

**Health Education Population Survey**

**Update from 2007 survey**

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## Table of Contents

Summary .....	i
1. Introduction .....	1
1.1 Background .....	1
1.2 Methodology.....	2
2. Attitudes to own health.....	6
2.1 Self-reported general health .....	6
2.2 Long-standing illness .....	6
2.3 Ability to influence own health .....	7
3. Physical activity .....	10
3.1 Reported behaviour.....	10
3.2 Knowledge and motivation .....	13
4. Diet.....	17
4.1 Reported behaviour.....	17
4.2 Knowledge and motivation .....	18
5. Smoking.....	22
5.1 Reported behaviour.....	23
5.2 Motivation .....	24
6. Alcohol.....	25
6.1 Reported behaviour.....	26
6.2 Knowledge .....	28
6.3 Motivation .....	30
7. Mental health .....	32
7.1 Stress .....	32
7.2 Common mental health problems (GHQ12).....	33

7.3	Mental Wellbeing .....	34
8.	Sexual health.....	36
8.1	Knowledge .....	37
APPENDIX 1.	Questions analysed .....	39
APPENDIX 2.	Base sizes for tables and charts.....	46
APPENDIX 3.	Tables for comparison with overview report .....	52
APPENDIX 4.	Physical activity levels .....	75

## Index of Figures

Figure 2.1 Percentage who feel their health is good by age/social grade/DEPCAT .....	6
Figure 2.2 Percentage with long-standing illness by age/social grade .....	7
Figure 2.3 Time trends in belief that individuals can make own life healthier (1996-2007) .....	8
Figure 2.4 Percentage who believe they can do something to make their own life healthier by age/ social grade.....	8
Figure 3.1 Time trends in physical activity (1996-2007) .....	11
Figure 3.2 Percentage who are sedentary by age/ social grade/ DEPCAT .....	11
Figure 3.3 Percentage walking for at least 30 minutes per day by sex/ social grade/ DEPCAT .....	12
Figure 3.4 Percentage aware of recommended duration of moderate intensity physical activity (1996-2007).....	13
Figure 3.5 Percentage aware of recommended frequency of moderate intensity physical activity by sex/ age/ social grade .....	14
Figure 3.6 Time trends in motivation to increase physical activity (1996-2007).....	15
Figure 4.1 Time trends in consumption of fruit and vegetables (1996-2007).....	17
Figure 4.2 Time trends in knowledge of recommended consumption and motivation to increase consumption of fruit and vegetables (1996-2007).....	19
Figure 4.3 Percentage who know recommended fruit and vegetable consumption by sex/age/social grade/DEPCAT.....	20
Figure 5.1 Time trends in adult cigarette smoking behaviour (1996-2007).....	23
Figure 5.2 Percentage of regular smokers by social grade/DEPCAT .....	24
Figure 6.1 Time trends in exceeding recommended weekly alcohol limits, by sex (1996-2007) .....	26
Figure 6.2 Percentage with 4+ binge drinking sessions ( $\geq 8/6$ units) in past month, by sex/age/social grade .....	27
Figure 6.3 Percentage with 4+ binge drinking sessions ( $\geq 16/10$ units) in past month, by sex (1996-2007) .....	28
Figure 6.4: Knowledge of recommended weekly limits for own sex .....	30
Figure 6.5 Time trends in motivation to cut down alcohol consumption (1996-2007).....	31
Figure 7.1 Time trends in GHQ scores (1996-2007) .....	33
Figure 7.2 Percentage scoring over 2 on GHQ12 by sex/age/social grade.....	34
Figure 8.1 Information needs.....	38

## Index of Tables

Table 4.1: Percentage eating at least five portions daily by sex/age/social grade/ DEPCAT .....	18
Table 6.1: Knowledge of recommended weekly limits for own sex.....	29
Table 7.1 WEMWBS Scores .....	35
Table 8.1 Proportion wanting more information on sexual health topics .....	37
Table A3.1 Percentage who feel their health is very/fairly good by age/social grade/DEPCAT .....	52
Table A3.2 Percentage who have a long-standing illness or disability by age/social grade.....	53
Table A3.3 Percentage who believe they can do something to make their own life healthier by self-perceived health/age/social grade.....	53
Table A5.1 Percentage who are sedentary by sex/age/social grade/DEPCAT .....	54
Table A5.2: Percentage walking at least 30 minutes per day by sex/social grade/DEPCAT .....	55
Table A5.3: Percentage achieving recommended levels of physical activity by sex/age/social grade/DEPCAT.....	56
Table A5.4: Knowledge of recommended levels for moderate activity .....	56
Table A5.5: Percentage who know that 26-30 minutes of moderate activity recommended by social grade/DEPCAT .....	57
Table A5.6: Motivation to increase activity levels .....	57
Table A6.1: Percentage not eating fruit and vegetables daily by sex/age/social grade/ DEPCAT .....	58
Table A6.2: Percentage eating at least five portions daily by sex/age/social grade/ DEPCAT .....	59
Table A6.3: Mean number of portions of fruit and vegetables consumed per day by sex/age/social grade/ DEPCAT.....	60
Table A6.4: Knowledge of recommended 5+ portions of fruit and vegetable consumption by sex/ social grade/ DEPCAT.....	60
Table A6.5 Motivation to eat more healthily.....	61
Table A6.6: Agree that women should be made to feel more comfortable breastfeeding in public by age .....	61
Table A6.7: Disagree that women should only breastfeed at home or in private by age/social grade.....	62
Table A6.8: Disagree that would be embarrassed to see a woman breastfeeding by sex.....	62
Table A7.1: Percentage of regular smokers by age/sex/social grade/DEPCAT .....	63
Table A7.2: Number of cigarettes smoked per day by sex .....	64
Table A7.3: Percentage of heavy smokers by age .....	64
Table A7.4: Motivation to cut down or quit smoking .....	65
Table A8.1: Percentage exceeding recommended weekly limits for alcohol by sex .....	65
Table A8.2: Percentage exceeding recommended weekly limits for alcohol by sex and age .....	65
Table A8.3: Percentage with 4+ binge drinking sessions (16/10 units) in past month by sex/age/social grade .....	66
Table A8.4: Knowledge of recommended weekly limits for own sex .....	67

Table A8.5: Motivation to reduce alcohol consumption .....	68
Table A9.1: Percentage with large amount of stress by sex/age.....	69
Table A9.2: Percentage with harmful stress by sex/age/social grade .....	69
Table A9.3: Percentage with GHQ12 score greater than two by sex/age/social grade/ DEPCAT .....	70
Table A9.4: Percentage with GHQ12 score of four or more by sex/age/social grade.....	71
Table A9.5: Mean GHQ12 scores by sex/age/social grade.....	72
Table A12.1: Percentage changing sexual behaviour because of HIV/AIDS by age/social grade.....	73
Table A12.2: Attitudes toward condom use – would not have sex with new partner without a condom .....	74
Table A12.3: Information needs regarding sexual health topics.....	74

# HEPS 2007

## Summary

### Background

- This report presents an update on time trends in health-related knowledge, attitudes, motivations and behaviours in Scotland over the period 1996-2007, providing data from the Health Education Population Survey in 2007. This report focuses on areas where there has been a change, or consolidation of an earlier change, in 2007.
- In 2007, 1,921 interviews were achieved, representing a response rate of 71%.
- More information on the survey can be found in the 1996-2003 HEPS report published by NHS Health Scotland.
- While the aim of the analysis is to assess the degree of significant change in these indicators over time, the sample size and design mean that it is sometimes difficult to distinguish observed variations due to actual small changes from those due to random sampling error.

### Overview – 2007 update

- Eight in ten (79%) respondents felt that their health was good, a significant increase from 72% in 1996, although this has fluctuated over time.
- Three in ten (30%) adults in 2007 were sedentary, while the proportion meeting the recommendations for physical activity has remained at around four in ten (42%).
- Consumption of fruit and vegetables has increased significantly since 1996; however, no further increase was seen in 2007. Knowledge of the recommendations for intake of fruit and vegetables has also increased significantly over time to 75% in 2007.
- The proportion of the population who smoke regularly has fallen over time from 36% in 1996 to 26% in 2007.
- The proportion of respondents who exceed the recommended weekly alcohol limits has decreased steadily since 2001, and now appears to be stabilising at just over one in ten (14%). Men remain more likely than women to exceed the limits.
- Around one fifth of men (21%) and 7% of women reported exceeding the recommended weekly limits. As discussed later, other evidence suggests these figures under-estimate the problem.
- Almost one in four respondents (23%) reported large amounts of stress and 36% felt stress in the past year had been harmful to their health.
- There were no changes in the area of sexual health in 2007, although information needs on all topics have decreased since the survey began.

### Attitudes to own health

- Eight in ten (79%) respondents felt that their health was good, a significant increase from 72% in 1996, although this has fluctuated over time.
- As in previous years, around a third (33%) reported having a long-standing illness or disability.



- Eight in ten respondents believe they can do something to influence their own health. This has increased slightly but significantly over time from 76% in 1996.
- Older people and those in social grade E remained least likely to think that their health was good, and most likely to have a long-standing illness or feel unable to influence their health

### **Physical activity**

- Three in ten (30%) adults in 2007 were sedentary. This proportion has not changed significantly since 2002 following a decrease from around 35% earlier in the survey series. People aged 55 and over, those in social grade E and those living in the most deprived areas (DEPCAT 6 and 7) were most likely to be sedentary.
- The proportion meeting the recommendations for physical activity has remained at around four in ten (42%). This figure has shown little change since 2002, but remains significantly higher than in 1996.
- Around six in ten respondents (62%) said that they walked for at least 30 minutes per day as part of their daily routine (excluding leisure time walking).
- Approximately three in ten respondents (29%) reported that 26-30 minutes of moderate intensity physical activity per day were needed to stay healthy.
- Half of adults (48%) were aware of the message that at least five 30-minute sessions of moderate physical activity per week are required to stay healthy.
- Six in ten respondents (61%) were motivated to increase their levels of physical activity. This proportion has remained stable since 2002 following an earlier significant increase. People aged 65 and over and those in social grade E were least likely to have tried to increase their amount of exercise, or to want to.

### **Diet**

- Reported consumption of fruit and vegetables has increased significantly since 1996; however, no further increase was seen in 2007. A third (34%) ate at least five portions a day, but a quarter (24%) did not eat fruit and vegetables on a daily basis. As in previous years consumption was highest amongst women, those in the highest socio-economic groups, and those living in the least deprived areas. All sub-groups have shown a significant increase in reported consumption over the survey series.
- Knowledge of the recommendations for intake of fruit and vegetables has also shown a dramatic improvement in awareness since the start of the survey.
- Since 2001, the proportion of respondents who are motivated to eat more fruit and vegetables has remained stable at around six in ten (58%).

### **Smoking**

- The proportion of regular smokers has fallen over time, from 36% in 1996 to 26% in 2007.
- There have been sustained decreases in the proportion of respondents smoking regularly over the survey series for both men and women; people aged 25-34 and 45-54, and those in social grades C2 and D.

- Smoking prevalence remains highest in the lower social grades and in deprivation categories 3-7.
- Around one third (35%) of smokers were classed as heavy smokers (smoking 20+ per day).
- Over eight in ten (82%) smokers were motivated to cut down or give up smoking. This overall figure is similar to previous years, but the proportion who would like to cut down or give up has declined while the proportion who have tried has increased over the survey series.

### **Alcohol**

- Men remain more likely than women to exceed the recommended weekly limits, around one fifth of men (21%) and 7% of women in 2007, although, as discussed in this chapter, other evidence suggests this is an under-estimation of the actual levels.
- Around a quarter (24%) of respondents were aware of the recommended weekly limits for alcohol consumption for their own sex. Women were more likely to be aware of the recommendations than men.
- Almost one in three respondents (28%) gave the current recommended limits for alcohol consumption as a daily figure demonstrating lower levels of awareness of the daily benchmarks compared to the weekly limits. This proportion has shown no change since 2001.
- A quarter of drinkers (25%) had either tried, or would like to try, to reduce their alcohol intake compared with half of those exceeding the weekly limit (49%).

### **Mental health**

- Almost one in four respondents (23%) reported large amounts of stress in the past year and 36% felt they had experienced a level that had been harmful to their health.
- Women remained more likely than men to have GHQ12 scores over 2 (26% compared with 22%) indicative of possible mental distress. As in previous years, those in social grade E were significantly more likely than those in other social grades to score more than two (46%) on the scale.
- The mean WEMWBS score for mental wellbeing was 50.34, with no significant differences by sex, age or social grade.

### **Sexual health**

- Expressed need for information on aspects of sexual health - recognising the symptoms of STIs, having an HIV test, HIV/AIDS transmission and emergency contraception - has significantly decreased since the survey began in 1996, although there has been little change since 2004.
- Demand for more information in these four areas of sexual health has also declined over time among 16-24 year olds.

# 1. Introduction

## 1.1 Background

The Health Education Population Survey (HEPS) monitors health-related knowledge, attitudes, behaviours and motivations to change among the adult population in Scotland. A report was published in 2004 presenting an overview of key findings and trends from HEPS data during the first eight years (1996-2003).<sup>1</sup> The aim of this report on the 2007 survey data is to highlight any changes (or consolidation of earlier changes) in 2007. The report will also highlight key differences for socio-demographic groups using the 2007 data. The tables in Appendix 3 give further information on all the issues covered in the 1996-2003 report.

The survey was commissioned by NHS Health Scotland.<sup>2</sup> A core element of the work of NHS Health Scotland, and health improvement generally, is to increase public awareness of health-related risk factors and how to make the lifestyle changes necessary to reduce such risks. Health education, information and communications activities seek to influence people's health-related knowledge and attitudes and to motivate and support the process of behaviour change. The main purpose of the survey is to collect the data required to monitor progress towards achieving this aim with respect to the priority topic areas identified in a series of policy documents on improving Scotland's health (*Health Education in Scotland*, 1991; *Scotland's Health - A Challenge To Us All*, 1992; *Towards a Healthier Scotland*, 1999; *Improving Health in Scotland - The Challenge*, 2003). The indicators presented in this report concern knowledge, attitudes, motivation and behaviour/health status among adults in relation to the following topics:

- attitudes towards own health
- physical activity
- diet
- smoking
- alcohol
- mental health
- sexual health (information needs).

The following areas were not included in the 2007 survey, and therefore are not reported on here:

- perceptions of mortality, morbidity and risk
- oral health
- drug use
- cannabis legislation

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<sup>1</sup> NHS Health Scotland. *Health Education Population Survey 1996-2003*. Edinburgh: NHS Health Scotland; 2004.

<sup>2</sup> In April 2003, the Health Education Board for Scotland (HEBS) was merged with the Public Health Institute of Scotland (PHIS) to form NHS Health Scotland.

- affectometer

This report also excludes some topics included in the 1996-2003 report, as there have been no significant changes in these areas in 2007. These are:

- breastfeeding in public
- sexual health behaviour and motivation.

Appendix 3 contains tables covering all of the issues included in the 1996-2003 report, including those above excluded from the discussion in this report.

In addition to providing monitoring data for the public communications and educational aspects of health improvement, the information collected by HEPS contributes towards the planning and development of future health improvement initiatives.

## **1.2 Methodology**

The survey was conducted by BMRB. Fieldwork began in March 1996 and was carried out twice a year (March and September) in mainland Scotland. The survey was suspended for three waves during 1999-2000, resulting in a gap in data collection for the three survey waves covering September 1999, March 2000 and September 2000. In 2006, the first fieldwork period was brought forward to January due to the introduction of the smoking ban on March 26<sup>th</sup> 2006. The second wave of the year began at the end of August 2006. This pattern was repeated for the 2007 survey with the first fieldwork beginning in January and the second at the end of August. The 2007 survey will be the last of its kind.

The survey was administered using computer assisted personal interviewing (CAPI) in respondents' homes, including a self-completion section for more sensitive information such as mental health, sexual health and drug use. Each survey wave had an achieved sample of approximately 900 people aged 16-74 years. Respondents were selected using a multi-stage clustered random sampling design with the Postal Address File as the primary sampling frame. A 'rolling' sampling procedure allowed results to be combined from consecutive waves. The data were weighted to adjust for differing probabilities of selection and response bias with respect to sex and age. Most questions were asked using prompted closed-format response categories, and those asked using unprompted open-format are identified in the text.

### *1.2.1 Sample size and response rates*

This report presents key data from all waves of the survey (1996-2007), using combined results for each year from the two waves of the survey conducted in that year. The exception to this was in 1999 when only one survey wave was carried out. The results for 1999 should therefore be treated with considerable caution since the much lower base will produce much greater levels of random variation. There was no survey in 2000.

The number of achieved interviews and response rates with respect to the eligible sample are shown below for each year.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Achieved interviews	1,810	1,795	1,794	880		1,757	1,742	1,720	1,784	1,822	1,759	1,921
Response rate	72%	73%	72%	72%		71%	72%	72%	70%	70%	68%	71%

### 1.2.2 Analysis

This report focuses on *changes over time* for key variables, both for the whole population and for subgroups with respect to sex, age, social grade and deprivation (base sizes for subgroups are given in Appendix 2). Differences between years are tested for statistical significance using t-tests for means or hypothesis tests for proportions as appropriate. Unlike other significance tests, these tests also take into account the estimated design effect due to the sampling procedure (see 1996-2003 report for more details). The report describes observed changes and explicitly points out where such a change is statistically significant ( $p < 0.05$ ). Differences should **not** be considered statistically significant unless it is specifically stated. Any use of the term *significant* is taken to mean statistically significant, but the use of this term does not imply *substantive* significance or importance. Changes over time that are significant are indicated by shaded rows in the tables. It should be noted that given the relatively small size of some of these differences, some caution is recommended in interpreting and generalising from this data in the absence of other supporting evidence.

The significance tests have been applied to look for change between two points in time (e.g. between 1996 and 2007). The period of change considered will be specified in the text, and any change will be considered in context. If the apparent change is not supported by trends of change in between the two points in time, or by change being sustained in the longer term, or by evidence of change from other sources, then caution should be used in interpreting the apparent change.

It is also not appropriate to attribute observed changes definitively and solely to health improvement activity as many other factors (e.g. macro-economic change, commercial marketing) will influence health-related attitudes and behaviours.

### 1.2.3 Self-reported behaviours

It is worth bearing in mind that the behavioural measures are self-reported, rather than observational. This is likely to mean some degree of under-reporting for behaviours such as alcohol consumption or over-reporting for behaviours such as physical activity or consumption of fruit and vegetables.

### 1.2.4 Classifications used

**Age:** In general, six age groups are used for analysis (16-24, 25-34, 35-44, 45-54, 55-64, 65-74). These are the standard groups used in presenting survey

findings. However, in the absence of clear gradients, or in the case of small base sizes, results may be presented in terms of more aggregated age groups to clarify observed patterns of difference.

*Social grade* is used as a household-based proxy measure of social class. This classification is based on the normal occupation of the chief income earner in the household, which is categorised into AB (professional, managerial and technical), C1 (skilled non-manual), C2 (skilled manual), D (partly skilled and unskilled) and E (dependent on state and casual workers) (Market Research Society, 1991). The social grade of a retired person with a pension from their job is based on their previous normal occupation. The social grade of widows or widowers receiving a pension from their spouse's job is based on the previous normal occupation of the spouse. For those unemployed for two months or less, social grade is based on their previous occupation - the longer term unemployed are graded as E. The main advantage of this classification system is that it provides a relatively stable population profile over time and all respondents can be assigned a social grade, unlike occupation-based systems such as the Registrar General's *Social Class based on Occupation* which excludes the long-term unemployed, arguably one of the most materially and socially disadvantaged population groups.

*Deprivation*: DEPCAT is used as an area-based measure of deprivation. This is based on the Carstairs scores which are derived from census data and are a measure of "access to material resources which provide access to those goods and services, resources and amenities and of a physical environment which are customary in society."<sup>3</sup> The scores do not apply to *individuals* but are summary codes applied at postcode sector level. The scores are a composite measure of four variables: overcrowding, male unemployment, low social class and having no car. The Carstairs scores are used to define seven DEPCAT groups, from 1 (the most affluent) to 7 (the most deprived). Carstairs scores are updated periodically when more up to date Census data are available, or when there are changes to postcode boundaries. The division of the scores into DEPCAT groups was first done in 1981 on a pragmatic basis, using the first Carstairs scores. More recent DEPCAT groups have been achieved by dividing the population (according to the latest Carstairs scores) into seven new DEPCAT groups, each containing the same proportions of the population as those produced in 1981. The latest available DEPCAT scores were used for analysis in this report. For further discussion of DEPCAT, see the 1996-2003 report.

*Motivation*: Three mutually exclusive categories are used to classify respondents according to their motivation to change health-related behaviours. Those who:

- have tried to change in the past year
- want to change, but have not tried in the past year
- have neither tried nor want to change.

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<sup>3</sup> McLoone P. *Carstairs Scores for Scottish Postcodes Sectors from the 1991 Census*. Glasgow: Public Health Research Unit; 2000.

