

**The development of adolescent pupils' knowledge about and
attitudes towards mental health difficulties
(grant number 1750/197)**

Project report to PPP Healthcare Medical Trust

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May 2002

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Acknowledgements: We are grateful to all of the pupils and teachers who participated and to their schools, to Susan Bailey and Nimmi Hutnik for help in planning and Rita de Bettencourt, Fabienne Cossin, Paul Dickerson and Dawn Jennifer in data collection and Rowan Hougham-Gough in data analysis and to PPP Healthcare Medical Trust for financial support.

EXECUTIVE SUMMARY

The present investigation investigated the effect of a mental health module on young people's attitudes towards and knowledge about people experiencing mental health difficulties. The six lessons in the module, based on the Royal College of Psychiatrists' Factsheets on mental health, focussed on mental health difficulties commonly experienced by adolescents, including depression, suicide and self-harm, eating disorders, bullying, learning disabilities and stress. The research followed a two-group, pre-test, post-test design in which the experimental classes received a teaching intervention of six 50-minute lessons on mental health issues and the control classes did not. Six months after the intervention all participants in the two schools were re-tested.

- Pupils in general valued the module. However, pupils who scored highly on the Prosocial behaviour subscale of the Strengths and Difficulties Questionnaire (SDQ) were significantly more likely to value the lessons on bullying, depression, stress and learning disabilities. Pupils who scored highly on the conduct problems and hyperactivity subscales of the SDQ were significantly less likely to perceive as important the lessons on bullying, stress and depression.
- Teachers in particular were concerned that there was not enough time to cover the topics in enough depth.
- Teachers were anxious about the lesson on suicide. However, the young people almost without exception reported that this topic, though painful and difficult to study, was one that they needed to understand; boys were especially affected by the lesson on suicide.
- It was found that pupils in the experimental classes used significantly fewer pejorative words at re-test to describe mental health difficulties than controls.
- They showed more knowledge about the topics and greater complexity in their thinking about the topics.
- They also showed greater sensitivity and empathy towards people experiencing mental health difficulties.
- There was a significant reduction in scores on the *conduct problems* subscale of the SDQ amongst pupils in the experimental classes in comparison with the controls.
- There was a significant increase in scores on the *prosocial behaviour* subscale of the SDQ amongst pupils in the experimental classes in comparison with the controls.
- There were no school or gender effects on the *emotional symptoms*, *hyperactivity*, *peer problems* and *total difficulties* subscales of the SDQ.

RECOMMENDATIONS

- It is important to teach young people about the fact that mental health difficulties are experienced by around 1 in 4 people at some point in their lives
- It is important to disseminate knowledge about the six mental health issues covered in the present project – depression, stress, bullying, eating disorders, suicide and self-harm, and learning disabilities - in the Personal, Social and Health Education curriculum
- Teachers benefit from the support of in-service training and well-researched resource materials, including the Royal College of Psychiatrists Factsheets and *1 in 4* video
- It is essential to give young people opportunities to explore their own feelings about people experiencing mental health difficulties and to understand the impact of stigmatising attitudes and behaviour on such people
- The Royal College of Psychiatrists Factsheets are informative for teachers but need to be adapted for use with young people
- Experiential lessons where teachers facilitate open exploration of feelings around the topics are the most successful
- In the light of the project findings, it is our view that the materials should be disseminated to all secondary schools, backed up by appropriate in-service training.

Mental Health and Young People: The background

A. The nature of mental health difficulties in young people

The World Health Organisation (WHO) recently demonstrated that depressive illness ranks with heart disease and cerebro-vascular disease as one of the three leading illnesses in Europe (Murray and Lopez, 1997). Concern for the mental health of young people has in recent years been high on the political agenda in the UK through such initiatives as *Sure Start*, National Healthy Schools Standard, *Connexions*, Excellence in Cities and regularly updated anti-bullying guidelines. At the heart of these policies lies a concern about the increasing incidence of mental health difficulties among the young. These have been defined in the following way:

‘A *mental health problem* can be seen as a ‘disturbance in functioning’ in one area of relationships, mood, behaviour or development. When a problem is particularly severe or persistent over time, or when a number of these difficulties are experienced at the same time, children are often described as having mental health *disorders*’ (Mental Health Foundation, [MHF],1999, p.6).

Mental health disorders are usually divided into two main types: *externalising* and *internalising disorders*. Young people with externalising disorders, such as conduct disorders and attention deficit hyperactivity disorder (ADHD), have overt behaviour problems visible to those around them. Internalising disorders are those disorders in which the affected person internalises their difficulties and becomes anxious or depressed or develops physical complaints or an eating disorder. These two terms roughly equate with the educational terms *emotional* and *behavioural* difficulties.

Externalising disorders

Children with externalising disorders are much more likely to be noticed in the classroom because of the disruption they cause. Aggressive behaviour is a common behavioural problem during childhood and adolescence. A number of conditions such as hyperactivity and short attention span are also linked to aggressive and disruptive behaviour which contribute additionally to low achievement at school. It is important to intervene early since research indicates that aggression in childhood predicts later delinquency, violence and anti-social acts (Tonry, Farrington and Ohlin, 1992). We ignore childhood aggression at our peril since it is one of the most costly mental health disorders in society:

‘A large proportion of these children remain involved throughout their lives, either in mental health agencies or within the criminal justice system. In other words, we all pay in the long run – personally, financially or both – when these children are left uncared for and their behaviour problems untreated’ (Webster-Stratton, 1999, p.27).

Internalising disorders

Depression is one of the most common mental disorders. Young people who are depressed are vulnerable to self-harm and suicidal thoughts. The main features of depression are

lowered mood and an inability to experience joy and pleasure in life. These young people are often unable to express their depression verbally and may show it instead through physical symptoms, such as irritability and withdrawal. They may have difficulties in sleeping, or sleep too much, often appearing apathetic and lacking in energy. Eating may be affected with the young person either eating too little or too much. It is estimated that over 1 in 100 adolescents has a serious eating disorder, such as anorexia nervosa or bulimia (Meltzer, 1999). If we include milder versions of the disorder, this proportion becomes substantially higher. Suicidal thoughts are also common amongst young people with depression, as are feelings of hopelessness and futility. The culture of 'laddism' which requires young men to appear tough prevents many from seeking help with emotional problems. On average twelve young men take their lives each week in the UK while attempted suicides by young men have nearly tripled since the 1980s; two-thirds of suicidal young men feel that they have no-one to turn to for help (Samaritans, 2000).

Alcohol and drug abuse

Adolescence is a time when young people experiment more and engage in higher risks than children do. This in itself is a normal part of growing up. However, there is evidence that drugs and alcohol play an increasingly central part in youth culture, particularly in urban areas. The main trends include drunkenness and the mixing of alcohol with drugs. Young people are at considerable risk of suffering harm from their own or others' drinking behaviour. There are links between high-risk drinking and permanent disability and death. Drug use has similar risks and, in addition, there are particular risks associated with different types of drugs. Drug-related damage through dependence, HIV, hepatitis and overdoses has a social impact, and is also related to delinquency, crime, stigmatisation and social exclusion. Alcohol dependence is one of the largest mental disorders in the world and although the proportion of young people with alcohol dependence is initially small, there is a link from high alcohol use in adolescence to alcohol dependence in later life. The foundations of alcohol and drug abuse are laid during childhood and adolescence.

B. The nature of stigma

Today's young people seem to face severe stresses that were unknown a generation ago. At the same time, although young people are accustomed to thinking about, for example, their physical health, the importance of keeping fit or taking account of the risks of unprotected sex, attitudes towards mental health seem to be different. There are two main reasons for this state of affairs. First, there is a lack of appropriate resources to support young people with mental health difficulties; second, as a society we still have negative and stereotypical views about mental illness and mental health problems. The sense of shame and embarrassment that surrounds the concept of mental health difficulty contributes to the fact that young people's mental health problems are often unrecognised or even denied. Only a minority of young people with mental health problems will be referred to and receive help from Child and Adolescent Mental Health Services (CAMHS). The majority will be left to deal with their difficulties on their own or with support from those around them: their family, friends, teacher, social worker. Those with internalising disorders may become quiet or withdrawn

but this is often assumed to be just a part of adolescence; those with externalising disorders are often seen as disaffected or disruptive.

Stigma is one of the biggest challenges that people with mental disorders face:

“It is the stigma, and the feelings of guilt and shame, or the defensive denial, that go with it that makes people with psychiatric symptoms reluctant to seek treatment, or even to accept that their symptoms exist and might be a manifestation of mental disorder” (Kendell, 2001, p.5).

The label of mental illness is one that sticks even after the person has made a full recovery. It is harder for a person with a history of mental illness to find work, to find a partner, to get a mortgage, to emigrate or even to obtain holiday insurance.

Why are people prejudiced against those with a mental health difficulty? Hayward and Bright (1997) suggest that there are four main answers to the question: the fear that the mentally ill are dangerous; the belief that they are responsible for their illness and could somehow ‘snap out of it’; the belief that there is a poor prognosis for the condition; discomfort at the disruption to normal social interaction. Kendell (2001) argues that stigmatisation is rooted in cultural attitudes towards ‘madness’. Our concept of ourselves as rational beings guided by reason is threatened by people who may behave in unusual ways, may hear imaginary voices, may be occasionally violent or may express inappropriate views and emotions. People deal with these fears by using such mechanisms as mockery and social distancing in order to reduce the threat posed by others with mental health difficulties.

In most cultures, including Western cultures, mental illness is viewed as incurable and hereditary. Even though psychiatrists insist that there is no clear difference between mental and physical illness, it is hard to convince the layperson – or even some other health care professionals – that this is the case. Journalists also encourage their readers to hold prejudiced views about mental disorders. For example, Wagg (2000), writing about footballers and mental health, notes that the media typically revile the idea that professional footballers might suffer mental distress and instead view symptoms of distress as indicating self-indulgence or lack of moral fibre.

However, there are signs that the stigma of mental illness is reducing. For example, people are now more willing to admit to having a depressive illness, having a child with an eating disorder or a parent with Alzheimer’s disease. There is less prejudice in Western Europe and North America than in other parts of the world. This generation is less prejudiced than previous generations. Part of the reason is an increase in:

- knowledge about the forms that mental illness takes;
- awareness of effective treatments;
- awareness that mental difficulties are quite common.

C. The Royal College of Psychiatrists' Changing Minds Campaign

In 1995, the Royal College of Psychiatrists (RCP) commissioned a survey of a random sample of the adult population to estimate the degree of stigma attached to six mental disorders (Crisp et al, 2000; Gelder, 2001). The conclusions drawn from the responses of 1737 respondents were that:

- Stigmatising opinions are frequent in the community but these opinions vary according to the disorder.
- People with schizophrenia are stigmatised by opinions that they are dangerous, unpredictable and hard to talk to, but people do not blame them for their illness.
- People with drug or alcohol addiction are stigmatised more. People expect them to be dangerous and unpredictable and more than half blame them for their condition.
- People with severe depression are less stigmatised in that few people expect them to be dangerous but more than half expect them to be unpredictable and hard to talk to.
- People with eating disorders are stigmatised the least but one third of people think that they are to blame for their condition and that they are hard to talk to.

The results indicate that a common feature of public opinion is that people with mental health disorders are perceived as being hard to talk to. If this view is put into practice, the outcome will be that people with mental health disorders are isolated so making it hard for the general public to understand and help them, despite initiatives like the Mind's Respect Campaign which was launched in 1997 with a mission to reduce discrimination on mental health grounds (Wilson, 2001). The authors recommend that any campaign to reduce stigma should take account of differences among disorders.

D. The attitudes of young people towards people with mental health difficulties

In a major longitudinal study, negative attitudes in children towards mental health difficulties have been seen to persist over nearly a decade (Weiss, 1986, 1994). Yet Armstrong et al (2000) point out that the young people's views on mental health are relatively unexplored in the fields of healthcare and practice, despite the trend towards greater empowerment of users of health services and despite the increasing incidence of mental health problems among young people in the last decade (RCP, 1995 cited in Gelder 2001; West, 1997). Young people's views matter for the following reasons:

- they are the precursors of future beliefs and attitudes;
- negative adult beliefs and attitudes have been shown to impact on service development and on the quality of life of those who experience mental health difficulties;
- embarrassment and stigma may prevent people experiencing mental distress from seeking out help;
- young people's opinions are important in their own right, especially in view of their right to be heard, as recommended by the UN Convention on the Rights of the Child (Children's Rights Development Unit [CRDU], 1993, p. 6).

