SUMMARY REPORT

Findings from an evaluation of Jigsaw's it's time to start talking workshop

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JIGSAW
Young people's health in mind

Contents

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Introduction

Background

In recent times, increased attention has been paid to youth mental health on an international and national level. In a national context, the National Task Force on Youth Mental Health was established in 2016 to "*to consider how best to introduce and teach resilience, coping mechanisms, greater awareness to children and young people, and how to access support services voluntarily at a young age"*. With prevention and early intervention underpinning the government health framework *Healthy Ireland* (2013-2025) and the national policy framework for children and young people *Better Outcomes, Brighter Futures* (2014-2020), early adolescence is a crucial time period for mental health education. This recognition of the importance of mental health education is realised through the *Guidelines for Wellbeing in Junior Cycle* (2017) which aim to support schools in planning and developing a coherent wellbeing programme.

Mental Health Knowledge

Canon, Coughlan, Clarke, Harley and Kelleher (2013) assert that mental health knowledge has the potential to reduce incidence, impact and continuity of mental health difficulties among young people and recommend including mental health education as a core part of the Irish educational system. There are mixed findings on young people's levels of mental health knowledge, not least because it is a difficult construct to measure. McEvoy (2009) identified, through consultations with teenagers, that young people had a strong awareness of mental health issues, an understanding of mental health, as well as an ability to recognise the signs of poor mental health. On the other hand, some researchers have found that few young people have adequate information regarding the signs of mental health problems in themselves and others, or of when there is need to call on professional help (Rickwood, Deane, Wilson & Ciarrochi, 2005).

Help-seeking

An important area to focus on in mental health education is help-seeking. It is not uncommon for young people to avoid talking about mental health difficulties and to avoid seeking help (Rickwood et al., 2005). It is important that young people feel they have someone to turn to as there is much evidence to suggest talking about problems is a protective factor for young people's mental health (Dooley & Fitzgerald, 2012; McEvoy, 2009). Looking to sources of support, a report on teenage mental health in Ireland published by ReachOut examined, among other topics, help-seeking preferences (Chambers, Ryan, Doolan, Kavanagh, & Healy, 2017). This report revealed there is a wide variety of support options for this generation of young people who seek help for mental health problems. The top likely sources of support reported by teenagers were online search (58%), friends (56%), mental health apps (41%), and family (39%) and the least frequent were GP (13%), HSE mental health services (9%), and helpline (6%). This is in-line with the 2012 My World Survey (Dooley & Fitzgerald, 2012) which identified friends, parents and internet as the main

sources of support likely to be utilised by 12-17 year olds, and a similarly low likelihood of using a help-line, psychologist, guidance counsellor and GP.

Stigma

Another key area to target in mental health education is the reduction of stigma surrounding mental health. The concept of mental health stigma can be understood as the interaction between three problems: ignorance, prejudice and discrimination (Thornicroft, 2006). Two main types of mental health stigma were identified in the literature, 1) self-stigma (Corrigan, Larson & Rusch, 2009) and, 2) stigma against people experiencing mental health difficulties, also referred to as societal or public stigma (Corrigan et al., 2009; McKeague, Hennessy, O'Driscoll & Heary, 2015; Thornicroft, 2006; Wei, McGrath, Hayden & Kutcher, 2015). Self-stigma is the personal reaction to, or internalisation of, negative stereotypes associated with mental health problems (Corrigan et al., 2009). This self-stigma can be detrimental to one's self-esteem and self-efficacy (Corrigan et al., 2009; Corrigan & Rao, 2012). With regards to the second type of stigma, Wei et al. (2015) describe stigma against people experiencing mental health difficulties in terms of social distance (the degree to which people are willing to accept people experiencing mental health difficulties in regular social life), personal stigma (personal attitudes toward people with mental health difficulties) and perceived stigma (beliefs about others' attitudes about mental health). This type of stigma can lead to the rejection and avoidance of people experiencing mental health difficulties (Thornicroft, 2006) and is particularly detrimental to young people as it can diminish the support provided to them by their peers (Yap & Jorm, 2011). It has also been suggested that stigma acts as a buffer against gaining knowledge about the mental health care system and a lack of fear of stigma is crucial to adequate help-seeking for mental health issues (Skre et al., 2013). Reducing stigma by debunking common myths and promoting positive attitudes to mental health through mental health education may facilitate emotional expression, improve help-seeking intentions and increase young people's use of mental health services (Rickwood et al., 2005).