Anyone who falls into either of the first two categories would be defined as “motivated to change”.

#### 1.2.5 Tables and figures

When using tables and figures, the following points should be noted:

- percentages may not add up to 100 due to rounding, or the exclusion of *don't know* responses where they only represent a small proportion of answers
- percentages are used throughout the report, irrespective of base size - for each percentage given, the number of individuals constituting the base is given in Appendix 2 and should be taken into account when interpreting the findings
- percentages less than 0.5% and greater than zero are denoted by ‘\*’, while ‘-’ denotes zero
- the base for percentages consists of all respondents (including those for whom data are missing), unless explicitly stated.

#### **Main points**

- This report presents an update on time trends in health-related knowledge, attitudes, motivations and behaviours in Scotland over the period 1996-2007, providing data from the Health Education Population Survey in 2007. This report focuses on areas where there has been a change, or consolidation of an earlier change, in 2007.
- In 2007, 1,921 interviews were achieved, representing a response rate of 71%.
- More information on the survey can be found in the 1996-2003 HEPS report published by NHS Health Scotland.
- While the aim of the analysis is to assess the degree of significant change in these indicators over time, the sample size and design mean that it is sometimes difficult to distinguish observed variations due to actual small changes from those due to random sampling error.

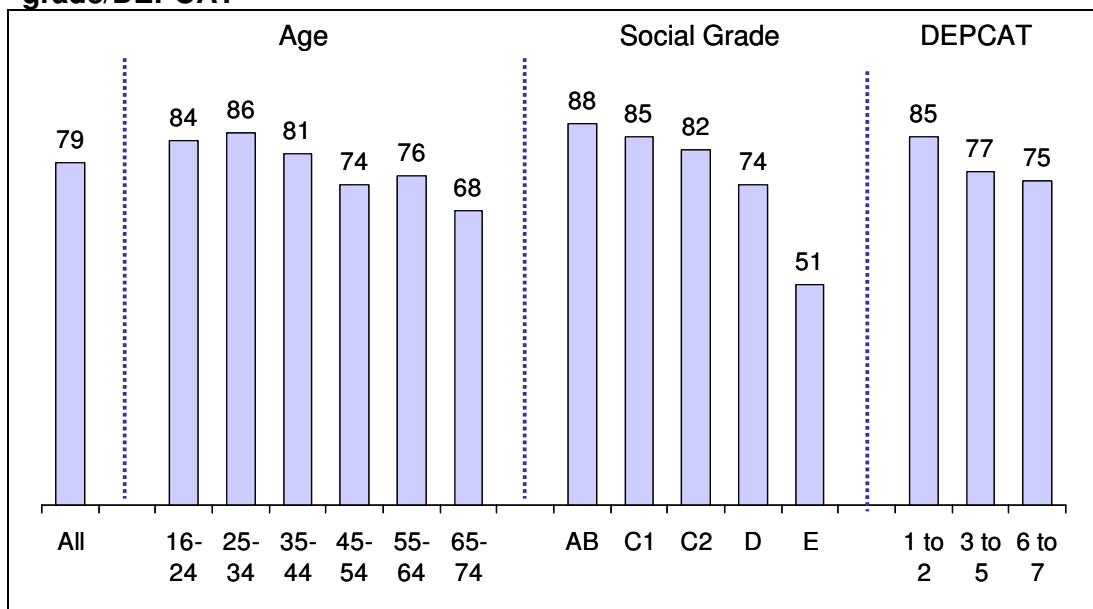
## 2. Attitudes to own health

An important area covered by the HEPS survey is how individuals view their own health, and the extent to which they feel they have an influence over this. The way individuals view their health is likely to have an impact on how they respond to health education messages. Furthermore, research has shown that self-assessed health status predicts mortality, independently of other factors, and it is used in Scotland as a measure of healthy life expectancy, along with limiting longstanding illness.<sup>4</sup>

### 2.1 Self-reported general health

Respondents were asked how they would rate their own health. Figure 2.1 shows the percentage of respondents in 2007 answering very good or fairly good, broken down by age, social grade, and deprivation category.

**Figure 2.1 Percentage who feel their health is good by age/social grade/DEPCAT**



*Base: all respondents 2007 (1,921)*

Overall, eight in ten (79%) respondents rated their health as very or fairly good, a significant increase from 72% in 1996, although this has fluctuated between these values over time. When comparing subgroups, the pattern is similar to previous years with self-reported health worst for older respondents, those in social grade E and those living in the most deprived areas.

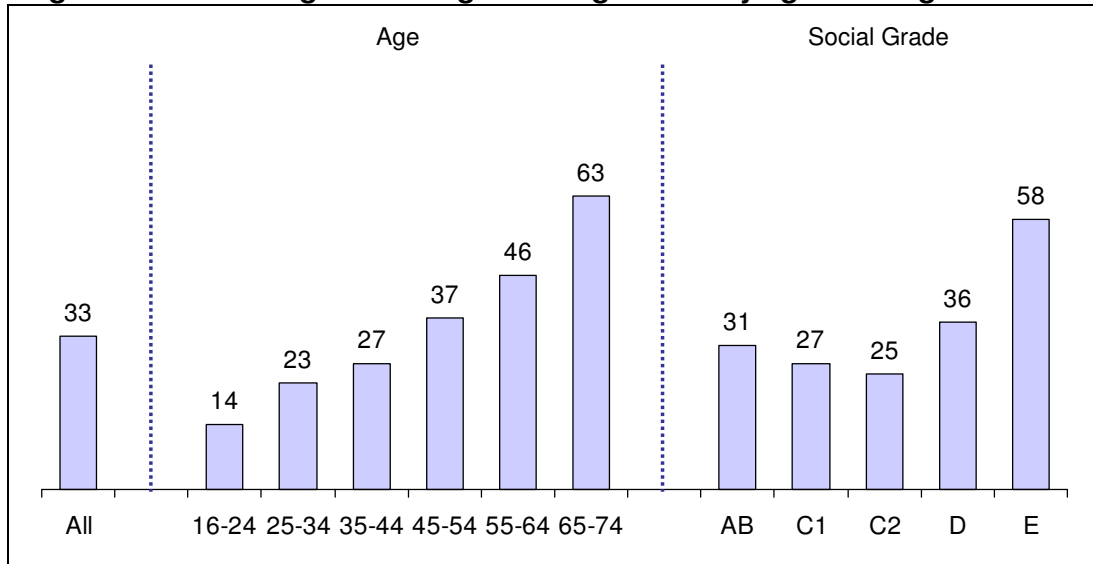
### 2.2 Long-standing illness

In 2007, a third (33%) reported having a long-standing illness. The proportion of respondents with a long-standing illness or disability has not changed significantly over time.

<sup>4</sup> ISD Scotland. *Healthy Life Expectancy in Scotland*. Edinburgh: ISD Scotland; 2004.



**Figure 2.2 Percentage with long-standing illness by age/social grade**



*Base: all respondents 2007 (1,921)*

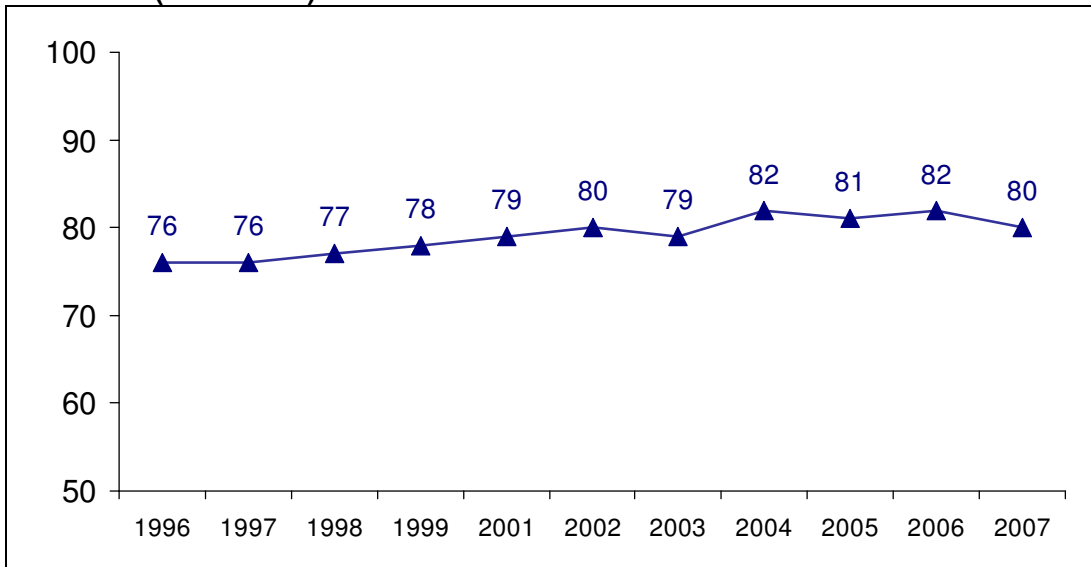
As shown in figure 2.2, those aged 65 and over and those in social grade E were most likely to have a long-standing illness, as was the case in previous years. There was a significant increase in the proportion with a long-standing illness among those in AB social grades from 23% in 2006 to 31% in 2007, although this has fluctuated over time from a high of 32% in 1996 to a low of 21% in 2001.

### **2.3 Ability to influence own health**

The control that people feel they have over their own health is a further important indicator of health behaviours and long-term health. In order for health improvement messages to be effective, individuals need to feel that they can take action to influence their own health. Encouraging individuals to feel that they can take steps to influence their health, and the health of their children, has been a central message of a number of health education campaigns in Scotland.

The proportion of respondents who believe that they can make their own life healthier has increased slowly but significantly over time from 76% in 1996 to around eight in ten more recently. Figure 2.3 shows this trend.

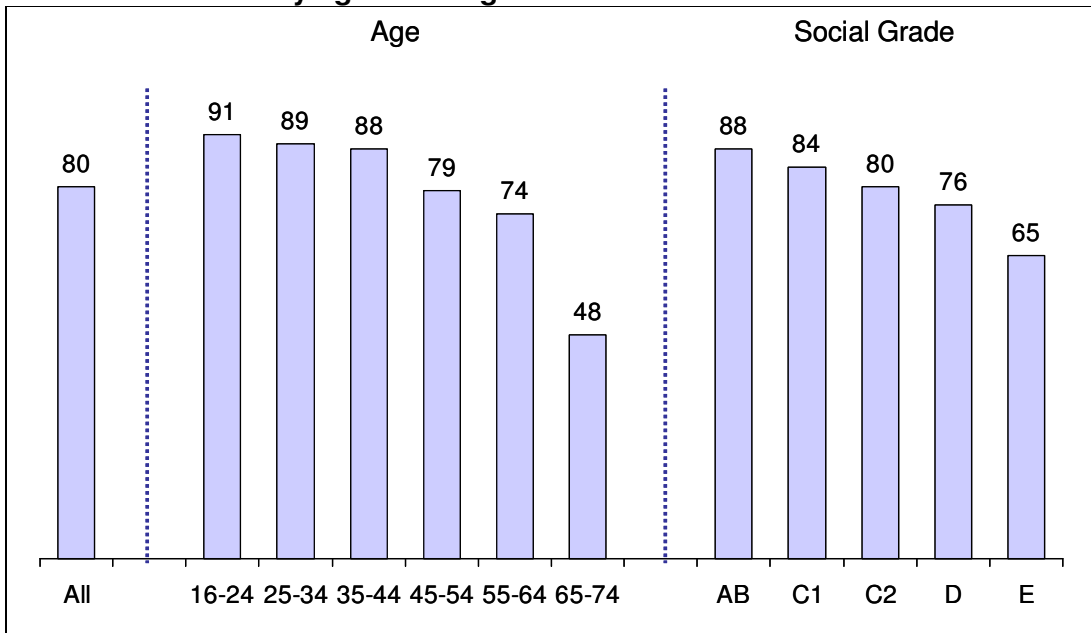
**Figure 2.3 Time trends in belief that individuals can make own life healthier (1996-2007)**



*Base: all respondents 2007 (1,921)*

Figure 2.4 presents the 2007 data in more detail. As in previous years, respondents aged 65 and over were least likely to feel that they could influence their own health (48%). The pattern by social grade was also similar to that of previous years, with those in grade E less likely to feel that they could influence their own health.

**Figure 2.4 Percentage who believe they can do something to make their own life healthier by age/ social grade**



*Base: all respondents 2007 (1,921)*

**Main points**

- Eight in ten (79%) respondents felt that their health was good, a significant increase from 72% in 1996, although this has fluctuated over time.
- As in previous years, around a third (33%) reported having a long-standing illness or disability.
- Eight in ten respondents believe they can do something to influence their own health. This has increased slightly but significantly over time from 76% in 1996.
- Older people and those in social grade E remained least likely to think that their health was good, and most likely to have a long-standing illness or feel unable to influence their health.

### 3. Physical activity

Physical activity is an important protective factor against a number of diseases, including coronary heart disease. It is also associated with mental and social wellbeing. Scotland currently uses a two-stage approach to promote physical activity, based on guidelines highlighting the health benefits of moderate intensity physical activity, or 'active living'. The 'active living' message particularly targets those who are sedentary, and therefore most at risk from coronary heart disease. This group is less likely to respond to the traditional exercise guidelines designed to increase fitness rather than health, which recommend three twenty-minute sessions of vigorous exercise per week, and would therefore benefit from more achievable targets in relation to moderate physical activity. Health education campaigns to explain the health benefits of moderate physical activity have focused on brisk walking, and were first introduced in 1996.

Three indicators were used to assess physical activity behaviour: being sedentary, a measure of physical *inactivity*, and two measures of physical *activity*. Being sedentary, or physically inactive, is considered to be a risk factor for coronary heart disease, and is therefore defined as a risk behaviour for the purposes of this report.

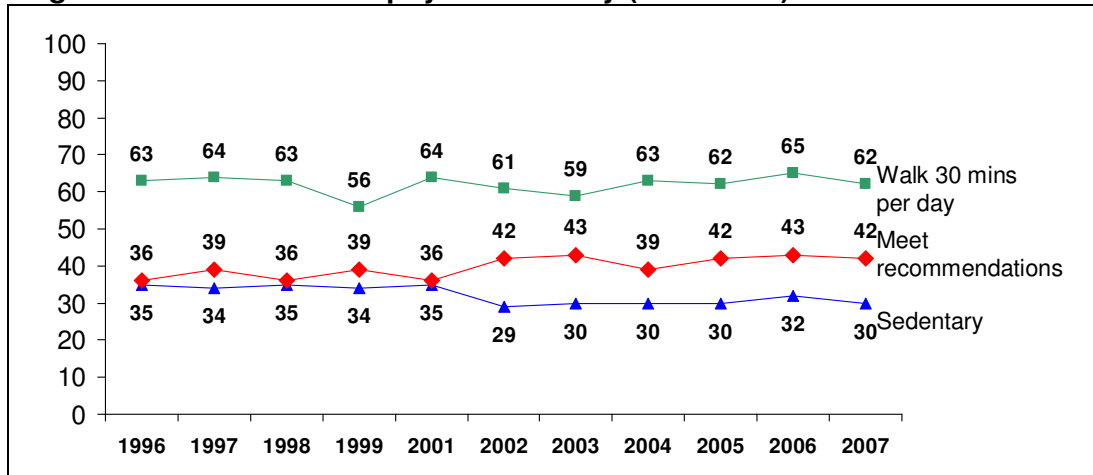
To determine physical activity levels, the HEPS includes a series of questions (outlined in Appendix 1) about the types of physical activity that respondents do in a typical week. Respondents report how many times per week and for how long on each occasion they complete an activity. The number of sessions of at least 30 minutes of *moderate* activity, or 20 minutes of *vigorous* activity is used to derive a summary activity level (method described in Appendix 4). Those achieving 5 or more sessions of moderate activity or 3 or more sessions of vigorous activity were classified as regular exercisers and meeting the recommendations. Those with *no* such sessions were defined as sedentary. In 2002, the questions used to derive activity level were only asked of half of all respondents as a new World Health Organisation (WHO) measure of physical activity was being trialled with the other half.

For the second measure of physical activity, respondents were asked how long they spend walking out of doors in an average day, excluding leisure time walking. This measure is used to assess inclination for 'active living' type exercise.

#### 3.1 Reported behaviour

Figure 3.1 shows the pattern over time for the three measures of physical activity behaviour: active living (walking 30 minutes per day), protective behaviour (meeting the recommendations), and risk behaviour (sedentary).

**Figure 3.1 Time trends in physical activity (1996-2007)**



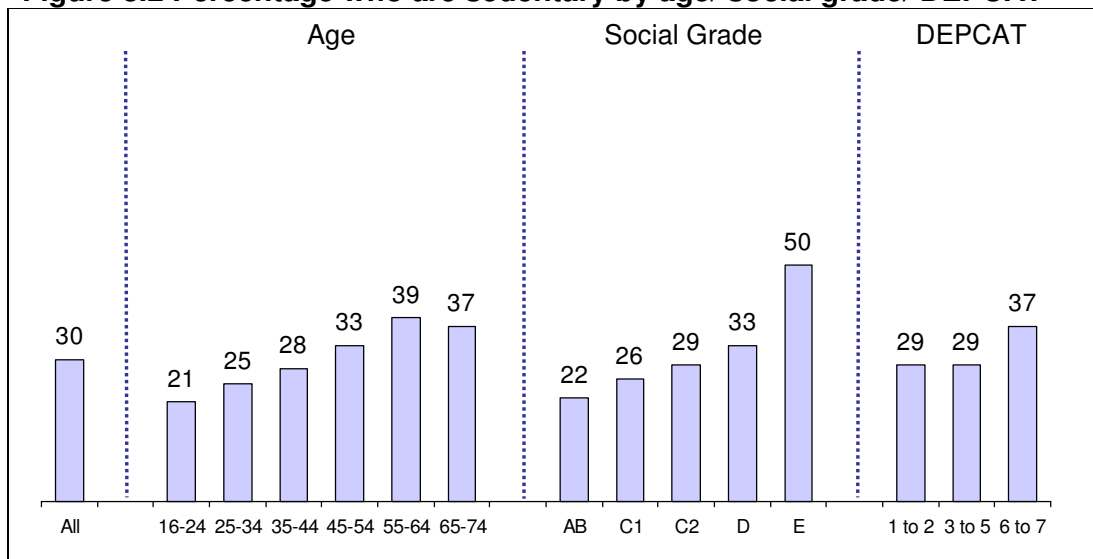
Base: all respondents (2007: 1,921)

Three in ten (30%) respondents in 2007 were sedentary. This level has shown little change since 2002 following a decrease from around 35% earlier in the survey series. In 2007 just over four in ten (42%) respondents met the recommendations for physical activity. Again, this proportion has shown little change since 2002 but remains significantly higher than 1996.

At 62% in 2007, the proportion of individuals walking for at least 30 minutes per day as part of their daily routine (excluding leisure time walking) has shown no consistent change over time.

Figure 3.2 looks at risk behaviour (respondents classified as sedentary) in 2007 by age, social grade, and deprivation category.

**Figure 3.2 Percentage who are sedentary by age/ social grade/ DEPCAT**



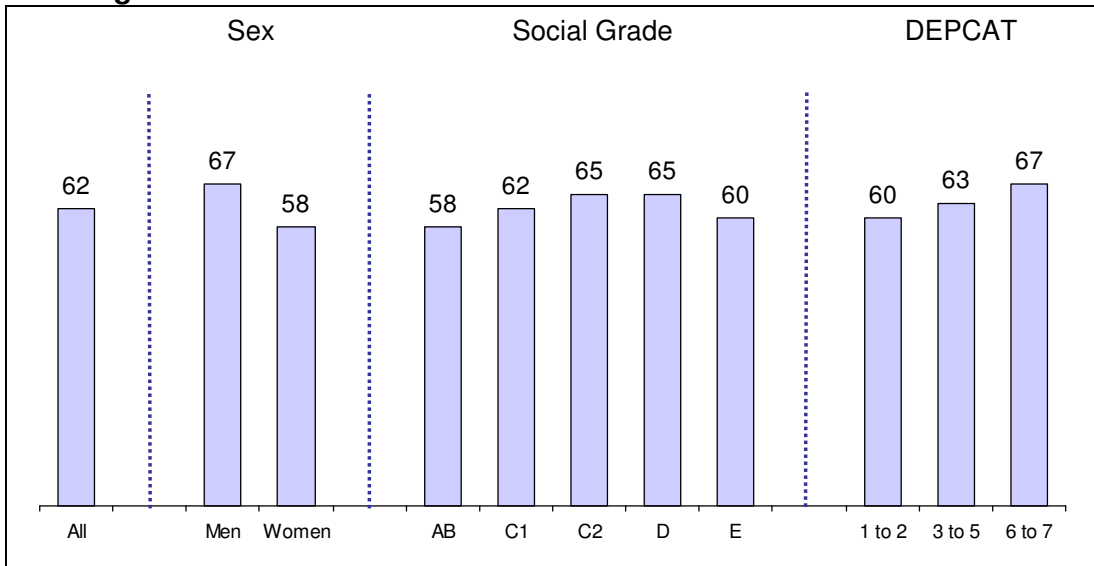
Base: all respondents 2007 (1,921)

Patterns of physical inactivity are similar to those measured in previous years. Unsurprisingly, physical activity decreases with age, with those aged 55 and over most likely to be sedentary. People in social grade E are also significantly more likely to be sedentary than those in other social grades. As in 2006, there does appear to be differentiation by deprivation level with those in the most deprived areas (categories 6 and 7) significantly more likely to be sedentary than those in categories 1-5 (37% and 29% respectively). However, findings within this group tend to fluctuate over time, and the figures are not significantly different from previous years.