In this section, we consider the limited amount of research that investigates perspectives on mental health of young people who have experienced mental health difficulties themselves,

and the views of a cross section of young people in the UK towards mental health difficulties.

Perspectives of young users of mental health services

Developing appropriate mental health services for children and adolescents is a challenging task. Difficulties include the actual location of services, the approach adopted by professionals working in multidisciplinary teams, and attitudes of young people and their families towards mental health issues. The Mental Health Foundation's inquiry into the emotional well-being of children and young people (reported in *Bright Futures*, MHF, 1999) sought the users' perspectives. Some respondents said that it was hard for them to access services and that they found the professionals intimidating or apparently uncaring. Some also found it embarrassing or awkward to be asked too quickly to disclose details about distressing incidents in their lives. However, many *were* satisfied with the quality of the care that they received. They appreciated being listened to and cared for, and they found the professionals to be flexible and informal. The inquiry concludes:

‘The responsiveness of the professionals they came into contact with was a major factor in determining how young people and their parents felt about the service they received. Where professionals were felt to be patronising, to be unwilling to share information with the young people about their illnesses, or appeared not to have any time for the young person, they in turn felt let down by the treatments on offer. A number spoke of the need for psychiatrists in particular to be “less bow-tie and more youth worker”. It was clear that a great deal could be done to transform young people's experience of services if professionals were trained in listening empathetically to young people and were able to have a more flexible response to meeting young people in more informal settings’ (MHF, 1999, p.95).

The Report also recommended that schools could play a significant part in promoting children's mental health through the recognition and implementation of social and emotional education in all aspects of the curriculum and in the life of the school. Counteracting the effects of stigma would be a key aspect of such activity.

Perspectives of young people from disadvantaged backgrounds

Gale and Holling (2000), as part of the Changing Minds campaign, established HEADSTUFF, a resource for 14-17-year-olds from socially disadvantaged backgrounds. They ran a series of focus groups to find out what these young people needed to know about mental health and how they would like it to be presented. There were three key findings:

- the young people's knowledge and understanding of mental health issues was very low;
- they lacked an appropriate emotional language to express themselves adequately about mental health difficulties;
- their limited knowledge and understanding, and their lack of emotional language was in spite of their proximity with the experience of mental illness in family members or friends.

For example, in combination, the words ‘mental’, ‘health’ and ‘problem’ did not promote much discussion in the focus groups. By contrast, words like ‘nutter’, ‘weirdo’ and ‘psycho’ were meaningful and suggested a wide range of behaviours and feelings. For example, young people in the focus groups stated that such words implied being ‘out-of control’ or ‘unusual’ or ‘having a disability’. Young people were more able to accept that depression was ‘being down ‘cos your budgie or your gran has died’ but far less likely to empathise with psychotic symptoms which they associated with ‘axe-wielding murderers’. The young people in the focus groups did not think that they were stigmatising those with mental health difficulties. In fact, they had little sense of people with such disorders, what a mental health problem meant, and how it could change a person’s life.

Perspectives of a broad cross-section of Scottish young people

Armstrong et al (2000) carried out a 16-month study exploring the attitudes and perceptions of a broad range of young people aged from 12-14 years towards positive mental health and mental illness. The main sample consisted of 145 young people from a variety of social and ethnic minority backgrounds who attended mainstream schools in rural, suburban and inner city areas of Scotland. Four further groups (N = 25 participants) from Chinese and Muslim Pakistani backgrounds were also recruited into the sample to ensure that the views of young people from ethnic minority backgrounds were also heard. These participants were interviewed by researchers from similar backgrounds. The researchers used focus group discussions and individual interviews to elicit the young people’s attitudes. The main points were presented under five headings: understanding of positive mental health; what might make young people feel mentally healthy and unhealthy; how other people might promote young people’s mental health; their own strategies for dealing with their own negative feelings; perceived differences between themselves and adults:

- **Positive mental health** Young people from less advantaged backgrounds had difficulty in defining the term ‘mentally healthy’; those from suburban schools and those from minority ethnic backgrounds referred to it as ‘the absence of illness’ or in terms of happiness and confidence. For some, the term was equated with ‘normality’ but the young people found it hard to define what they meant by normality.
- **What might make young people feel mentally healthy and unhealthy** Key elements were: family and friends; having someone to talk to; personal achievement; feeling good about yourself.
- **Promoting positive mental health** A key theme was the role of adults to help young people feel safe, both physically and emotionally. These adults could be parents but other adults could also fill this role. Many of the participants felt that there were no professionals that they could really trust, though they specifically mentioned ChildLine as a valuable service that could be used for confidential matters. Those from ethnic minority backgrounds felt strongly that personal issues should not be discussed outside the family and that, on issues which could not be discussed with parents, members of the extended family (often close to them in age) were appropriate people to approach.
- **Dealing with negative feelings** There were two main categories of response: reactions to angry feelings and reactions to sadness. Young people reacted to feelings of anger by taking it out on inanimate objects, on siblings or on peers, through aggressive acts, such as fighting; there were few behavioural differences between

boys and girls but the boys discussed their aggression openly in the focus groups while the girls disclosed them privately on self-completion forms. Feelings of sadness, by contrast, were dealt with through internalisation. Suicidal thoughts were discussed by one group; some described eating or sleeping; others spoke of talking to a trusted other, including a professional, as a coping strategy. Counselling was perceived positively by some as active coping but by others as a stigma.

- **Perceived differences between themselves and adults** All the participants identified factors common to both adults and young people, for example, the death of friends and relatives, falling out with people and stress. However, factors distinctive for adults included: job insecurity, financial concerns and worries about children. By contrast, young people's issues were often described as less important than those of adults' were.

The authors conclude that there are important implications arising from this study. The term 'mental health' did not appear to have much meaning for young people in this study so the authors recommend use of a different vocabulary in educational or therapeutic work with young people. They also noted the relatively unsophisticated methods that young people used to deal with problems, such as bottling them up, sleeping, drinking alcohol or simply hoping that they would go away. There was also the tendency to trivialise the problems of young people in comparison with those of adults.

Survey findings on young people's understanding of mental health issues

Bailey (1999) reports the results of a questionnaire study of 106 young people aged 11-17 who attended a lecture at the RCP. The participants were asked to list the names that they had heard other young people call persons with a mental health problem. All implied that there was something missing or a deficit in such people, for example 'One slice short of a loaf', 'demented', 'retarded' or 'nutter'. Overall, the respondents displayed a wide range of levels of understanding and acceptance of the mentally ill. There seemed to be an urgent need to provide a programme of education to challenge the widespread use of pejorative terms and stigmatising attitudes. Bailey considers that the challenge is for healthcare professionals to join with educators to provide programmes of education and understanding if attitudes are to change.

Attitudes towards suicide

Eskin (1995a) investigated young people's attitudes towards suicide and a suicidal classmate among 98 girl and 69 boy Swedish high school students. The Swedish sample was then compared with 167 (89 girls and 78 boys) Turkish high school students from a previous study. Among Swedish students, more boys than girls said that people have the right to commit suicide and that suicide can be a solution to some problems. More girls than boys expressed a belief in life after death. Swedish adolescents appeared to hold more liberal attitudes towards suicide than their Turkish counterparts. However, Turkish adolescents showed greater acceptance for a suicidal peer than did Swedish. Eskin argues that there is a need for educational programmes to provide basic knowledge about suicide and effective ways of dealing with suicidal peers. In a further study, Eskin (1995b) found that 9.4% of Swedish and 10.9% of Turkish adolescents reported that they had actually made suicide attempts. Previous psychiatric contact, girl gender, low perceived family support and suicide

attempts in the family for the Swedish group, and suicide attempts in the family and previous psychiatric contact in the Turkish sample were found to be associated with suicide attempts. Low perceived family support, previous suicide attempts, low positive assertion skills and a small number of friends for the Swedish; and low perceived family support, previous suicide attempts, low perceived peer support, suicide attempts in the family and previous psychiatric contact for the Turkish group were found to be significant predictors of current suicidal risk.

The present study

The present investigation has attempted to find out if it is possible through direct teaching to improve, adolescents’ knowledge, understanding of, and attitudes towards the mental health difficulties and problems that young people suffer from.

INSERT SECTION ON THE ANTI-STIGMA

CAMPAIGN

Method and Materials

Design

The research design is outlined in Figure 1. This is A classic experimental or two-group, pre-test, post-test design in which one group (School E - Experimental) received a teaching intervention of six 50-minute lessons on mental health issues and the other group (School C - Control) did not.

Figure 1: Matched experimental-control research design

	<i>School E</i>	<i>School C</i>
<i>Pre-test</i>		
November 2000	✓	✓
<i>Intervention</i>		
November 2000-January 2001		
6 fifty-minute lessons on mental health	✓	X
<i>Intervention evaluation</i>		
Pupil lesson evaluations; interviews with teachers	✓	X
and pupils about the lessons.	✓	X
<i>Post-test</i>		
June 2001	✓	✓

Sample

Having previously sought and obtained approval for the research from the University of Surrey Roehampton’s Ethics Committee, the researchers’ selected two mixed-gender secondary comprehensive schools for 11-18-year-olds. These schools were matched, as far as possible, using published data (Department for Education and Skills – DfES - 2000) on

their number of pupils on roll and on their performance profiles regarding pupil non- authorised absences and public examination results for 16-year-olds (the General Certificate of Secondary Examination - GCSE) (Table 1). They were also selected because they serve similar suburban catchment areas in Greater south-west London. Consultative meetings were held with senior teachers in these schools and with form tutors in School E. All of these teachers agreed to participate in the study.

In these schools all of the Year 10 (14-15-years-old) pupils were selected for study. This age group was chosen because in School E the Personal, Social and Health Education (PSHE) curriculum for Year 10 includes a programme of work on mental health, whereas in School C this topic is not presented until Year 11. The parents of all of the School E pupils involved in the study received a letter (Appendix A) outlining the teaching programme and the purposes of the research. Parents were invited to contact the school or a member of the research team with any queries that they may have about the teaching programme or the research.

Table 1: Profiles of the participating schools (1999-2001) (DfES, 2002)

<i>School</i>	<i>Year</i>	<i>Pupils on roll</i>		<i>% pupil non- authorised absences</i>			<i>% pupils gaining 5 or more A*-C grade GCSE passes</i>			<i>Mean % pupils achieving 5 or more A*-C grade GCSE passes 1999-2000</i>
		<i>2001</i>	<i>2000</i>	<i>2001</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>1998-2001</i>		
<i>E (experimental)</i>		1300	0.20	0.30	47	57	51	49.0		
<i>C (control)</i>		1492	0.40	0.90	46	52	47	47.8		

The final samples of pupils who participated in the pre- and post-testing to investigate the impact of the teaching intervention are shown in Table 2.

Table 2: Samples (N) of pupils in participating schools (% in brackets)

<i>School</i>	<i>Boy</i>	<i>Girl</i>
<i>E</i>	84 (56.4)	65 (43.6)
<i>C</i>	106 (51.2)	101 (48.8)

In addition, but for School E only, four pupils from each of the seven teaching groups and their teachers together with the teacher-in-charge of the PSHE programme were interviewed, the pupils in groups and the teachers individually, on the conclusion of the teaching programme about their experiences and perceptions of the topics covered.

