Victimisation of Mentally Ill Patients living in the Community: is it a lifestyle issue?

The Mental Health Act for England and Wales (1959) spawned the beginnings of Community Care leading to the de-institutionalisation of people suffering from mental illness (Dobson, 1998). One aim of the act was to enable patients to live in the community with the support of social and other health care workers. Another was also to extinguish the stigma that has often surrounded mental illness (Dobson, 1998).

Research has focused on the risk, usually of violence, posed by the mentally ill to the community (Silver, 2002). Scant attention has been paid to the criminal victimisation of people suffering from mental illness (Marley & Buila 2001). Even victimisation surveys, thought to capture the hidden figures of unreported crime (Hollin, 1992) do not assess the victimisation of the mentally ill. The largest and most regular of these conducted in the United Kingdom, the British Crime Survey, excludes residents of supported community-based accommodation by regarding their accommodation as an 'institution' (Williams, 1993).

This is surprising since the vulnerability of individuals may explain observed variations in victimisation rates, (Clarke & Felson, 1993). Certain social factors relate to increased vulnerability of victimisation, e.g. low socio-economic status (Wohlfarth, Winkel, Ybema & van den Brink, 2001), living in urban areas (Hope, Bryan, Trickett, & Osborn, 2001) and unemployment (Laub, 1997). Mental illness can result in low socio-economic status (Wilton, 2003) and unemployment due to the stigma of mental illness (Hiday, Swartz, Swanson, Borum, & Wagner, 1999) Visible symptoms may exacerbate this vulnerability (Hiday et al., 1999). Bizarre or 'strange' behaviour may result in hostile responses from others (Silver, 2002). Our study aimed to redress some of this imbalance by examining the extent and nature of victimisation of mentally ill patients.

Some studies have reported the victimisation of mentally ill patients (Marley & Buila, 2001). In particular, mentally ill patients are more likely to be violently assaulted than are the

general public (Hiday et al., 1999; Silver, 2002). Hiday et al. (1999) revealed that although property crimes experienced by people with severe mental illness were comparable with those reported by the general population, the risk of violent victimisation was two and a half times greater for the mental illness group than for the general population. Mentally ill women have also been found to be more at risk from sexual victimisation than general population females (Marley & Buila, 2001). Similarly, mentally ill males were more frequent victims of robbery or assault than general population males (Marley & Buila, 2001). These findings reinforce arguments that those suffering mental illness are particularly vulnerable to victimisation. Hiday (1995) suggested that this vulnerability stems from being mentally ill and the lifestyle or social context mentally ill patients experience.

Not only strangers victimise mentally ill patients. Cascardi, Mueser, DeGiralomo and Murrin (1996) looked at violence and physical aggression directed at psychiatric patients by family members or partners. They found that nearly half (45.8%) reported being physically victimised by a relative and more than half (62%) by a partner. Jacobson and Richardson (1987) found that 81% of their sample of psychiatric inpatients had at some point been the victim of serious physical or sexual assault.

There are limits to the conclusions that can be drawn from victimisation research conducted on populations suffering mental illness. Many studies are based on data gathered from clinical populations (e.g. Hiday et al., 1999; Silver, 2002) often recruited from psychiatric hospitals, which are a highly selective population, so not necessarily representative of mentally ill patients. Some researchers point out that studies are 'dominated by data on hospitalised/discharged patients, but most mentally ill patients are not hospitalised' (Walsh Buchanan & Fahy et al., 2002, p.493). It seems likely that hospitalised patients represent the extreme end of the mental illness continuum and so are unrepresentative of the majority of people who suffer from some form of mental illness. Also, people recently

discharged may be more vulnerable due to inexperience of community based life than those who live solely in the community. Also, much of the research has been conducted in the U.S. (e.g. Hiday et al., 1999; Marley & Buila, 1999). This may not adequately reflect the experiences mentally ill patients have in the U.K. Bearing this in mind, our study aimed to assess the experiences of a community-based sample of mentally ill patients in the U.K.