The School as a Setting for Mental Health Education

The school setting provides the ideal opportunity to reach young people at a critical developmental stage (Barry, 2009). In addition, schools may be a useful environment for enhancing mental health knowledge due to their educational focus (Jorm, 2012). The importance of mental health promotion in improving wellbeing among young people in schools has been evident for some time and mental health interventions have been delivered in thousands of schools across the world (Weare & Nind, 2011). However, few of these interventions have been rigorously evaluated (Jorm, 2012; Weare & Nind, 2011).

Evaluating Jigsaw's 'It's Time To Start Talking' Workshop

Reducing the stigma associated with mental health difficulties, increasing knowledge about mental health and improving hep-seeking for mental health problems have been identified by many researchers as essential areas of change targeted by mental health promotion interventions (Rickwood, Cavanagh, Curtis & Sakrouge, 2012). In response to these needs,

Jigsaw developed a 40 minute workshop named 'It's Time To Start Talking' which is targeted at young people aged 13-17 years, and primarily delivered in a school setting. The objectives of this 40-minute workshop are to:

- Positively influence attitudes to mental health by promoting a holistic understanding of mental health;
- Promote help-seeking by encouraging young people to talk to someone they trust when feeling worried, sad, or down;
- Help young people to identify trusted informal sources of support;
- Provide information about how to access formal support.

This report outlines the evaluation of 'It's Time to Start Talking' (ITTST). The evaluation was conducted by Jigsaw's Research and Evaluation team, in partnership with Jigsaw Dublin City and the Jigsaw Education and Training team. The aim was to examine the impact, if any, of the ITTST workshop on young people's mental health knowledge, help-seeking intentions, and stigma towards peers experiencing mental health difficulties.

Method

Participants

Participants consisted of 294 students who attended an ITTST workshop delivered in four schools in Dublin City centre. This group of students was comprised of 84 males (29%) and 210 females (71%) and ages ranged from 12 years to 16 years (*M* = 13.3, *SD* = .929). A further breakdown of gender by age is shown in Figure 1 below. Two of the schools were co-educational, one was a single-sex girls' school and one was a single-sex boys' school. Two of these schools were part of the Department of Education and Skills Delivering Equality of Opportunity in Schools (DEIS) scheme.

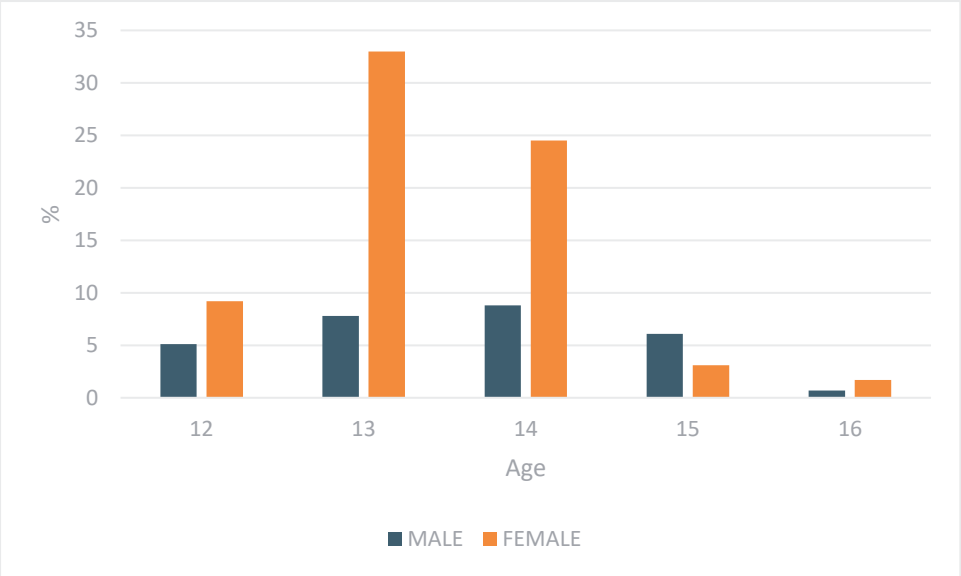

Figure 1. Percentage Breakdown of Participant Age and Gender (*N*=294)