Lessons on mental health topics

In School E six 50-minute lessons on mental health issues were delivered by some of the schools' teachers over a six-week period, from 8th November to 18th December 2000 (i.e. one lesson per week). These lessons were designed by the teacher in charge of the Year 10 PSHE

curriculum in School E in collaboration with the research team. The topics of these lessons were:

- *Stress;*
- *Depression;*
- *Suicide and self-harm;*
- *Eating disorders;*
- *Bullying;*
- *Learning difficulties.*

These topics, amongst others, are identified by the Royal College of Psychiatrists (RCP, 1996 and 1999) as being particularly relevant to young people. The teacher in charge of Personal, Social and Health Education in School E and the research team felt that these topics were most relevant to the age group of the participating pupils. Lesson plans on these topics were based on a variety of resources, including: in-house school materials that had been used in previous years; some of the RCP's *Changing Minds* leaflets (RCP, 2000a) and *Factsheets* (RCP, 2000b) and its leaflet *Surviving Adolescence* (RCP, 2000c); some of *The Chalkface Project* teaching materials (various authors and dates of publication); some *Independence* books (Donellan, 1998; 2000); some of the Mental Health Foundation's *All about ...* series (MHF, 2000); the video films *1 in 4* (RCP, 2000d), *Headstuff* (RCP, 2000e) and *Don't Die of Embarrassment* (PAPYRUS, 2000); and various internet websites on themes related to mental health.

Procedures

On 13 October 1999, about three weeks before the first of the mental health lesson was scheduled to occur, the teachers responsible for delivering this programme of lessons were given one day's training on the teaching of mental health. This training day consisted of: an 'introduction to mental health' facilitated by an external trainer from MIND; specific information about teaching the mental health topics provided by the school's Head of PSHE; and background information on the research, including the teachers and pupils part in it, led by members of the research team.

The week before the six lessons on mental health were scheduled to be taught in School E, the pupil participants in both Schools E and C completed the Mental Health Quiz (MHQ) (Appendix B) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1996) (Appendix C). These questionnaires were completed again in June 2001, that is, some six months after the last of the mental health lessons. In each school, class teachers administered the questionnaires using instructions prepared by the research team (Appendix D). Typically, most pupils completed both of these questionnaires in 35 minutes.

At the end of each of the mental health lessons in School E, class teachers were asked to administer pupil lesson evaluation forms. Pupils typically took no more than five minutes to complete each of these forms.

In the PSHE lesson immediately following the completion of the programme of mental health lessons in School E, teachers administered the 'pupil's overall evaluation of the work on mental health form' (Appendix E). Most pupils completed these forms within 40 minutes.

Instruments and measures

The Mental Health Quiz (MHQ)

This questionnaire was designed and adapted from the RCP's *Attitudes to Mental Health and Knowledge of Mental Health Issues Questionnaires* (RCP, 1998) by the research team. The MHQ consists of 15 questions designed to elicit respondents' knowledge and understanding of and attitudes towards the mental health topics of the PSHE mental health lessons in School E. Except where otherwise stated, comparative data for Times 1 and 2 have been analysed using repeated measures ANOVA to investigate school and gender effects. Where qualitative data have been categorised, the categories have been derived from the raw data and the reliability of use of the categories has been assessed using the inter-rater reliability method and statistically tested using Cohen's kappa (K) on random samples of respondents' protocols.

Question 1 'What is mental Health?'. Through content analysis the responses were coded on a 5-point sophistication of knowledge scale:

- 1 – 'Don't know', tautologous responses, e.g. 'How healthy you are mentally'.
- 2 – Presents one example or illustration of MH, usually a negative one, e.g. 'When someone is mentally disturbed', or is vague, e.g. '... is things going on in your head'.
- 3 – Explicitly or implicitly considers both good and poor mental health, e.g. 'Its the state people can be in whether they are well or ill in their mind not just their body', 'Mental health is the state that someone's mind is in'.
- 4 – Comprehensive, probably with illustration, e.g. 'Mental health is the state in which your mind is in and the way you view the world', 'Mental health is how happy and confident you are about yourself and others'.

By Cohen's K , the inter-rater reliability statistic for a random sample of 79 respondents' scripts (18%) is $>.827$.

Question 2: This is an 8-item Likert-type attitude scale (validity and test-retest reliability unknown) which has been adapted from the RCP questionnaire (1998). For the purpose of statistical analysis, this scale has been reduced to 5 items. Items have been eliminated on the basis of their lack of face validity. The items used in the analyses are:

- They are easy to talk with
- They have only themselves to blame for their condition
- They would improve if given treatment
- They feel the way we all do at times
- They could pull themselves together if they wanted to.

Q3a: Name five difficulties or problems and Q3b Name 5 people/places to go for help. These questions have been treated as unrelated questions for purposes of analysis. Each question

has been scored on counts of the total number of acceptable responses. For Q3a the inter-rater reliability by Cohen's *K* of a random sample of 23 (5.5%) protocols is $>.854$ and for Q3b based on a random sample of 49 (11%) protocols it is $>.919$.

Q4a What percentage of young people get depressed? Circle ONE percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Responses have been coded using this percentage scale.

Q4b Why do some people get depressed? Responses have been scored on a 5-point scale on their explicitness and detail of taking the depressive other's point of view:

- 0 No concern with other's point of view and/or tautologous e.g. 'Because everyone has to have a depressed moment'.
- 1 Vaguely implied e.g. 'School'.
- 2 Elaborated implied statement e.g. 'Pressures in school'.
- 3 Simple but explicit statement e.g. 'They feel like this because they are upset about something'.
- 4 Elaborated explicit statement e.g. 'They feel neglected and unloved, or stupid. Like they are failing people'.

The scale is a measure of the extent to which the respondent is able to think about what is going on in another person's mind, commonly defined as theory of mind (Baron-Cohen et al, 1985). Theory of mind is the ability of individuals to attribute mental states to themselves and others in order to explain and predict behaviour (Sutton et al, 1999). Additionally, there is the realisation that they may have beliefs that differ from our own. The inter-rater reliability by Cohen's *K* on a random sample of 79 (18%) protocols is $>.924$.

Q5a What percentage of people your age has thoughts that life is not worth living? Circle ONE percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Responses have been coded using this percentage scale.

Q5b Why do some people think that life is not worth living?

The responses have been coded on a 5-point scale on the basis of their explicitness of and detail in of taking the potentially suicidal other's point of view:

- 0 'Because everyone wants to live'.
- 1 Vaguely implied e.g. 'Things keep going wrong for them'.
- 2 Implied e.g. 'Someone has been picking on them or bullying them or they've done something wrong'.
- 3 Simple but explicit statement e.g. 'Because they feel like nothing is worth living for going through problems that they don't believe they can solve'.
- 4 Elaborated explicit statement e.g. 'They are so depressed. They are in a dark tunnel with no light at either end. It's like there is no way out'; 'They must have severe problems, peer pressure-bullying-unhappy with their looks, weight, friends, family'.

The scale is a measure of the extent to which the respondent is able to think what is going on in the other's head. This question, like Q4b, we suggest is a measure of Theory of Mind.

The inter-rater reliability by Cohen's *K* on random sample of 80 (19%) protocols is $>.979$.

Q6 What percentage of people worries about their weight? Circle ONE percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Responses have been coded using this percentage scale. There was no supplementary question on this topic.

Q7a What percentage of young people goes on diets? Circle ONE percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Responses have been coded using this percentage scale.

Q7b When does dieting become a problem? The responses to this question have been scored on a five-point scale:

- 0- Don't know/irrelevant
- 1- Inaccurate perception of body/easily influenced by others, e.g. 'When they think they are fat when there not'.
- 2- Miss meals, e.g. 'When meals are missed and the diet goes too far'.
- 3- Over diet, e.g. 'They become too thin'.
- 4- Stop eating/have a clinical condition, e.g. 'When they stop eating'; 'When you become obsessive e.g. anorexia'.

The inter-rater reliability by Cohen's *K* on a random sample of 100 scripts (23%) is $>.864$.

Q8 What is stress? Responses have been scored on a five-point sophistication of ideas scale:

- 0 - Nothing about stress and/or tautologous.
- 1 - Unexplained but legitimate symptoms e.g. 'anger', 'annoyed'.
- 2 - Unelaborated example(s) of things which may well cause stress e.g. 'school', 'exams'.
- 3 - Weak or vague description e.g. 'A lot of pressure is put on you'.
- 4 - Fuller/more detailed description e.g. 'Stress is when you've got too many agenda's in your head and things tend to get on top of you'.

The inter-rater reliability by Cohen's *K* on a random sample of 81 (19%) protocols is $>.823$

Q9 What are two common causes of stress? Responses have been categorised using the following categories:

- Nothing offered
- Appearance

Relationships (other than bullying)
Bullying
Schoolwork
Unspecified 'pressure'
Biochemical (e.g. 'hormones')
Other (e.g. money, depression).

The totals for each category have been derived from both responses and they have then been graphed. The inter-rater reliability by Cohen's *K* data of a random sample of 79 (18%) protocols is $>.819$. Since it is not possible to investigate change in such categorical in responses over time statistically, these data have been used to construct graphs.

Q10 What percentage of people your age is bullied? Circle ONE percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Responses have been coded using this percentage scale.

Q11 Why do some people bully others? The responses to this question have been scored on the number of acceptable ideas produced. The inter-rater reliability by Cohen's *K* data on random sample of 66 (15%) protocols is $>.921$.

Q12 Why do some people get bullied? The coding of responses is on a count of legitimate ideas. The inter-rater reliability by Cohen's *K* data on random sample of 94 (22%) protocols is $>.853$.

Q13 How are bullied people affected? Responses to this question have been scored on a seven-point scale:

- 0 - Don't know/irrelevant.
- 1 - Responses expressed in terms of bullies actions/behaviour.
- 2 - Dismissal or denial of possible negative effects.
- 3 - Effects but without actual or implied negativity mentioned.
- 4 - One **possible** negative effect mentioned.
- 5 - Two **possible** negative effects mentioned.
- 6 - Three or more **possible** effects mentioned.

The inter-rater reliability by Cohen's *K* data on random sample of 81 (19%) $>.823$.

Q14: What are learning difficulties/disabilities? Responses have been scored on five-point scale of acceptable ideas :

- 0- Don't know/irrelevant/tautologous.
- 1- Vague e.g. 'When someone finds something hard'.
- 2- One accurate idea e.g. 'Dyslexia'.
- 3- Two accurate, different ideas, e.g. 'Dyslexia, can't concentrate'.
- 4- Three or more accurate ideas, e.g. 'Difficulties in concentration, being unclever, dyslexic'.

The inter-rater reliability by Cohen's *K* data on random sample 76 scripts (18%) is $>.936$.

The responses have also been dichotomously scored on the bases of whether or not they are: acceptable; cognitive deficit explanations which **do not** 'blame the person'; and, attention deficit explanations (e.g. 'Don't listen', 'Can't concentrate') which **do** blame the person. The outcomes have been analysed using the McNemar test. The inter-rater reliability of these codings has been assessed using Cohen's *K* on random sample of 79 (18%) protocols and the outcome is 1.000.

Q15 Give as many causes as you can for learning disabilities. – The pupils' responses have been scored on count of acceptable answers. The inter-rater reliability by Cohen's *K* on random sample of 90 (22%) protocols is .911.

Use of pejorative terms/language

Finally, the total number of pejorative terms and language in responding to the MHQ questions for Times 1 and 2 separately have been counted. Appendix L contains examples of such terms and language found in the respondents' protocols. We reason that one positive effect of the teaching on mental health topics will be to sensitise, over time, School E pupils to what is and what is not appropriate language about mental health. By comparison with the pupils in School C we believe that for the pupils in School E there will be a reduction over time in their use of negative language. The data have been analysed for school and gender effects by repeated measures ANOVA.

The SDQ

This questionnaire is a behavioural screening questionnaire that concerns children and young people's (4-16-years) behaviours, emotions, and relationships. The SDQ asks about 25 attributes, 10 of which are concerned with strengths, 14 of which are about difficulties, and one of which – "gets on better with adults than with other children" – is neutral. These 25 SDQ items are divided between 5 scales of 5 items each, as shown below.

Hyperactivity Scale. "Restless, overactive, cannot stay still for long"; "Constantly fidgeting or squirming"; "easily distracted, concentration wanders"; "*Thinks things out before acting*"; and "*Sees tasks through to the end, good attention span*".

Emotional Symptoms Scale. "Often complains of headaches; stomach-ache or sickness"; "Many worries, often seems worried"; "Often unhappy, down-hearted or tearful"; "Nervous or clingy in new situations, easily loses confidence"; and "Many fears, easily scared".