We also explored the reporting rates of mentally ill patients. This issue has received little consideration and so not much is known about mentally ill patients' revelations of victimization to the police or others (Marley & Buila, 1999). To our knowledge, only one study (Marley & Buila, 1999) has looked at disclosure of victimization by mentally ill patients. This may be an important issue relating not only to assessing the action taken by the victims, but also the responses and actions taken by those to whom the victimization was revealed. If mentally ill patients receive negative responses from the police, this may affect future disclosure of victimization. This could have long-term consequences, particularly if the victimization is ongoing (Sparks, Genn & Dodd, 1977). Also, many studies have focused on specific aspects of victimization, such as frequency or type (Marley & Buila, 1999). To gain a broader picture of this form of crime, we examined frequency of victimization, repeat victimization, specific types of victimization and the relationship between the victim and the offender.

Past research has compared the victimisation of mentally ill patients with that of the general population (e.g. Hiday et al., 1999; Silver, 2002; Marley & Buila, 2001). However, mentally ill patients often have low socio-economic backgrounds, leaving them vulnerable to victimisation through lifestyle (Hiday, 1995; Silver, 2000). Our study compared mentally ill patients' reports of victimisation with undergraduate students' reports of victimisation. Students often experience low socio-economic status and a lifestyle, which leads them to be more at risk from victimisation through exposure. Indeed, studies have found that students

experience high victimisation relative to the general population (Barberet, Fisher, Farrell & Taylor, 2003). Consequently, meaningful comparisons in terms of lifestyle risk can be made between students and mentally ill patients.

Our study aimed to answer a number of research questions. Firstly, we wanted to know, do students and mentally ill patients differ in rates of victimisation? It may be expected that mentally ill patients experience more victimisation than others (Silver, 2000). Few studies have looked at this within a community sample and no other studies known to the current researchers have compared a mental health population with another 'lifestyle risk' group. Our second research question was, do mentally ill patients and students experience different forms of victimisation? Research suggests that mentally ill patients experience more personal victimisation than the general population (Hiday et al., 1999). Nevertheless, the frequency of victimisation experienced by mentally ill patients may be similar to the experiences of other 'lifestyle risk' groups, such as students A further question our study addressed was, are there gender differences in rates and types of victimisation between students and mentally ill patients? Previous work reveals that mentally ill women are more at risk from sexual assault than the general population, and that mentally ill men are more at risk from assault than the general population (Marley & Buila, 2001). However, these differences may not occur between 'lifestyle risk' groups. Our fourth research question was, do mentally ill patients and students hold different attitude to the police? If mentally ill patients display more negative attitudes to the police than students, they may also be less likely to report victimisation (Sparks et al., 1977). Bearing this in mind our final research question was, do mentally ill patients and students differ in reporting victimisation to the police? If they do then there will be implications for the perceived frequency of victimisation experienced by mentally ill patients.

Method

Participants:

Of 40 approached, 20 national charities agreed to distribute questionnaires to mentally ill patients on behalf of the researchers. These charities could not allow us to approach mentally ill patients directly. Of the 225 questionnaires sent to the charities 24 were completed. This gives a low response rate of just over 10% (n = 24). No reasons for the lack of response were offered either by the charity or any service users. One charity did allow us to hand out questionnaires to patients and of the 17 people approached, 16 participated. The one patient who refused to take part did so due to lack of time.

The mentally ill patients (n = 40) consisted of 22 females and 18 males with a mean age of 42.28 years (SD = 11.27). Of the mentally ill patients, 32.5% suffered from depression, 15% suffered manic depression, 12.5% suffered schizophrenia and 12.5% had a dual diagnosis. Individual diagnoses included personality, anxiety and eating disorders. Patients were mainly white (97.5%) the remainder being black (2.5%).