When looking at the proportions meeting the recommendations, a similar pattern is reflected - older respondents and those in social grade E are least likely to be regularly physically active.

However, a different pattern is found for the proportion walking outdoors for at least 30 minutes per day (excluding leisure time walking), as shown in Figure 3.3. The highest levels of daily walking were found in social grades C2 and D (65%, although these are not significantly higher than other grades in 2007). This is a similar picture to previous years, and is likely to be related to car ownership and access to public transport, as discussed in the 1996-2003 report. As in previous years, men (67%) were significantly more likely than women (58%) to walk for at least 30 minutes per day.

**Figure 3.3 Percentage walking for at least 30 minutes per day by sex/ social grade/ DEPCAT**



*Base: all respondents 2007 (1,921)*

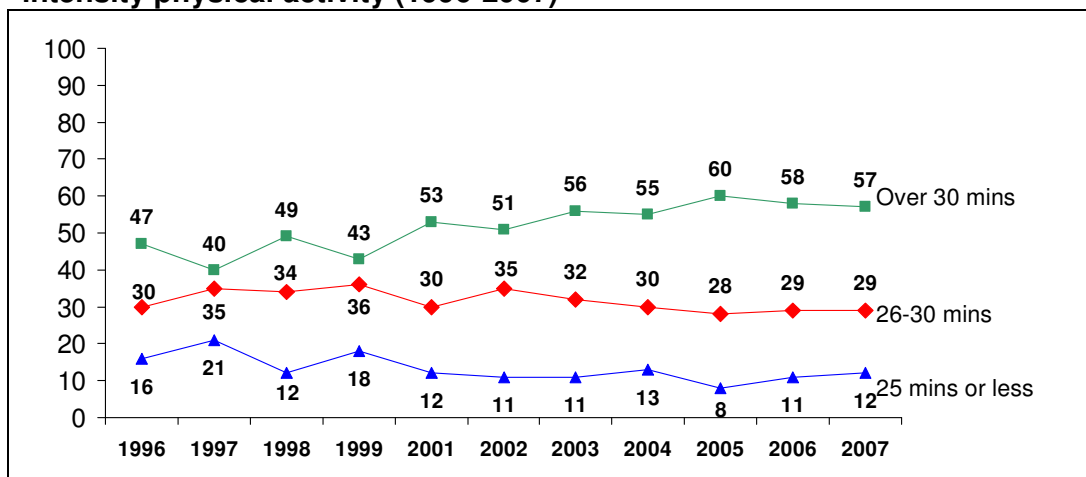
### 3.2 Knowledge and motivation

Another key area covered in the HEPS is knowledge of the recommendations for physical activity, and motivation to change behaviour. The knowledge indicator used in the survey is geared towards the original 'active living' message which emphasised the benefits of accumulating at least 30 minutes of moderate intensity physical activity on most days. From 1996, the survey has asked respondents how much *time per day* they think somebody needs to engage in moderate intensity activity to help them stay healthy. However, more recently this message has been revised to a frequency of at least five days per week. Thus, from Autumn 2004, it has also asked how many *times a week* people should do about half an hour of moderate intensity activity.

#### **Duration (1996-2007)**

To measure awareness of the duration component of the active living' message (at least 30 minutes of moderate physical activity), respondents were asked to state how many minutes per day of moderate physical activity, such as brisk walking or heavy gardening, they thought were needed to stay healthy. Figure 3.4 summarises answers over time.

**Figure 3.4 Percentage aware of recommended duration of moderate intensity physical activity (1996-2007)**



Base: all respondents (2007: 1,921)

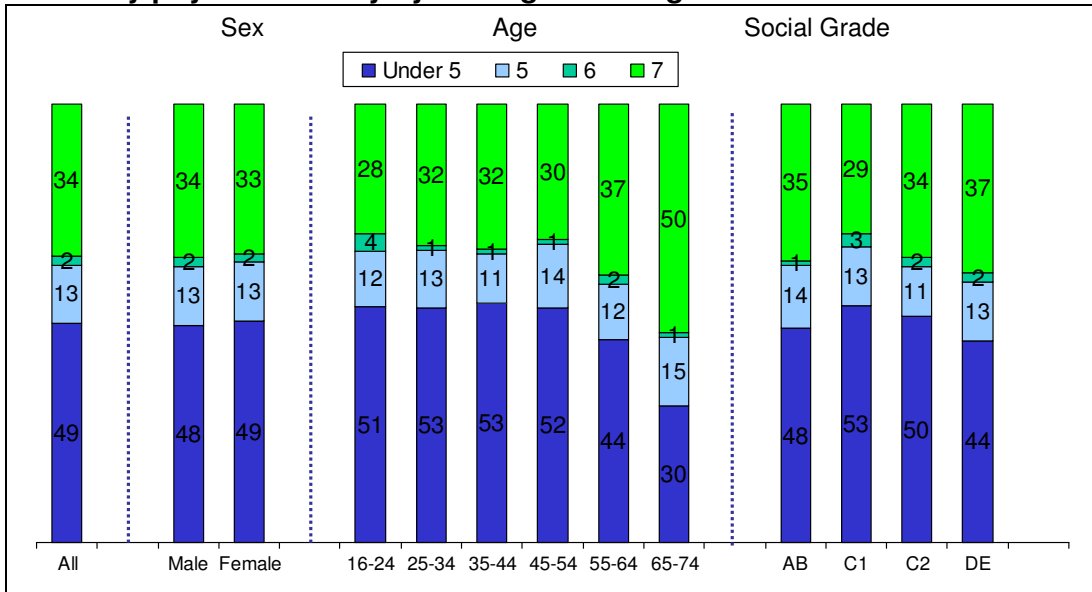
The proportion giving an answer of 26-30 minutes has fluctuated over time but shown no sustained change, remaining at around three in ten (29%). In 2007, about six in ten (57%) respondents overestimated the amount of moderate physical activity needed to stay healthy (i.e. they reported over 30 minutes per day). This has also fluctuated over time, but is a significant increase from 47% in 1996. Such over-estimation could act as a disincentive to exercise if people feel the targets are unachievable.

Around one in ten (12%) believed that 25 minutes of exercise or less were needed per day and therefore underestimated the amount of activity needed for health. Again, this has fluctuated over time, but has decreased significantly since 1996.

**Frequency**

Half (48%) gave the correct answer that someone should undertake 30 minutes of moderate intensity physical activity in order to keep healthy five or more times per week. Just over one in ten gave an answer of 5 (13%), and a third (34%) gave an answer of 7.

**Figure 3.5 Percentage aware of recommended frequency of moderate intensity physical activity by sex/ age/ social grade**



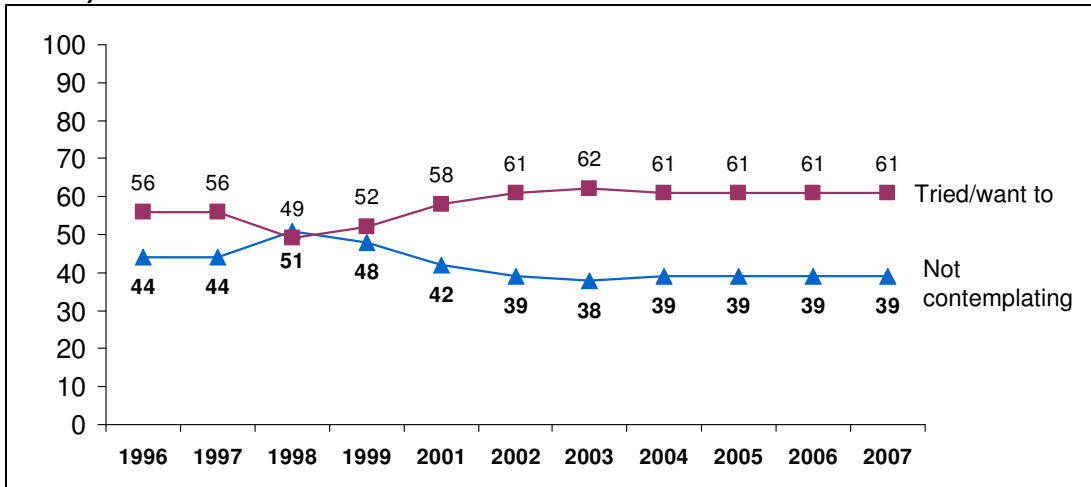
Base: all respondents 2007 (1,921)

Several groups showed a significant increase in their awareness of the recommended frequency of moderate intensity activity. The proportion of women giving the correct answer increased from 41% in 2006 to 48% in 2007, and correct answers among people aged 65-74 also increased significantly from 45% to 65%. Respondents in social grades AB and DE also showed significant increases in the proportion giving the correct answer in 2007 compared with 2006.



## Motivation

**Figure 3.6 Time trends in motivation to increase physical activity (1996-2007)**



*Base: all respondents (2007: 1,921)*

Figure 3.6 shows the time trends in motivation to increase physical activity. Between 1999 and 2002 there was a significant increase in those motivated to change their behaviour (i.e. had tried or would like to increase their levels of physical activity). This proportion has subsequently remained stable at around six in ten (61% in 2007), with estimates from 2002 onwards all significantly higher than those from 1996 to 1999.

In 2007, four in ten (39%) were not contemplating any change to their physical activity behaviour. A further four in ten (43%) had tried to increase the amount of physical activity they do, and the remaining two in ten (18%) said that they would like to.

As in previous years, motivation to increase physical activity was lowest amongst individuals aged 65 and over (36%) and those in social grade E (49%). Forty-three per cent of those classified as sedentary were not contemplating or had not tried to change their physical activity behaviour. This figure was higher, as may be expected, among regular moderate exercisers (53%) who presumably do not feel the need to change the amount they exercise.

**Main points**

- Three in ten (30%) adults in 2007 were sedentary. This proportion has not changed significantly since 2002 following a decrease from around 35% earlier in the survey series. People aged 55 and over, those in social grade E and those living in the most deprived areas (DEPCAT 6 and 7) were most likely to be sedentary.
- The proportion meeting the recommendations for physical activity has remained at around four in ten (42%). This figure has shown little change since 2002, but remains significantly higher than in 1996.
- Around six in ten respondents (62%) said that they walked for at least 30 minutes per day as part of their daily routine (excluding leisure time walking).
- Approximately three in ten respondents (29%) reported that 26-30 minutes of moderate intensity physical activity per day were needed to stay healthy.
- Half of adults (48%) were aware of the message that at least five 30-minute sessions of moderate physical activity per week are required to stay healthy.
- Six in ten respondents (61%) were motivated to increase their levels of physical activity. This proportion has remained stable since 2002 following an earlier significant increase. People aged 65 and over and those in social grade E were least likely to have tried to increase their amount of exercise, or to want to.

## 4. Diet

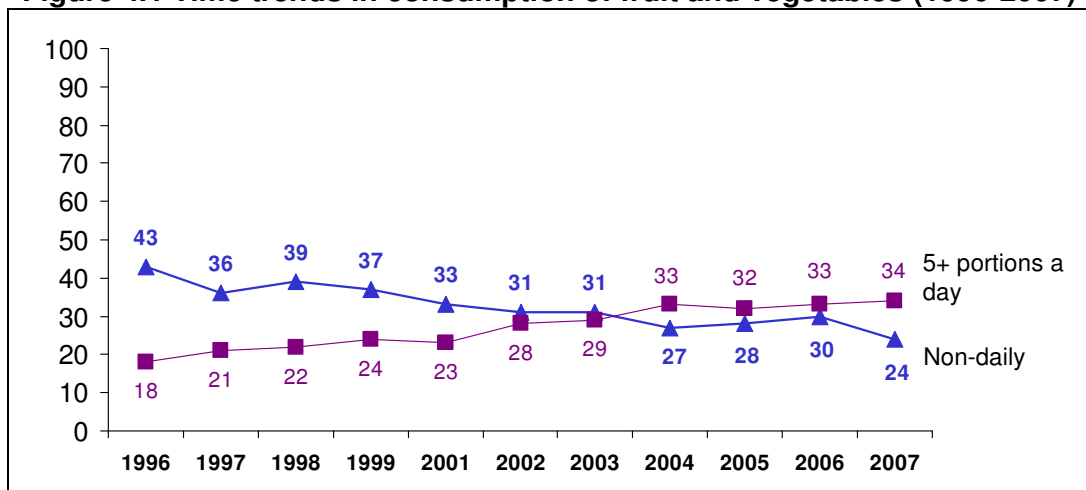
Healthy eating is another key area for health improvement, and has implications for cardiovascular disease, certain cancers, oral health and the rising levels of adult and childhood overweight and obesity. High consumption of fruit and vegetables has been shown to reduce the risks of cardiovascular disease and certain cancers. The target for consumption of fruit and vegetables is to increase the average intake to at least 400g (five portions) a day by the year 2010.<sup>5</sup>

For the purposes of this survey, daily consumption of fruit and vegetables is used as a proxy indicator of a generally healthy diet, as good nutrition has been found to correlate strongly with intake of fruit and vegetables. Additional analyses of HEPS data have shown that those who consumed fruit and vegetables daily had a healthier diet, consuming more complex carbohydrates and fish, less sugar and fewer high-fat foods. They were also more likely to have tried to change their diet to improve their health.

### 4.1 Reported behaviour

Reported consumption of fruit and vegetables has increased significantly over time, however there has been no further increase in 2007. The proportion of respondents eating five or more portions of fruit or vegetables per day rose steadily over the period 1996 to 2004, and in 2004, for the first time, it exceeded the proportion not eating fruit or vegetables daily. This has remained the case (Figure 4.1) but consumption of five or more portions a day appears to have stabilised at around a third (34% in 2007). The proportion not eating fruit and vegetables on a daily basis has decreased significantly over time from 43% in 1996, and saw a further significant decrease to 24% in 2007.

**Figure 4.1 Time trends in consumption of fruit and vegetables (1996-2007)**



Base: all respondents (2007: 1,921)

<sup>5</sup> Scottish Executive. *Improving Health in Scotland: the Challenge*. Edinburgh: The Stationery Office; 2003.

There has been a steady increase over time in the average reported number of portions of fruit and vegetables consumed per day, from 2.8 in 1996, to 3.7 in 2007. Although this is a clear improvement, it is still short of the five a day target.

Table 4.1 shows the proportion of respondents eating at least five portions of fruit and vegetables a day from 1996 to 2006, broken down by sex, age, social grade and deprivation category.

**Table 4.1: Percentage eating at least five portions daily by sex/age/social grade/ DEPCAT**

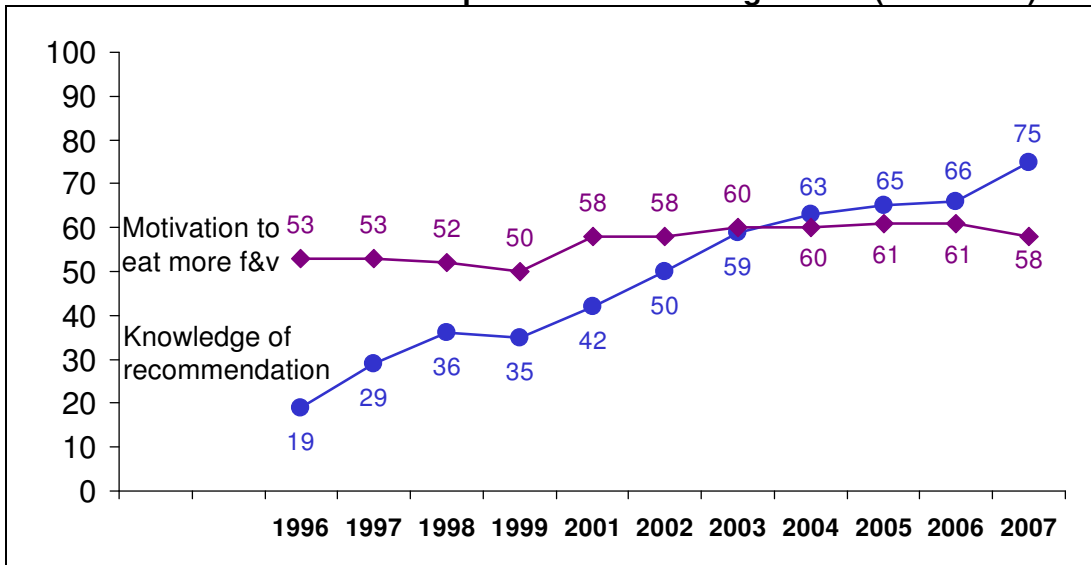
%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<i>All</i>	18	21	22	24		23	28	29	33	32	33	34
<i>Sex</i>												
Men	14	17	16	22		16	21	21	27	27	24	26
Women	22	25	28	27		29	36	36	39	37	41	42
<i>Age</i>												
16-24	12	15	15	9		15	15	19	18	17	28	34
25-34	12	20	17	20		23	26	28	32	28	26	27
35-44	19	17	22	33		23	30	27	36	31	37	36
45-54	22	24	25	28		26	32	34	39	47	38	32
55-64	27	28	27	35		20	35	34	37	37	37	39
65-74	22	25	29	24		34	30	31	38	31	30	43
<i>Social grade</i>												
AB	27	23	35	44		35	41	47	45	38	50	51
C1	21	27	26	25		32	29	28	36	39	39	36
C2	18	17	15	20		15	20	28	33	29	30	29
DE	13	17	14	18		13	25	20	32	23	20	25
<i>DEPCAT</i>												
1-2	27	27	30	28		28	40	41	36	39	43	41
3-5	17	20	20	25		26	27	27	35	33	33	33
6-7	15	18	16	18		12	19	20	21	20	22	27
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

The distribution of fruit and vegetable consumption in 2007 is largely similar to that reported in previous years. Women, those in social grades AB and those living in the least deprived areas of Scotland remain most likely to meet the recommendation of at least five portions a day. Although results within subgroups fluctuate, all have shown a significant increase in fruit and vegetable consumption over the survey series.

## 4.2 Knowledge and motivation

As shown in figure 4.2, knowledge of the recommendation for consumption of fruit and vegetables has increased significantly over time. In 2007, three quarters (75%) of respondents gave a figure of five or more when asked the recommended daily level of fruit and vegetable consumption. This is a significant increase from 2006 and shows a dramatic improvement in awareness of the recommended levels of consumption since the start of the survey.

**Figure 4.2 Time trends in knowledge of recommended consumption and motivation to increase consumption of fruit and vegetables (1996-2007)**

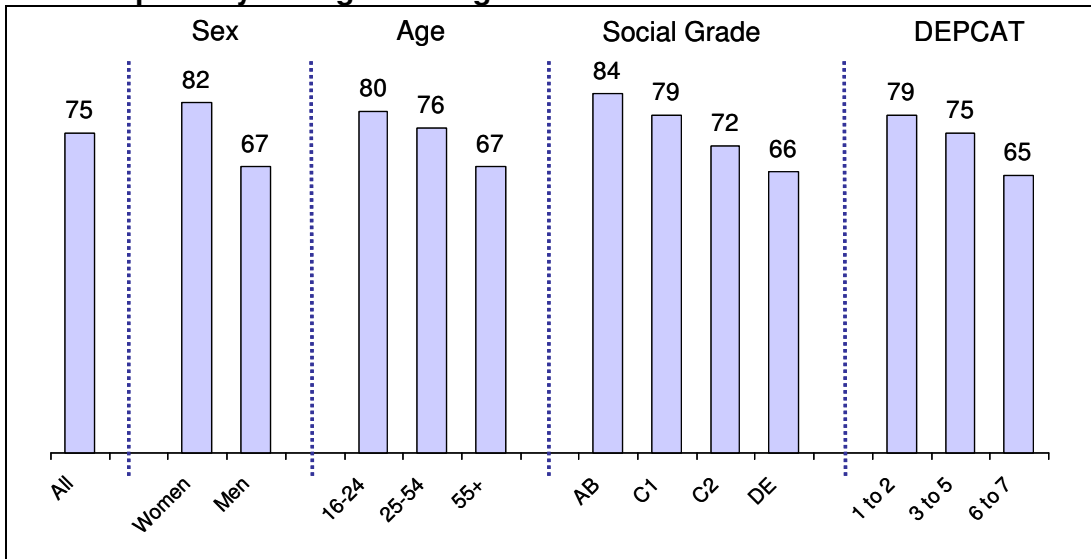


*Base: all respondents (2007: 1,921)*

The improvement in motivation to increase consumption of fruit and vegetables has been less marked over time. The proportion of respondents who had either tried to eat more healthily, or would like to do so, has increased significantly since 1996 but appears to have stabilised at around six in ten (58% in 2007).

