

Working with young people: the impact of mental health awareness programmes in schools in the UK and Canada

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The persistent and disabling nature of psychiatric stigma has led to the establishment of global programmes to challenge the negative stereotypes and discriminatory responses that generate social disability, but these initiatives are rarely evaluated. This study compares the effectiveness of school-based interventions with young people aged 14-16 aimed at increasing mental health literacy and challenging negative stereotypes associated with severe mental illness in sites in Canada and the UK. In both countries, short educational sessions were delivered involving a facilitator with direct experience of mental illness. Students in Canada at baseline (N=1501) were significantly more aware than those in the UK (N=635) that schizophrenia is not a split personality, that mental illness is prevalent and that it is a myth that people with schizophrenia are any more likely to be violent than members of the general population. Both the UK and Canada programmes had a favourable impact on students' factual recall and reported attitudes at first follow-up. The cumulative proportion of students expressing no social distance across 4 key items improved over time in both the UK (N=512) and Canada (N=634). Therefore, this study shows that short educational workshops can produce positive change in young people's views of mental illness. However, more robust evaluations are needed to assess the long-term impact of both short and integrated whole school approaches to increasing mental health literacy across the globe.

Key words: Mental health literacy, schools, schizophrenia

Across the world, levels of mental health literacy are low and the stigma, discrimination and social exclusion related to mental illness are recognized as a major public health concern (1). A number of mental health promotion and anti-stigma programs have been launched. The World Psychiatric Association's Programme Fighting Against Stigma and Discrimination Because of Schizophrenia is now operating in over 20 countries. Eleven countries are currently working with young people in school based programs (e.g., 2-4). This paper compares the impact of two school-based mental health awareness programmes undertaken as part of the World Psychiatric Association's Programme, one based in Alberta, Canada, and one in West Kent, UK.

The rationale for targeting young people for anti-stigma interventions tends to be two-fold. Firstly, stigma and discrimination are fuelled by ignorance and misinformation (5). Children and young adults are the next generation of mental health consumers. Providing young people with basic knowledge and skills for protecting mental health and understanding mental health problems is seen as increasingly important in light of research showing that prognosis for severe mental illness is improved through early detection and intervention (6,7). Mental health promotion in schools provides opportunities to build positive responses to emerging emotional and behavioural problems, and promote social and learning environments that are supportive to emotional well-being and collective growth (8).

Secondly, young people are the future generation of doctors, journalists and the "general public" with the power to sustain and perpetuate stigma and discrimina-

tion, or eliminate it. Cultural stereotypes of madness are assimilated from an early age, developed in part by media representations that socialize young people into stigmatized views of mental illness (9,10). Research on young people and children's views of mental illness show that children make judgements about what is "normal" from a young age and ascribe labels to behaviour that is constructed as "abnormal" (11), though most young people do not have a clear idea of what mental illness actually is, how it presents itself, and the cultural stereotypes associated with it are not fully developed until adolescence or early adulthood (3). Therefore, young people are an attractive audience for attitude-change programmes seeking to influence young minds before unhealthy attitudes and beliefs towards mental illness become entrenched.

METHODS

In the UK and Canada, the school workshop programme is only one component of a larger school mental health promotion project. The primary goals of the workshop were to provide basic information on mental illness, and tackle stigma and discrimination; activities that would be supported by other activities across the school curriculum. A key feature of both the UK and Canadian programmes was the co-facilitation role of people with direct experience of mental illness. In Canada, the junior and senior high school programme was delivered in Calgary and Drumheller by a partnership programme operated by the local chapter of the Schizophrenia Society. This programme works with people with schizophrenia, their family members and medical pro-

professionals to bring together their skills and knowledge to deliver consistent messages and facts about schizophrenia. In southern England, two local mental health awareness groups delivered workshops to secondary school students in the county of Kent. The groups are made up of members committed to fighting discrimination on the grounds of mental health, and include mental health consumers, family members, medical professionals and workers from the voluntary sector (e.g., MIND and Rethink). Again, the school programme is focused on delivering clear messages that are relevant and appropriate for young people to promote greater understanding of mental illness in general, and schizophrenia and depression specifically.

The approaches are similar. Both base the lessons around an exploratory series of group exercises, discussions, and short talks from key presenters. However, the delivery and content of workshops did vary to take into account local cultural context, variations in student abilities, time tabling considerations (two short sessions in the UK, one long session in Canada). The program emphasis was also different. In Canada, the emphasis was on schizophrenia; in the UK, on mental health problems more generally (for more information on the content of these programmes please see [2,4,12]).

Evaluation design

Students completed a short questionnaire prior to receiving the workshop, and after the workshop was completed. In Canada, the questionnaires were completed anonymously in two separate surveys. The first was administered by teachers several weeks prior to the workshop. The second was administered by the workshop leader at the close of the session. In the UK, students were followed over time. Results from the UK study, including paired analysis and longer follow-up data, are found elsewhere (12).