Conduct Problems Scale. "Often has temper tantrums or hot tempers"; "*Generally obedient, usually does what adults request*"; "Often fights with other children or bullies them"; "Often lies or cheats"; and "Steals from home, school or elsewhere".

Peer Problems Scale. "Rather solitary, tends to play alone"; "*Has at least one good friend*"; "*Generally liked by other children*"; "Picked on or bullied by other children"; and "Gets on better with adults than with other children".

Prosocial Scale. "Considerate of other people's feelings"; "Shares readily with other

children (treats, toys, pencils, etc)”; “Helpful if someone is hurt, upset or feeling ill”; “Kind to younger children”; and “Often volunteers to help others (parents, teachers, other children)”.

Each item is marked “not true”, “somewhat true” or “certainly true”. For all of the items except the five in italics above, the item is scored 0 for “not true”, 1 for “somewhat true”, and 2 for “certainly true”. The five italicised items are scored 2 for “not true”, 1 for “somewhat true”, and 0 for “certainly true”. The score for each of the five scales is calculated by summing the scores for the five items that make up that scale, thereby generating a scale score range from 0 to 10. Total difficulties score (0 to 40) can be calculated by summing the scores for hyperactivity, emotional symptoms, conduct problems, and peer problems. The prosocial score is not incorporated in the reverse direction into the total difficulties score “since the absence of prosocial behaviours is conceptually different from the presence of psychological difficulties” (Goodman, 1997, p.582). The SDQ has been found to be as good as the long-established and well-respected Rutter behavioural screening questionnaires (Elander and Rutter, 1996) in being able to discriminate between dental and psychiatric cases. The inter-measure and inter-rater correlations for parents and teachers on the SDQ and Rutter questionnaires are very similar measures. The SDQ has the distinct advantages over the Rutter questionnaires of being in a shorter format; focussing on strengths as well as difficulties; better coverage of inattention, peer relationships, and prosocial behaviour; and offering a version for completion by young people themselves. It is this version which has been used in this study. The teacher and parent versions were not used.

A comparison (by repeated measures ANOVA) of pupils’ SDQ scores at Time 1 and at Time 2 has been made to investigate any effects, by school and gender, that the teaching intervention has had.

School attendance

For School E data were collected from the official registers about participant pupils’ absences from their PSHE lessons on mental health. The effects of pupils’ attendance at the programme of mental health lessons on their MHQ response have been investigated by repeated measures ANOVA.

Pupil’s lesson evaluation form

The research team designed the form for pupil lesson evaluations (Appendix E). Pupils completed these forms in the final five minutes of each lesson. These forms ask pupils to name the subject of the lesson and to rate the topic on a 5-point Likert scales of: its importance; how much they had learned; how much they had enjoyed the lesson; and their overall feelings about the lesson. The form also asked respondents to say what was the most important thing that that they had learned in this lesson. However, since the completion of these evaluation forms is ‘patchy’ and very incomplete (Table 3), varying from teacher-to-teacher and from lesson-to-lesson, these data have not been analysed.

Table 3: Frequencies of completed pupil lesson evaluation forms by lesson

	08-11-00	15-11-00	22-11-00	29-11-00	06-12-00	13-12-00	20-12-00	17-01-01
<i>N Valid</i>	109	48	52	117	117	114	40	148

Missing	81	142	138	73	73	76	150	42
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Pupil's overall evaluation of the work on mental health form

This form (Appendix F) was also designed by the research team. To begin with, the form dealt with each of the topics of the six lessons separately. Respondents were asked to indicate on 5-point Likert scales, the importance of the topic, the amount that they had learned about the topic, and how much they had enjoyed it. We think that this instrument has provided the pupils in School E with an important opportunity to express their reasoned reactions and attitudes towards each of the mental health topics of the teaching programme. Pupils typically required 40 minutes for completing these questionnaires which most of them did (78%) on 17th January 2001 (Table 4). Of the 43 pupils who did not complete the form, 18 were registered absent on that day. The remaining 25 pupils were all in the same class and their teacher did not administer the questionnaire.

Table 4: Attendance 17-01-01

	<i>Frequency</i>	<i>%</i>	<i>Valid %</i>	<i>Cumulative %</i>
<i>Present</i>	168	88.4	88.4	88.4
<i>Late</i>	4	2.1	2.1	90.5
<i>Absent</i>	18	9.5	9.5	100.0
<i>Total</i>	190	100.0	100.0	

Responses have been investigated by one-way ANOVA for gender effects. Respondents were also asked to name the most important thing they had learned about the topic and to respond 'Yes' or 'No' to the question 'Do you think that this topic is suitable for Year 10 pupils?' For the present purposes, these questions have not been analysed. The form concluded by asking respondents to indicate on a 3-point scale – Very, Quite, Not very – the importance of each of the six topics for Year 10 pupils to be. Again, these responses have been investigated by one-way ANOVA for gender effects. There was also space for respondents to make 'any other comments about the lessons'. Any additional comments have not been analysed.

School E pupils' Time 2 SDQ scores have been correlated by Spearman's *rho* against their assessments of 'How important for Year 10 pupils they think each topic is', 'How much they thought they had learned about each topic' and 'How much they said they had enjoyed each topic'.

Pupil group and teacher interviews

A small group of pupils from each class and each of these pupils' teachers were interviewed by members of the research on completion of the all of the lessons on mental health using schedules (Appendix G) designed by the research team. These schedules are for semi-structured interviews in that they consist of suggested topics and questions about each of the six lessons but allow interviewers to follow-up, for example, interesting comments made by interviewees. These interviews typically lasted for 30 minutes.

Teacher's logbook of lessons

A teacher's log was also designed by the research team (Appendix H). The teaching programme teachers were asked to record information in these logbooks about what they had attempted to teach in each of their PSHE mental health lessons. However, during the period of the presentation of the mental health lessons all of the teachers, with the support of teacher trade unions and professional associations, were involved in taking industrial action in protest about the amount of 'paperwork' central government expects teachers to complete. For this reason, all of the teachers in School E who were involved in the present study did not complete the logbooks.

Results

Except where otherwise stated, the analyses of pupils' data, by gender and school, have been conducted using repeated measures ANOVA for Time 1 compared with Time 2. The statistical outcomes are reported here and the descriptive data are in Appendices I-M.

MHQ

The descriptive statistics used to investigate school and gender effects over time are in Appendix I.

Question 1: 'What is mental Health?'

No main effects of school ($F_{(1, 312)} = 2.130, p < .145$) or gender ($F_{(1, 312)} = .145, p < .704$) have been found. Also, no school-gender interaction effect ($F_{(1, 312)} = .669, p < .414$) has been found.

Question 2: 5-item attitude scale.

No main effects of school ($F_{(1, 347)} = 1.469, p < .226$) or gender ($F_{(1, 347)} = 3.136, p < .164$) have been found. There is also no school-gender interaction effect ($F_{(1, 347)} = .071, p < .790$). However, there is a bigger positive shift for School E than there is for School C and girls positively shift more than boys do.

Q3a Name five difficulties or problems.

A main effect of school ($F_{(1, 266)} = 4.686, p < .031$) has been found, with respondents in School E showing a greater improvement over time in being able to name mental health difficulties than those in School C do. There is no main effect of gender ($F_{(1, 266)} = .130, p < .719$) and no school-gender interaction effect ($F_{(1, 266)} = .007, p < .933$).

Q3b Name 5 people/places to go for help.

There are no main effects of school ($F_{(1, 257)} = .527, p < .468$) and gender ($F_{(1, 257)} = 1.502, p < .221$) and there is no school-gender interaction effect ($F_{(1, 257)} = .777, p < .379$).

Q4a What percentage of young people get depressed? Circle one percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Although there a larger increase in the mean responses for pupils in School E compared with those in School C, no main effects of school ($F_{(1, 345)} = 2.798, p < .095$) or gender ($F_{(1, 345)} =$

1.707, $p < .425$) have been found and nor is there a school-gender interaction effect ($F_{(1, 345)} = .928, p < .336$).

Q4b Why do some people get depressed?

A main effect of school ($F_{(1, 331)} = 7.311, p < .004$) has been found with respondents in School E showing an increased ability to take the depressed person's point of view. No main effect of gender ($F_{(1, 331)} = .015, p < .902$) or of a school-gender interaction effect ($F_{(1, 331)} = 1.743, p < .188$) has been found.

Q5a What percentage of people your age has thoughts that life is not worth living? Circle one percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No main effects of school ($F_{(1, 343)} = .025, p < .874$) or of gender ($F_{(1, 343)} = .373, p < .542$) have been found. Also, there is no school-gender interaction effect ($F_{(1, 343)} = .001, p < .188$).

Q5b Why do some people think that life is not worth living?

A main effect of school ($F_{(1, 325)} = 5.600, p < .019$) has been found, with the respondents in School E showing a greater improvement over time in their ability to adopt the viewpoint of the potential suicide than do those in School C. No main effect of gender ($F_{(1, 325)} = .292, p < .590$) or a school-gender interaction effect ($F_{(1, 325)} = 3.141, p < .077$) has been found.

Q6 What percentage of people worries about their weight? Circle one percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No main effects of school ($F_{(1, 347)} = .436, p < .510$) or of gender ($F_{(1, 347)} = .154, p < .695$) or of a school-gender interaction effect ($F_{(1, 347)} = .198, p < .656$) have been found.

Q7a What percentage of young people goes on diets? Circle one percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

A main effect of school ($F_{(1, 344)} = 5.321, p < .023$) has been found with the mean response for pupils in School E showing a significant increase over time. No main effect of gender ($F_{(1, 344)} = 1.372, p < .242$) or of a school-gender interaction effect ($F_{(1, 344)} = 1.641, p < .201$) has been found.

Q7b When does dieting become a problem?

No main effects of school ($F_{(1, 336)} = .024, p < .876$) or of gender ($F_{(1, 336)} = .849, p < .357$) have been found. Also, no school-gender interaction effect ($F_{(1, 336)} = .354, p < .552$) has been found.

Q8 What is stress?

A main effect of school ($F_{(1, 318)} = 10.334, p < .001$) has been found with the pupils in School E showing an improvement and those in School C a deterioration in the quality of

their responses over time. No main effect of gender ($F_{(1, 318)} = 1.002, p < .317$) or of a school-gender interaction effect ($F_{(1, 318)} = .122, p < .727$) has been found.

Q9 What are two common causes of stress?

Respondents' categorised answers to this question by school and gender for Times 1 and 2 are shown in Figures 1 and 2 respectively. Comparison of these charts reveals some similarities and differences. At Time 2 for both schools and genders there are fewer responses which offer 'appearance', 'bullying' and 'unspecified pressure' as causes of stress, and which offer no causes at all whilst there is a marked increase for all pupil groups in the proportion of responses which invoke 'schoolwork' as a cause. This cause of stress is by far the most commonly offered by all pupil groups. For School E boys only, there is an increase in the proportion that offered 'Relationships (other than bullying)' as a cause of stress.

INSERT FIGS 2 and 3 here

Q10 What percentage of people your age is bullied? Circle one percentage from those given below.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

A main effect of school ($F_{(1, 344)} = 4.828, p < .029$) has been found with the pupils in School E showing an increase in the mean estimate whilst those in School C show a decrease over time. No main effect of gender ($F_{(1, 344)} = .178, p < .673$) or of a school-gender interaction effect ($F_{(1, 344)} = .127, p < .772$) has been found.

Q11 Why do some people bully others?

No main effects of school ($F_{(1, 346)} = 3.008, p < .084$) or gender ($F_{(1, 346)} = .444, p < .506$) have been found. Also, there is no school-gender effect ($F_{(1, 346)} = 1.686, p < .195$).

Q12 Why do some people get bullied?

No main effects of school ($F_{(1, 342)} = .085, p < .771$) or gender ($F_{(1, 342)} = 3.269, p < .071$) have been found. Also, there is no school-gender effect ($F_{(1, 342)} = .226, p < .635$).

Q13 How are bullied people affected?