The student participants (n = 80) consisted of 46 females and 34 males. Students were asked if they had ever suffered from a mental illness: none said they had. They were recruited by opportunity sampling at a university campus: all those approached agreed to participate. The students' mean age was 22.14 years (SD = 2.74) and they were predominately white (87.5%). Other ethnic backgrounds included, Asian (5.1%), black (2.5%), and other unspecified (4.9%).

Materials

A 55-item victimisation questionnaire was adapted from the British Crime Survey England and Wales (2000) and the National Crime Victimization Survey (2000). Reliability analysis revealed that the scale had a high internal consistency (Cronbach's alpha = .82). The scale had four sections. The first two focused on property and personal crime experiences in

the previous 12 months and included quantitive and qualitative items. Six property offences and five personal offences required 'yes'/'no' responses. If participants responded 'yes' to any item they were asked to complete four follow-up questions. The first two determined the frequency of the crime and if they knew the perpetrator. The final two asked, 'Did you report the incident to the police?' and, 'If you did report the incident to the police please indicate how satisfied you were with their response on the scale below.' Satisfaction was then assessed using a five-point scale ranging from 'Very satisfied' to 'Very unsatisfied.'

The third section was a quantitive assessment adapted from the National Crime Victimization Survey (2000). Reliability analysis revealed that the scale had high internal validity (Cronbach's alpha = .87). It measured perceptions and experiences of the police by asking participants how much they agreed with statements such as, 'I think that the police are never around when you need them.' Questions in the first half were positively worded and items in the second half negatively worded to control for acquiescence biases.

The final section consisted of ten demographic items assessing age, sex, occupation and ethnicity.

Procedure

A pilot study employing 20 students revealed no comprehension problems with the scales. The materials were then sent to service users via the 20 mental health organizations. Participants were given an information sheet about the study, an informed consent form, a de-briefing sheet and a participant number, which could be used to identify the questionnaire should the participant decide to withdraw from the study. The mentally ill patients were supplied with pre-paid envelopes to return questionnaires. Students and the mentally ill patients who could be approached directly, were asked for their consent and then they completed the questionnaires alone before returning them to the researcher.

Ethical considerations

Several ethical issues had to be considered in conducting this study due to its sensitive nature and the potential vulnerability of participants. The voluntary nature of participation was made clear throughout the information, consent forms and debriefing sheets. Informed consent was sought from all participants. Participants were informed of their rights to withdraw at any time. To ensure confidentiality and anonymity, questionnaires were numbered and kept separate from consent forms. Participants were given our contact details should they want to withdraw or ask any further questions.

Results

All statistical analyses were conducted using 0.05 alpha level

Demographic data:

Demographic data showed that 87.5% (n = 35) of mentally ill patients were not employed. Of these, 32.5% (n = 13) claimed they were unable to work because of their illness. A further 10% (n = 4) were in part-time employment and 2.5% (n = 1) claimed to be studying. None was employed full-time. Similarly, 16.25% (n = 13) of students had full time jobs and 3.75% (n = 3) had part time jobs. Of the mentally ill patients, 40% (n = 16) rented property from the council and 15% (n = 6) lived in residential homes or units. Most students (62.5%, n = 50) rented a house or flat from a private landlord and a further 26.25% (n = 21) lived in halls of residence. Nearly a third of mentally ill patients (32.5%, n = 13) and 61.25% (n = 49) of students owned either a car or bicycle.

Victimisation rates:

Of the total sample, 42.5% (n = 51) had been victimised in the previous 12 months. Half (50%, n = 20) of the mentally ill patients and just over a third (38.75%, n = 31) of students reported being victimised at least once.

Repeated victimisation:

Being victimised more than one time was reported by 23.3% (*n* = 28) of all participants. Of the mentally ill patients 32.5% (*n* = 13) reported repeat victimisation as did 18.75% (*n* = 15) students. Of these, 22.5% (*n* = 9) of mentally ill patients and 5% (*n* = 4) of students reported being victimised more than four times in the previous 12 months.

