In Fact
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Measuring stigma: Attitudes towards social inclusion of people with mental illness within a sports club setting

Background

The consequence of public stigma and discrimination towards people with mental illness and distress is substantial. The impacts include, but are not limited to; self stigma, poor perceived health status, difficulties with employment, difficulties in help-seeking behaviour and increased prevalence of suicide (Evans-Lacko, Corker, Williams, Henderson & Thornicroft, 2014, p. 121). The Health Promotion Agency (HPA) leads the Like Minds, Like Mine programme to increase social inclusion and reduce stigma and discrimination for people who experience mental illness and distress (Ministry of Health & Health Promotion Agency, 2014). HPA's Health and Lifestyles Survey (HLS) monitors New Zealanders' behaviour and attitudes towards a range of health topics, including mental health. This fact sheet reports on attitudes towards social inclusion of people with mental illness and distress within a sports club setting.

Methodology

Respondents in the 2014 HLS were asked about their attitudes towards acceptance and inclusion of a community member with mental illness and distress using the following statement:

You are a member of a local sports club. A new person wants to join the club. You know they have schizophrenia. When they are alone, they often shout and argue as if someone else was there with them. They speak carefully using uncommon and sometimes made-up words. They are polite but avoid talking with other people.

Respondents were given a number of scenarios attached to the statement. They were asked if they would be comfortable (yes/no): a) 'if they were a member of the sports club?'; b) 'if they were in your sports team?'; c) 'socialising with them outside of the sports club?'; and d) 'inviting them to your house for a meal?'.

Responses were compared by gender, age, ethnicity, neighbourhood deprivation status, educational background and employment status. Only those group differences that were statistically significant ($p < .05$) are reported.

Social inclusion scenarios

Respondents were most comfortable with the least socially inclusive scenario, where almost two-thirds (65%, 62-67%) were comfortable having someone with a diagnosis of schizophrenia as a member of their sports club (see Table 1). The proportion comfortable with each scenario dropped with the scenario's relative social inclusiveness, where two in five (41%, 38-43%) respondents were comfortable inviting someone with a diagnosis of schizophrenia to their home for a meal. Over one-quarter (27%, 24-29%) of respondents weren't comfortable with inviting them to their house for a meal, with a further 28% (25-31%) who didn't know if they would be comfortable. There was a high percentage of 'don't know' responses for all four scenarios.

Table 1: Responses to social inclusion scenarios

Scenario (from least to most socially inclusive)		% (95% CI)			
		Yes	No	Don't know	Refused
a	Comfortable if person with mental illness was a member of the sports club	65 (62-67)	13 (11-15)	19 (16-21)	4 (2-5)
b	Comfortable if person with mental illness was in their sports team	59 (56-62)	16 (14-18)	21 (18-23)	4 (2-6)
c	Comfortable socialising with person with mental illness outside of the sports club	51 (48-54)	20 (18-23)	25 (22-27)	4 (2-6)
d	Comfortable inviting person with mental illness to their house for a meal	41 (38-43)	27 (24-29)	28 (25-31)	5 (3-7)

Note: 95% CI = 95% confidence interval

Scenario A: Member of the sports club

Those respondents who were more likely to be comfortable with having a person with a diagnosis of schizophrenia as a member of their sports club (compared to those who weren't, didn't know or refused) were:

- 15 to 24-year-olds (68%), compared with over 65-years-old (56%)
- European/Other (68%), compared with Pacific peoples (54%) and Asian (47%)
- those with secondary school qualification (64%), trade certificate/professional/diploma (66%) or degree/postgraduate (73%), compared to those with no formal qualification (55%).

Scenario B: In your sports team

Those respondents who were more likely to be comfortable with having a person with a diagnosis of schizophrenia as a member of their sports team (compared to those who weren't, didn't know or refused) were:

- European/Other (62%), compared with Asian (40%)
- those with trade certificate/professional/diploma (61%) or degree/postgraduate (65%), compared to those with no formal qualification (51%).

Scenario C: Socialising outside of the sports club

Those respondents who were more likely to be comfortable with socialising with a person with a diagnosis of schizophrenia outside of their sports club (compared to those who weren't, didn't know or refused) were:

- male (55%), compared to female (47%)
- 15 to 24-year-olds (54%), compared with over 65-years-old (42%)
- European/Other (52%), compared with Asian (34%).

Scenario D: Invitation home for a meal

Those respondents who were more likely to be comfortable with inviting a person with a diagnosis of schizophrenia to their home for a meal (compared to those who weren't, didn't know or refused) were:

- European/Other (42%), compared with Asian (25%)
- living in a high deprivation neighbourhood (47%), compared to those in a low deprivation neighbourhood (38%)
- those in full-time employment (42%), compared to those in part-time employment (32%).

Key points

- There was a decrease in the comfort level respondents expressed as the scenarios became more socially inclusive (ie, the more interaction the respondent would have with a person with a diagnosis of schizophrenia).
- There was an increase in both the discomfort level of respondents and those who did not know if they would be comfortable or not, as the scenarios became more socially inclusive.
- Responses to the social inclusion scenarios generally differed by age, ethnicity and educational background.

About the Health and Lifestyles Survey

- The HLS is a nationwide in-home face-to-face survey conducted every two years since 2008.
- The 2014 HLS consisted of a sample of 2,594 New Zealanders aged 15 years and over, who provided information about their health behaviours and attitudes relating to tobacco, sun safety, healthy eating, gambling, alcohol, exercise, immunisation and mental health. The response rate was 73.2%.
- The 2014 HLS sample included 1,420 European/Other people, 564 Māori, 393 Pacific people and 217 Asian people (prioritised ethnicity).
- The data have been adjusted (weighted) according to 2013 Census data to ensure they are representative of the New Zealand population.
- For this analysis, jack-knife proportions and associated 95% confidence intervals were produced. Sub-group differences were tested using logistic regression.
- Comparison groups for these analyses were as follows (in next column):
  - Gender (males, compared with females).
  - Age (25 to 44 years, 45 to 64 years and 65 + years, compared with 15 to 24 years).
  - Ethnicity (Māori, Pacific and Asian, compared with European/Other).
  - Neighbourhood deprivation status (mid and high deprivation levels, compared with low deprivation level).
  - Educational background (secondary school, trade certificate/professional/diploma and degree/postgraduate, compared with no formal qualification).
  - Employment status (part-time employed, homemaker and other, compared with full-time employed).
- A full description of the HLS methodology and further HLS publications can be found at http://www.hpa.org.nz/research-library/research-publications.

References

Evans-Lacko, S., Corker, E., Williams, P., Henderson, C. & Thornicroft, G. (2014). Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: An analysis of survey data. *Lancet Psychiatry, 1*, 121-128.

Ministry of Health & Health Promotion Agency. (2014). *Like Minds, Like Mine national plan 2014-2019: Programme to increase social inclusion and reduce stigma and discrimination for people with experience of mental illness.* Wellington: Ministry of Health.

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About HPA

HPA is a Crown entity that leads and delivers innovative, high quality and cost-effective programmes and activities that promote health, wellbeing and healthy lifestyles, prevent disease, illness and injury. HPA enables environments that support health and wellbeing and healthy lifestyles, and reduce personal, social and economic harm.

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