



Effects of a classroom-based educational resource on adolescent mental health literacy: A cluster randomised controlled trial



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A B S T R A C T

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Evidence suggests that poor mental health literacy is a key barrier to help-seeking for mental health difficulties in adolescence. Educational programs have shown positive effects on literacy, however, the evidence base remains limited and available studies have many methodological limitations. Using cluster Randomised Control Trial (RCT) methodology, the current study examines the impact of 'HeadStrong', a school-based educational intervention, on mental health literacy, stigma, help-seeking, psychological distress and suicidal ideation. A total of 380 students in 22 classes (clusters) from 10 non-government secondary schools was randomised to receive either HeadStrong or Personal Development, Health and Physical Education (PDHPE) classes. Participants were assessed pre- and post-intervention, and at 6-month follow-up. Literacy improved and stigma reduced in both groups at post-intervention and follow-up, relative to baseline. However, these effects were significantly greater in the HeadStrong condition. The study demonstrates the potential of HeadStrong to improve mental health literacy and reduce stigma. © 2014 The Foundation for Professionals in Services for Adolescents. Published by Elsevier Ltd. All rights reserved.

Introduction

Background

Mental health disorders have detrimental effects on wellbeing, functioning and development in adolescence (Kessler, Foster, Saunders, & Stang, 1995; O'Connell, Boat, & Warner, 2009). However, young people are reluctant to seek professional help for mental illness. Less than one in four 16–24 year old Australians diagnosed with a mental disorder accessed health services in the previous year (Reavley, Cvetkovski, Jorm, & Lubman, 2010). A recent review of help-seeking for mental

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disorders found lack of knowledge regarding mental health to be a key obstacle preventing young people from seeking assistance (Gulliver, Griffiths, & Christensen, 2010).

Mental health literacy is defined as ‘knowledge and beliefs about mental disorders which aid their recognition, management and prevention’ (Jorm et al. 1997). Poor literacy is associated with lower rates of help-seeking and service use, as well as societal stigma and discriminatory behaviour (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012; Rusch, Evans-Lacko, Henderson, Flach, & Thornicroft, 2011; Thornicroft, 2008).

A second barrier to recognition, disclosure of distress and accessing mental health care is stigma and embarrassment. Stigma around mental illness has two aspects; public stigma refers to negative prejudicial attitudes and discrimination towards individuals with mental illness endorsed by the general population, while self-stigma describes an individuals’ internalisation of these negative attitudes and beliefs (Corrigan & Rao, 2012; Evans-Lacko et al., 2012). Both public and self-stigma have a broad range of negative ramifications for those with mental illness, notably social exclusion and reduced treatment-seeking (Conner et al., 2010; Evans-Lacko et al., 2012; Patel et al., 2010).

Negative attitudes towards mental illness are commonly endorsed by adolescents (Reavley & Jorm, 2011). High levels of these stigmatising attitudes amongst adolescents are associated with reduced intentions to seek professional help and a lower likelihood of viewing such support as helpful (Yap, Reavley, & Jorm, 2013), and influence the first aid actions adolescents take towards distressed peers (Yap & Jorm, 2011). Moreover, in a recent study, a majority of Australian youth expressed a strong reluctance to disclose the presence of various mental illnesses (Reavley & Jorm, 2011), representing an important barrier to help-seeking in this population (Gulliver et al., 2010).

Education is critical to enhancing mental health knowledge, reducing stigma and improving access to care (Kelly, Jorm, & Wright, 2007). However, the evidence base for educational interventions targeting youth is limited. To date, there have been four small randomised trials conducted in American (Battaglia, Coverdale, & Bushong, 1990; Esters, Cooker, & Ittenbach, 1998; Pinto-Foltz, Logsdon, & Myers, 2011) and Pakistani (Rahman, Mubbashar, Gater, & Goldberg, 1998) secondary schools. These trials demonstrated promising findings amongst students, following an educational intervention, including enhanced mental health literacy, attitudes and willingness to seek professional help. However, findings are tempered by study limitations including small sample sizes, lack of follow-up, low response rates and potential for intergroup contamination. Accordingly, there is a clear need for additional, well-controlled research in this area (Pinto-Foltz, Logsdon, & Myers, 2011).

Objectives

The current study represents the first stage of a cluster Randomised Controlled Trial (RCT) designed to evaluate the impact of HeadStrong, a universal, curriculum-based educational program, relative to Stage 5 Personal Development, Health and Physical Education (PDHPE) classes. Given the time-intensive and costly nature of field work, this trial was planned in stages, in order to determine the effect size on the key outcome variables, guide ongoing sample size estimates, streamline implementation in non-government school systems and refine operational issues associated with implementing a large-scale trial. A cluster design was chosen as HeadStrong was delivered to classes not individuals, with randomisation occurring at the school level.

We hypothesised that individuals receiving the HeadStrong curriculum would demonstrate superior mental health literacy to those in the control condition. We also anticipated that the program would have a positive impact on personal stigma, and help-seeking.

The effect of the intervention on psychological distress and suicidal ideation was also examined in exploratory analyses. There is evidence in the adult literature that psychoeducation can be associated with a reduction in symptoms (Donker, Griffiths, Cuijpers, & Christensen, 2009). Therefore, we aimed to determine whether participation in the program, possibly via hypothesised improvements in help-seeking, would also reduce symptoms of distress and suicidal thinking.

Method

Participants

Participants were 380 secondary school students in Year 9 or 10, recruited from five Catholic (56%) and five Independent (44%) schools in Central West New South Wales, Australia. Between one and seven classes participated in each school. Participants were aged 13–16 years ($M = 14.75$ years) with equal representation across genders. Over 97% of participants spoke English at home, and approximately 5% of the sample identified as Aboriginal or Torres Strait Islander. Due to the universal nature of the intervention, there were no exclusion criteria for this study.

Procedure

School principals were contacted in writing and invited to allow their schools to participate in the study. Once the principals’ informed consent was obtained, PDHPE teachers were contacted in writing to ensure that they were willing to deliver the HeadStrong program (or classes as usual) and to facilitate the administration of the assessment measures. Following this, a letter was sent to the parent(s)/guardian(s) of Year 9 and 10 students with a consent form for each child who was eligible to participate in the study. Students whose parents provided consent were given an information and consent form in their PDHPE class, at the commencement of the trial.

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