The UK data were collected from five schools selected to provide a range of different learning environments with respect to academic ability, gender, ethnicity and rural-urban location, though the study sites did not contain inner city areas. In Canada, schools from two locations (one rural and one urban) were approached by program staff and volunteered to participate in the program. Both sites used the same standardized core questions to assess factual recall, self-reported attitude change, and changes in feel-

ings of social distance. Aggregate attitude scores were created for both attitudes and social distance by totalling scores on all relevant individual items so that comparisons could be made for “perfect” factual and social distance scores. Data are analyzed as two separate surveys.

RESULTS

Response rates

In the UK, 635 students attended the first mental health awareness lesson and completed the baseline questionnaire. A total of 512 completed the workshop programme and returned the one-week follow-up survey, providing an 81% response rate at follow-up. In Canada, 1501 students completed a pre-intervention survey. Post-test surveys were collected for the first 634 students who received the workshop. Neither the teachers nor the workshop leaders kept track of the number of students who did not complete a survey (because they were away on the day of the survey or because they refused), so response rates cannot be calculated. However, all students who were in class were given a questionnaire, and class time was set aside for these to be completed. Therefore, it is likely that the response rate is comparable to that of the UK.

Sample characteristics

The two samples had different baseline demographic profiles. In the UK, at baseline, 76% (483) were females compared to 48% (697) in Canada (chi square = 149.3, $p < 0.0001$). The Canadian sample was also significantly younger (chi square = 173.0, $p < 0.0001$). In Canada 38% were 14 years old (compared to 52% in the UK); 32% were 15 years old (compared to 43% in the UK), and 30% were 16 years old (compared to 5% in the UK). The baseline country age and gender profiles for the UK and Canada were identical at post-test. The UK survey also asked students to disclose personal knowledge of mental illness through contact with someone with mental health problems. At baseline, 44% (208) students indicated they had such personal experience.

Impact on mental health literacy

Table 1 provides the percentage of students having positive scores in each sample, using all eligible respondents in

Table 1 Comparison of pre- and post-educational session ratings in UK and Canada

Site	Mental health myths and facts tested	% positive at baseline (N)	% positive follow-up (N)	p
Canada	Myth: People with schizophrenia have a split personality	45 (647 of 1501)	83 (523 of 634)	< 0.001
UK	Myth: People with schizophrenia have a split personality	10 (60 of 635)	52 (268 of 512)	< 0.001
Canada	Fact: 1 in 100 people will develop schizophrenia over the course of their lifetime	70 (1053 of 1501)	88 (559 of 634)	< 0.001
UK	Fact: 1 in 4 people will develop a mental health problem over the course of their lives	36 (226 of 635)	82 (422 of 512)	< 0.001
Canada	Myth: People with schizophrenia are likely to be violent	73 (1094 of 1501)	87 (550 of 634)	< 0.001
UK	Myth: People with mental health problems are likely to be violent	37 (234 of 635)	70 (359 of 512)	< 0.001

the denominator. The question relating to the first item was identically worded. In the remainder of the items, Canadian students rated people with schizophrenia whereas UK students rated people with mental health problems. Large differences were noted between the two samples in baseline levels of literacy for all of the items. Thirty-five percent more Canadian students were aware that people with schizophrenia do not have a split personality, 34% more were aware of the frequency of schizophrenia, compared to UK students' knowledge of the frequency of mental health problems in general, and 36% more were aware that people with schizophrenia (or mental health problems) are not prone to violence. Both programmes had a significant impact on students' factual recall and reported attitudes on all of the items; however, the overall percentage improvement was lower in Canada for all items. Five percent (N=81) of Canadian students received perfect scores at baseline, compared to 18% (114) at the post-survey. This difference was greater than expected by chance (chi square = 86.1, df=1, p < 0.001). In the UK, perfect scores were provided by only one person at baseline (0.2%) and 42 (8%) at post-survey (chi square = 50.9, df = 1, p < 0.001).

The Canadian programme had a greater impact on literacy among male pupils, whereas the UK program had a greater impact on female pupils. In the UK, gender comparisons were undertaken between male and female pupils attending co-education schools, thus removing students in single sex schools from the analysis to prevent possible confounding. The same results were achieved. The impact of age in the UK and Canada was similar, with mean scores at both baseline and follow-up showing higher levels of understanding for older as compared to younger students.

Impact on social distance

Table 2 describes differences in social distance ratings. The percent of socially accepting responses for UK students was calculated by collapsing the two extreme scores of each 5-point scale. Recoding was not required for the Canadian


survey, which used a 3-point scale. At baseline, UK students were more accepting of people with a mental illness than were Canadian students of people with schizophrenia. The percentage improvement among UK students was less for every item, ranging from 1% to 14%, whereas, in the Canadian sample, percentage improvement ranged from 6% to 23%. The Canadian sample showed statistically significant improvements in all four items, whereas UK students showed significant improvement in two of the items. Virtually no changes were noted in the percent of UK students who thought they would be able to make friends with someone having mental health problems, and a small improvement was noted in the percent that thought they would be embarrassed if their friends knew that a member of their family had a mental health problem. At baseline, 40% (254) of the UK students expressed no social distance, compared to 53% (271) at post-survey (chi square = 20.4, df=1, p<0.001). In Canada, 15% (225) reported no social distance at baseline compared to 31% (195) at post-survey (chi square = 70.1, df = 1, p<0.001).