For the fourth year running, awareness levels of the recommendation remained higher than motivation to eat more fruit and vegetables with the gap widening to 17 percentage points in 2007. This trend could have implications for the promotion of healthy eating; although there is an increased awareness of the message this will not have the desired impact on behaviour unless the individual has the motivation to change.

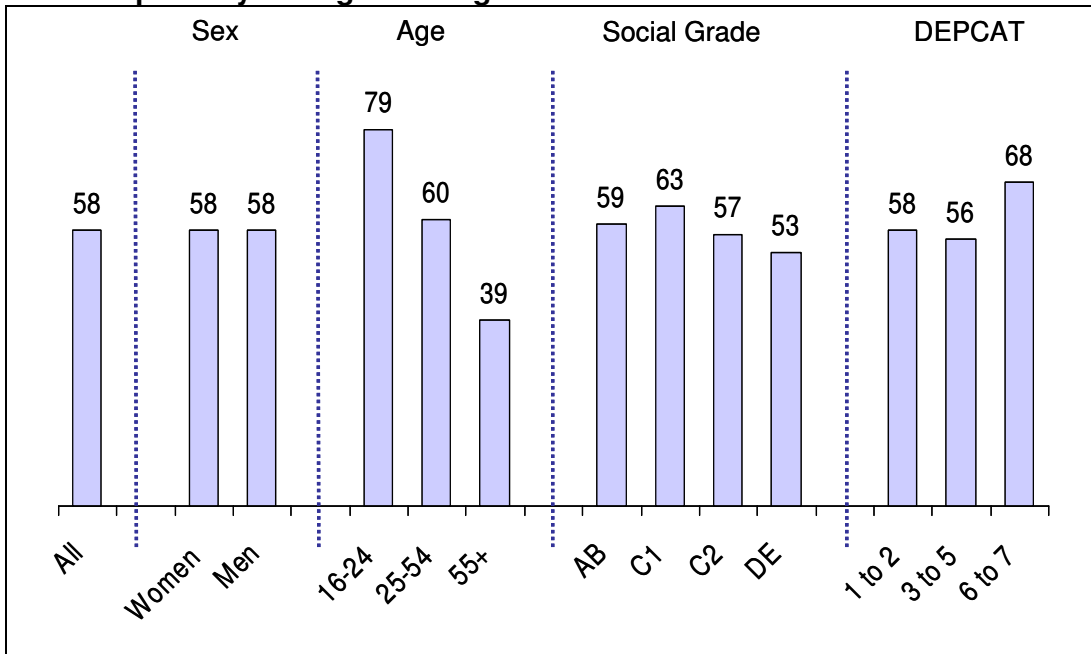
**Figure 4.3 Percentage who know recommended fruit and vegetable consumption by sex/age/social grade/DEPCAT**



*Base: all respondents 2007 (1,921)*

When looking at awareness of the recommendation for consumption of fruit and vegetables amongst different subgroups, with the exception of age, the picture is similar to that of actual consumption. Respondents over 55 years are more likely to meet the recommendations than younger age groups but they are less likely to be aware of them. As in previous years, women, younger individuals, those in the higher social grades and living in the least deprived areas were more likely to say that five or more portions per day should be eaten for health. The observed improvement in awareness of the recommendation (over the survey series as a whole) applies to all subgroups. In 2007 compared to 2006, awareness of the five-a-day message was significantly higher in all subgroups except 16-24 year olds, those from the highest social grades (AB) and least deprived backgrounds (Depcat 1-2).

**Figure 4.4 Percentage motivated to increase fruit and vegetable consumption by sex/age/social grade/DEPCAT**



*Base: all respondents 2007 (1,921)*

There was no difference in motivation to eat more fruit and vegetables between men and women, or by social grade. However younger respondents (16-24 year olds) and those living in the most deprived areas (Depcat 6 to 7) were more likely to be motivated to eat more healthily.

**Main points**

- Reported consumption of fruit and vegetables has increased significantly since 1996; however, no further increase was seen in 2007. A third (34%) ate at least five portions a day, but a quarter (24%) did not eat fruit and vegetables on a daily basis. As in previous years consumption was highest amongst women, those in the highest socio-economic groups, and those living in the least deprived areas. All sub-groups have shown a significant increase in reported consumption over the survey series.
- Knowledge of the recommendations for intake of fruit and vegetables has also shown a dramatic improvement in awareness since the start of the survey.
- Since 2001, the proportion of respondents who are motivated to eat more fruit and vegetables has remained stable at around six in ten (58%).

## 5. Smoking

Smoking remains the single largest preventable cause of illness and premature death in Scotland accounting for more than 13000 deaths annually.<sup>6</sup> It is estimated that up to 1000 deaths per year might be attributed to passive smoking amongst non-smokers.<sup>7</sup> In 2004, the Scottish Executive, now the Scottish Government, published *A Breath of Fresh Air for Scotland*,<sup>6</sup> the Tobacco Control Action Plan, that sets out measures designed to reduce smoking and tobacco-related harm focusing on prevention and education, smoking cessation services, protection and controls, and secondhand smoke. NHS smoking cessation services have been established throughout Scotland, with information on quit attempts available from the Scottish Public Health Observatory e.g. [http://www.scotpho.org.uk/home/Publications/scotphoreports/pub\\_smokingcessationstats2007.asp](http://www.scotpho.org.uk/home/Publications/scotphoreports/pub_smokingcessationstats2007.asp). One of the significant actions to reduce the impact of passive smoking was the introduction of legislation to ban smoking in enclosed public places in March 2006. In addition, the Smoking Prevention Working Group published its recommendations intended to protect and dissuade all young people in Scotland from starting to smoke and to deter adults, individually and collectively, from encouraging or enabling them to smoke.<sup>8</sup> This has been followed up by *Scotland's Future is Smoke-free: A Smoking Prevention Action Plan* published in May 2008.<sup>9</sup>

Mass media anti-smoking campaigns in Scotland aim to inform people of the harmful effects of both smoking and passive smoking to motivate smokers to quit and to publicise support available to smokers wishing to quit. A series of testimonial style adverts have been produced to promote 'Smokeline', the telephone helpline, and the expanding network of smoking cessation services across Scotland. These adverts incorporate the message that smokers are four times more likely to quit if they access behavioural support in conjunction with pharmacotherapies such as nicotine replacement therapy (NRT) or bupropion.<sup>10</sup> There has also been an increasing focus on the harmful effects of passive smoking, particularly in the period prior to the introduction of the legislation banning smoking in public places.

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<sup>6</sup> Scottish Executive. *A Breath of Fresh Air for Scotland: Improving Scotland's Health*. Edinburgh: The Stationery Office; 2004.

<sup>7</sup> NHS Health Scotland. *Passive Smoking and Associated Causes of Death in Scotland*. Edinburgh: NHS Health Scotland; 2005.

<sup>8</sup> Scottish Executive. *Towards a Future without Tobacco: The Report of the Smoking Prevention Working Group*. Edinburgh: The Stationery Office; 2006.

<sup>9</sup> The Scottish Government. *Scotland's Future is Smoke-free: A Smoking Prevention Action Plan*. Edinburgh: The Scottish Government; 2008.

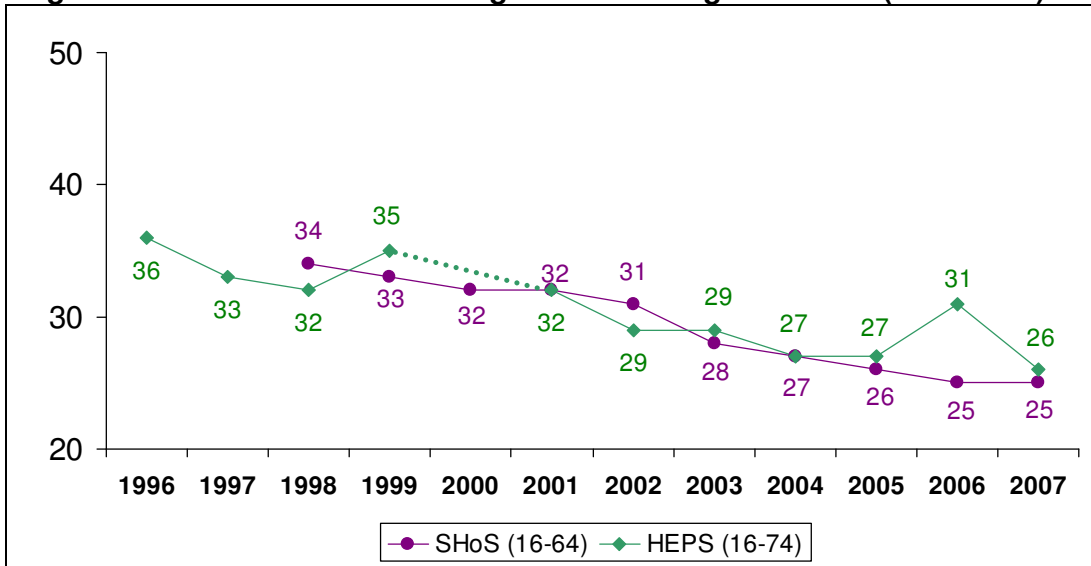
<sup>10</sup> NHS Health Scotland & ASH Scotland. *Smoking Cessation Guidelines for Scotland: 2004 Update*. Edinburgh: NHS Health Scotland; 2004.



## 5.1 Reported behaviour

Figure 5.1 shows the proportion of respondents smoking regularly over time. Data from the Scottish Household Survey (SHoS) are provided for comparison.

**Figure 5.1 Time trends in adult cigarette smoking behaviour (1996-2007)**

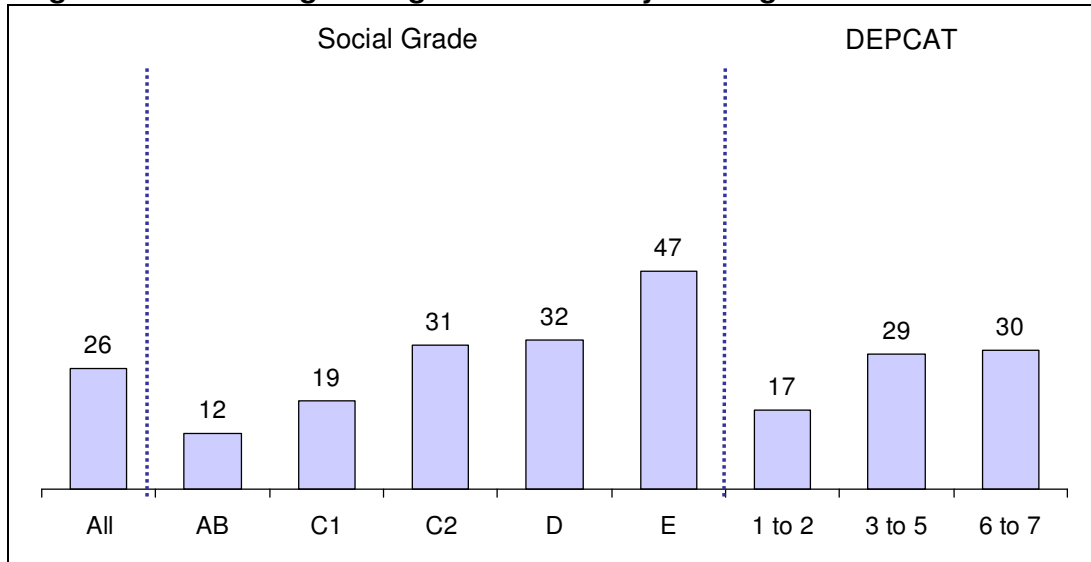


*Base: all respondents (2007: 1,921)*

The proportion of regular smokers has fallen over time, from 36% in 1996 to 26% in 2007. The rise to 31% in 2006 is likely to be due to random variation associated with the survey's relatively small sample size. This is supported by the subsequent return to a level consistent with a pattern of decline in this survey, combined with the estimate from the Scottish Household Survey (which provides Scotland's most robust data on smoking) remaining at 25%.

Over time, there has been a consistent gradient in smoking by social grade. As shown in figure 5.2, this continues to be the case in 2007. However, the gradient previously seen by DEPCAT was not evident in 2007 with similar proportions smoking regularly in categories 3-5 compared with 6-7. There have been sustained decreases in the proportion of respondents smoking regularly over the survey series for both men and women, people aged 25-34 and 45-54, and those in social grades C2 and D. Smoking prevalence remains highest in the lower social grades and in deprivation categories 3-7.

**Figure 5.2 Percentage of regular smokers by social grade/DEPCAT**



*Base: all respondents 2007 (1,921)*

Just over a third (35%) of smokers in 2007 were heavy smokers (defined as smoking 20 or more cigarettes per day) and 18% were light smokers (defined as smoking less than ten cigarettes a day). The proportion of heavy smokers has decreased significantly since 2006 from 42% to 35%.

## 5.2 Motivation

Over eight in ten (82%) regular smokers were motivated to cut down or give up smoking, with around six in ten (58%) having tried and a further quarter (24%) saying they would like to. At around eight in ten over the survey series, the summed figure indicates no change in motivation levels over time, however the proportion who “would like to cut down or quit” has decreased while the proportion who “have tried to cut down or quit” has increased.

### Main points

- The proportion of the population who smoke regularly has fallen over time, from 36% in 1996 to 26% in 2007.
- There have been sustained decreases in the proportion of respondents smoking regularly over the survey series for both men and women; people aged 25-34 and 45-54, and those in social grades C2 and D.
- Smoking prevalence remains highest in the lower social grades and in deprivation categories 3-7.
- Around one third (35%) of smokers were classed as heavy smokers (smoking 20+ per day).
- Over eight in ten (82%) smokers were motivated to cut down or give up smoking. This overall figure is similar to previous years, but the proportion who would like to cut down or give up has declined while the proportion who have tried has increased over the survey series.

## 6. Alcohol

Alcohol related deaths in Scotland have risen sharply from less than 1 in 100 of all deaths in 1980 to 1 in 30 of all deaths in 2003, about three-quarters of which occurred in men.<sup>11</sup> Alcohol is a major cause of liver cirrhosis and there has been an exponential increase in cirrhosis mortality rates in Scotland between 1950 and 2002 giving considerable cause for concern.<sup>12</sup> Excessive consumption of alcohol is associated with a range of health conditions including cancer and stroke and a host of social problems such as violence, drunkenness, drink driving and public disorder. The *Plan for Action on Alcohol Problems: Update*<sup>13</sup> builds on progress made to change drinking cultures and reduce alcohol-related harm through government action, partnership working, and encouraging individuals to take personal responsibility. Health education activities have mainly focused on young people, with the *Think About It* campaign targeting 12-17 year olds and the *Don't let too much alcohol spoil a good night out* campaign targeting 16-25 year olds. This advertising and promotional campaign was introduced in Scotland in 2003 to encourage individuals and society as a whole to take personal responsibility for the negative impact of alcohol misuse by challenging Scotland's drinking culture. Other health education activities in Scotland have focused on raising awareness of alcohol problems in the workplace.

Original guidance on sensible drinking for adults was expressed in terms of weekly limits: up to 21 units per week for men and up to 14 units for women, with 1 or 2 alcohol-free days each week for both sexes.<sup>14</sup> In 1995, the Department of Health (England) produced new guidelines on sensible drinking for adults based on daily benchmarks.<sup>15</sup> These state that regular consumption of between 3 and 4 units a day by men and between 2 and 3 units a day by women will not accrue significant health risk. Men are therefore advised against consistently drinking 4 or more units a day and women against 3 or more. Although the daily benchmarks were intended to supersede the earlier weekly sensible drinking levels for adults, there is a substantial body of opinion that the latter remain relevant. Since 2001, the HEPS has been structured so that respondents may express the current recommended limits for alcohol consumption in weekly and/or daily terms.

For the purposes of this survey, respondents were classified as 'drinkers' if they had consumed any alcohol in the past year.

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<sup>11</sup> ISD. *Alcohol Statistics Scotland*. Edinburgh: ISD; 2005.

<sup>12</sup> Leon DA, McCambridge J. *Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data*. *Lancet* 2006;367(9504):52-56.

<sup>13</sup> Scottish Executive. *Plan for Action on Alcohol Problems: Update*. Edinburgh: The Stationery Office; 2007.

<sup>14</sup> *Lord President's report on action against alcohol misuse*. London: HMSO; 1991.

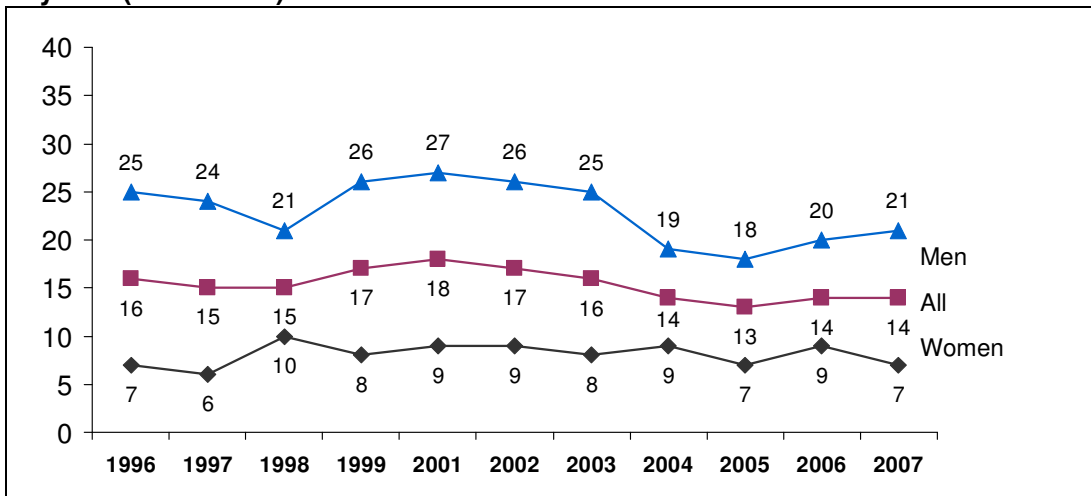
<sup>15</sup> Department of Health. *Sensible Drinking: The Report of an Inter-Departmental Working Group*. London: The Stationery Office; 1995.

## 6.1 Reported behaviour

All 'drinkers' were asked about their alcohol consumption in the last week, including the types of alcohol they had consumed. This was used to calculate their weekly intake, and compare this to the recommended guidelines.

Figure 6.1 shows the proportion of respondents exceeding the recommended weekly limits.

**Figure 6.1 Time trends in exceeding recommended weekly alcohol limits, by sex (1996-2007)**



Base: all respondents (2007: 1,921)

In 2007, men remain more likely than women to exceed the recommended weekly alcohol limits, 21% compared to just 7%. However, the actual figures will be higher; surveys are known to underestimate alcohol consumption and a recent review<sup>16</sup> indicates that this has become more pronounced in the past few years due to increases in the strength and size of some drinks. These changes are likely to explain the apparent reduction in male intake between 2001 and 2007. Figures from the most recent Scottish Health Survey (2003) have been recalculated to take account of increased drink strength and suggest that one third of men and a quarter of women exceed the weekly limits.<sup>17</sup>

Drinking at levels of higher than usual consumption, often referred to as 'binge drinking', is a second measure of excessive drinking. There is currently no nationally or internationally agreed definition of binge drinking. The HEPS has traditionally measured the number of times respondents drank 16 units or more (men) or 10 units or more (women) on one occasion in the last month. In 2006, the survey introduced the Office of National Statistics definition of heavy

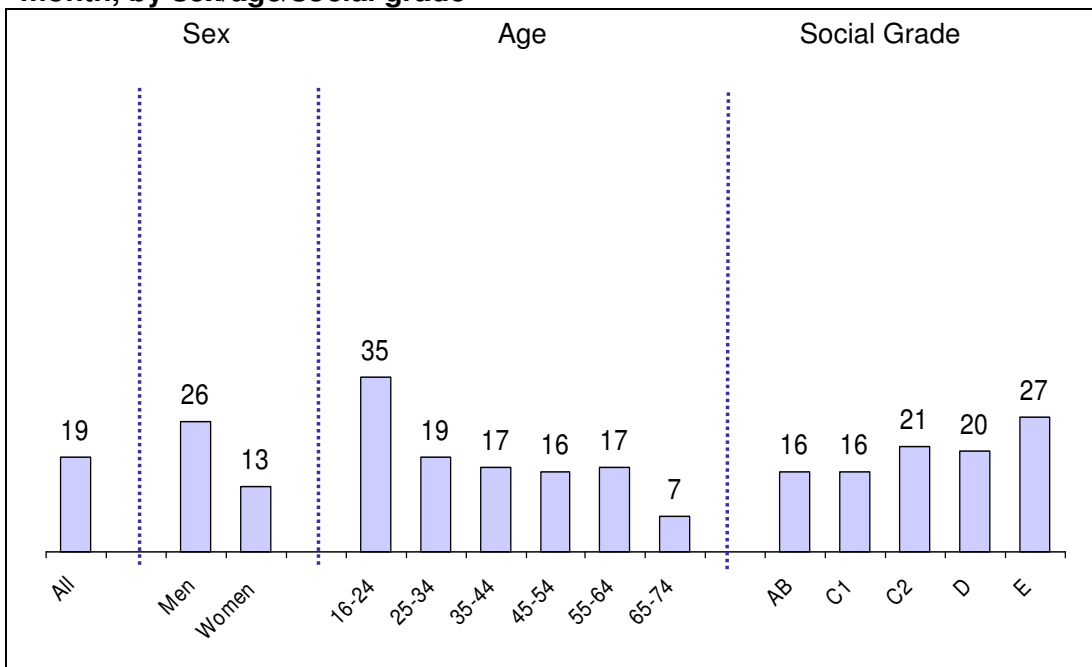
<sup>16</sup> Catto S, Gibbs D. *How much are people in Scotland really drinking? A review of data from Scotland's routine national surveys*. Glasgow: NHS Health Scotland; 2008.