A main effect of school ($F_{(1, 349)} = 12.018, p < .001$) has been found with respondents in School E producing more acceptable ideas at Time 2 than at Time 1 and with School C producing fewer from Time 1 to Time 2. No main effect of gender ($F_{(1, 349)} = .353, p < .553$) or a school-gender interaction effect ($F_{(1, 349)} = .026, p < .872$) has been found.

Q14 What are learning difficulties/disabilities?

No main effects of school ($F_{(1, 315)} = .030, p < .863$) or gender ($F_{(1, 315)} = .000, p < .983$) have been found. No school-gender interaction effect ($F_{(1, 315)} = .445, p < .505$) has been found.

For the dichotomised codings of responses on the bases of the acceptability of the responses, and on whether or not they represent cognitive deficit and attention deficit explanations, the Chi-square tables of the outcomes are in Appendix I. Regarding the acceptability of the responses, for School E, boys (McNemar Test = 71, $p < .017$) compared with girls (McNemar

Test = 60, $p < .824$) show a significant improvement in the proportion who produced an acceptable answer at Time 2. There are no significant changes for School C boys (McNemar Test = 95, $p < .324$) or girls (McNemar Test = 94, $p < .281$).

For the cognitive deficit explanations (i.e. **not blaming** the person) School E boys do so more at Time 2 than at they do at Time 1 (McNemar Test = 102, $p < .044$). There are no significant differences between Time 1 and Time 2 for School E girls (McNemar Test = 88, $p < .636$) or School C boys (McNemar Test = 123, $p < 1.000$) and girls (McNemar Test = 119, $p < 1.000$).

For attention deficit explanations (i.e. **blaming** the person) the converse is partially true. That is, there is no significant difference for School E at Time 1 compared with at Time 2 (McNemar Test = 190, $p < .607$) but there is for School C (McNemar Test = 242, $p < .041$).

Q15 Give as many causes as you can for learning disabilities.

No main effects of school ($F_{(1, 261)} = 1.316$, $p < .252$) or gender ($F_{(1, 261)} = .608$, $p < .436$) have been found. No school-gender interaction effect ($F_{(1, 261)} = .006$, $p < .941$) has been found.

Respondents' use of pejorative terms

Examples of pejorative terms and 'diminishing the question/topic' responses are in Appendix L and the descriptive statistics used in investigating gender and school differences over time are in Appendix M. A main effect of school ($F_{(1, 411)} = 13.972$, $p < .0005$) has been found with School E showing a decrease and School C an increase in the use of pejorative terms from Time 1 to Time 2. There is no main effect of gender ($F_{(1, 411)} = 1.261$, $p < .262$) but there is a school-gender interaction effect ($F_{(1, 411)} = 4.031$, $p < .045$).

School attendance and MHQ responses

By comparison with pupils in School C and by gender, no effects of pupils' attendance at the programme of mental health lessons on their MHQ responses have been found. This appears to be because almost all of the pupils in School E who responded to the MHQ at Times 1 and 2 attended all six of the lessons on mental health.

Pupils' lesson evaluations (for School E only)

The descriptive statistics used to investigate school and gender effects over time of pupils' evaluations of the mental health lessons are in Appendix J.

Teaching topic by gender analyses:

How much did you learn about (each topic)?

For the topics of *Bullying* ($F_{(1, 111)} = .110$, $p < .741$), *Depression* ($F_{(1, 139)} = 2.400$, $p < .124$), *Stress* ($F_{(1, 121)} = .372$, $p < .543$), *Learning disabilities* ($F_{(1, 93)} = 3.477$, $p < .065$) and *Eating disorders* ($F_{(1, 98)} = .207$, $p < .650$), there is no main effect of gender in the amount respondents say that they learned. Regarding *Self-harm/suicide*, however, there is a main effect of gender with girls saying that learned significantly more than boys did ($F_{(1, 116)} = 4.978$, $p < .028$).

How important do you think (each topic) is for you?

For the topics of *Self-harm/suicide* ($F_{(1, 120)} = 5.522, p < .024$), *Depression* ($F_{(1, 139)} = 6.336, p < .013$) and *Eating disorders* ($F_{(1, 101)} = 10.438, p < .002$), there is a main effect of gender with girls saying that these topics are more important than boys do. However, there is no main effect of gender regarding the topics of *Bullying* ($F_{(1, 112)} = 2.031, p < .157$), *Stress* ($F_{(1, 121)} = 2.963, p < .089$) and *Learning disabilities* ($F_{(1, 94)} = 1.563, p < .204$).

Importance of topic for Year 10 pupils:

More generally, respondents were also asked about how important they feel each topic is for Year 10 pupils. There are three significant findings. In the cases of the topics of *Depression* ($F_{(1, 139)} = 6.366, p < .013$), *Self-harm/ suicide* ($F_{(1, 120)} = 5.222, p < .024$) and *Eating disorders* ($F_{(1, 101)} = 10.438, p < .002$), girls said that they are more important for Year 10 pupils than boys did.

How much did you enjoy the topic of (each topic) ...?

There is no main effect of gender regarding this question for any of the topics.

Teaching topic by gender and SDQ scores analyses:

How important do you think this (each) topic is?

Responses to this question have been correlated (Spearman *rho*) against the respondents' Time 2 SDQ sub-scale scores. Significant correlates are listed in Table 5.

Table 5: Significant correlates between perceived importance of topic and SDQ scale scores.

<i>Gender</i>	<i>SDQ scale</i>	<i>Significant topic correlates</i>
<i>Girl</i>	Emotional symptoms	None found
	Conduct problems	None found
	Hyperactivity	None found
	Peer problems	Stress: .351 $p < .013$ (N=49)
	Prosocial behaviour	None found
	Total difficulties	None found
<i>Boy</i>	Emotional symptoms	None found
	Conduct problems	Bullying: -.419 $p < .001$ (N=59). Depression: -.444 $p < .0005$ (N=60). Stress: -.314, $p < .016$, N=58. Learning disabilities: -.289, $p < .028$, (N=58).
	Hyperactivity	Bullying: -.364 $p < .005$ (N=59). Depression: -.331, $p < .010$ (N=60). Stress: -.347, $p < .008$ (N=58).
	Peer problems	None found
	Prosocial behaviour	Bullying: .425, $p < .001$, (N=59) Depression: .465, $p < .005$, N=60 Stress: .461, $p < .0005$, N=58 Learning disabilities .533, $p < .0005$, N=58

Total difficulties	Bullying: -.403 p<.002 (N=59). Stress: -.316 p<.016 (N=58).
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For girls, the only significant correlate is that between the *Peer problems* SDQ scores and the importance of the topic of *Stress*. For boys, however, there are a many correlates. The *Conduct problems* SDQ scores are negatively correlated with the perceived importance of the topics of *Bullying*, *Depression*, *Stress* and *Learning difficulties*. *Hyperactivity* SDQ scores are also negatively correlated with each of these topics except *Stress*. All four of these topics are also positively correlated with the *Prosocial behaviour* SDQ scores. Finally, the topics of *Bullying* and *Stress* are negatively correlated with the SDQ *Total difficulties* scores.

How much did you learn about (each) topic?

Responses to this question have been correlated (Spearman *rho*) against the respondents' Time 2 SDQ sub-scale scores. Significant correlates are listed in Table 6.

Table 6: Significant correlates between amount learning of topic and SDQ scale scores.

Gender	SDQ scale	Significant topic correlates
Girl	Emotional symptoms	Eating disorders: .329, p<.027, N=45
	Conduct problems	None found
	Hyperactivity	None found
	Peer problems	None found
	Prosocial behaviour	Stress: .303, p<.026, N=54. Eating disorders: .419, p<.004, N=45
	Total difficulties	None found
Boy	Emotional symptoms	None found
	Conduct problems	Bullying: -.281, p<.032, N=58 Stress: -.535, p<.0005, N=59. Learning disabilities: -.390, p<.006, N=48. Suicide: -.518, p<.0005, N=55 Eating disorders: -.331, p<.023, N=47
	Hyperactivity	Bullying: -.275, p<.035, N=59. Stress: -.378, p<.003, N=59. Learning disabilities: -.406, p<.001, N=48 Suicide: -.304, p<.024, N=55
	Peer problems	None found
	Prosocial behaviour	Bullying: .312, p<.016, N=59. Depression: .283, p<.021, N=67. Stress: .507, p<.0005, N=59. Learning disabilities: .314, p<.030, N=48.
	Total difficulties	Bullying: .285, p<.030, N=58. Stress: -.313, p<.016, N=59. Learning disabilities: -.386, p<.007, N=48.

Girls' SDQ *emotional symptoms* scores are positively correlated with the amount that they say they learned about *Eating disorders* whilst their *Prosocial behaviour* SDQ scores are

positively correlated with the amount that they say they learned about the topics of *Stress* and *Eating disorders*. For boys the picture which emerges is more complex. Their *Conduct problems* SDQ scores are negatively correlated with the amount that they claim to have learned about the topics of *Bullying*, *Stress*, *Learning disabilities*, *Suicide* and *Eating disorders*. With the exception of *Eating disorders*, all of these topics are also negatively correlated with their *Hyperactivity* SDQ scores but positively correlated with their *Prosocial behaviour* scores. Finally, their *Total difficulties* SDQ scores are positively correlated with the amount that they say they learned about *Bullying* and negatively correlated with their learning of the topics of *Stress* and *Learning disabilities*.

How much did you enjoy (each) topic?

Responses to this question have been correlated (Spearman *rho*) against the respondents' Time 2 SDQ sub-scale scores. Significant correlates are listed in Table 7.

Table 7: Significant correlates between enjoyment of topic and SDQ scale scores.

Gender	SDQ scale	Significant topic correlates
Girl	Emotional symptoms	None found
	Conduct problems	Suicide: -.416, $p < .002$, $N = 51$. Eating disorders: -.328, $p < .032$, $N = 43$.
	Hyperactivity	None found
	Peer problems	None found
	Prosocial behaviour	Eating disorders: .339, $p < .026$, $N = 43$.
	Total difficulties	None found
Boy	Emotional symptoms	Suicide: -.354, $p < .008$, $N = 55$.
	Conduct problems	Bullying: -.304, $p < .020$, $N = 58$. Stress: -.324, $p < .015$, $N = 56$.
	Hyperactivity	Bullying: -.323, $p < .012$, $N = 59$. Suicide: -.303, $p < .024$, $N = 55$.
	Peer problems	None found
	Prosocial behaviour	Bullying: .277, $p < .034$, $N = 59$. Depression: .320, $p < .009$, $N = 66$. Stress: .546, $p < .0005$, $N = 56$. Learning disabilities: .355, $p < .014$, $N = 47$.
	Total difficulties	Bullying: -.346, $p < .008$, $N = 58$. Suicide: -.391, $p < .003$, $N = 55$.

Regarding girls, their *Conduct problems* SDQ scores are negatively correlated with their stated enjoyment of the topics of *Suicide* and *Eating disorders*. Again, for boys the picture is more complicated. Their *Emotional symptoms* SDQ scores are negatively correlated with their enjoyment of the topic of *Suicide*. There are also negative correlations between their *Conduct problems* SDQ scores and their *Total difficulties* SDQ score and their enjoyment of the topics of *Bullying* and *Stress*. Their *Prosocial behaviour* SDQ scores are positively correlated with their stated enjoyment of the topics of *Bullying*, *Depression*, *Stress* and *Learning disabilities*.

Changes in SDQ scores from Time 1 to Time 2:

The descriptive statistics used to investigate gender effects over time are in Appendix K.

Emotional symptoms score

No main effects of school ($F_{(1, 351)} = .114, p < .735$) or gender ($F_{(1, 351)} = .410, p < .522$) have been found and no school-gender interaction effect ($F_{(1, 351)} = .035, p < .852$) has been found.

Conduct problems score

A main effect of school ($F_{(1, 350)} = 12.613, p < .0005$) has been found with School E showing a reduction in the mean *Conduct problems* score whilst there is no such reduction for School C. There is no main effect of gender ($F_{(1, 350)} = .562, p < .454$) and no school-gender interaction effect ($F_{(1, 350)} = .068, p < .794$).

Hyperactivity score

No main effects of school ($F_{(1, 345)} = .221, p < .638$) or gender ($F_{(1, 345)} = .227, p < .634$) have been found. No school-gender interaction effect ($F_{(1, 345)} = .000, p < .989$) has been found.