DISCUSSION

Overall, our data describe improvements in short-term factual recall, attitudes and social distance after a brief educational intervention, suggesting that the attitudes of young people can be significantly and favourably influenced by short "awareness raising" sessions. This is consistent with other studies that have assessed the impact of short educational interventions on stigma change (13-15).

Incorporating mental health awareness and emotional health promotion into the school curriculum is important, because it establishes the importance of mental health issues alongside other life-skills programmes such as sex and relationships, diet and nutrition, and physical exercise. It also provides a basic framework for understanding emotional well-being and mental illness. Programmes in both the UK and Canada received a positive response from students and school representatives, reflecting a growing

Table 2 Pre- and post-educational session ratings for social distance in UK and Canada

Site	Question	% Socially accepting (N)		p
		Baseline	Follow-up 	
Canada	Would you be afraid to talk to someone with schizophrenia?	54 (808 of 1501)	77 (485 of 634)	< 0.001
UK	Would you be afraid to talk to someone with mental health problems?	66 (416 of 635)	75 (385 of 512)	< 0.001
Canada	Would you be upset or disturbed to be in the same class as someone with schizophrenia?	67 (996 of 1501)	81 (511 of 634)	< 0.001
UK	Would you be upset or disturbed to be in the same class as someone with mental health problems?	80 (510 of 635)	89 (453 of 512)	< 0.001
Canada	Would you be able to be friends with someone with schizophrenia?	30 (452 of 1501)	43 (272 of 634)	0.001
UK	Would you be able to be friends with someone with mental health problems?	69 (435 of 635)	70 (359 of 512)	0.556
Canada	Would you be embarrassed if your friends knew that a member of you close family had schizophrenia?	65 (964 of 1501)	70 (442 of 634)	0.01
UK	Would you be embarrassed if your friends knew that a member of you close family had mental health problems?	76 (480 of 635)	80 (410 of 512)	0.07

commitment to promoting mental health and well-being in the classroom.

Differences between the UK and Canada in terms of the impact of the sessions on literacy and attitudes were noted. At baseline, Canadian students were more aware than their UK counterparts. This may be a reflection of general levels of mental health literacy in the UK, known to be poor (16), which have resulted in the recent commitment of government to improve the mental health of the population and reduce discrimination and social exclusion experienced by people with mental health problems (17,18). By comparison, the Canadian public has been shown to be generally knowledgeable about mental illness and progressive in their understanding of schizophrenia and its treatment (19). Students in both countries reported significant overall levels of reductions in social distance. However, Canadian students were generally more rejecting. This may be a consequence of the fact that the Canadian programme targeted schizophrenia, whereas the UK programme targeted more general mental health problems, since the members of the public are known to hold different attitudes towards people with different types of disorders (20) and schizophrenia is widely associated with the most negative stereotypes, including those linking violence and mental illness (21).

Results should be interpreted in light of several general limitations. There are problems whenever attitudes are measured using self-report schedules that are subject to social desirability bias, and proxy indicators to assess for changes in human behaviour (22). In addition, this evaluation measured immediate changes in students' views and did not consider longer-term impacts. The analysis of the UK data at six months revealed some weakening of effect, but a continued statistically significant impact (4). No school stigma-intervention studies have yet adopted a longer longitudinal design (over a number of years) to address how attitude changes stimulated at school are maintained through adult life. This will remain a future challenge.

Another limitation concerns the complex and non-linear relationship between attitudes and behaviour. While brief mental health education sessions can raise awareness and influence knowledge and attitudes, changing behaviours, and sustaining this change, will require a much longer-term commitment of resources. In educational terms this may reflect a holistic approach to emotional health promotion starting with toddlers and their parents, proceeding with children and adolescents and then with adults through sites of learning and the work place. In a school setting, a holistic or "whole school" approach might consider the emotional needs of teachers and their attitudes and actions when working with young people with mental health problems, as well as students, their parents, schools governors, support staff, and other people in the wider community who have contact with schools. Research shows that anti-stigma approaches must be multi-level and multi-faceted to effectively reduce discrimination (23). Targeted educational work

may be particularly effective when included as one part of a wider programme addressing long-term change in society's approach to people living with mental health problems.

To conclude, schools are important sites for mental health education programmes. The short-term interventions described here produced significant changes in student factual recall, attitudes, and overall social distance ratings, showing that favourable changes in young people are possible. Future evaluation of mental health awareness programmes in a wider range of sites and settings will offer information on whether this type of intervention has longer-term effects, and whether it is suitable for wider dissemination as an effective method of reducing stigma and discrimination because of mental illness.

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