<sup>17</sup> Bromley C, Corbett J, Erens B, Moody A. *The Scottish Health Survey 2003: Revised Alcohol Consumption Estimates*. Edinburgh: The Scottish Government; 2008.

drinking (8 or more units for men and 6 or more units for women) to measure frequency of binge drinking in the last month.

As shown in Figure 6.2, around two in ten (19%) reported four or more binge drinking sessions (8/6 units or more) in the past month. Men were significantly more likely to binge drink by this definition than women (26% and 13% respectively), as were younger respondents (35% of 16 to 24 year olds). Those in social grade E (27%) were also significantly more likely to report four or more binge drinking sessions of 8/6 units or more in the past month than ABs (16%) or C1s (16%). Again, these figures are subject to under-estimation. Actual levels of binge-drinking will be closer to the recalculated estimates from the 2003 Scottish Health Survey.

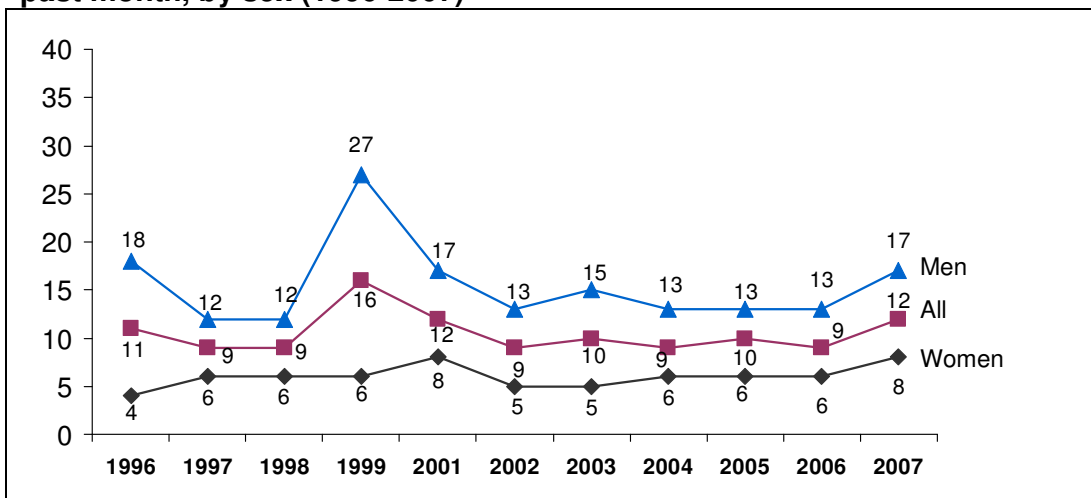
**Figure 6.2 Percentage with 4+ binge drinking sessions ( $\geq 8/6$  units) in past month, by sex/age/social grade**



*Base: all respondents (2007: 1,921)*

As shown in Figure 6.3, around one in ten (12%) reported four or more heavy drinking sessions of 16/10 units or more in the past month. This figure has shown little change over time, with the exception of 1999, where the apparently higher levels (amongst men) are likely to be the result of random fluctuation. Using this definition (16/10 units or more), men remained significantly more likely than women to report four or more binge drinking sessions in the past month (17% compared with 8% of women).

**Figure 6.3 Percentage with 4+ binge drinking sessions ( $\geq 16/10$  units) in past month, by sex (1996-2007)**



Base: all respondents (2007: 1,921)

## 6.2 Knowledge

All drinkers were asked to state the recommended weekly limit of alcohol consumption for their own sex. This question was only asked in the March waves of fieldwork in 1996 and 1997, and was then put to all respondents from 2001-2007.

From 2001 onwards, respondents could express this limit either as a daily or weekly limit. Respondents were asked to state what they believed the current recommended units were. Interviewers were briefed to record their numeric response, and also record whether they had spontaneously given this figure as a daily limit, weekly limit, or something else. For those giving daily limits, answers were multiplied by seven in order to give a weekly equivalent.

In 2007, 6% of respondents said that they did not know what a unit was. This figure, included in the “don’t know” category of table 6.1, has fallen from 15% in 1996 to 7% in 2001, and has remained stable over recent years.

**Table 6.1: Knowledge of recommended weekly limits for own sex**

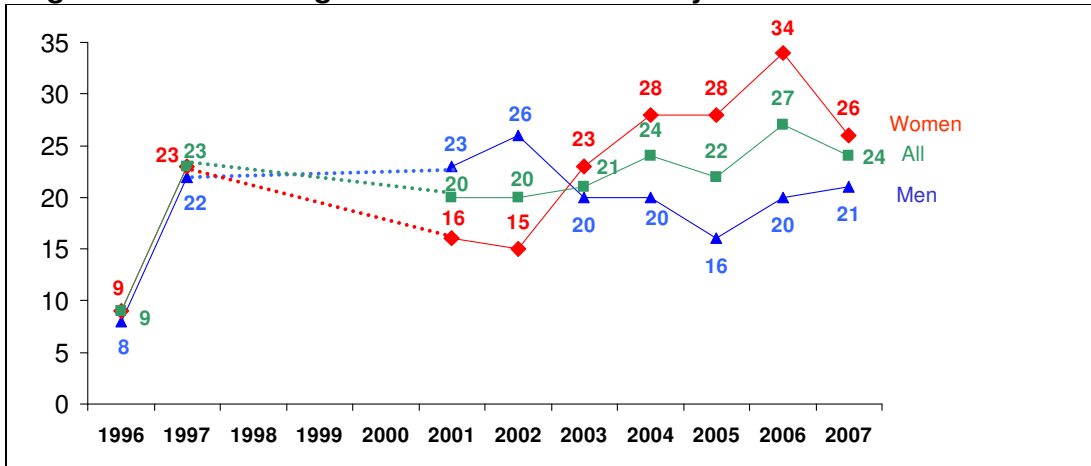
%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
Under limit	23	33				34	35	32	36	28	30	32
Exact limit (21/14 units per week)	9	23				20	20	21	24	22	27	24
Over limit	24	11				16	15	17	12	13	18	18
Don't know	44	33				32	30	30	29	37	26	27
<b>Men</b>												
Under limit	19	28				26	29	36	39	35	33	33
Exact limit (21 units per week)	8	22				23	26	20	20	16	20	21
Over limit	19	10				14	11	20	15	16	25	23
Don't know	53	40				37	34	25	26	33	22	22
<b>Women</b>												
Under limit	26	38				41	41	27	32	22	26	30
Exact limit (14 units per week)	9	23				16	15	23	28	28	34	26
Over limit	29	12				17	18	15	9	10	10	12
Don't know	36	26				26	26	34	31	40	30	31
<b>Men exceeding weekly limits</b>												
Under limit	16	34				44	39	28	35	29	37	38
Exact limit (21 units per week)	12	29				13	16	22	28	20	21	17
Over limit	36	14				28	19	30	21	21	27	26
Don't know	36	23				16	26	20	16	30	16	19
<i>Base: All who have had alcoholic drink in past year (March waves only 1996-1997)</i>	801	787				1533	1520	1486	1452	1558	1508	1689

In 2007, the proportion over-estimating the weekly limit remained at 18% (as in 2006) but this has fluctuated over time. A third of drinkers under-estimated the limit (32%) and over a quarter (27%) did not know what the limits were.

The proportion of both men and women giving the exact recommended weekly limit for their own sex has increased significantly since 1996, showing an improvement in knowledge levels over time. This has been accompanied by a significant reduction in the proportion of women over-estimating their limit, but no significant change in the proportions either under-estimating or who did not know the limit. Among men there has been a significant increase in the proportion under-estimating their recommended weekly limits and a significant decrease in the proportion who said they did not know it.

As shown in Figure 6.4, the proportion able to give the correct weekly alcohol limit was 24% in 2007. In 2004, for the first time, women were significantly more likely to be aware of the weekly limit for their own sex than men. This trend has continued in 2007 when 26% of women gave the correct limit, compared with only 21% of men.

**Figure 6.4: Knowledge of recommended weekly limits for own sex**



*Base: All who have had alcoholic drink in past year (2007: 1,689)*

Around a quarter of respondents expressed the current recommended limits for alcohol consumption as a daily figure (28%). This proportion has shown no change since 2001 and suggests lower levels of awareness of the daily benchmarks compared to the weekly limits (55% gave limits as a weekly figure). Of those who expressed the recommended limits as a daily level, four in ten men (41%) gave the correct figure of three or four units and over half (55%) of women gave the correct figure of two or three.

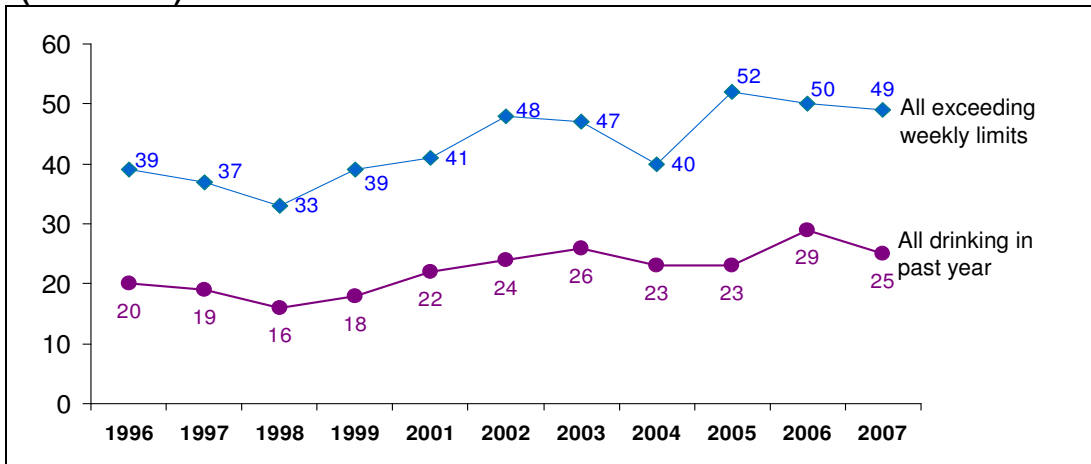
### 6.3 Motivation

As shown in Figure 6.5, most drinkers in the 2007 survey were not contemplating reducing their intake, with only a quarter (25%) saying that they either had tried, or would like to try, to cut down the amount of alcohol they consume. Levels of motivation to cut down alcohol consumption have increased significantly over the survey series.

Half (49%) of those who exceeded the weekly limits were motivated to reduce their alcohol intake in 2007, remaining stable since 2005. This proportion has fluctuated over time but results show a significant increase from 1996.



**Figure 6.5 Time trends in motivation to cut down alcohol consumption (1996-2007)**



*Base: all who have had an alcoholic drink in the past year (2007: 1,689)*

**Main points**

- Men remain more likely than women to exceed the recommended weekly limits, around one fifth (21%) and 7% of women in 2007, although, as discussed in this chapter, other evidence suggests this is an under-estimation of the actual levels.
- Around a quarter (24%) of respondents were aware of the recommended weekly limits for alcohol consumption for their own sex. Women were more likely to be aware of the recommendations than men.
- Almost one in three respondents (28%) gave the current recommended limits for alcohol consumption as a daily figure demonstrating lower levels of awareness of the daily benchmarks compared to the weekly limits. This proportion has shown no change since 2001.
- A quarter of drinkers (25%) had either tried, or would like to try, to reduce their alcohol intake compared with half of those exceeding the weekly limit (49%).

## 7. Mental health

Mental health is an integral part of health as defined by the World Health Organisation and consists not just of the absence of mental health problems but also mental wellbeing (also referred to as positive mental health). Mental health is a priority area for the NHS in Scotland, indeed the most common problems presented to GPs are linked to mental health. Many factors affect mental health, both negatively (e.g. social and cultural discrimination, socioeconomic deprivation, neighbourhood violence and crime) and positively (e.g. social support, social participation, economic security and good relationships). In addition, mental health impacts on other aspects of life such as physical health, relationships and health behaviours. For example, material and social disadvantage can affect health through indirect psychosocial pathways, thus contributing to the added burden of morbidity and mortality attributable to behavioural factors.

Mental health has been an underlying theme in much health improvement and public health activity. In 2001, the Scottish Executive, now the Scottish Government, launched the National Programme for Improving Mental Health and Wellbeing (see [www.wellscotland.info](http://www.wellscotland.info)). This programme aimed to raise the profile of and support further action in promoting mental health and wellbeing, eliminating the stigma of mental health problems, recovery from mental health problems and suicide prevention. In November 2007 the Scottish Government embarked on a discussion process with the publication of *Towards A Mentally Flourishing Scotland: The Future Of Mental Health Improvement In Scotland 2008-11 - a discussion paper*. This paper outlined the proposed future direction for mental health improvement and population mental health for 2008-11, building on the work of the National Programme for Improving Mental Health and Wellbeing.

The Scottish Government has conducted its own national survey *Well? What do you think?* to assess public attitudes to mental health, wellbeing and mental health problems. The survey was conducted in 2002, 2004 and 2006 to provide population level information on a broad spectrum of mental health issues.

The HEPS survey includes questions which assess stress, possible psychiatric morbidity (common mental health problems) and mental wellbeing (positive mental health). Analyses of these are given below.

### 7.1 Stress

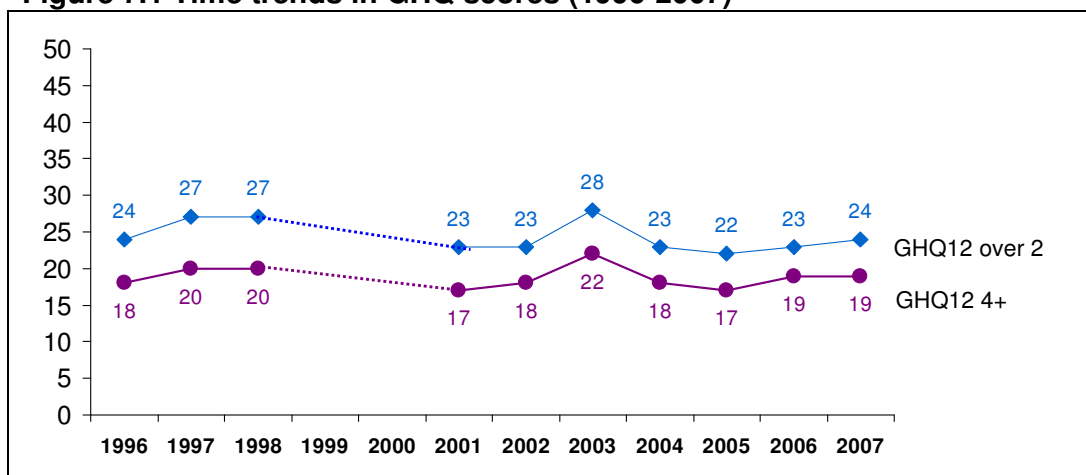
In 2007, almost one in four (23%) respondents reported having experienced a large amount of stress in the last year. Around one in three (36%) said they had experienced levels of stress that were harmful to their health; this figure has fluctuated over time but is the lowest observed since 2002.

## 7.2 Common mental health problems (GHQ12)

Along with the *Scottish Health Survey* and the *Well? What do you think?* survey, HEPS uses the twelve-item version of the General Health Questionnaire (GHQ12) as an indicator of mental health problems. This tool has been widely used in general population surveys to assess levels of possible psychiatric morbidity. The items ask respondents to rate their functioning across a range of symptoms or feelings (e.g. happiness, anxiety, sleep disturbance) in the previous two weeks relative to normal. Item scores (0 or 1) are combined to give an overall score of between zero and twelve for each respondent. Higher scores reflect more severe possible psychiatric morbidity. The generally recommended threshold score for detecting possible psychiatric morbidity is two.<sup>18</sup> For the purposes of this survey, a score greater than two is taken as indicating the presence of possible mental distress. Consideration is also given to those with a score of four or more as indicating the presence of a possible psychiatric disorder.<sup>19</sup>

The GHQ12 is part of the self-completion section of the questionnaire and was completed in full by all those who answered this part of the survey. The scale was not included in 1999 and 2000.

**Figure 7.1 Time trends in GHQ scores (1996-2007)**



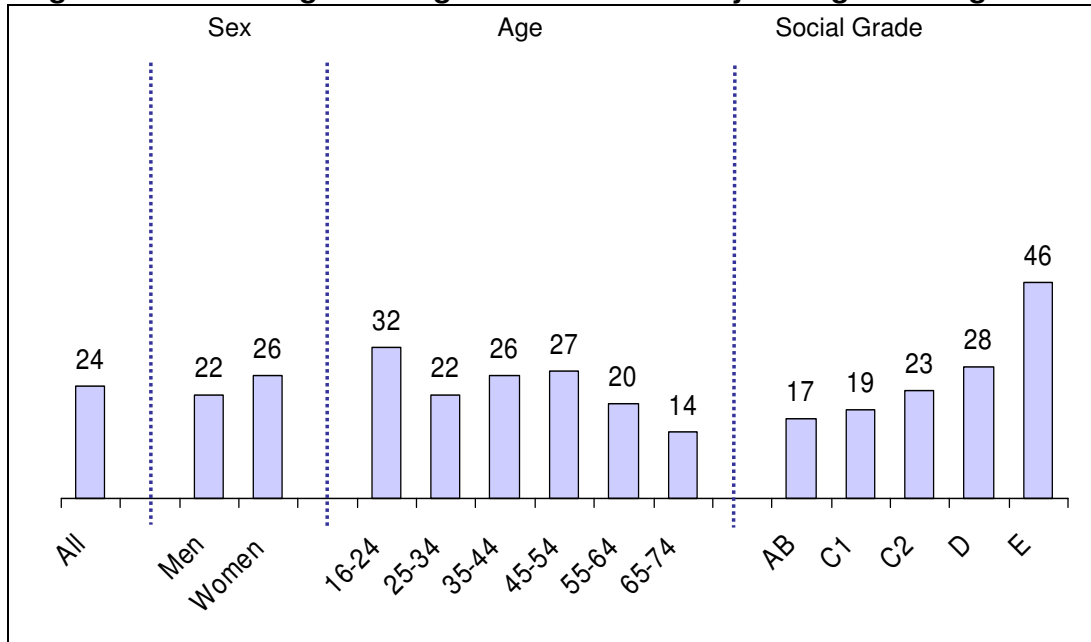
*Base: all answering self completion (2007: 1,752)*

The mean GHQ12 score in 2007 was 1.8, remaining fairly stable from previous years. Around a quarter of respondents scored over 2 (24%) and approximately two in ten scored over 4 (19%).

<sup>18</sup> Goldberg DP and Williams P. *A User's Guide to the General Health Questionnaire*. Windsor: NFER-Nelson; 1988.

<sup>19</sup> This is the threshold reported on in several other national Scottish surveys e.g. the *Scottish Health Survey* and the *Well? What do you think?* survey.

**Figure 7.2 Percentage scoring over 2 on GHQ12 by sex/age/social grade**



Base: all answering self completion (2007: 1,752)

Women remained more likely than men to have GHQ12 scores over 2 (26% versus 22%) indicative of possible mental distress. As in previous years, those in social grade E were significantly more likely to score more than two (46%) on the scale than people from other social grades.

### 7.3 Mental Wellbeing

The HEPS used the Affectometer 2 measurement scale to assess mental wellbeing (positive mental health) in three waves of the survey: Autumn 2002 and 2005, and Spring 2006.<sup>20</sup> Affectometer 2 has since been validated in the UK and a shorter revised scale developed, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS).<sup>21</sup> The 14-item WEMWBS replaced Affectometer 2 as the means of assessing population mental wellbeing in Autumn 2006 and Spring 2007 of the HEPS. As WEMWBS was only included in one wave in both the 2006 and 2007 surveys, these are combined and presented here to enable analysis of a full year's data, rather than the usual calendar year.<sup>22</sup> The Autumn 2007 wave piloted a shorter 8-item version of WEMWBS which will be reported on elsewhere.

<sup>20</sup> Kammann R and Flett R. *Affectometer 2: A scale to measure current level of general happiness*. Australian Journal of Psychology 1983 35(2)259-265.