Peer problems score

No main effects of school ($F_{(1, 351)} = 1.234, p < .267$) or gender ($F_{(1, 351)} = .535, p < .465$) have been found. No school-gender interaction effect ($F_{(1, 351)} = .582, p < .446$) has been found.

Prosocial behaviour score

A main effect of school ($F_{(1, 350)} = 12.310, p < .001$) has been found with School E showing an increase in the mean *Prosocial behaviour* score whilst School C shows a decrease. There is no main effect of gender ($F_{(1, 350)} = .908, p < .341$) and no school-gender interaction effect ($F_{(1, 350)} = .596, p < .441$).

Total difficulties score

No main effects of school ($F_{(1, 344)} = 2.056, p < .152$) or gender ($F_{(1, 344)} = .033, p < .855$) have been found. No school-gender interaction effect ($F_{(1, 344)} = .121, p < .728$) has been found.

Interview data:

In this section we present selected extracts from the teacher and pupil interview transcripts on their mental health lessons which focus on their perceptions of the importance of each topic in turn, and on teachers' experiences of teaching them. In order to protect the identity of individuals, all names used are pseudonyms.

Stress

When asked which of the six topics was most important, a teacher had this to say:

“I think stress, because it is so close to home and their own experiences and worrying about exams and worrying about how their friends think about them. So it is quite close to home really.” (Jane)

Jane continued:

“The other thing that occurs to me is that stress may be linked to suicide and self-harm.”

Some pupils seemed to confirm this teacher’s view. For example, one pupil said:

“It’s important because everybody can get stressed like at some point, through work or family business or something.”

Like the teacher, another pupil emphasised the importance of the topic and its relationship to that of depression, by saying:

“I think it is more important than the rest because everyone goes through stress all the way through their life. Whereas depression, you have got to go through a lot of stress to get depressions.”

One girl pupil also commented on the importance of the topic in these terms:

“It was more relevant to us. We were told that whatever people say to you everyone feels stressed in a certain way and no one can tell you that you aren’t stressed or upset. It’s got more importance to us because we do feel stressed and lots of people think that only older people who work or have families get stressed and it’s not only that, it’s younger people who have bigger downs, who have relationship and family problems.”

Depression

A number of pupils expressed the view that depression is an important topic. For example, two girls had these things to say:

Catherine: “Very important, because it is people’s lives. If someone gets depressed, you don’t know what they are going to do, commit suicide or something.”

Penny: “I think they are all important. All of them, I think, are important because we have got to understand what other people go through when they are depressed.”

However, another pupil speculated on whether it was necessary to have experienced depression in order to teach the topic:

“It would be better to talk to someone who is going through it or have been through it and get them to talk to us rather than our teacher because, I mean, he may have been depressed in his life but we don’t know that ... It’s as if he knew what to say and had been through it, and he had to tell us about it so ...”

This raised an interesting issue that could be applied to each one of the topics. While for the teacher it may help to have experienced some mental health difficulty in order to speak with authority on the subject, it is certainly not necessary to have experienced all of the difficulties under discussion. The pupil, however, was expressing a concern about being heard with sensitivity and with empathy. This illustrates the value of the video, *I in 4*, in disseminating the idea that many people at some point in their lives will either experience a mental health difficulty themselves or be close to someone who is experiencing it.

Bullying

In response to the question: “So when bullying came up again did you think, ‘Oh no, not again’, a man teacher said:

“No, no, because it is always a different slant, isn’t it. You have got to be careful that if you do bullying every year, you are going to get that youngster who thinks, ‘Oh, here we go again. We have done this already, why are we doing it again?’. But I think if it is treated in a different way every time, I don’t think there is an issue there. It is something that you need to keep revisiting. The school is very conscious of national issues in relation to bullying and our own bullying policy. Therefore I think it is important that it does feature quite heavily.” (Jim)

There was a broad consensus amongst pupils that bullying is an important topic for Year 10 pupils to consider despite having had lessons on it earlier in their school careers. For example, one pupil, Helen, said bullying is important

“ ... because I think people need to be aware of how bullying affects other people and, you know, how it might be fun for the person that is doing it, but the person who is being bullied isn’t having that much fun. They need to know, like, what is going on around them.” (Helen)

And in a group interview, the following conversation about bullying occurred:

Rebecca: “It is very important because there are always kids getting bullied in every year.”
Interviewer: “How do lessons on bullying help?”
Rebecca: “It helps them learn how to cope with it and who to tell.”
Interviewer: “Would it help bullies as well?”
Eunice: “Yeah, because it makes them more aware of what they are doing to people. I mean everyone gets a chance to speak about it, but people always need reminding because it is still happening.”

Learning difficulties

This topic was one which some of the teachers did not teach. When asked why this was, Paul, the school's Head of PSHE with responsibility for devising and resourcing all of the topics, explained why some teachers did not teach this topic:

“I think that perhaps learning disabilities was something which people shied away from. The reason for that, they told me, is that they felt that it seemed to sit uneasily with the remainder of the course. And many felt, given the short time available, they would prefer to do two weeks on, say, depression or eating disorders and really focus on a subject that the students reacted well to, rather than say ‘Right, we have finished that, now we move on regardless of how it sits.’” (Paul)

The idea that ‘learning disabilities’ does not ‘fit’ well with the other mental health topics in the teaching programme, is explored by Jane in this way:

“Well, learning disabilities, I didn’t think that somehow it fitted in with the rest and I don’t quite know why. It was sort of, you know, learning disabilities, although, as an adult I can see the link, between the fact that if people have got learning disabilities they might feel alienated and therefore that might cause stress or suicide or depression, or whatever. But I don’t think that the kids can make the link. Learning disabilities is people who do have problems but it doesn’t necessarily mean that because you have got learning difficulties you are necessarily bullied or you are depressed or you are stressful. So I don’t think it quite sat in that group of topics.”

One of the class teachers, Jim, who omitted teaching this topic, was asked why this was. His response was more pragmatic:

“Time, purely on time. I think the problem with what we looked at, was the fact that you could have spent twice as long on any of the individual topics. I did eating disorders first and I spent longer on that and then realised that if I am to cover all areas I am going to struggle. It just so happened that was an area I didn’t get to. It wasn’t through any priority, it was just the way it worked out.”

However, a number of pupils expressed the view that, for them, it is an important topic. One pupil said that it is:

“... very important because some people have learning disabilities and we have got to learn to cope with them.” (Samantha)

Another pupil revealed his personal interest in the topic:

“It’s really relevant to me so I listened really carefully in that lesson; my brother has epilepsy and Asperger’s Syndrome. Not everyone is as quick as everyone else so people with learning disabilities may get frustrated because everyone else is doing the work and they can’t. It was quite informative for me because it helped me learn a bit more about my brother because he has got conditions.” (Richard)

Other pupils, perhaps showing greater empathy with learning disabled peers said:

“Some people don’t find out they are dyslexic until they get to like, our age, or just below. And it is hard to adjust and suddenly realise that you are not normal. It is important for people to understand that it is OK to be like it. You can go to someone to sort it out and you can learn. Just because someone says you are dyslexic don’t mean you are going to be dyslexic, because you can get help.” (John)

“Yeah, it’s a mental health difficulty. You have to be aware of other people because everyone isn’t the same and whether someone looks - you can have a disability from looking at it - but people can also have disabilities that you can’t actually see and it’s best to understand that person to realise that there is something wrong. I mean you can’t treat them as if they are different because they are humans, but we have to be considerate and realise what their problems are.” (Luke)

Unlike some of the teachers, many of the pupils were in no doubt that the topic of learning disabilities is a mental health issue. They were also clear that the issue of stigma is very relevant to young people who are different by, for example, having a learning disability.

Eating disorders

Two teachers, Jane and Jim, had different views about the responses of girls compared with boys to this topic. Jane had this to say:

The weight and eating disorders we did as a group discussion. Again it got taken up by the girls - society and the effects of fashion and all the rest of it and healthy eating. We got on to health and looking at what makes healthy eating and why people have eating disorders. We read out some examples, I think there were three or four, a couple from famous people, of their feelings, you know, the experiences they had when they were younger about weight and eating disorders. And I can’t remember who it was, one of the Spice Girls I think, had anorexia. We read them out and we discussed them, ... but it was more female orientated. The boys sort of sat there and said: ‘Oh, we haven’t got a problem’ which was interesting because actually men statistically are more overweight than women proportionately.”

By contrast, Jim said:

“I think there was an equal weighting there in terms of interest... Although it is stereotypically viewed as an issue for females, I think the boys empathise and I think the boys were interested, didn’t switch off.”

Some pupils suggested that this is an important topic for them because of their increasing awareness of their body image. For example, one girl said:

“I think it is really important because mostly teenagers, like our age, think they are fat, or they think they are too thin. They start like, making themselves sick, or they are like, anorexic, so I think it is quite important at this age.”

And another girl said:

“It’s important because a lot of people our age think that they are fat or they have lots of eating disorders and stuff.”

Pupils also often suggested that role models and idols that they see and hear about in the media are an important influence on their self-images:

“I think it is a shame that so many teenagers have got to like, lose weight to look like pop stars and everything.”

“Everybody’s image now is based around what pop stars are. Nobody’s ever overweight.”

“All the models are like a size five and everybody wants to be that thin. If you are fat, if you are quite big, there is no way you can get that thinestness (*sic*) unless you make yourself ill. So, I think it is really important.”

Finally, one pupil made a link between the topic of eating disorders and many of the others when she said:

“I think that it sort of linked because lots of people can become depressed if they have an eating disorder or if they have a weight problem. It is important because lots of people worry about their physical appearance at our age, whether people will like them, because they are either too fat or too skinny, or what they feel about themselves. When they go home and look in the mirror and say ‘Oh, no! Look at me. I look awful. No one is going to like me.’ And lots of people at our age do that. So I think it is important to know about it.”

Suicide

The topic of self-harm and suicide generated, by far, the most controversy amongst our interviewees. We begin with what Paul (the school’s Head of PSHE) had to say in response to the question: “Do you have any feelings about which of the topics is the most difficult, or your teachers found is the most difficult one to deal with?”. He had no hesitation in replying that it was:

“Suicide and self-harm.”

He went on to explain his concerns about teaching the topic and the care with which he had thought through how to avoid causing pupils distress:

“I certainly anticipated a great deal of problem there, and it was the one module of work that caused me the greatest amount of anguish and stress in writing the (lesson plan). In the end, I thought the only fair way to enable tutors to deliver this, in order to ease the burden on them ... would be to write a lesson plan that was highly directed, almost scripted and which gave them, of all the subjects, the least leeway in allowing them to tailor it to their own individual requirements. If nothing else, they could blame me for it going wrong ... because some teachers felt uncomfortable with this. It was also a concern that the students might react to this in ways that could range from levity, unable to deal with the subject, and reacting by turning off to the subject entirely, or possibly just finding it too much to cope with. It might lead to some upsets. So I was very concerned to set the ground rules on that one right. All Heads of House were notified that this was going to go ahead. All tutors were asked to refer to their Heads of House to check whether or not students, as I knew there are in Year Ten, did have some experience of family members committing suicide (or attempting it) ... to ensure that those students had an opportunity to discuss beforehand whether or not they wished to participate in the lesson. It is an upsetting subject by its very nature, it could have lead to distress. We did feel that even though letters had gone out at the beginning of the project and tutors were very concerned to provide the students with lots of support, that we had covered everything that we possibly could do.”

This teacher’s concerns about the topic of suicide and self-harm, are echoed by Jane in the context of the lesson’s impact on her pupils, especially on the boys:

“ I did find the boys in the group, they did offer responses, but it was almost, they were quiet, very quiet, particularly when we discussed issues that actually there is more older men that commit suicide, and men, at this point in time, in terms of statistics there is more chance of men committing suicide than women. I think they found that very daunting and there was almost a quietness that went over them, which I have not seen before on any other topic. The girls did say afterwards that they felt it was very male orientated in terms of how it was delivered. They felt it dealt with more male issues than female, but given the statistics perhaps that is understandable.”

She was also concerned that some pupils responded defensively or with embarrassment to the topic.