Victim offender relationship:

Of the repeat victim students, 13.75% (*n* = 11) had been victimised by friends or partners, 51.25% (*n* = 41) were victimised by strangers and 5.08% (*n* = 4) had been victimised by people they knew by sight, such as neighbours. None of the student sample reported being victimised by a family member. Of the mentally ill repeat victims 22.5% (*n* = 9) were victimised by family members, 20% (*n* = 8) by friends or partners, 32.5% (*n* = 13) by strangers and 17.5% (*n* = 7) by people they knew by sight.

Research Questions:

1. Do mentally ill patients and student samples differ in rates of victimisation?

An independent t-test with equal variances not assumed was used to compare the number of times mentally ill patients and students had been victimised in the previous 12 months. Results revealed that mentally ill patients experienced more frequent victimisation (M = 1.89, SD = 2.82) than did students (M = 0.81, SD = 1.44), t (46.4) = 2.23, $p < .05$, η = .06, power = .78.

2. Do mentally ill patients and students experience different forms of victimisation?

Types of victimisation were collapsed into either ‘personal’(e.g. physical and sexual assault) or ‘property’ victimisation. An independent t-test using equal variances not assumed was used to compare the number of times mentally ill patients and students had been victimised in a personal or a property sense. Results revealed that mentally ill patients experienced more frequent personal victimisation (M = 1.03, SD = 1.97) than did students (M = .35, SD = .90), t (44.5) = 2.02, $p < 0.05$, η = .05, power = .72. There was no difference

between mentally ill patients' (M = .92, SD = 1.34) and students' (M = .46, SD = 1.01) experiences of property victimisation, t (57.93) = 1.87, p > .0.05, η = .03, power = .78.

3. Are there gender differences in rates and types of victimisation between the two samples?

To examine gender differences in rates of victimisation a 2(Gender: male, female) x 2 (Group: mentally ill patients, students) ANOVA was conducted on frequency of victimisation. Results revealed a main effect of gender, F (1, 117) = 8.48, p < .005, η = 0.07, power = .82 and a main effect of group F (1,117) = 7.20, p < .01, η = .06, power = .76. There was an interaction between gender and group, F (1,117) = 13.33, p < .001, η = .10, power = .95, revealing that mentally ill females experience more frequent victimisation than did mentally ill males or students of either gender (see Figure 1).

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FIGURE 1 TO GO HERE

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A further 2(Gender: male/female) x 2(Group: Mentally ill patients/students) x 2(Victimisation: Personal/property) ANOVA was conducted to see if type of victimisation was relevant. However, no main effects of victimisation type, F (1, 114) = .02, p > 0.05, η = .008, power = .052, or interactions between victimisation type and group, F (1,114) = .52, p > 0.05, η = .005, power = .11, or victimisation type and gender, F (1,114) = 2.31, p > 0.05, η = .02, power = .33, were found.

4. Do mentally ill patients and students hold different attitude to the police?

An independent t-test revealed that mentally ill patients (M = 33.42, SD = 7.54) held more negative attitudes to the police than did students (M = 26.12, SD = 6.49), t (116) = 3.25, $p < 0.005$, $\eta = .084$, power = .89.

5. Do mentally ill patients and students differ in reporting victimisation to the police?

An independent t-test was used to examine differences between the two groups in reporting victimisation to the police. Results showed that mentally ill patients (M = 1.08, SD = 1.30) did not differ from students (M = .79, SD = .1.13), t (116) = 1.24, $p > 0.05$, $\eta = .01$, power = .23.