<sup>21</sup> R Tennant, L Hiller, R Fishwick, S Platt, S Joseph, S Weich, J Parkinson, J Secker and S Stewart-Brown 2007 *The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation*. Health and Quality of Life Outcomes 5:63 doi:10.1186/1477-7525-5-63

<sup>22</sup> The Autumn 2006 data have been used in research to validate WEMWBS, the results of which are reported elsewhere, see <http://www.healthscotland.com/understanding/population/mental-health-indicators.aspx>.

Possible WEMWBS scores range from 14 to 70. As there are no recommended cut off points, the table below shows the score mean, standard deviation, range and 95% confidence intervals.

Overall, the mean WEMWBS score was 50.34 with a median of 51.00 (see table 7.1). This indicates generally good mental well-being. There were no significant differences by sex, age or social grade.

**Table 7.1 WEMWBS Scores**

<i>%</i>	<i>Mean score</i>	<i>Median score</i>	<i>Standard deviation</i>	<i>Minimum</i>	<i>Maximum</i>	<i>95% Confidence Interval</i>
<i>All</i>	50.34	51.00	8.68	18.00	70.00	±0.42
<i>Sex</i>						
Men	50.40	51.00	8.37	18.00	70.00	±0.61
Women	50.28	50.00	8.98	19.00	70.00	±0.58
<i>Age</i>						
16-24	50.25	51.00	7.56	19.00	70.00	±1.16
25-34	50.05	51.00	8.44	24.00	70.00	±1.10
35-44	49.20	50.00	8.70	19.00	70.00	±0.94
45-54	49.52	50.00	8.49	23.00	70.00	±0.95
55-64	51.26	51.00	8.73	18.00	70.00	±0.91
65-74	53.20	52.00	10.06	27.00	70.00	±1.19
<i>Social grade</i>						
AB	50.79	51.00	7.84	18.00	69.00	±0.91
C1	51.35	51.00	7.91	19.00	70.00	±0.75
C2	50.74	51.00	7.92	24.00	70.00	±0.80
DE	48.86	49.00	10.05	19.00	70.00	±0.84

*Base: all answering WEMWBS section (1,652)*

### **Main points**

- In 2007, almost one in four respondents (23%) reported large amounts of stress in the past year and 36% felt they had experienced a level that had been harmful to their health.
- Women remained more likely than men to have GHQ12 scores over 2 (26% compared with 22%) indicative of possible mental distress. As in previous years, those in social grade E were significantly more likely than those in other social grades to score more than two (46%).
- The mean WEMWBS score for mental wellbeing was 50.34, with no significant differences by sex, age or social grade.

## 8. Sexual health

While the incidence of teenage pregnancy has been relatively stable over the past ten years, live birth rates among this group are relatively high in Scotland and the UK compared with other countries in Western Europe. It is also increasingly clear that socio-economic disadvantage can be both a cause and a consequence of teenage parenthood.<sup>23</sup> The major policy focus in sexual health includes reducing the incidence of teenage pregnancy and sexually transmitted infections (STIs), whilst recognising the need to address broader issues of sexuality and personal relationships in order to achieve this. The rising number of reported STIs among young people, particularly young women, is a growing cause for concern, although increased reporting may be partly explained by greater awareness of the symptoms of STIs and the risks of untreated infections, as well as a willingness to seek treatment. Strategic responses include *Towards a Healthier Scotland*,<sup>24</sup> which highlighted the importance of continued vigilance with respect to sustained levels of new HIV infections, and the first national strategy for Scotland on sexual health and relationships published in 2005, *Respect and Responsibility*.<sup>25</sup> This was supported through a series of evidence papers, including the current evidence around young people's sexual health and wellbeing (available on [www.healthscotland.com/wish](http://www.healthscotland.com/wish)). Further information on this area can be found in initial findings from the national health demonstration project, Healthy Respect ([www.healthyrespect.co.uk](http://www.healthyrespect.co.uk)) which is now being mainstreamed in NHS Lothian, and in the work being taken forward by Health Scotland's sexual health and wellbeing programme ([www.healthscotland.com/wish](http://www.healthscotland.com/wish)), the National Sexual Health Advisory Committee and local sexual health strategy groups ([www.scotland.gov.uk/Topics/Health/health/sexualhealth/intro](http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/intro)).

Sexual health improvement activities have focused on targeting young people via the provision of information on STIs including HIV, advice and treatment services, sex and relationships education in schools, encouraging delay in initial sexual debut and, if sexually active, using condoms. In addition, the increased funding available through Respect and Responsibility has supported additional reproductive and sexual health services for the general adult population.

HEPS measures self-reported changes in sexual behaviour because of HIV/AIDS, attitudes towards condom use, and information needs on sexual health topics. These questions were asked in the self-completion section of the questionnaire.

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<sup>23</sup> Department of Health. *Report of the Independent Inquiry into Inequalities in Health (Acheson Report)*. London: The Stationery Office; 1998.

<sup>24</sup> The Scottish Office. *Towards a Healthier Scotland – A White Paper on Health*. Edinburgh: The Stationery Office; 1999.

<sup>25</sup> Scottish Executive. *Respect and Responsibility: A strategy and action plan for improving sexual health*. Edinburgh: The Stationery Office; 2005.

As in recent years, there have been no changes in behaviour or in attitudes towards condom use, so these areas are not discussed in this report. The figures are shown in Appendix 3.

## 8.1 Knowledge

Respondents were asked if they had enough information on a series of sexual health topics. From 1996 to 2002, these questions were only asked in either March or September. Although there have been no significant changes in this area in recent years, the results are briefly described below as this is an area that has changed since the survey began.

**Table 8.1 Proportion wanting more information on sexual health topics**

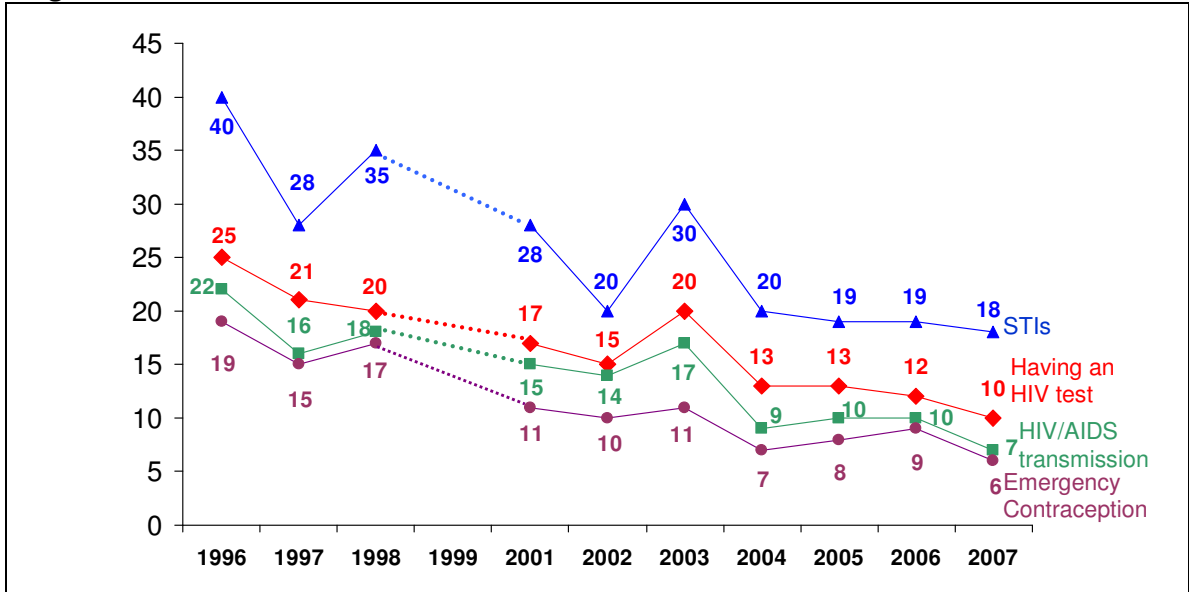
%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
STIs	40	28	35			28	20	30	20	19	19	18
Having an HIV test	25	21	20			17	15	20	13	13	12	10
HIV/ AIDS transmission	22	16	18			15	14	17	9	10	10	7
Emergency contraception	19	15	17			11	10	11	7	8	9	6
<b>16-24s</b>												
STIs	63	60	61			56	58	45	31	40	34	36
Having an HIV test	41	42	31			34	40	37	28	17	30	27
HIV/ AIDS transmission	24	12	25			23	31	28	16	14	20	13
Emergency contraception	41	27	20			20	28	23	9	17	18	14
<i>Base size: All adults</i>	850	862	827			774	823	1529	1542	1599	1552	1752
<i>Base size:16-24</i>	105	83	91			114	108	172	187	185	140	185

*Base: respondents answering the self-completion section - only one wave per year 1996-2002*

Expressed need for information on each of these topics has fallen significantly since the survey began in 1996, although there has been little change since 2004. Despite rising numbers of reported STIs, the greatest decline has been in the need for information about recognising the symptoms of STIs; less than one in two respondents said they would like more information in this area. Nonetheless, this level of demand remains higher than for information on having an HIV test, HIV/AIDS transmission and emergency contraception.

The proportion of younger respondents (16-24 year olds) wanting more information in these four areas of sexual health has also declined over time, although figures remain higher than for the adult population as a whole.

**Figure 8.1 Information needs**



*Base: respondents answering the self-completion section - only one wave per year 1996-2002 (2007:1,752).*

**Main points**

- Expressed need for information on aspects of sexual health - recognising the symptoms of STIs, having an HIV test, HIV/AIDS transmission and emergency contraception - has significantly decreased since the survey began in 1996, although there has been little change since 2004.
- Demand for more information in these four areas of sexual health has also declined over time among 16-24 year olds.



## APPENDIX 1. Questions analysed

Instructions to interviewers and question routings are shown in **UPPER CASE BOLD**. The questions are shown in the order they appear in the interview.

### ***Self-perceived health***

How good is your health overall?

- Very good
- Good
- Fair
- Poor
- Very poor
- Don't know

Do you have any long-standing illness, disability, or infirmity? By long standing I mean anything that has troubled you, or that is likely to affect you **OVER A PERIOD OF TIME**.

- Yes
- No
- Don't know

Do you feel there is anything you can do to make your own life healthier?

- Yes
- No
- Don't know

### ***Motivation to change***

In the past year, have you tried to make any of the following changes in your lifestyle to improve your health, even if only for a short time? Just read out the numbers. **SHOW CARD**

Which of the changes on the card, if any, would you like to make?

Which of the changes you would like to make are you thinking of making in the next six months?

- Cut down **smoking**
- Stop **smoking**
- Cut down the amount of **alcohol** I drink
- Increase the amount of **exercise** I take
- Control **weight**
- Eat more **healthily**
- Reduce level of **stress**

### **Healthy eating behaviour and knowledge**

I'm going to read out some different types of food. For each one, please tell me how frequently **you** eat each type of food. **SHOW CARD**

(Scale is *several times a day/about once a day/several times a week/about once a week/less often/never*)

Fruit, salad and vegetables - not including potatoes

Thinking just about **yesterday** can you tell me how many portions of fruit - fresh, frozen or tinned - you ate?

And still thinking about **yesterday**, how many portions of salad and vegetables - fresh, frozen or tinned, but **not** including potatoes - you ate?

How many portions in **total** of fruit, vegetables and salad do you think people **should** eat each day for a healthy balance of foods?

### **Breastfeeding**

The following statements are things some people have said about breastfeeding. Please could you tell me how much you agree or disagree with each one?

**REMINDER OF QUESTION: HOW MUCH DO YOU AGREE OR DISAGREE WITH THIS STATEMENT?**

(Scale is *strongly agree/ tend to agree/ tend to disagree/ strongly disagree*)

Women should be made to feel comfortable breastfeeding their babies in public

Women should only breastfeed their babies at home or in private

I would feel embarrassed seeing a woman breastfeeding her baby

### **Physical activity behaviour and knowledge**

In an average day, how much time do you spend walking out of doors? Do not include leisure time walking such as hillwalking rambling or golf.

**IF NECESSARY, CLARIFY WE ARE THINKING ABOUT THE CURRENT TIME / IN THE LAST MONTH OR SO**

I would like to ask you about any physical activity you have done in the LAST WEEK, NOT INCLUDING DAY TO DAY WALKING.

In a TYPICAL WEEK, which, if any, of the following physical activities have you done to the point where you were BREATHING FASTER THAN USUAL through physical exertion?

Cycling

Exercise eg, keep fit, aerobics, weight training etc.

Swimming

Running/jogging

Sports eg, football, tennis etc.

Leisure time walking eg, hillwalking, golf, rambling

Dancing

Heavy gardening

Heavy work around the home, eg housework, DIY  
Heavy manual work as part of your job

**ASK FOR EACH ACTIVITY MENTIONED**

How many times do you usually do this activity in a week?

Do you usually put in enough effort to make you sweaty and out of breath?

How long on average do you do this activity on each occasion?

I would now like you to think about **moderate physical activity**, that is brisk walking or heavy gardening etc. How much time **per day** do you think somebody needs to engage in moderate physical activity to help them to stay **healthy**?

Still thinking about MODERATE PHYSICAL ACTIVITY. How many times a week do you think someone needs to be physically active to stay healthy?

By MODERATE PHYSICAL ACTIVITY I mean spending about half an hour walking briskly or doing gardening etc, to a level that makes you breath slightly faster than usual

***Alcohol consumption***

**IF DRINKER AND HAD ALCOHOL IN LAST 7 DAYS**

In the last 7 days, how many did you drink of each of the following? **READ OUT**

Pints of normal strength beer, lager or cider

Pints of extra strong beer, lager or cider

Glasses of martini/ sherry/ port

Single measures of spirits / liqueur such as whisky, gin, vodka etc.

Glasses of wine

Have you drunk any **other** alcoholic drinks in the last 7 days which do not fit into any of these categories, such as designer drinks or alcoholic lemonade?

**IF YES**

What did you drink? How many glasses/ cans or bottles did you drink?

**RECORD DETAILS OF QUANTITY**

Castaway

Red/Reef/Metz/Hoopers Hooch

Vodka Source/Bacardi Breezer/Rigo

Red Square/Smirnoff Ice/Mule

MD 20/20

Buckfast

Something else **WRITE IN**

As you know, some drinks contain more alcohol than others. The amount is sometimes measured in terms of 'units of alcohol'. Have you heard about measuring alcohol in units?

**IF HEARD OF UNITS**

How many units of alcohol do you think is the current recommended weekly limit for men?

How many units of alcohol do you think is the current recommended weekly limit for women?

One unit of alcohol is half a pint of normal strength beer, a glass of wine, a single measure of spirits or a small glass of sherry.

**SHOWCARD 2**

How many times did you drink 16/10 units or more ON ONE OCCASION during the LAST

MONTH? Just read out the letter.

**IF NECESSARY, ADD:** 16/10 units is 8/5 pints of normal strength beer or lager or 16/10 measures of spirits or glasses of wine.

- C. None
- F. Once
- B. Two or three times
- G. Four or five times
- A. Six to ten times
- H. Eleven to fifteen times
- D. Sixteen to twenty times
- E. More than twenty times

One unit of alcohol is half a pint of normal strength beer, a glass of wine, a single measure of spirits or a small glass of sherry.

**SHOWCARD 2**

How many times did you drink 8/6 units or more ON ONE OCCASION during the LAST

MONTH? Just read out the letter.

**IF NECESSARY, ADD:** 8/6 units is 4/3 pints of normal strength beer or lager or 8/6 measures of spirits or glasses of wine.

- C. None
- F. Once
- B. Two or three times
- G. Four or five times
- A. Six to ten times
- H. Eleven to fifteen times
- D. Sixteen to twenty times
- F. More than twenty times

***Smoking behaviour***

Do you smoke cigarettes nowadays - including roll ups, nowadays, even if only occasionally?

**IF YES PROMPT** Is that regularly or occasionally?

- Yes, regularly
- Yes, occasionally
- No

## **IF SMOKE**

About how many cigarettes do you usually smoke on a WEEKDAY?  
And at WEEKENDS about how many cigarettes do you usually smoke A DAY?

### ***Mental health (stress)***

Which of these statements best describes the amount of stress or pressure you have experienced in the past year?

- Completely free of stress
- Small amount of stress
- Moderate amount of stress
- Large amount of stress
- Don't know

How harmful would you say the amount of stress you have experienced has been to your health? Has it been...

- Very harmful
- Fairly harmful
- Not particularly harmful
- Don't know

### ***Mental health (self completion)***

## **GHQ12**

Here are some questions regarding the way you have been feeling over the past few weeks. For each of the questions please select the number next to the answer that best suits the way you have felt.

(Scale for positive attributes is *more than usual/same as usual/less than usual/much less than usual, less and much less* responses score 1; scale for negative attributes is *not at all/no more than usual/rather more than usual/much more than usual, rather more and much more* responses score 1)

Have you recently

- Been able to concentrate on what you are doing?
- Lost much sleep over worry?
- Felt that you were playing a useful part in things?
- Felt capable of making decisions about things?
- Felt constantly under strain?
- Felt you couldn't overcome your difficulties?
- Been able to enjoy your normal day-to-day activities?
- Been able to face up to your problems?
- Been feeling unhappy and depressed?
- Been losing confidence in yourself?
- Been thinking of yourself as worthless?
- Been reasonably happy, all things considered?

## WEMWBS

For each of the following statements, please select the option that best describes your experience over the last two weeks

(Scale: *None of the time / Rarely / Some of the time / Often / All of the time*)

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been feeling interested in other people
- I've had energy to spare
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling good about myself
- I've been feeling close to other people
- I've been feeling confident
- I've been able to make up my own mind about things
- I've been feeling loved
- I've been interested in new things
- I've been feeling cheerful

### **Sexual health (self completion)**

Do you feel you have adequate knowledge or information about the following topics, or would you like to know more? Please tick one box on each line

(Scale is *know enough/want more information/don't know*)

Ways in which HIV (the AIDS virus) can be passed on  
Contraception/ birth control  
Emergency ('morning after') contraception  
How to have a satisfying sex life  
Recognising symptoms of sexually transmitted diseases  
Abortion  
Having a blood test for HIV  
How to use a condom  
Safer sex

Have you changed your own sexual lifestyle in any way, or made any decisions about sex, because of concern about catching HIV (the AIDS virus)?

Yes

No

My sexual lifestyle has changed, but not because of AIDS

Don't know

The following are a number of things people have said about condoms and HIV (the AIDS virus). Please tick in a box for each line to show how much you agree or disagree with each one.

(Scale is *strongly agree/tend to agree/tend to disagree/strongly disagree/not applicable*)

- If I wanted to have sexual intercourse with a new partner, I would stop if we had no condoms

***Drugs (self completion)***

Have you EVER taken cannabis, even if it was a long time ago?

Yes

No

Don't know

Refused

## APPENDIX 2. Base sizes for tables and charts

Below are the unweighted base sizes for the tables and charts.

<b>Base</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>Total</b>	1810	1795	1794	880	1757	1742	1720	1784	1822	1759	1921
<b>Sex</b>											
Men	771	762	761	360	738	742	728	771	727	744	847
Women	1030	1032	1033	520	1019	1000	992	1013	1095	1015	1074
<b>Age</b>											
16-24	215	194	194	88	228	214	179	199	185	150	190
25-34	395	394	327	170	322	284	268	285	232	230	281
35-44	330	362	349	182	353	330	355	382	332	361	380
45-54	279	267	333	160	269	279	296	298	309	318	337
55-64	289	287	281	149	295	319	317	292	387	344	410
65-74	282	289	302	128	290	316	305	328	377	356	323
<b>Social grade</b>											
AB	229	294	303	124	252	298	250	338	296	242	385
C1	478	516	512	268	544	518	528	539	515	452	482
C2	356	358	354	167	423	363	361	335	380	445	404
D	325	259	306	135	210	270	256	249	308	252	324
E	401	360	312	179	328	293	325	323	322	347	326
<b>Deprivation Category</b>											
1-2	310	342	418	173	324	366	383	342	417	391	514
3-5	1130	1112	1088	566	1064	1055	1045	1207	1145	1093	1186
6-7	370	341	288	141	369	321	292	235	248	275	221
<b>Regular smokers</b>											
All	650	617	551	263	525	529	530	507	504	521	531
Men	279	257	247	109	225	229	227	243	210	232	249
Women	368	360	304	154	300	300	303	264	294	289	282
16-24	69	67	67	29	67	80	56	66	59	46	56
25-34	167	169	118	58	121	108	103	87	71	87	96
35-44	112	120	109	57	113	103	136	104	117	125	125
45-54	119	99	107	54	85	98	83	102	88	94	97
55-74	178	162	147	65	139	140	152	148	169	169	157
<b>Heavy smokers</b>	333	280	272	124	224	214	231	215	201	229	206
<b>Consumption of fruit and vegetables</b>											
Daily	1044	1134	1151	559	1220	1235	1211	1313	1322	1293	1448
Non-daily	766	661	643	321	537	507	509	471	500	466	473
<b>Activity level</b>											
Sedentary	649	641	620	331	645	296	582	607	623	609	653
<b>Age within sex - women</b>											
16-24	120	111	112	49	133	124	100	110	112	79	92
25-34	233	233	204	109	192	162	151	151	144	132	165
35-44	181	215	200	110	210	195	194	211	206	211	219
45-54	145	143	184	93	137	143	173	175	179	188	195
55-64	163	157	154	75	176	187	191	163	218	193	216
65-74	179	173	174	83	171	189	183	203	236	212	187



<b>Base Age within sex</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>men</b>											
16-24	95	83	82	39	95	90	79	89	73	71	98
25-34	162	161	123	61	130	122	117	134	88	98	116
35-44	149	147	149	72	143	135	161	171	126	150	161
45-54	134	124	149	67	132	136	123	123	130	130	142
55-64	126	130	127	74	119	132	126	129	169	151	194
65-74	103	116	128	45	119	127	122	125	141	144	136
<b>Drinkers</b>											
All	1593	1587	1576	771	1533	1520	1486	1542	1557	1508	1689
Men (March only 96-97)	359	340	690	322	664	675	644	692	645	670	767
Women (March only 96-97)	438	447	886	449	869	845	842	850	912	838	922
<b>Exceed alcohol limit</b>											
All	243	251	224	113	274	263	239	232	206	250	244
Men (March only 96-97)	97	183	150	74	185	182	160	142	137	165	168

The table below gives the unweighted base sizes for those answering the **self-completion** section.