“I think that some of them. Definitely there was a maturity problem there, they couldn’t understand it. Especially, I would think, not just all boys, but a few boys in the group did have difficulties, they couldn’t understand why they were doing it basically... I think if anything, that two of the louder girls in the group felt, I don’t know about alienated, but the fact is that this was targeted more at boys and I did send one girl out at one point, because, I am sure it wasn’t through embarrassment, she did have a negative effect on the rest of them for a very short time, or made an inappropriate comment, as it were”.

Jane observed that teachers would need more time and support to prepare for this topic.

“I don’t think it is something you can just get out of a book really. You are dealing with people’s deepest emotions and psychological problems. Even drugs would be easier, because at least with drugs you can learn the names of the drugs, you can learn what they do, you can go at it from that angle, whereas suicide, you can say well, people do this because. I just think, and the self-harm as well, I just thought it was such a sensitive issue, I am not sure that going home with two or three books on the subject would help me really.”

Despite anxieties about teaching the topic of suicide, most teachers maintained that the topic was essential for Year 10 pupils:

“... schools erroneously shy away from mental health issues. If we are going to cover physical health issues and we are going to cover, for instance, a deeply upsetting subject like lung cancer as a result of smoking. In many cases if we are talking about alcohol or other drug abuse, and we are talking about the consequences of that, we are going to deal with what is potentially very distressing subject material. I don’t honestly feel that there is any subject, by the time you get to Year Ten, that students are not able to deal with. As long as there is a substantial, well thought out policy behind it and it is delivered in an appropriate way, I think that all students are well capable of dealing with those subjects. It is the manner in which it is approached which is important.” (Paul)

“I know it is vital. There is no way that you can’t teach it and make them aware of it. And also, suicide is ridiculously high in young people and I think that it is something that they will come across in day-to-day life, and therefore they need to know.” (Man).

“They actually want to know how people commit suicide and they don’t laugh. They want to know how it feels, what happens and it did remind me very much of early sex education when children keep coming back and saying, ‘Well, isn’t there more you ought to tell us?’ And they really want to know the ins and outs of it. They do.” (Barbara).

“That was the one that wasn’t distressing, but the mood of it was very sombre and serious ... they were very focused ... they know the boy it happened to so it was very kind of, yeah, we do know somebody who has been affected by that. It was a good one to have at the end because it focussed a lot of what they were saying, that any one of the conditions or situations that we were discussing could lead to this. That was very important.” (Mike)

Yet another teacher comments on his anxieties about teaching the subject but also on its success and importance in this way:

“I think it was very successful but it was obviously very distressing for the children, they were able to empathise with the situation. I know that there is a pupil in my

group who does self-harm. So that was something I was particularly conscious of. The problem was ... there wasn't enough time. It needed two lessons to cover it and there hasn't been the opportunity to follow it up with looking after yourself and that sources of help are available". (Ted)

In this next comment, a woman who had experienced behaviour management problems with her class in some earlier lessons in the series, describes the very different response of the class to this topic:

"I didn't think that it was a good idea to do suicide just before Christmas so we did self-harm and suicide on 10th January. There was a video for that which was interspersed with information on paper, and OHPs (overhead transparencies), and they did respond well to that. Actually, that was the quietest I have seen them viewing a video ever." (Diane)

Another woman teacher also describes the extraordinarily subdued response of her pupils, particularly the boys, to the topic:

"Because so many of them were interested in suicide, we then watched the Panorama Programme on Bullies and we watched it all the way through. There was silence in the class. I didn't have to ask them to be quiet. I just asked them to remember that if they spoke about it, somebody else in the group might take it as a comment. I said: 'You don't know what everybody else is thinking, so be careful when you say something that you say 'I think this'. The boys were actually moving in the room so that they could see better. They sat for the full hour and didn't make any comment.'" (Barbara)

A number of pupils confirmed that from their perspective, the topic is important, as shown by these comments from three girls:

"I didn't find it upsetting. I found it more shocking because I actually realised that what people think of themselves can make them so distraught that they want to hurt themselves either to get the attention or to make themselves feel better. Some people even resort to killing themselves because of what is happening in their lives." (Emily)

"I think it is important as well. 'Cos people our age sometimes do feel like we have got too much pressure put on us with school. You don't want to do your homework, you just want to go out. It all gets you down at some point." (Phillipa)

"It is like growing up. We have got other things, like friends, family, social life, everything like builds up and at least some kids know they have got help and other kids have been through it. I think it (the topic of suicide) is very important, especially at our age, because you need to know that there is someone there that you can go to and it is not worth taking the whole of your life away just for that couple of years." (Ginny)

In Ginny's concluding comment - 'just for that couple of years' - she is referring to examination pressures during years 10 and 11. Another pupil said that he did not find this topic as important as 'stress' because it is relatively uncommon. The interview conversation went:

"I don't think it is as important as stress.... Right, it is not less important, but less people do it and stress is just one of those things that you have to deal with every day of your life." (James)

General comments

We conclude this section on interview material by considering some general comments made by teachers and pupils about the teaching of 'mental health'.

In response to the question: 'Which do you feel was the most successful topic for the youngsters?' Jim said:

"The students were massively engaged when we looked at the issues of bullying, ... stress and depression. They were very interested because I think some could relate to that whether through personal circumstance, or family or friends."

Another teacher comments on the way in which he sees 'bullying', 'stress' and 'depression' as being interconnected:

"I related into bullying, depression and stress, I tied that in and did a separate lesson, but I tied that in because its going to lead to depression, it leads to stress and truancy, so I related it to school life, and even up to the GCSE, the pressure of exams, course work, I linked it to that. (Steven)

Explaining how and why he tried to relate the lesson topics to one another, a male teacher said:

"I think it can help, because teaching something in isolation is hard, whereas if the kids can relate it to something else and learn they can fit it into the grand scheme of things and it makes more sense. So I think that's why I tried to tie it into as much else as possible, and I was able to talk about self-harm in relation to eating disorders, you know the whole self worth and self image thing. So I was able to tie it into something they could learn about because its kind of difficult with a topic like this, mental health. I have spoken to loads of mental health specialists in the past weeks and even those experts have no idea what is going on in that person's head, so to be able to explain it to the kids is difficult."

Some of the pupils too, noted the inter-relationships between topics as this interview conversation between the interviewer and a group of pupils illustrates:

"Stress is kind of like depression. I think they should have covered stress and depression in one." (George)

“They all lead into each other. If you are getting bullied, you suffer from depression, if you are depressed you are going to commit suicide. They are all like chains and they all lead into each other.” (Belinda)

These two pupils also comment on the relevance of ‘mental health’ to themselves:

“I think they are all important (topics), the whole subject of mental health. Nearly everybody has got a mental health problem, something like stress, eating disorders, whatever. And people want to know what the symptoms are, so it is good to find out.” (Mandy)

: “It happens to all of us, so it is important. So if you are going through one of them, you know how to deal with them and you know who to talk to about it. You can relate to other people going through the same thing.” (Richard)

However, in the next comment, the woman teacher expresses some a cautionary note about the teaching of ‘mental health’ and how she attempted to circumvent the problems she saw:

“The snag about all this, I felt, it was very heavy. There was no fun. There was no laughter and it was too many weeks in a row of miserable work. So then I said ‘Right we will do a play’. So they chose to do any scenario related with their topic, in groups of about five, and they had one week preparing it. Now, I didn’t want any child to be victimised by saying: ‘You are the person who is going to have the eating disorder, you are the person who is going to commit suicide’. So I said they could do it about the person who committed suicide, who wasn’t there. I wanted to displace it. I asked them to give that person a fictitious name. So they had a week doing that, and they really enjoyed it. So it was serious but then there was some laughter on the way, at the acting, at the involvement, at what they were going to say.” (Barbara)

It seems that this teacher may also be one of those who did not always ask her class to complete the end of lesson evaluation forms. About these forms, she said:

“I found it incredibly difficult to do the forms at the end of each session. That seemed to bring it down to, back in to school and I think we had managed to get some of the conversations as being much wider, feeling what it is like out there. These people are walking about and we will all know somebody, or may involve ourselves, and it is not anything other than in balance.” (Barbara)

Commenting on the different response of girls compared with boys, Jane, says:

Jane: “It is the realisation that lots of things in life can cause people to have stress or depression, and they show themselves in different forms. So, again, we had more of a discussion and again, more taken over, I am afraid, by the girls in the group.”

- Interviewer: “When you ‘taken over by,’ what do you mean?”
- Jane: “Well, they have a lot more to say on the issues. They want to comment more on the discussion.”
- Interviewer: “Is that because they are more mature than the boys, do you think, or what is the reason?”
- Jane: “I think that one or two of them are. In my group, it is a role reversal. I think some of the boys are more mature than some of my girls. But I think I have one or two very mature girls. But I think also their communication skills are a lot more developed. They are more willing to discuss things and have views on things, whereas the boys just sit there: ‘We don’t want to show that we have views. We do, but we ...’. They feel a little bit more unsure, I think, of themselves.”
- Interviewer: “So, they are less willing to express themselves and show their feelings and emotions and so on.”
- Jane: “Yes, I think so. Some do. I have got to say that some of the boys do contribute. They don’t just sit there and say nothing.”
- Interviewer: “So, what you seem to be saying, is that the girls participate, or the girls tend to participate better than the boys.”
- Jane: “In my group, yes. I think it is just because of the issues and because they can communicate their feelings better. I wouldn’t say that is a standard thing in all lessons. In my technology lessons the boys are quite often the ones ‘there’.”

When asked about his pupils’ general response to the series of lessons, Jim said:

“I thought it was positive. It was quite a long-term block of work. I think some of them were slightly confused over the concept of mental health and that it covered such a wide range of areas. I think they were engaged. I think it was an appropriate age group to target. No, I was impressed. Also, the way they took on board the questionnaire side of things. It was a bit tricky: ‘Oh, we have got to fill this in again at the end of the session’; in terms of looking at the way the teacher delivered the material; and what they took on board. I don’t know how many youngsters took it seriously. They appeared to at first. My impression was that they appeared to. I think they took a lot away from the sessions.”

The interviewer also had the following conversation with Jim about the amount of time devoted to teaching about mental health:

Interviewer: “You just said that it was quite a long period of time to be dealing with the same set of issues. How does that square with what you said earlier about there not being enough time and you could have spent a lot more time on these topics?”

Jim: “Well, I mean, it is like all these things, we seem to dip our feet into so many key areas and I think that if you take something like eating disorders, there are all sorts of issues there in terms of group discussion, written work, looking at video information, looking at a little bit more statistical work, looking at teen magazines. There are so many things as to why it is an issue. It isn’t just a girl thing now. Boys increasingly are very conscious of that area. I mean there is just so much you could cram in, in terms of life skills, in terms of all this stuff, you just have to be selective.”

One pupil, whose teacher had omitted teaching about learning disabilities, also commented on the issue of time for teaching about all of the topics and he also offers a solution for fitting in ‘learning disabilities’:

Bill: “I think they should have put learning disabilities in and squashed stress and depression together.”

Bill’s solution recognises the inter-relatedness of stress and depression.

Jim also commented on the issue of preparing teachers adequately to teach about mental health:

“For any tutor dealing with a number of controversial issues, I just think that there is an issue over the amount of time that teachers have to prepare for the lessons. One of the best ways of preparation is meeting with specialists. I know that we had a very good session before we started the course and met together with a number of specialists and that was very useful and I just think to ensure that that sort of thing would be very useful if somebody was doing it from scratch.”

Jim was also asked:

“Over this six- or seven-week period, did you feel, get any sense, that the youngsters were becoming more sensitive and caring about, and maybe, in a sense less macho, about the issues of mental health?”

Jim’s response was:

“Yes. I think youngsters started to challenge when somebody made what might be deemed an inappropriate response. I think the sensitive youngsters were sensitive. There were one or two youngsters who perhaps took one or two issues a little too lightly. Sadly, I don’t think you are going to win everybody over and you still had

one or two inappropriate responses, which is disappointing, but sadly, not surprising from a group of twenty-five or –six, fourteen or fifteen-year-olds. But overall, I felt that they had a very mature approach and I think that I did get that sense across the sessions.”