Procedure

Ethical approval for this research was granted by Jigsaw's ethical review panel, and the study was carried out in accordance with the 2013 Declaration of Helsinki. Following the administration of information sheets, students who returned consent forms signed by themselves and their parents/guardians were invited to participate in the evaluation of the ITTST workshop. Participants completed a short questionnaire immediately prior to the workshop and the same questionnaire 2-4 weeks after the workshop.

Questionnaires

Participants were first asked to complete a short demographic questionnaire which contained questions about age and gender. They were then asked to identify from a list, activities/events that have taken place in their school which related to mental health; for example, posters displayed about mental health, talk about mental health by a celebrity, mental health walk/run. Participants were also asked to name any organisations in their community that offer support to young people who have mental health difficulties.

Next, participants were asked to complete a short questionnaire about help-seeking intentions (adapted from the My World Survey, Dooley & Fitzgerald, 2012). This questionnaire displayed a list of formal and informal sources of support. Participants were asked to rate their likelihood of using these services if they had a mental health difficulty, on a five-point Likert scale from 'very unlikely' to 'very likely'. Higher scores indicated higher likelihood. They were asked if they had a problem would they talk to someone about it and, if yes, who to.

Third, participants were invited to complete an author designed questionnaire assessing young people's mental health knowledge. This questionnaire was comprised of items relating to 1) understanding the meaning of mental health *('everyone has mental health', 'mental health is the same as mental illness', 'only people with problems need to look after their mental health')*, 2) knowledge of the prevalence of mental health problems *('only a small number of people will ever have mental health problems'),* 3) negative beliefs about mental health problems *('people with mental health problems are more likely to carry out crimes')*, and knowledge of how to cope *('If I'm feeling stressed, worried or down, there are things I can do to make myself feel better', 'talking about worries or problems can make things worse')*. Participants were asked to rate their agreement with each of these statements. Higher scores on a 5-point Likert scale from 'strongly disagree' to 'strongly agree' indicated higher levels of mental health knowledge.

Finally, stigma towards peers experiencing mental health difficulties was assessed using an adapted version of the Peer Mental Health Stigmatization Scale (McKeague et al., 2015). The stigma agreement component (8 items), which examines personal endorsement of stigmatising statements, and the positive subscale (4 items), consisting of statements relating to friendship, intellectual ability, and recovery, were utilised for this study. High scores on the overall questionnaire indicate high peer mental health stigmatisation. Higher scores on the stigma agreement subscale indicate higher levels of stigma agreement (personal endorsement of stigma), while lower scores on the positivity subscale indicate higher levels of positivity towards young people with mental health difficulties.

Data Analysis

All data were entered into SPSS version 22. Quantitative data were analysed using descriptive and inferential statistics to examine differences pre- and post- intervention on mental health knowledge, help-seeking intentions, and peer mental health stigma.

Results

Mental Health Activities in School

Pre- and post- responses to this question are displayed in Figure 2 below. The most common mental health related activities identified by participants were posters about mental health, Mental Health Week, talk about mental health by someone in school and SPHE classes about mental health. When asked this again at Time 2, frequencies were higher for all events and activities.