<b>Base</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>All</b>	1698	1733	1663	811	1606	1583	1529	1523	1599	1552	1752
<b>Sex</b>											
Men	734	737	706	327	668	679	640	664	634	661	781
Women	961	996	957	484	938	904	889	859	965	891	971
<b>Social grade</b>											
AB	221	284	291	118	243	279	233	306	279	223	365
C1	457	500	473	255	509	478	481	461	454	415	445
C2	334	348	333	150	390	333	325	288	326	402	370
D	331	254	284	126	190	245	224	212	281	209	297
E	361	340	275	155	274	248	266	256	258	284	275
<b>Age</b>											
16-24	209	192	190	86	219	203	172	187	168	140	185
25-34	385	390	317	163	303	266	253	249	216	208	263
35-44	316	353	335	172	334	309	324	340	297	315	347
45-54	266	262	316	148	245	264	259	257	278	290	306
55-64	272	273	243	132	266	279	284	242	330	301	378
65-74	240	263	254	110	239	262	237	248	310	298	273
<b>Deprivation Category</b>											
1-2	294	328	391	165	306	335	354	299	377	345	471
3-5	1059	1075	1009	513	971	951	915	1032	988	764	1087
6-7	345	330	263	133	329	297	260	192	222	233	194

Below are the weighted base sizes for the tables and charts.

<b>Base</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>Total</b>	1810	1795	1794	880	1757	1742	1720	1784	1822	1759	1921
<b>Sex</b>											
Men	886	841	879	431	863	856	845	877	895	864	944
Women	925	954	916	449	894	886	875	907	927	895	976
<b>Age</b>											
16-24	300	280	298	146	270	268	264	274	280	270	295
25-34	397	387	389	192	360	357	352	365	373	360	392
35-44	334	355	333	164	362	359	354	367	375	362	396
45-54	301	304	298	145	310	308	304	315	322	311	340
55-64	257	257	251	124	250	248	245	254	259	250	273
65-74	218	211	218	106	205	203	201	208	213	205	224
<b>Social grade</b>											
AB	248	335	318	120	238	321	262	355	298	265	400
C1	507	540	526	281	594	573	587	581	592	475	525
C2	388	411	398	162	472	393	407	357	371	496	423
D	337	256	298	152	199	246	230	241	340	234	332
E	321	240	249	154	253	210	235	249	221	269	240
<b>Deprivation Category</b>											
1-2	328	345	388	186	310	351	373	331	456	362	513
3-5	1107	1084	1075	548	976	1057	1032	1227	1034	1093	1190
6-7	378	365	331	147	471	333	315	226	322	304	218
<b>Regular smokers</b>											
All	658	588	566	308	563	512	504	488	488	536	498
Men	317	266	283	172	281	246	254	256	239	286	257
Women	341	321	283	136	282	266	250	231	249	250	241
16-24	95	70	102	69	67	86	72	68	67	81	74
25-34	189	165	134	85	129	118	125	110	111	132	115
35-44	117	124	102	62	128	124	121	90	119	112	131
45-54	111	109	108	40	91	89	79	102	92	84	91
55-74	144	118	117	51	148	99	106	119	100	127	87
<b>Heavy smokers</b>											
All	323	253	259	103	233	183	235	215	182	222	172
<b>Consumption of fruit and vegetables</b>											
Daily	1031	1156	1095	551	1171	1198	1187	1310	1313	1225	1455
Non-daily	782	639	700	329	586	544	533	474	509	534	466
<b>Activity level</b>											
Sedentary	632	606	632	298	618	246	518	543	552	554	575
<b>Age within sex - women</b>											
16-24	147	139	145	71	132	131	129	134	137	132	145
25-34	196	211	194	95	179	177	175	181	185	179	194
35-44	167	196	167	83	182	180	178	185	189	182	199
45-54	153	155	151	74	157	156	154	159	163	157	172
55-64	135	139	132	65	130	129	128	132	135	131	143
65-74	122	114	123	60	114	113	111	115	118	114	124

<b>Base Age within sex</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>men</b>											
16-24	153	141	152	75	138	137	135	140	143	138	151
25-34	200	176	196	97	181	180	177	184	188	181	198
35-44	166	159	166	81	180	179	176	183	187	180	197
45-54	148	149	146	71	153	152	150	156	159	154	168
55-64	121	118	119	59	119	118	117	121	124	120	131
65-74	96	97	95	46	92	91	90	93	95	92	100
<b>Drinkers</b>											
All	1630	1615	1591	775	1570	1545	1513	1549	1582	1519	1698
Men	424	405	811	394	791	794	758	773	790	795	857
(March only 96-97)											
Women	391	392	780	381	779	752	755	775	792	724	841
(March only 96-97)											
<b>Exceed alcohol limit</b>											
All	288	262	273	147	313	298	278	245	227	254	267
Men	114	106	182	111	235	222	210	167	164	176	197
(March only 96-97)											

The table below gives the weighted base sizes for those answering the **self-completion** section.

<b>Base</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
<b>All</b>	1727	1735	1687	823	1648	1621	1563	1544	1645	1585	1787
<b>Sex</b>											
Men	851	807	829	403	804	797	766	763	804	783	885
Women	877	928	858	420	844	823	797	781	841	802	902
<b>Social grade</b>											
AB	241	326	307	117	230	306	245	329	284	244	383
C1	489	512	493	269	565	540	546	499	537	444	493
C2	368	402	380	146	444	368	369	312	316	453	394
D	326	252	280	143	185	223	206	207	322	198	314
E	294	229	220	136	224	183	197	197	186	228	204
<b>Age</b>											
16-24	296	277	292	144	262	254	258	264	262	250	289
25-34	389	378	381	184	342	337	330	613	354	333	368
35-44	318	348	320	157	346	345	328	320	334	319	364
45-54	288	299	279	136	284	293	264	269	294	280	314
55-64	244	246	219	113	234	221	222	214	225	223	251
65-74	189	186	189	89	179	170	161	162	177	181	198
<b>Deprivation Category</b>											
1-2	317	333	369	178	297	328	349	294	425	327	480
3-5	1051	1049	1005	509	912	967	926	1057	907	990	1113
6-7	361	353	313	136	439	317	288	193	303	268	194

### APPENDIX 3. Tables for comparison with overview report

NOTE - All bases are unweighted.

#### ATTITUDES TOWARDS OWN HEALTH

**Table A3.1 Percentage who feel their health is very/fairly good by age/social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	72	76	77	74		76	79	76	77	76	74	79
<b>Age</b>												
16-24	82	78	85	69		85	84	89	82	89	88	84
25-34	76	85	85	91		86	90	80	78	82	77	86
35-44	81	80	83	70		84	84	75	86	74	81	81
45-54	67	78	69	72		74	79	77	77	77	78	74
55-64	60	67	67	69		57	74	71	66	67	61	76
65-74	58	58	63	69		57	56	58	58	65	52	68
<b>Social grade</b>												
AB	89	86	86	89		90	91	86	87	88	90	88
C1	80	80	83	90		87	84	83	87	81	80	85
C2	77	77	80	76		78	82	76	77	80	78	82
D	72	73	79	45		66	74	70	69	74	76	74
E	42	55	44	58		41	52	51	43	45	42	51
<b>DEPCAT</b>												
1-2	80	83	86	88		82	89	86	86	81	85	85
3-5	74	77	77	73		78	80	77	76	75	77	77
6-7	61	67	64	59		67	67	60	68	73	53	75
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A3.2 Percentage who have a long-standing illness or disability by age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	36	31	30	32		34	30	32	33	31	33	33
<b>Age</b>												
16-24	18	15	14	32		16	18	16	18	7	14	14
25-34	19	20	17	14		22	22	22	18	16	20	23
35-44	29	24	24	22		28	18	33	27	30	28	27
45-54	44	34	39	33		37	33	34	37	41	34	37
55-64	56	52	46	52		57	42	44	52	48	52	46
65-74	65	55	55	55		58	58	54	57	55	62	63
<b>Social grade</b>												
AB	32	25	25	23		21	27	24	27	25	23	31
C1	30	30	25	21		25	26	25	26	26	27	27
C2	26	25	28	34		32	26	28	32	28	26	25
D	30	34	26	47		39	31	39	36	29	36	36
E	64	51	54	44		67	50	59	55	61	61	58
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1821	1759	1921

**Table A3.3 Percentage who believe they can do something to make their own life healthier by self-perceived health/age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	76	76	77	78		79	80	79	82	81	82	80
<b>Self-perceived health</b>												
Good	79	79	80	80		84	84	82	85	84	86	83
Fair	76	72	73	74		70	70	71	81	75	79	74
Poor	47	52	62	52		45	43	64	61	65	51	59
<b>Age</b>												
16-24	86	85	90	92		91	90	83	93	91	94	91
25-34	84	85	88	92		93	88	91	95	94	91	89
35-44	81	87	84	87		85	91	86	91	87	88	88
45-54	79	81	77	79		79	80	80	79	81	84	79
55-64	67	57	68	61		58	72	69	70	67	66	74
65-74	43	45	43	37		50	44	49	51	55	57	48
<b>Social grade</b>												
AB	88	82	86	85		85	83	84	87	88	87	88
C1	79	76	81	83		88	86	83	85	86	85	84
C2	80	81	77	75		80	79	81	84	82	86	80
D	73	74	75	79		68	76	71	79	80	83	76
E	59	59	62	63		58	67	65	70	62	66	65
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

## PHYSICAL ACTIVITY

**Table A5.1 Percentage who are sedentary by sex/age/social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	35	34	35	34		35	29	30	30	30	32	30
<b>Sex</b>												
Men	34	28	33	27		35	26	26	29	29	31	28
Women	35	39	37	40		36	31	34	32	32	32	31
<b>Age</b>												
16-24	21	23	28	17		20	16	17	16	15	15	21
25-34	36	31	26	26		25	20	22	24	24	21	25
35-44	28	28	23	27		31	26	29	27	28	32	28
45-54	40	29	36	39		41	21	30	30	32	28	33
55-64	38	46	53	48		48	46	38	44	45	44	39
65-74	51	56	58	59		56	54	55	51	46	59	37
<b>Social grade</b>												
AB	28	30	24	20		27	21	19	19	23	32	22
C1	29	31	27	29		27	24	23	24	26	27	26
C2	33	33	34	35		31	30	32	29	31	24	29
D	39	35	36	32		44	31	37	37	30	35	33
E	47	49	68	56		63	51	51	57	52	52	50
<b>DEPCAT</b>												
1-2	30	29	25	25		27	23	20	28	31	24	29
3-5	35	32	33	33		31	31	30	29	30	33	29
6-7	38	43	54	47		49	25	42	41	29	36	37
<i>Base: all respondents half sample in 2002</i>	1810	1795	1794	880		1757	877	1720	1784	1822	1759	1921



**Table A5.2: Percentage walking at least 30 minutes per day by sex/social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	63	64	63	56		64	61	59	63	62	65	62
<b>Sex</b>												
Men	65	67	68	56		69	64	62	66	66	69	67
Women	61	60	59	55		60	59	57	61	59	62	58
<b>Social grade</b>												
AB	50	60	56	48		54	46	56	51	57	55	58
C1	63	58	60	52		61	64	57	63	59	63	62
C2	69	65	68	69		72	66	60	67	66	74	65
D	72	74	72	55		65	65	67	74	72	72	65
E	57	69	65	57		68	63	57	66	57	57	60
<b>DEPCAT</b>												
1-2	64	58	57	52		60	57	56	57	59	65	60
3-5	61	66	64	57		62	61	60	66	64	66	63
6-7	68	62	68	58		71	68	61	57	62	64	67
<i>Base: all respondents half sample in 2002</i>	1810	1795	1794	880		1757	877	1720	1784	1822	1759	1921

**Table A5.3: Percentage achieving recommended levels of physical activity by sex/age/social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	36	39	36	39		36	42	43	39	42	43	42
<b>Sex</b>												
Men	41	50	41	46		43	50	49	46	47	45	47
Women	31	29	31	32		30	36	37	32	36	41	38
<b>Age</b>												
16-24	52	44	41	39		46	59	57	54	49	63	55
25-34	39	47	44	58		49	57	53	48	45	53	50
35-44	40	44	49	40		44	38	40	42	50	43	43
45-54	28	42	31	34		32	40	46	37	40	42	37
55-64	30	27	23	31		22	32	31	27	31	28	29
65-74	24	19	17	20		11	21	23	17	27	17	35
<b>Social grade</b>												
AB	35	36	42	44		36	41	45	40	44	38	44
C1	38	41	37	47		38	45	45	42	41	44	43
C2	39	43	39	42		46	47	50	43	44	50	47
D	38	46	39	51		33	42	40	39	49	43	45
E	30	25	18	32		19	28	29	23	26	31	25
<b>DEPCAT</b>												
1-2	38	39	40	49		45	45	47	38	44	42	37
3-5	37	41	37	35		37	42	44	41	41	43	45
6-7	34	32	26	38		30	43	37	30	41	44	42
<i>Base: all respondents half sample in 2002</i>	1810	1795	1794	880		1757	877	1720	1784	1822	1759	1921

**Table A5.4: Knowledge of recommended levels for moderate activity**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
25 minutes or less	16	21	12	18		12	11	11	13	8	11	12
26-30 minutes	30	35	34	36		30	35	32	30	28	29	29
Over 30 minutes	47	40	49	43		53	51	56	55	60	58	57
<b>Sedentary</b>												
25 minutes or less	14	34	12	17		16	11	15	19	13	12	15
26-30 minutes	30	30	33	39		29	42	31	29	29	34	29
Over 30 minutes	45	29	47	39		49	44	51	47	53	49	50
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921
<i>Base: all sedentary</i>	632	606	700	329		586	544	509	607	623	609	653

**Table A5.5: Percentage who know that 26-30 minutes of moderate activity recommended by social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	30	35	34	36		30	35	32	30	28	29	29
<b>Social grade</b>												
AB	40	37	45	48		37	43	34	36	35	50	36
C1	31	42	35	34		34	34	35	29	28	30	30
C2	33	30	31	39		29	36	30	27	29	22	28
DE	24	28	30	31		22	31	29	28	23	23	22
<b>DEPCAT</b>												
1-2	27	42	43	35		34	39	38	31	30	38	34
3-5	30	35	35	39		29	35	31	30	28	28	26
6-7	33	29	22	28		28	32	28	24	27	20	30
<i>Base: all respondents half sample in 2002</i>	1810	1795	1794	880		1757	877	1720	1784	1822	1759	1921

**Table A5.6: Motivation to increase activity levels**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
Not contemplating	44	44	51	48		42	39	38	39	39	39	39
Would like to	18	16	16	17		20	19	18	18	18	18	18
Have tried	37	40	33	35		38	42	44	42	43	43	43
<b>Sedentary</b>												
Not contemplating	56	52	66	53		50	49	53	50	47	49	43
Would like to	21	18	16	22		25	23	19	21	20	23	20
Have tried	23	30	19	25		25	28	28	30	34	28	37
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921
<i>Base: all sedentary</i>	632	606	700	329		586	544	509	607	623	609	653

## DIET

**Table A6.1: Percentage not eating fruit and vegetables daily by sex/age/social grade/ DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	43	36	39	37		33	31	31	27	28	30	24
<b>Sex</b>												
Men	48	41	44	39		39	40	37	30	34	37	31
Women	39	31	34	35		28	23	25	23	22	24	18
<b>Age</b>												
16-24	44	46	47	57		37	44	42	46	36	46	28
25-34	51	38	52	41		35	36	34	27	36	29	30
35-44	49	35	33	32		34	32	30	22	28	27	22
45-54	41	36	36	34		32	27	26	21	20	20	23
55-64	28	31	33	31		32	22	26	22	20	27	22
65-74	41	25	24	25		28	23	25	23	25	37	17
<b>Social grade</b>												
ABC1	35	26	31	26		21	25	23	21	21	22	19
C2DE	49	45	46	47		44	37	38	33	34	37	30
<b>DEPCAT</b>												
1-2	39	27	26	24		24	20	20	20	23	16	15
3-5	43	35	40	39		38	31	31	27	30	29	24
6-7	47	45	50	48		50	45	43	32	29	51	45
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.2: Percentage eating at least five portions daily by sex/age/social grade/ DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	18	21	22	24		23	28	29	33	32	33	34
<b>Sex</b>												
Men	14	17	16	22		16	21	21	27	27	24	26
Women	22	25	28	27		29	36	36	39	37	41	42
<b>Age</b>												
16-24	12	15	15	9		15	15	19	18	17	28	34
25-34	12	20	17	20		23	26	28	32	28	26	27
35-44	19	17	22	33		23	30	27	36	31	37	36
45-54	22	24	25	28		26	32	34	39	47	38	32
55-64	27	28	27	35		20	35	34	37	37	37	39
65-74	22	25	29	24		34	30	31	38	31	30	43
<b>Social grade</b>												
AB	27	23	35	44		35	41	47	45	38	50	51
C1	21	27	26	25		32	29	28	36	39	39	36
C2	18	17	15	20		15	20	28	33	29	30	29
DE	13	17	14	18		13	25	20	32	23	20	25
<b>DEPCAT</b>												
1-2	27	27	30	28		28	40	41	36	39	43	41
3-5	17	20	20	25		26	27	27	35	33	33	33
6-7	15	18	16	18		12	19	20	21	20	22	27
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.3: Mean number of portions of fruit and vegetables consumed per day by sex/age/social grade/ DEPCAT**

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	2.8	3.0	2.9	3.1		3.1	3.3	3.4	3.6	3.5	3.6	3.7
<b>Sex</b>												
Men	2.5	2.7	2.5	2.8		2.7	2.8	2.9	3.4	3.2	3.2	3.2
Women	3.1	3.3	3.3	3.3		3.4	3.8	3.8	3.9	3.9	4.1	4.1
<b>Age</b>												
16-24	2.6	2.5	2.4	2.2		2.5	2.4	2.7	2.7	2.5	3.0	3.5
25-34	2.2	2.6	2.5	2.8		3.0	3.3	3.1	3.5	3.1	3.4	3.3
35-44	2.9	2.9	3.1	3.3		3.1	3.5	3.4	3.8	3.6	3.7	3.8
45-54	3.3	3.2	3.3	3.4		3.4	3.6	3.7	4.0	4.2	3.8	3.7
55-64	3.3	3.6	3.1	3.5		3.0	3.8	3.7	3.9	4.1	4.1	3.9
65-74	2.9	3.4	3.7	3.4		3.8	3.5	3.6	3.9	3.6	3.8	4.0
<b>Social grade</b>												
AB	3.6	3.5	3.8	4.4		3.9	4.1	4.4	4.4	4.2	4.3	4.5
C1	3.2	3.3	3.2	3.1		3.5	3.5	3.4	3.9	3.8	4.1	3.9
C2	2.8	2.5	2.6	2.7		2.7	2.9	3.1	3.4	3.4	3.5	3.4
D	2.3	2.7	2.3	2.6		2.8	3.1	2.9	3.2	3.0	3.2	3.2
E	2.2	2.4	2.5	2.7		2.2	2.9	2.8	2.7	3.0	2.8	3.1
<b>DEPCAT</b>												
1-2	3.5	3.5	3.6	3.5		3.5	3.9	4.1	3.9	4.1	4.3	4.0
3-5	2.7	3.0	2.8	3.0		3.3	3.3	3.3	3.7	3.5	3.5	3.6
6-7	2.5	2.6	2.5	2.7		2.3	2.8	2.7	4.1	2.8	3.1	3.3
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.4: Knowledge of recommended 5+ portions of fruit and vegetable consumption by sex/ social grade/ DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	19	29	36	35		42	50	59	63	65	66	75
<b>Fruit and vegetable consumption</b>												
Daily	26	37	46	43		52	58	68	68	72	72	79
Non-daily	10	14	21	21		22	32	39	47	49	52	62
<b>Sex</b>												
Men	13	18	23	25		28	38	48	52	51	55	67
Women	26	39	48	45		56	62	70	73	79	76	82
<b>Social grade</b>												
AB	33	35	48	58		60	60	76	75	80	79	84
C1	24	39	43	42		49	58	67	69	72	72	79
C2	15	20	34	27		39	45	53	59	68	65	72
DE	13	21	24	22		27	38	47	49	50	53	66
<b>DEPCAT</b>												
1-2	26	38	53	45		52	62	76	70	66	74	79
3-5	18	28	33	33		45	50	60	62	65	68	75
6-7	17	24	26	27		28	38	38	55	63	48	65
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.5 Motivation to eat more healthily**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
Not contemplating	47	47	49	50		42	42	40	40	39	39	42
Would like to	11	11	11	8		10	14	10	12	11	11	8
Have tried	42	43	41	42		48	45	51	48	50	51	50
<b>Not eating fruit and vegetables daily</b>												
Not contemplating	49	46	49	45		46	34	46	41	36	40	39
Would like to	13	15	13	14		13	22	16	18	19	18	12
Have tried	38	39	37	42		41	44	40	41	45	42	49
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1874	1822	1759	1921
<i>Base: all not daily</i>	766	661	643	321		537	507	509	471	500	466	473