Participants who reported victimisation to the police were asked how dissatisfied they were with the police response. An independent samples t-test using equal variances not assumed revealed that mentally ill patients (M = 5.18, SD = 2.89) were more dissatisfied with the police response than were students (M = 2.41, SD = 1.31), t (21) = 2.91, $p < .05$, $\eta = .30$, power = .82. Dissatisfied participants were asked to state why they felt this way. Typical reasons offered by students included:

> ‘They just filed the incident and didn’t follow it up’ (Student participant no. 15)

> ‘They said they could not do anything as there was not enough officers,
> they said that they had too many officers in the office being pen pushers’ (Student participant no. 71)

Although both groups expressed dissatisfaction with the speed with which the police responded, or their ability to help at all, only mentally ill patients expressed dissatisfaction with the way the police responded to them on a personal level. For example:

'They don't take action or take you seriously if you suffer from mental health problems' and 'they were very bullying towards me' (Mentally ill patient participant 112)

'They didn't really believe me and couldn't do anything'(Mentally ill patient participant no. 140)

Discussion

The aim of our study was to compare victimisation experiences of mentally ill patients recognised as facing a lifestyle risk of victimisation (Hiday, 1995), with the victimisation experiences of students, who also face lifestyle risk of victimisation (Barberet et al., 2003).

The first research question was whether mentally ill patients and students differed in frequency of victimisation. Our results show that mentally ill patients reported more frequent victimisation than did students. These findings support previous results comparing victimisation of mentally ill patients with that of the general population (e.g. Hiday et al., 1999; Marley & Buila, 1999; Silver, 2002). Although students and the mentally ill patients are arguably equally vulnerable to lifestyle risk from factors such as unemployment, we did find differences between the two groups. Most mentally ill patients rented property from the local council whereas most students either rented property from private landlords or lived in university halls of residence. Consequently, both groups may experience factors associated with risk of victimisation such as unemployment whereas the lifestyle risk of renting from a local council (Hope et al., 2001) applied only to the mentally ill patients. However, the mean age of students was considerably lower than the mean age of mentally ill. Research shows that age is negatively related to victimisation (Laub, 1997) and so students' risk may be increased because they were younger. All in all, it appears that students and mentally ill patients do indeed face a similar number of lifestyle risks, and this makes the higher rate of victimisation reported by mentally ill patients particularly surprising.

The second research question examined the type of victimisation experienced by the two groups. We found that mentally ill patients experienced more frequent personal victimisation than did students. This also supports earlier findings that mentally ill patients experience more personal victimisation than the general population (Hiday et al., 1999; Silver, 2002). However, previous work employed participants with severe mental illness, or psychiatric inpatients (Cascardi et al., 1996; Hiday et al., 1999; Jacobson, 1989). In contrast, participants in our study lived in the community and suffered from less severe illnesses. Previous work also suggests that visible symptoms (e.g. Hiday et al., 1999) or bizarre behaviour (Silver, 2002) increase chances of victimisation. For instance, someone who is suffering from active psychosis may be more vulnerable to personal victimisation than someone with depression. Our results dispel this possibility by revealing that all forms of mental ill health result in vulnerability to personal victimisation by others and that this applies as much to community-based individuals as it does to hospitalised patients.

The third research question examined gender differences in rates and types of victimisation between and within the two groups. Results showed that mentally ill women were victimised more often than any other sub sample. Mentally ill men and male and female students did not differ from each other on rates of victimisation. This is consistent with previous research (e.g. Marley & Buila, 2001). Our findings also showed that mentally ill males and females and male and female students did not differ from each other in the type of victimisation experienced. This gives cause for concern especially if it is considered in light of consistent findings that, except for sexual abuse, men experience more personal victimisation than women (Lauritsen, 2001). That mentally ill men and women and male and female students did not differ across type of victimisation makes mentally ill females' overall victimisation stand out. Considering the frequency of family victimisers cited by mentally ill patients, mentally ill females appear to be vulnerable to both personal and property

victimisation by family members as well as by friends and strangers. This implies that mentally ill women living in the community are vulnerable to victimisation in a way that mentally ill men and male and female students are not. This could also be an underestimation since domestic or sexual abuse, crimes often committed by a partner or family member, frequently remain unreported (Cascardi et al., 1996).

However, it must be borne in mind that men are less willing to report victimisation than women (Walklate, 1997). Perhaps the men in our study were also reluctant to reveal the extent of victimisation they experienced and this shaped the results. Nonetheless, the frequency of victimisation experienced by mentally ill females reveals a vulnerability that warrants further examination.