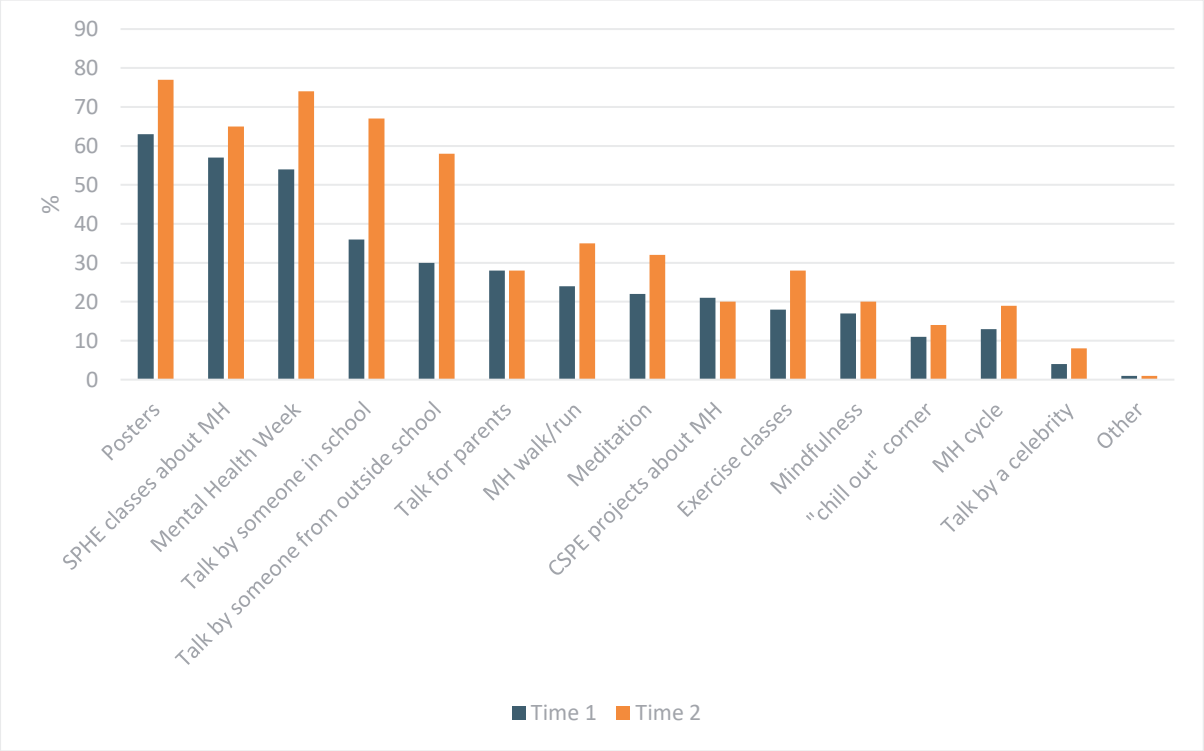

Figure 2. Participant Responses to 'Have any of these activities happened at your School?' (%)

Knowledge of Organisations that Support Young People

At Time 1, 45% (*n*=133) of the total sample answered this question. Of these, 34% said 'yes' and 66% said 'no' or 'unsure'. At Time 2, 48% of the total sample (*n*=140) responded. Fifty-four percent said 'yes' and 46% said 'no' or 'unsure'. Therefore, knowledge of services supporting mental health in their communities increased by 20%. Of those who said 'yes' at Time 1, the top three services identified were youth services (18%), help-lines (13%), and more formal mental health services such as CAMHS and Lucena (11%). At Time 2 the same three types of services were the most common: youth services (11%), help-lines (7%) and formal mental health services (5%). Many of the services named were disability services such as St. Michael's House and the Central Remedial Clinic, with 9% at Time 1 and 5% at

Time 2. Jigsaw was identified as a mental health service in the community by 22% of participants who responded to this question at Time 1 and by 53% at Time 2.

Help-seeking Intentions

When asked 'if you had a problem, would you talk about it with anyone?' 88% (*n* = 257) of young people said 'yes' before the workshop, and 91% (*n* = 268) said 'yes' after the workshop. Although this is a 3% percent increase, McNemar's test indicated no significant difference from Time 1 to Time 2 on participants' likelihood of talking to someone if they had a problem, (*N* = 293, *p* = .152).

Two Chi-square tests for independence were performed to examine the relationship between gender and reported likelihood of talking about a problem. At Time 1, females (91%) were significantly more likely to talk to someone about a problem than were males (81%), $\chi 2$ (1, *n* = 293) = 5.39, *p* = .02, with a small effect size (*phi* = .15). At Time 2, no significant difference was observed indicating that, following the workshop, males (87%) reported being as likely to talk to someone about a problem as females (93%), $\chi 2$ (1, *n* = 293) = 1.92, *p* = .17, *phi* = .094.

