

Online-only Table 1 (SuppT1). Sample characteristics (n=1751, before weighting)

	N or Mean	%
Age (years), mean +/- SD	46.0 +/- 18.3	
Female gender, N and %	939	53.6
Ethnicity, N and %		
White	1542	88.1
Black	63	3.6
Asian	112	6.4
Mixed	22	1.3
Social grade, N and %		
Professional or managerial occupations	279	15.9
Other non-manual occupations	454	25.9
Skilled manual occupations	389	22.2
Unskilled manual occupations or benefit recipients	629	35.9

Online-only Table 2 (SuppT2). Correlations between measures of attitudes, knowledge and contact
(n=1751) ^(a)

	Prejudice and Exclusion ^(b)	Tolerance and support for community care ^(b)	Knowledge about mental illness ^(c)	Past and present contact ^(d)
Tolerance and support for community care ^(b)	-.51	1.0		
Knowledge about mental illness ^(c)	-.28	.44	1.0	
Past and present contact ^(d)	-.35	.20	.17	1.0
Intentions for future contact ^(d)	-.60	.49	.32	.34

^(a) All correlations significant (two-sided p-values < .001)

^(b) Based on 14 (prejudice/exclusion) and 13 (tolerance/community care) attitude items, higher scores indicating more prejudice/exclusion or tolerance/support for community care, respectively (see Appendix 1)

^(c) Mental Health Knowledge Schedule (MAKS), higher scores indicating better knowledge about mental illness

^(d) Reported and Intended Behaviour Scale (RIBS), higher scores indicating more contact with people with mental illness

Online-only Appendix 1 (SuppA1).

Factor analyses of attitude items in two separate data-sets: Rationale, statistical approach and results.

Exploratory factor analysis

In order to identify internally consistent and replicable underlying attitude factors that could be used as independent variables in the regressions on help-seeking and disclosure, we took a two-step approach for the 27 attitude items. First, we performed an exploratory factor analysis of all 27 items, using principal component analysis and varimax rotation in SPSS 15.0. The goal of this analysis was to find subscale scores that had satisfactory internal consistency (Cronbach's $\alpha > .60$) and were conceptually meaningful. Attitude subscale scores are more useful predictors than single attitude items, because they allow for a more parsimonious and powerful analysis. Exploratory factor analysis determines a small number of latent variables (attitude factors) that account for the variation in observed variables (attitude items). Exploratory factor analysis is exploratory, because no a priori restrictions are placed on the pattern of relationships between observed variables and latent variables (Brown TA: *Confirmatory factor analysis for applied research*. London, Guilford Press, 2006). Factor solutions were extracted with eigenvalues greater than 1. All items with the highest loading on a factor were then averaged into subscales of attitude scores. The resulting subscale scores for each factor solution were then examined for internal consistency, and only the solution that yielded subscales with acceptable internal consistency (Cronbach's $\alpha > .60$) was retained (see the Table below for the results of the exploratory factor analysis).

Confirmatory factor analysis

In a second step, we used an independent dataset and confirmatory factor analysis to test the factor structure which had been identified by exploratory factor analysis in the 2009 data as described above. For this purpose we used AMOS 7.0 and the analogous 2008 Department of Health survey data, in which 1703 English adults, independent from participants in the 2009 survey, had completed the same 27-item attitude questionnaire. Different from exploratory factor analysis, in confirmatory factor analysis the number of factors and the loading of each observed variable on each factor is pre-specified. Our model contained no double-loading items and all measurement error was presumed to be uncorrelated. The two latent factors were permitted to be correlated based on theory and prior evidence. Confirmatory factor analysis evaluates goodness-of-fit, i.e. how well the specified model reproduces the observed variances. We used a widely recommended index of fit, the root mean square error of approximation (RMSEA) to assess the model fit. The RMSEA assesses the extent to which a model fits reasonably well in the population, a lower RMSEA indicating a better fit, and RMSEA values less than .08 suggest adequate model fit (Brown TA: Confirmatory factor analysis for applied research. London, Guilford Press, 2006). Results of the confirmatory factor analysis are provided in the results section of the main article.

(continued with Table below)

Table. Results of the exploratory factor analysis of attitude items, using data from the 2009 Department of Health survey. The table presents factor loadings, using varimax rotation, of 27 attitude items on the factor prejudice/exclusion and the factor tolerance/support for community care (highest factor loadings in bold font).

	Factor 1 ^(a) : Prejudice/ Exclusion	Factor 2 ^(a) : Tolerance/ Support for community care
1. One of the main causes of mental illness is a lack of self- discipline and will- power.	.67	-.01
2. There is something about people with mental illness that makes it easy to tell them from normal people.	.61	-.12
3. As soon as a person shows signs of mental disturbance, he should be hospitalized.	.65	-.12
4. Mental illness is an illness like any other.	-.16	.45
5. Less emphasis should be placed on protecting the public from people with mental illness.	.12	.34
6. Mental hospitals are an outdated means of treating people with mental illness.	.27	.38
7. Virtually anyone can become mentally ill.	-.28	.48
8. People with mental illness have for too long been the subject of ridicule.	-.22	.50
9. We need to adopt a far more tolerant attitude toward people with mental illness in our society.	-.19	.64
10. We have a responsibility to provide the best possible care for people with mental illness.	-.27	.52
11. People with mental illness don't deserve our sympathy.	.42	-.20
12. People with mental illness are a burden on society.	.40	-.39
13. Increased spending on mental health services is a waste of money.	.48	-.36
14. There are sufficient existing services for people with mental illness.	.48	.01
15. People with mental illness should not be given any responsibility.	.62	-.19
16. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.	.58	-.13
17. I would not want to live next door to someone who has been mentally ill.	.53	-.37
18. Anyone with a history of mental problems should be excluded from taking public office.	.61	-.12
19. No-one has the right to exclude people with mental illness from their neighbourhood.	-.25	.57
20. People with mental illness are far less of a danger than most people suppose.	-.18	.52
21. Most women who were once patients in a mental hospital can be trusted as babysitters.	-.28	.19
22. The best therapy for many people with mental illness is to be part of a normal community.	-.16	.63
23. As far as possible, mental health services should be provided through community based facilities.	-.06	.56
24. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.	-.17	.52
25. It is frightening to think of people with mental problems living in residential neighbourhoods.	.60	-.27

26. Locating mental health facilities in a residential area downgrades the neighbourhood.	.39	-.31
27. People with mental health problems should have the same rights to a job as anyone else.	-.23	.51

^(a) Percentage of variance accounted for is 16.8% (factor 1) and 15.6% (factor 2)