Our fourth research question concerned attitudes to the police. Mentally ill patients held more negative attitudes to the police than did the students. Interestingly, previous research shows that people of all ages, including adolescents, (Murray & Thompson, 1985) often hold favourable attitudes to the police (Sparks et al., 1977). Nonetheless, victims of crime tend to express more negative opinions of the police than non-victims (Sparks et al., 1977) as do people living in high crime areas (Mawby, 1980). As a result, the higher crime rates experienced by mentally ill patients and the areas in which they live could explain the negative attitudes expressed.

A further point to consider is the experiences mentally ill patients had of the police. Some claimed to be continually stopped by the police for no obvious reason. Others claimed that because they were mentally ill, the police were unhelpful. In contrast, dissatisfied students did not claim the police were unhelpful. Instead, they felt the police were hindered by lack of resources resulting in an inefficient service. This requires further attention. Poor relations between the police and mentally ill patients may affect reporting of crimes by this group (Sparks et al., 1977).

Finally, we investigated differences between the two groups in reporting victimisation to the police. No differences were found. This is surprising given the more negative attitudes to the police held by mentally ill patients. However, offences perceived as serious are more likely to be reported to the police (Laub, 1997). For instance, all the mentally ill women who reported that they had been the victim of sexual assault maintained that they had been raped, and reported the offence to the police. In contrast, female students who reported being sexually assaulted did not mention rape, and many claimed the incident was too trivial to report. Thus, it seems that mentally ill patients often experience more serious crimes they feel compelled to report. Other than to speculate on this possibility is beyond the scope of this work. However, this area clearly requires further attention.

Implications of this study

Our findings have wider implications. The frequency of victimisation reported by mentally ill patients gives cause for concern. Currently it is not clear if those who live in supported housing are included in the British Crime Survey. If they are not, then the victimisation of these people will remain a hidden figure. If they are included, their existence as a distinct group is not noted and so the issue of their victimisation remains cloudy at best.

A further implication concerns the negative perceptions of the police held by mentally ill patients. This finding points to the importance of improving police relations with mentally ill patients. One of the main ways in which police are alerted to criminal activity is through reporting (Greenberg, Ruback & Westcott, 1982). However, if the police fail to take seriously the complaints of mentally ill patients then they are likely to remain oblivious to at least some crimes. A further consequence could be that mentally ill patients stop reporting to the police, with obvious consequences for the clear-up rates of crimes against this particular group. Similarly, perpetrators of crimes against mentally ill patients are likely to be aware of police responses and be encouraged to select mentally ill patients as easy targets. In this way,

mentally ill patients are doubly vulnerable: perpetrators target them and the police doubt them. Awareness of this group's vulnerability should also be a focal point for those working with them. Training on how to assist victims may help the way victimisation is dealt with. Recognising the vulnerability of mentally ill patients may help challenge the stereotype that mentally ill patients are a danger to the public by pointing out the less obvious contrary position.

Methodological Limitations

There are several limitations to our study. Methodological limitations of self-report studies must be borne in mind. Instances such as forgetting and telescoping, or recalling incidents that happened more than 12 months ago, may have influenced results (Wohlfarth et al., 2001). Schneider (1981) underlines that minor offences are less likely to be telescoped than major offences and this could mean that a larger proportion of serious victimisation was reported compared to less serious offences. An interesting point suggested by Winkel et al., (2003), concerns mood congruence effects. This suggests that unhappy people may be more inclined to recall negative events (Winkel et al., 2003). In our study many mentally ill patients were suffering from depression and this may have shaped their responses. Nevertheless, although such possibilities need to be considered, nothing in our study suggested that mentally ill patients' responses were influenced by anything other than facts.