Participants were asked who they would be most likely to talk to if they had a problem. Prior to the intervention the top response here was immediate family (81%; *n*=209). Looking at the individuals within the family separately, young people most frequently nominated both parents (33%; *n*=85), followed by mum alone (30%; *n*=78), siblings (7%; *n*=19) and dad alone (2%; *n*=5). Some young people simply stated 'family' (8.5%; *n*=22). The second most common response was friends (32%; *n*=83) and the third was school staff member (3.5%; *n*=9) such as teacher, guidance counsellor or principal. These remained the top three responses following the intervention, with 73% (*n*=195) naming family, 37% naming friends (*n*=100), and 3.5% naming school staff members (*n*=9).

In order to delve further into help-seeking intentions, participants were asked to rate their likelihood of using a variety of formal and informal supports such as parent or GP. This questionnaire consisted of 10 items. However, as a significant number of participants did not answer the last question, 'If you were feeling stressed, worried or down how likely would you be to use 'other' sources', this was excluded from analyses. Internal reliability of the 9-item scale was acceptable at Time 1 and at Time 2 with Cronbach's alpha scores of .726 and .732 respectively.

Percentage likelihood of availing of a variety of resources for mental health support are outlined in the table below. At Time 1, the top three sources of support participants were likely/very likely to use were friend (83%), parents/guardians (82%) and relatives (54%). At Time 2, these were unchanged. At both time points participants reported being much less likely to avail of a GP, helpline, psychologist or internet for feelings of stress or worry. Therefore, the workshop did not influence the participants' order of preference for source of support. Looking specifically at responses to engaging with Jigsaw, prior to the workshop, 11% of the participants said they would attend Jigsaw whereas after the workshop 18% said

they would attend. However, at both time points most young people selected 'neither likely nor unlikely' in relation to Jigsaw, indicating many were unsure about whether or not they would avail of it for support (Time 1: 36%, Time 2: 31%)

Table 1.

Sources of Support at Time 1 (N = 257) and Time 2 (N = 257)

	Very Unlikely		Quite Unlikely		Neither likely nor unlikely		Quite likely		Very likely	
	n	%	n	%	n	%	n	%	n	%
Time 1										
Doctor/GP	101	39	92	36	38	15	21	8	5	2
Psychologist/Counsellor/Therapist	101	39	72	28	40	16	32	13	12	5
Friend	4	2	14	5	25	10	91	35	123	48
Internet	82	32	61	24	66	26	31	12	17	7
Phone help-line	157	61	56	22	56	22	28	11	12	5
Teacher/Guidance Counsellor	62	24	58	23	64	25	60	23	13	5
Parents/Guardians	9	4	14	5	22	9	67	26	145	56
Relatives (e.g. aunty, uncle, cousin)	37	14	37	14	45	18	76	30	62	24
Jigsaw	76	30	60	23	92	36	19	7	10	4
Time 2										
Doctor/GP	100	39	81	32	49	19	23	9	4	2
Psychologist/Counsellor/Therapist	69	27	78	30	53	21	47	18	10	4
Friend	5	2	12	5	23	9	85	33	132	51
Internet	68	27	74	29	66	26	40	16	9	4
Phone help-line	128	50	76	30	38	15	12	5	3	1
Teacher/Guidance Counsellor	49	19	55	21	74	29	65	25	14	5
Parents/Guardians	10	4	10	4	26	10	60	23	151	59
Relatives (e.g. aunty, uncle, cousin)	27	11	39	15	38	15	77	30	76	30
Jigsaw	72	28	60	23	80	31	41	16	4	2

A paired samples *t*-test revealed a significant increase in help-seeking scores from Time 1 (M = 15.93, SD = 5.69) to Time 2 (M = 16.89, SD = .35), $t(256) = -3.288$, $p < .05$ (two-tailed). The mean difference in scores was -.957 with a 95% confidence interval ranging from -1.530 to -.384. The effect size was small with an eta squared score of .04. Therefore, following attendance at the ITTST workshop, overall levels of help-seeking intentions were higher.