**BREASTFEEDING**

**Table A6.6: Agree that women should be made to feel more comfortable breastfeeding in public by age**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>		84	82	82		88	88	88	88	89	90	89
<b>Age</b>												
16-24		78	82	64		91	85	90	89	87	89	90
25-34		91	91	93		92	90	91	95	86	94	91
35-44		88	91	90		94	92	92	91	94	92	93
45-54		83	80	81		90	91	88	86	93	92	92
55-64		82	68	81		86	84	84	84	88	86	83
65-74		71	74	74		65	79	81	79	83	84	84
<i>Base: all respondents</i>		1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.7: Disagree that women should only breastfeed at home or in private by age/social grade**

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>		<b>73</b>	<b>73</b>	<b>74</b>		<b>78</b>	<b>82</b>	<b>81</b>	<b>81</b>	<b>83</b>	<b>84</b>	<b>86</b>
<b>Age</b>												
16-24		70	74	59		79	81	81	76	78	81	83
25-34		82	84	89		89	85	87	92	85	88	92
35-44		80	81	82		87	87	88	84	88	89	88
45-54		76	68	74		79	85	85	84	89	86	90
55-64		65	59	67		72	75	71	74	81	77	77
65-74		54	65	60		46	68	64	64	71	75	75
<b>Social grade</b>												
AB		79	75	76		85	87	90	87	85	87	90
C1		76	75	85		76	82	85	79	85	86	88
C2		71	73	71		81	81	79	82	88	84	83
DE		67	70	65		73	77	72	76	77	80	83
<i>Base: all respondents</i>		1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A6.8: Disagree that would be embarrassed to see a woman breastfeeding by sex**

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>		<b>81</b>	<b>80</b>	<b>80</b>		<b>87</b>	<b>85</b>	<b>86</b>	<b>86</b>	<b>87</b>	<b>88</b>	<b>89</b>
<b>Sex</b>												
Men		75	77	76		85	81	83	84	83	85	86
Women		86	82	84		89	89	89	88	91	91	92
<i>Base: all respondents</i>		1795	1794	880		1757	1742	1720	1784	1822	1759	1921



## SMOKING

**Table A7.1: Percentage of regular smokers by age/sex/social grade/DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	36	33	32	35		32	29	29	27	27	31	26
<b>Sex</b>												
Men	36	32	32	40		33	29	30	29	27	33	27
Women	37	34	31	30		32	30	29	26	27	28	25
<b>Age</b>												
16-24	32	25	34	47		25	32	27	25	24	30	25
25-34	48	43	34	44		36	33	36	30	30	37	29
35-44	35	35	31	38		35	35	34	25	32	31	33
45-54	37	36	36	28		29	29	26	32	29	27	27
55-64	29	25	33	27		38	25	29	28	24	30	22
65-74	32	25	15	17		26	16	17	23	17	25	12
<b>Social grade</b>												
AB	16	16	13	17		11	14	13	17	13	8	12
C1	28	26	22	35		23	27	26	17	23	27	19
C2	37	40	36	30		34	31	34	34	28	33	31
D	47	42	47	52		52	42	33	35	34	34	32
E	54	48	52	37		53	42	44	49	43	50	47
<b>DEPCAT</b>												
1-2	24	20	21	34		19	21	19	19	19	19	17
3-5	37	33	31	34		26	31	30	29	28	31	29
6-7	43	45	47	41		52	35	39	30	35	42	30
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A7.2: Number of cigarettes smoked per day by sex**  
 % 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>													
Light (< 10 per day)		10	10	11	23		13	15	12	16	16	17	18
Medium (10-19 per day)		41	47	43	43		46	49	42	44	46	42	47
Heavy (20+ per day)		49	43	46	33		41	36	43	40	39	42	35
<b>Men</b>													
Light (< 10 per day)		9	6	10	30		13	13	11	17	18	14	17
Medium (10-19 per day)		43	46	39	47		46	49	42	42	43	40	46
Heavy (20+ per day)		48	48	51	24		40	37	47	41	39	45	37
<b>Women</b>													
Light (< 10 per day)		10	13	12	15		12	15	12	15	13	19	19
Medium (10-19 per day)		39	47	48	39		45	49	43	47	48	44	49
Heavy (20+ per day)		50	39	41	46		43	34	45	38	39	37	32
Base: regular smokers		650	617	551	263		525	529	530	507	504	521	531
Base: male smokers		279	257	247	109		225	229	227	243	210	232	249
Base: female smokers		368	360	304	154		300	300	303	264	294	289	282

**Table A7.3: Percentage of heavy smokers by age**  
 % 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>													
		48	42	46	33		41	36	46	39	39	42	35
16-24		27	27	21	12		16	13	25	10	12	10	12
25-34		50	33	40	2		26	36	46	19	26	32	30
35-44		59	59	52	51		49	35	55	43	43	46	38
45-54		60	53	60	54		67	51	52	63	58	57	50
55-64		57	45	58	45		33	46	50	53	50	52	44
65-74		31	38	48	34		63	39	35	56	35	65	30
Base: regular smokers		658	588	566	308		563	512	530	507	504	521	531

**Table A7.4: Motivation to cut down or quit smoking**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>Regular smokers</b>												
Not contemplating	22	20	23	16		16	17	24	20	19	16	18
Would like to	31	32	27	32		26	35	27	27	30	24	24
Have tried	48	48	50	52		58	48	49	53	51	59	58
<b>Heavy smokers</b>												
Not contemplating	20	22	22	16		18	19	21	23	26	19	21
Would like to	36	40	32	41		34	43	34	37	32	31	30
Have tried	44	38	46	44		49	38	44	41	42	51	49
<i>Base: regular smokers</i>	650	617	551	263		525	529	530	507	504	521	531
<i>Base: heavy smokers</i>	333	280	272	124		224	214	231	215	201	229	206

**ALCOHOL****Table A8.1: Percentage exceeding recommended weekly limits for alcohol by sex**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All	16	15	15	17		18	17	16	14	12	14	14
Men	25	24	21	26		27	26	25	19	18	20	21
Women	7	6	10	8		9	9	8	9	7	9	7
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A8.2: Percentage exceeding recommended weekly limits for alcohol by sex and age**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>Women</b>	7	6	10	8		9	9	8	9	7	9	7
<b>Women by age</b>												
16-24	17	13	30	18		16	14	16	10	13	19	15
25-34	15	8	7	8		11	12	7	11	3	6	8
35-44	4	4	8	7		6	8	7	8	8	5	6
45-54	5	7	11	4		9	9	6	14	9	11	6
55-64	1	4	1	6		8	2	9	4	5	8	4
65-74	1	1	2	2		2	4	*	3	3	5	3
<b>Men</b>	25	24	21	26		27	26	25	19	18	21	21
<b>Men by age</b>												
16-24	33	26	17	57		43	32	32	19	29	16	35
25-34	33	22	29	18		31	27	36	18	17	17	19
35-44	30	35	22	33		28	30	19	18	17	26	17
45-54	22	19	24	15		24	26	25	26	20	21	20
55-64	14	21	16	17		13	24	16	21	15	25	20
65-74	6	15	11	7		20	9	15	9	10	16	16
<i>Base: all men</i>	771	762	761	360		738	742	728	771	727	744	847
<i>Base: all women</i>	1030	1032	1033	520		1019	1000	992	1013	1095	1015	1074

**Table A8.3: Percentage with 4+ binge drinking sessions (16/10 units) in past month by sex/age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<i>All</i>	11	9	9	16		12	9	10	9	10	9	12
<b>Sex</b>												
Men	18	12	12	27		17	13	15	13	13	13	17
Women	4	6	6	6		8	5	5	6	6	6	8
<b>Age</b>												
16-24	21	20	23	36		33	19	15	13	25	16	27
25-34	16	11	10	28		10	14	14	13	11	12	12
35-44	11	8	6	16		14	7	12	8	10	10	11
45-54	7	6	7	3		8	6	8	9	4	7	12
55-64	3	4	4	3		3	5	6	5	5	4	7
65-74	1	3	2	3		2	1	2	3	3	2	1
<b>Social grade</b>												
AB	4	7	5	5		6	7	4	6	5	6	8
C1	13	6	8	25		14	9	10	10	11	11	10
C2	12	11	13	12		13	10	12	12	10	9	17
DE	12	11	10	16		12	10	12	10	11	10	14
<i>Base: all respondents</i>	1810	1795	1794	880		1757	1742	1720	1784	1822	1759	1921

**Table A8.4: Knowledge of recommended weekly limits for own sex**  
 % 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
Under limit	23	33				34	35	32	36	28	30	32
Exact limit (21/14 units per week)	9	23				20	20	21	24	22	27	24
Over limit	24	11				16	15	17	12	13	18	18
Don't know	44	33				32	30	30	29	37	26	27
<b>Men</b>												
Under limit	19	28				26	29	36	39	35	33	33
Exact limit (21 units per week)	8	22				23	26	20	20	16	20	21
Over limit	19	10				14	11	20	15	16	25	23
Don't know	53	40				37	34	25	26	33	22	22
<b>Women</b>												
Under limit	26	38				41	41	27	32	22	26	30
Exact limit (14 units per week)	9	23				16	15	23	28	28	34	26
Over limit	29	12				17	18	15	9	10	10	12
Don't know	36	26				26	26	34	31	40	30	31
<b>Men exceeding weekly limits</b>												
Under limit	16	34				44	39	28	35	29	37	38
Exact limit (21 units per week)	12	29				13	16	22	28	20	21	17
Over limit	36	14				28	19	30	21	21	27	26
Don't know	36	23				16	26	20	16	30	16	19
<i>Base: All who have had alcoholic drink in past year(March waves only 1996-1997)</i>	801	787				1533	1520	1486	1452	1558	1508	1689

**Table A8.5: Motivation to reduce alcohol consumption**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All drinkers</b>												
Not contemplating	80	81	84	82		78	76	74	77	77	71	75
Would like to	4	5	4	5		5	6	5	5	4	6	5
Have tried	16	14	13	14		18	18	22	18	19	24	20
<b>Those exceeding weekly limits</b>												
Not contemplating	61	63	67	61		59	52	53	60	49	50	51
Would like to	14	15	10	15		14	15	14	14	12	15	17
Have tried	24	23	23	24		27	33	33	26	40	35	32
<i>Base: All who have had alcoholic drink in past year</i>	1593	1587	1576	771		1533	1520	1486	1542	1558	1508	1689

**Table A9.1: Percentage with large amount of stress by sex/age**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>				20		23	25	25	24	26	22	23
<b>Sex</b>												
Men				16		20	21	20	22	24	18	20
Women				25		26	30	28	26	28	26	25
<b>Age</b>												
16-24				9		25	22	12	15	19	13	15
25-34				17		22	29	29	20	30	24	20
35-44				32		23	28	32	32	36	30	32
45-54				31		31	29	31	30	31	31	28
55-64				22		24	25	22	24	20	17	21
65-74				8		9	14	13	16	11	12	15
<i>Base: all respondents</i>				880		1757	1742	1720	1784	1822	1759	1921

**Table A9.2: Percentage with harmful stress by sex/age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>				40		36	36	38	41	39	40	36
<b>Sex</b>												
Men				34		33	28	33	36	33	34	35
Women				45		39	44	43	47	46	46	37
<b>Age</b>												
16-24				28		39	30	24	31	33	25	23
25-34				47		32	38	46	39	42	44	37
35-44				45		38	33	46	50	45	47	44
45-54				45		46	42	39	52	45	46	44
55-64				38		34	39	36	40	35	40	35
65-74				25		21	34	32	31	31	32	25
<b>Social grade</b>												
AB				28		32	35	31	46	39	46	32
C1				37		33	35	34	37	39	38	34
C2				37		35	33	38	37	35	33	32
D				35		49	35	42	36	36	39	38
E				74		53	48	55	55	54	51	51
<i>Base: all respondents</i>				880		1757	1742	1720	1784	1822	1759	1921

**Table A9.3: Percentage with GHQ12 score greater than two by sex/age/social grade/ DEPCAT**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	24	27	27			23	23	28	23	22	23	24
<b>Sex</b>												
Men	20	21	22			19	19	22	19	18	18	22
Women	27	32	32			27	27	33	27	26	29	26
<b>Age</b>												
16-24	21	32	32			26	32	25	24	25	20	32
25-34	33	31	25			25	23	33	23	25	24	22
35-44	23	28	30			24	23	30	24	24	34	26
45-54	26	26	30			23	24	31	26	22	20	27
55-64	14	18	22			24	13	25	19	17	18	20
65-74	20	20	21			10	19	16	20	14	17	14
<b>Social grade</b>												
AB	16	25	20			23	18	24	22	17	30	17
C1	25	25	25			19	23	25	19	22	18	19
C2	19	25	27			25	18	26	24	19	17	23
D	15	25	31			18	25	27	23	22	21	28
E	42	37	40			34	38	44	34	35	37	46
<b>DEPCAT</b>												
1-2	17	20	23			28	18	21	27	22	18	21
3-5	23	28	28			21	22	27	21	20	24	24
6-7	31	28	31			23	31	39	31	29	27	32
<i>Base: Respondents answering self- completion section</i>	1698	1733	1663			1606	1583	1529	1523	1599	1552	1752



**Table A9.4: Percentage with GHQ12 score of four or more by sex/age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<i>All</i>	18	20	20			17	18	22	18	17	19	19
<b>Sex</b>												
Men	15	17	15			13	14	18	15	14	14	18
Women	22	24	24			20	21	26	21	21	24	19
<b>Age</b>												
16-24	15	22	19			19	23	19	17	23	14	23
25-34	27	25	19			18	18	25	20	18	19	17
35-44	17	22	23			19	18	26	21	20	34	23
45-54	20	21	23			18	19	23	17	16	16	20
55-64	10	13	16			16	11	21	14	15	13	16
65-74	16	16	15			7	14	13	19	10	13	10
<b>Social grade</b>												
AB	12	20	14			17	14	18	17	13	26	15
C1	19	20	19			13	16	20	15	17	12	14
C2	14	19	17			19	13	21	20	15	14	17
D	11	18	24			14	21	23	17	21	18	20
E	35	29	31			24	34	37	27	24	34	40
<i>Base: Respondents answering self- completion section</i>	1698	1733	1663			1606	1583	1529	1523	1599	1552	1752

**Table A9.5: Mean GHQ12 scores by sex/age/social grade**

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	1.8	1.9	1.9			1.7	1.8	2.0	1.7	1.7	1.8	1.8
<b>Sex</b>												
Women	2.0	2.2	2.1			2.0	2.2	2.3	2.0	2.0	2.1	1.9
Men	1.4	1.6	1.6			1.4	1.5	1.6	1.4	1.4	1.4	1.6
<b>Age</b>												
16-24	1.4	2.2	2.1			1.9	2.4	1.8	1.6	2.1	1.5	2.1
25-34	2.5	2.2	1.8			1.7	1.8	2.3	1.7	1.8	1.9	1.7
35-44	1.6	1.9	2.2			1.9	1.9	2.3	1.8	1.8	2.4	2.1
45-54	1.9	1.9	1.9			1.9	2.0	2.0	1.8	1.7	1.7	2.0
55-64	1.2	1.3	1.5			1.6	1.1	1.7	1.4	1.3	1.3	1.5
65-74	1.4	1.6	1.4			0.8	1.4	1.2	1.8	1.1	1.3	1.0
<b>Social grade</b>												
AB	1.3	1.8	1.4			1.6	1.5	1.5	1.7	1.3	2.0	1.3
C1	1.6	1.8	1.7			1.4	1.8	1.9	1.4	1.6	1.3	1.4
C2	1.5	1.7	1.7			1.7	1.4	1.8	1.6	1.5	1.4	1.6
D	1.3	1.8	2.2			1.6	1.8	2.0	1.8	1.8	1.7	1.9
E	3.2	2.7	2.6			2.6	3.3	3.0	2.7	2.6	3.0	3.6
<i>Base: Respondents answering self- completion section</i>	1698	1733	1663			1606	1583	1529	1523	1599	1552	1752

## SEXUAL HEALTH

**Table A12.1: Percentage changing sexual behaviour because of HIV/AIDS by age/social grade**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>	13	13	15			15	14	15	15	14	13	14
<b>Age</b>												
16-24	31	27	26			16	32	11	23	22	22	17
25-34	21	21	29			28	19	26	20	20	18	23
35-44	10	8	12			19	14	18	14	10	12	16
45-54	7	5	5			9	9	8	11	14	12	7
55-64	3	6	6			4	6	11	8	4	5	5
65-74	2	2	1			6	2	6	6	8	4	13
<b>Social grade</b>												
AB	10	11	12			17	10	14	12	10	9	11
C1	16	14	18			18	19	15	14	13	14	14
C2	13	12	16			10	10	15	15	17	14	16
D	16	13	13			16	12	15	11	15	15	18
E	10	12	10			14	21	12	23	12	13	11

Base size: 1698 1733 1663 774 823 1529 1523 1599 1552 1752

Base: respondents answering the self-completion section (March wave only 2001-2002)

**Table A12.2: Attitudes toward condom use – would not have sex with new partner without a condom**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
Tend to agree	19	18	19	20		28	28	28	30	25	26	25
Strongly agree	47	49	44	44		56	55	58	54	55	53	57
<b>16-24</b>												
Tend to agree	32	26	23	37		27	15	34	41	35	34	27
Strongly agree	48	65	57	45		60	65	57	46	45	45	51
<i>Base size: All adults</i>	1698	871	1663	811		1606	823	792	1523	1599	1552	1752
<i>Base size: 16-24</i>	209	109	190	86		219	108	90	187	185	140	185

*Base: respondents answering the self-completion section (September wave only 1997, March wave only 2002-2003)*

**Table A12.3: Information needs regarding sexual health topics**

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>All</b>												
STIs	40	28	35			28	20	30	20	19	19	18
Having an HIV test	25	21	20			17	15	20	13	13	12	10
HIV/ AIDS transmission	22	16	18			15	14	17	9	10	10	7
Emergency contraception	19	15	17			11	10	11	7	8	9	6
<b>16-24s</b>												
STIs	63	60	61			56	58	45	31	40	34	36
Having an HIV test	41	42	31			34	40	37	28	17	30	27
HIV/ AIDS transmission	24	12	25			23	31	28	16	14	20	13
Emergency contraception	41	27	20			20	28	23	9	17	18	14
<i>Base size: All adults</i>	850	862	827			774	823	1529	1542	1599	1552	1752
<i>Base size: 16-24</i>	105	83	91			114	108	172	187	168	140	185

*Base: respondents answering the self-completion section - only one wave per year 1996-2002*

## APPENDIX 4. Physical activity levels

The following flowchart describes how the physical activity levels used in this report were derived. The levels described as *regular moderate* and *regular vigorous* correspond to current public health recommendations (at least five sessions of moderate activity per week, or at least three sessions of vigorous activity). Sessions consist of 30 minutes for moderate activity (activity where respondent breathes faster than normal through physical exertion) and 20 minutes for vigorous activity (activity which makes respondent sweaty and out of breath). Heavy gardening and work around the house are considered as moderate physical activity. The Health Education Population Survey questions on physical activity are shown in Appendix A.

If number of sessions of vigorous activity is					
0			1-2		3+
And number of sessions of moderate activity is			And number of sessions of moderate activity is		
0	1-4	5+	0-4	5+	
Then physical activity level is classified as					
Sedentary	Irregular moderate	Regular moderate	Irregular moderate	Regular moderate	Regular vigorous