…about someone's drug use	Yes, M=27.7 No, M=26.1	ns.	Yes, M=24.3 No, M=24.0	ns.

4. Key findings and conclusions

Two measures of mental health-related stigma were explored in this survey: awareness of public stigma and help-seeking stigma. Scores on both scales were midrange indicating that stigma was neither high nor low among survey participants. However, there were a number of outliers for help-seeking stigma indicating there were some polarised views. It was estimated that approximately one in ten held highly stigmatising views (9% of awareness of public stigma and 10% of help-seeking stigma). Findings were consistent across gender, disability status, deprivation, whether participants worked in HSC or whether participants worked in the areas of mental health and/or suicide prevention.

Awareness of public stigma was lower among those aged 65+ years compared to all other age groups, and was higher among those living in the Southern HSCT compared to all other Trust areas and in higher among those living rural compared to urban areas. Help-seeking stigma was higher among those in C2DE socioeconomic groups compared to ABC1. Finally, help-seeking stigma was higher among those who reported having experienced mental ill health compared to those who had not. It is concerning that help-seeking stigma is high among those who have experienced mental ill health. Stigma is a major barrier for help-seeking and can have a detrimental impact on recovery from mental ill health [22, 31, 24, 30]. Interventions targeting those in lower socioeconomic groups and those who experience mental ill health should incorporate anti-stigma messaging.

Stigmatising attitudes were associated with negative attitudes towards mental health and suicide, coping styles and behaviours. Awareness of public stigma and help-seeking stigma were associated with believing that there is nothing you can do to protect your mental health. Help-seeking stigma was also associated with disagreement that you can look after your mental health in the same way that you can look after your physical health. Dismissing suicidal behaviour and the belief that suicide is not preventable was also associated with help-seeking stigma.

With respect to coping styles, help-seeking stigma was associated with decreased active coping and instrumental social support. Active coping refers to the measures taken to directly tackle a problem that is causing stress. Instrumental social support related to seeking advice on how to deal with a problem from others. Together these findings indicate that individuals who think that seeking help for mental ill health are less likely to have effective coping strategies to help them deal with significant stressors. This puts these individuals at a major disadvantage should they experience mental ill health as they are less likely to seek help and do not have effective coping strategies to deal with problems themselves.

Findings were mixed with respect to awareness of public stigma, attitudes and coping styles. On one hand, high awareness of public stigma was associated with greater reluctance to intervene if they were concerned someone was at suicidal risk. Yet on the other hand, higher public stigma awareness as associated with having intervened in someone who was self-harming, intervening when concerned about someone's alcohol use and/or drug use. High awareness of public stigma was associated with increased likelihood of engaging in self-distraction coping measures and active coping strategies. These contradictory findings are difficult to explain.

A final key finding was that stigma was associated with not engaging in all five ways to wellbeing. The five ways to wellbeing included socialising with friends, having social support if needed, taking notice of surroundings, learning new things and engaging in physical activity. This meant that those scoring high for awareness of public stigma and help-seeking stigma were less likely to engage in ways that can help maintain good mental wellbeing.

Together, the findings in this report demonstrate the detrimental impact that stigma can have on attitudes, coping styles and behaviours that can help maintain wellbeing. While stigma was

midrange on both stigma measures, it can be difficult to disentangle socially desirable responding from responses that indicate stigmatising views. Those with mental illness report experiencing stigma and resulting discrimination [29]. Nonetheless, the findings presented here provide good insight into stigma among the general population surveyed.

References

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Appendix

Table 2: Associations between self stigma of mental illness and key demographic variables

		Base	M
Overall		998	26.1
Gender	Male	482	25.6
	Female	512	26.5
Age* **	18–29	152	26.3
	30–44	324	28.0
	45–64	292	26.1
	65+	203	23.7
Socioeconomic group	ABC1	475	26.1
	C2DE	476	23.4
HSCT* **	Belfast	198	23.9
	Northern	283	26.2
	South Eastern	195	25.5
	Southern	172	29.4
	Western	150	25.6
Disability	Yes	200	25.5
	No	789	26.2
Settlement**	Urban	600	25.4
	Rural	398	27.1
Deprivation	Most deprived	185	25.8
	Quintile 2	197	26.9
	Quintile 3	212	26.7
	Quintile 4	207	26.3
	Least deprived	197	24.5
Work in HSC	Yes	124	26.1
	No	874	26.1
Work in mental health/suicide prevention	Yes	45	26.6
	No	953	26.0
Experienced mental ill health, self	Yes	397	26.9
	No	601	25.5
***** p≤.001; ** p≤.01; * p≤.05**			

Table 3: Associations between self-stigma of seeking help and key demographic variables

		Base	M
Overall		995	24.0
Gender	Male	480	23.9
	Female	510	24.1
Age	18–29	151	24.0
	30–44	323	24.5
	45–64	290	24.1
	65+	204	23.4
Socioeconomic group*	ABC1	472	23.6
	C2DE	472	24.4
HSCT	Belfast	196	24.3
	Northern	281	24.1
	South Eastern	196	23.8
	Southern	170	23.7
	Western	152	24.0
Disability	Yes	200	24.7
	No	785	23.9
Settlement	Urban	597	23.8
	Rural	398	24.3
Deprivation	Most deprived	186	24.3
	Quintile 2	197	23.9
	Quintile 3	208	24.0
	Quintile 4	207	23.9
	Least deprived	197	23.9
Work in HSC	Yes	121	24.3
	No	874	24.0
Work in mental health/suicide prevention	Yes	43	24.3
	No	952	24.0
Experienced mental ill health, self**	Yes	399	24.5
	No	596	23.7
***** p≤.001; ** p≤.01; * p≤.05**			

Table 4: Associations between strong help-seeking stigma and key demographic variables

		Base	%
Overall		1,009	10.0
Gender	Male	487	10.3
	Female	517	9.9
Age	18–29	152	8.6
	30–44	325	12.0
	45–64	297	10.1
	65+	235	8.1
Socioeconomic group	ABC1	478	9.4
	C2DE	478	11.3
HSCT	Belfast	200	12.0
	Northern	283	10.2
	South Eastern	197	8.1
	Southern	172	11.0
	Western	157	8.3
Disability	Yes	202	11.9
	No	797	9.7
Settlement	Urban	606	9.6
	Rural	403	10.7
Deprivation	Most deprived	190	11.6
	Quintile 2	200	8.5
	Quintile 3	212	9.4
	Quintile 4	208	10.1
	Least deprived	199	10.6
Work in HSC	Yes	124	10.5
	No	885	9.9
Work in mental health/suicide prevention	Yes	45	15.6

	No	964	9.8
Experienced mental ill health, self**	Yes	401	12.0
	No	608	8.7
***** p≤.001; ** p≤.01; * p≤.05**			