Mental Health Knowledge

Internal consistency of the author designed measure of mental health knowledge was low at Time 1, with a Cronbach's alpha value of .416. This was higher at Time 2 with a value of .603. However, it is not unusual for scales composed of a small number of items (i.e., fewer than 10) to have quite small Cronbach's alpha values (Pallant, 2013).

The figure below displays participants' responses on each item on this questionnaire before and after the workshop (*N* = 269). It is evident from this data that young people's knowledge of mental health improved over time. For example, agreement with 'Everyone has mental health' (Q1) increased from 65% at Time 1 to 75.5% at Time 2 and disagreement with 'Only a small number of people will ever have mental health problems' (Q5) increased from 67.7% to 72.5%. All items moved in a positive direction indicating an increase in mental health knowledge.

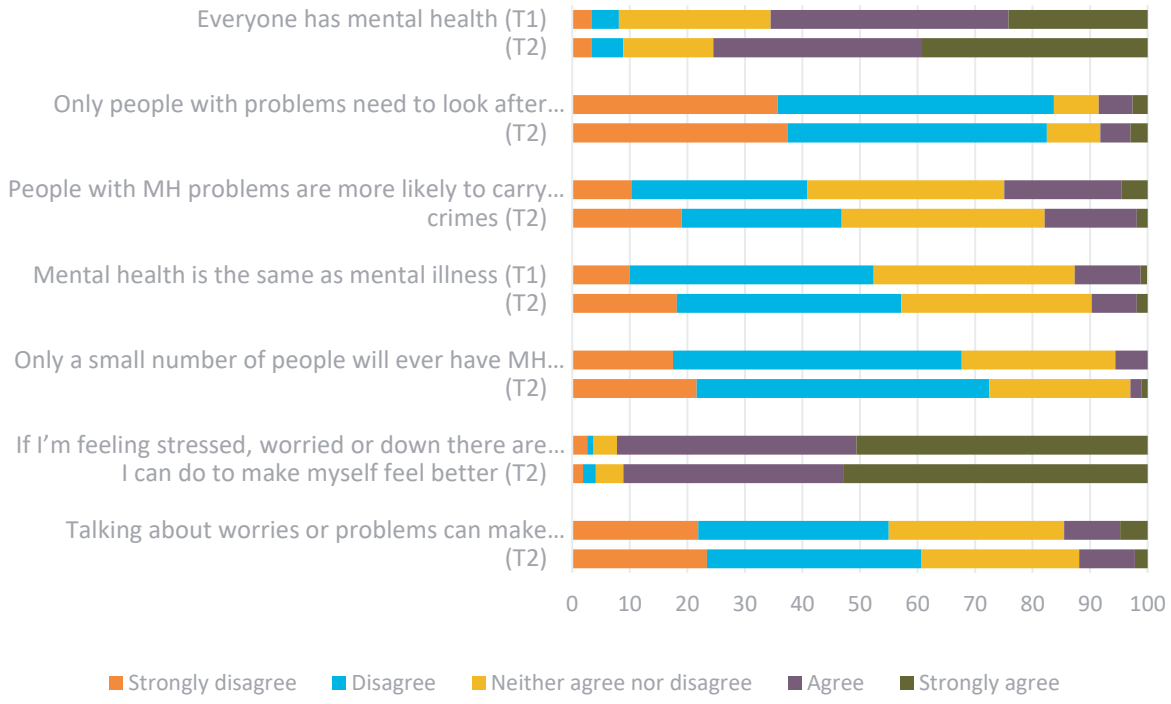

Figure 3. Agreement with statements about mental health at Time 1 and Time 2 (%)

Inferential statistics were conducted in order to garner further information from the data. A paired samples *t*-test revealed a significant increase in mental health knowledge scores from Time 1 (*M* = 19.3, *SD* = 3.09) to Time 2 (*M* = 20.19, *SD* = 3.6), *t*(268) = -5.04, *p* <.001 (two-tailed). The difference in mean scores was -0.89 with a 95% confidence interval ranging from -1.24 to -.54. The eta squared statistic (.10) indicated a large effect size. This finding provides evidence in support of the effectiveness of the workshop on improving young people's mental health knowledge.