Finally, we let a pupil have the last word on the importance of lessons on mental health:

Edward: “Before we studied this topic and in one of the first lessons we did to introduce it, lots of people turned round, as a natural reaction, and said that if they saw someone with a disability they would turn round and say something, not to that person but to their friends. They would probably point and look and not because they were being nasty but as a natural thing that lots of people do. And now you can sit there, you do look at that person because they are different to everyone else, but you look at them and think why? You don’t think, ‘Oh, that person is a bit strange.’ ‘Oh, that person has got something wrong with them’. You sit there and you think, ‘Oh, I wonder why, what has happened to them in their lives’. You don’t judge them as much.”

Discussion

In comparing pupils in the control and experimental schools at Time 1 and Time 2, the present research has found a number of positive effects (there are no negative effects) of the six lessons on pupils' knowledge and understanding of and values and attitudes towards mental health difficulties and problems.

MHQ outcomes

The outcomes from the MHQ suggest the following positive effects of the intervention in School E on its pupils by comparison with those in School C. Improvements have been found in:

- Boys' and girls' **knowledge** as measured by their abilities to:
 - name five mental health difficulties or problems that people suffer from (Q3a);
 - name five people or places to which people suffering from mental health difficulties or problems might go to for help (Q3b);
 - describe what stress is (Q8).

Earlier, we presented Gale and Hollings (2000) conclusion that young people’s knowledge and understanding of mental health issues was very low. It is therefore encouraging to find that this knowledge base is not impervious to change.

- Boys' and girls' **empathy** in understanding:
 - why some people get depressed (Q4b);
 - why some people think that life is not worth living (Q5b);
 - how bullied people are affected (Q13).

As we have suggested earlier, young people who are depressed, perhaps because they are bullied, are vulnerable to self-harm and suicidal thoughts which make these findings about empathising with people who are suffering from

internalising disorders a particularly important and encouraging set of complimentary effects of the teaching intervention. These findings strongly imply that the pupils in School E are now also less prejudiced and likely to stigmatise sufferers of mental health difficulties than they were experiencing the teaching intervention.

- Boys' and girls' **sensitivity** in thinking and writing about mental health difficulties and problems as shown in:
 - their definitions of learning disabilities and difficulties in terms which do not 'blame the person' (i.e. in cognitive deficit rather than attention deficit terms) (Q14).
 - their use of pejorative terms and language over time.Again, Gale and Hollings (2000), as we reported earlier, found the young people in their focus group research lacking an appropriate emotional language to express themselves adequately about mental health difficulties and that this was in spite of their proximity with mental illness in family members or friends. On the basis of her research, Bailey (2000) too, concluded that there is an urgent need to challenge young people's widespread use of pejorative terms and stigmatising attitudes. For these reasons we think that it is particularly encouraging to find that a main effect of the teaching intervention was to have improved the emotional literacy of the pupils in School E on issues to do with mental health.
- Boys' **sensitivity** in thinking about relationships as shown by their accounts of stress in terms of 'Relationships (other than bullying)'. Previous research (for example, Clare, 2000; Hinde, 1996; Naylor and Cowie, 1999) has suggested that adolescent boys tend to hold 'macho' or 'laddish' values about relationships in comparison to girls. It seems that the teaching programme in the present intervention has heightened boys' awareness of the importance and nature of relationships.

By comparison with pupils in School C, these pupils also showed significant increases in their estimates of the percentages of:

- young people who go on a diet (Q7a);
- and, young people who are bullied (Q10).

These estimates are exaggerations of the actual incidence of these problems. It may be that these exaggerations arise not because they were given inaccurate statistics during the lessons (they were probably not given any statistics), but because the lessons raised their awareness of these problems so that they came to think that they are more prevalent than they are in reality.

The question, 'What are two common causes of stress?' (Q9) has elicited reductions in some categories of response from Time 1 to Time 2 for both schools and genders. At Time 2 compared with Time 1 there are fewer responses which offer 'appearance', 'bullying' and 'unspecified pressure' as explanations for stress. This may reflect changes in respondents' physical and psychological maturity over this period. These factors may also explain the finding that there are fewer nil responses at Time 2 than there were at Time 1.

Question 9 also elicited an increase from Time 1 to Time 2 for all pupil groups in the proportions which invoked 'schoolwork' as a cause of stress. We suggest that the most likely explanation for this change is the increasing academic workload demands imposed on Year 10 pupils generally, as they proceed through their GCSE (General Certificate of Secondary Education) courses towards their culmination at the end of Year 11.

The present research has found that no significant differences between the respondents in School E and School C from Time 1 to Time 2 in their ability to define 'mental health' (Q1). This finding confirms those of Gale and Holling (2000) and Armstrong et al (2000), as discussed earlier. We offer two reasons for this finding. As the definition (MHF, 1999) presented earlier suggests, the concept of 'mental health' is very abstract and it may be that it is beyond the comprehension of most early to middle adolescents like those in the present study. Also, in the lessons on mental health no definition of the term was discussed and so School E respondents had to rely on examples (typically, the names of the lesson topics) in providing their definitions. We recommend either the explicit exploration of the concept or, like Armstrong et al (2000), the use of a different vocabulary with young people. School E respondents had similar difficulties in defining learning disabilities and difficulties (Q14) and, we suggest, that this may be for similar reasons.

In comparing School E and C and from Time 1 to Time 2, no difference was found in respondents' ability to 'say why some people bully others' (Q11), 'say why some people get bullied' (Q12), 'say when dieting becomes a problem' (Q7b) and to 'give causes for learning disabilities' (Q15). It may simply be that the lessons on each of these topics did not explicitly address these each of these issues rather instead focussing on the effects of bullying on the victim. We also know from the interview with the School E's Head of PSHE that not all teachers gave a lesson on learning disabilities because, as he says:

“... many tutors felt perhaps (that it) hadn't been appropriate to the subject (of mental health), and many shied away from it”.

There were also no school and gender differences found in respondents' attitudes towards mental health as measured by the 5-item scale (q2). We should, however, treat this finding with caution since the internal validity and test-retest reliability of the scale have not been established. Also, as we discuss below, we believe that there is strong evidence of positive attitudinal change in School E by comparison with School C respondents revealed in their responses to the teaching programme evaluation questionnaire.

Finally, there are no significant differences by school, gender and over time, in respondents' estimates of the percentages of 'young people who get depressed' (Q4a), 'who have thoughts that life is not worth living' (Q5a) and 'who worry about their weight' (Q6). However, for both schools it is true to say that respondents have generally over-estimated the incidence of these problems possibly simply because being asked the question biased their responses.

Pupils' evaluations of mental health lessons

Pupils' evaluations of the mental health lessons which were elicited on conclusion of the six lessons, also reveal some interesting patterns which strongly suggest that the intervention has had a number of positive effects on the values and attitudes of pupils in School E towards mental health matters as revealed by their responses to issues concerning the importance and enjoyment of and amount learned about each topic. There are also a number of gender differences although there are none concerning stated enjoyment of the topics.

For example, in response to the question, 'How much did you learn about (each topic)?', there was only one gender difference that is for the topics of *Self-harm/suicide*. Girls say that they learned significantly more about this topic than boys did. Girls also said that the topics of *Self-harm/suicide*, *Depression* and *Eating disorders* were more important for themselves and for Year 10 pupils more generally than boys did. These findings are interesting in that self-harm and suicide, and by implication as we suggested earlier, depression, afflict young men (18-25-years-old) much more commonly than they do young women. Boys' claim that they did not learn as much about these topics or see them as being as important for themselves as girls have, may represent the 'truth'. However, it may be that boys are denying the amount of their learning and the importance of these topics through trying to protect their 'macho' or 'laddish' self-images by showing prosocial 'internalised' concern (Clare, 2000; Hinde, 1996) and 'externalised' behaviour (Naylor and Cowie, 1999) as girls are more willing to do. The findings of the present study would seem to lend support to those of Eskin (1995a) who found in his sample of Swedish students that more boys than girls expressed the 'tough' views that people have the right to commit suicide and that suicide can be a solution to some problems.

Turning to the correlations between respondents' SDQ scores and their stated importance of the topics for Year 10 pupils generally, there are many interesting findings. For girls there is only one strong correlation. Girls who are experiencing peer problems (as measured by the *Peer problems* SDQ sub-scale) indicate that they value the topic of *Stress*. It may be that for many of these girls their peer problems were relieved by studying 'stress'; for them, it had a therapeutic effect.

For boys there are many correlates. Those who have high *Conduct problems* SDQ scores or *externalising problems* do not see as very important the topics of *Bullying*, *Depression*, *Stress* and *Learning difficulties*. Interestingly, with the exception of *Stress*, the same is true for boys' *Hyperactivity* SDQ scores which is another indication of *externalising problems*. Furthermore, all four of these topics are also positively correlated with the *Prosocial behaviour* SDQ scores. Taken together these findings seem to be consistent with one another in that they suggest that boys who are experiencing *externalising problems*, also have largely unempathic and antisocial attitudes towards problems that others may have (see also the findings of Sutton et al, 1999). A very similar set of findings about the amount that boys say that they learned about the topics pertains. It seems reasonable, therefore, to interpret these results in much the same way.

Responses to the questions 'How much did you learn about (each) topic?' and correlated against the respondents' Time 2 SDQ sub-scale scores have also produced some important findings. The finding that girls' *Emotional symptoms* SDQ scores are related to the amount

that they say they learned about *Eating disorders*, we suggest, provides some confirmation for what we already know about eating disorders, particularly in women and girls. This interpretation is supported by the finding that girls' *Prosocial behaviour* SDQ scores are related to the amount that they say they learned about the topics of *Stress* and *Eating disorders*. This suggests, as we might expect, that prosocial girls are concerned about other people's *internalising problems*.

There are some important outcomes of the correlations between respondents' answers to the questions 'How much did you enjoy (each) topic?' and their Time 2 SDQ scores. It may be that the correlation between girls with conduct problems (as measured by the *Conduct problems* SDQ sub-scale) and their saying that they did not enjoy the topics of *Suicide* and *Eating disorders* is because they find these *internalising problems* psychologically distressing or threatening. They may see 'eating disorders' and 'suicide' as possible consequences for themselves of continued poor behaviour and do not wish to be confronted by these possibilities. Again, for boys the picture is more complicated. Their *Emotional symptoms* SDQ scores are negatively correlated with their enjoyment of the topic of *Suicide*. This may be because they are uncomfortable with being confronted by having to study suicide whilst suffering the *internalising problem* of their personal unhappiness. We suggest the finding of a negative correlation between boys' *Conduct problems* SDQ scores and their stated enjoyment of the topics of *Bullying* and *Stress* can be explained in a similar way. Finally, we have found that boys' *Prosocial behaviour* SDQ scores are positively correlated with their stated enjoyment of the topics of *Bullying*, *Depression*, *Stress* and *Learning disabilities*. It seems then, that prosocial behaviour is related to prosocial values and attitudes towards pupils' stated enjoyment of studying of these topics.

Changes in SDQ sub-scale scores from Time 1 to Time 2:

Comparison of respondents' Time 1 with their Time 2 SDQ scores has produced some unexpected findings. There do not seem to be gender or school effects on respondents' *Emotional symptoms*, *Hyperactivity*, *Peer problems* and the *Total difficulties* SDQ scores. Looking at the items which make up these sub-scales, we conclude that the teaching intervention has had little impact on pupils' internal psychological turmoils and on their being able to sustain 'good' relationships with their peers (as measured by the *Peer problems* scale). In other words, the teaching programme seems to have had little impact on pupils who are experiencing *internalising disorders*.

However, comparison of the *Conduct problems* and *Prosocial behaviour* SDQ scores on the same bases, suggests that the teaching intervention has had the effect of reducing School E respondents' *Conduct problems* SDQ scores and increasing their *Prosocial SDQ* scores. No such positive effects have been found for School C respondents. From this, we conclude that the teaching intervention has had the profound effects of reducing pupils' antisocial behaviour or *externalising disorders*, and at the same time increasing their prosocial behaviour towards others.

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The Chalkface Project: Milton Keynes: **PUBLISHER?**

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