A further limitation could be that participants may have taken part in our study because they had experienced victimisation. This may have biased results to include a higher proportion of victims of crime. Coleman and Moynihan (1996) state that the 'incentive to participate in a victimisation survey could have been stronger for victims than non-victims' (p. 76). On the other hand, it could also be suggested that victims are less inclined to participate (Mayhew, Aye Maung, & Mirrlees-Black, 1993). Nonetheless, such response

biases would apply to both mentally ill patients and students, so comparisons are still justified.

Also, although the students claimed never to have suffered from any form of mental illness, it is possible that some had and were reluctant to admit it to us. However, this sort of problem is difficult to overcome methodologically. It would not be possible to test participants for all forms of mental illness and so we have to rely on self report.

Finally, our study required that respondents were literate in order to complete the questionnaire. This may mean that individuals who were less literate did not take part. To overcome this problem, future work could adopt an interview design, such as that used in the British Crime Survey.

Future Research

There are a number of promising avenues for future research. Future studies could focus on the outcomes of victimisation for mentally ill patients. Further work could broaden the issues raised in this study by examining victims' perceptions not only of the police, but also of other areas in the Criminal Justice System. A larger sample size would allow more detailed analyses and the separation of different mental health problems to see if frequency of victimisation relates to specific mental illnesses. It may also be possible to examine perpetrators of crime to see if mentally ill patients are targeted because of their illness. If so it would be interesting to see if this targeting is because mentally ill patients are 'soft options' or because some instances may be classified as hate crimes. Hate crimes are defined as 'harm inflicted on a victim by an offender whose motivation derives primarily from hatred directed at some apparent characteristic of the victim' (Garofalo, 1997).

To conclude, our study examined victimisation experienced by mentally ill patients and students. We found that mentally ill patients experience higher victimisation rates than students who face a similar lifestyle risk. Mentally ill women experienced the highest

victimisation rates in the study. Mentally ill patients held more negative attitudes to the police than did students. Clearly, victimisation of mentally ill patients requires more attention. This may lead to improving services for mentally ill patients and ultimately a reduction in the frequency of crime experienced by this vulnerable group of people.

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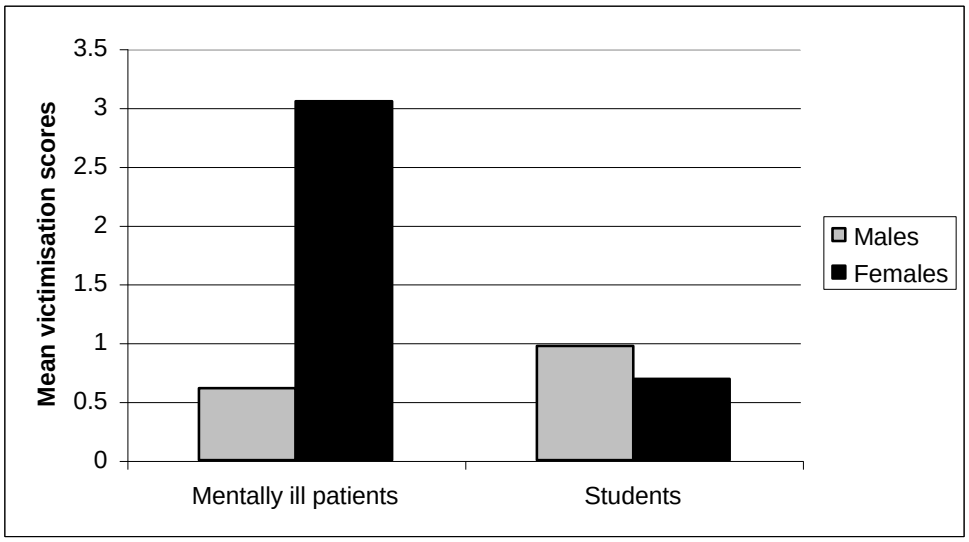
Figure Captions

Figure 1: Victimisation by group and gender.


Mean victimisation scores
3.5
3
2.5
2
1.5
1
0.5
0
Mentally ill patients
Students
Males
Females