Stigma

Reliability was strong for the total scale with Cronbach's alpha scores of .814 at Time 1 and .841 at Time 2. On the 'stigma agreement' component, consisting of 8 items, reliability again was strong with a Cronbach's alpha of .819 at Time 1 and .841 at Time 2. The 4-item positive subscale yielded lower reliability scores of .503 at Time 1 and .614 at Time 2. In order to examine discriminant validity, the relationship between stigma agreement and positivity towards peer mental health at Time 1 was measured using Pearson product-moment correlation coefficient. A strong positive correlation between the two variables was observed, $r = .571$, $n = 253$, $p < .01$, with high scores of perceived stigma (higher scores indicating higher stigma) associated with high scores of positivity (higher scores indicating low positivity).

Paired samples *t*-tests were conducted on the total Peer Mental Health Sigmatization Scale ($N = 257$), as well as on the subcomponents of 'Stigma Agreement' and 'Positivity'. A statistically significant decrease in peer mental health stigmatization following attendance at the ITTST workshop was observed, $t(252) = 5.435$, $p < .001$ (two-tailed). Mean scores decreased from pre-workshop ($M = 12.87$, $SD = 5.90$) to post-workshop ($M = 11.41$, $SD = 6.23$). The mean decrease in scores was 1.46 with a confidence interval ranging from .93 to 1.98. The eta squared value reveals a large effect size. Within this scale, a statistically significant reduction in stigma agreement from Time 1 ($M = 8.55$, $SD = 4.51$) to Time 2 ($M = 7.51$, $SD = 4.73$) was observed $t(252) = 5.104$, $p < .001$ (two-tailed). In addition, with lower scores indicating higher levels of positivity, it is evident that positivity towards peer mental health improved from Time 1 ($M = 4.32$, $SD = 2.02$) to Time 2 ($M = 3.91$, $SD = 2.19$), $t(252) = 3.267$, $p < .001$ (two-tailed). These findings indicate that the ITTST workshop aids the reduction of stigmatization towards peer mental health.

Discussion

This evaluation provides evidence that the ITTST workshop positively impacts on young people's help-seeking intentions, mental health knowledge and stigma towards peers experiencing mental health difficulties. Following attendance at the workshop, overall levels of help-seeking intentions were higher and young people's understanding of mental health, although high prior to the workshop, improved over time. In addition, a reduction in mental health stigma was observed, with lower levels of stigma agreement and higher levels of positivity towards peers with mental health problems reported. These findings are in line with the objectives of this mental health education workshop which were to promote help-seeking, to positively influence attitudes towards mental health and to help young people identify sources of support.

Overall, participants were aware of a wide range of mental health events and activities happening in their schools, particularly following the workshop, indicating schools are very active in this area. It is likely that at Time 2 participants were more attuned to mental health related information and also had more time for recall. Prior to the workshop, just over a third of participants were aware of services in their community that offer mental health support for young people. This increased to 54% after the workshop. The most well-known services were youth services, helplines such as Childline, and formal mental health services such as CAMHS. Just one participant identified a GP as a support service and this was at Time 1.

Although not significant, a slightly higher percentage of participants reported being more likely to talk to someone about their problems following the workshop. The lack of significance is perhaps unremarkable due to the high percentage at baseline. It is encouraging to learn that such a high proportion of young people in this age group share the difficulties they are experiencing with someone else. Females reported being more likely to talk about their problems than males before the workshop, but a significant difference between the gender groups was not observed following attendance at the workshop. In other words, males showed a slightly greater increase in likelihood of talking about their problems than females. This is a positive finding as research indicates that females are usually more likely to discuss mental health difficulties than males (Dooley & Fitzgerald, 2012). This outcome suggests that the ITTST workshop helps to narrow the gap between males and females in terms of in their likelihood to seek help.

With regards to who participants would share their concerns with if they were experiencing difficulties with their mental health, the order of preference for sources of support did not change over time. As expected, favoured resources for mental health difficulties were friends and family, corroborating findings from a number of previous studies (Dooley & Fitzgerald, 2012; Rickwood et al., 2005, Rickwood, Deane & Wilson, 2007; Sullivan, Arensman, Keeley, Corcoran & Perry, 2004). The internet was a surprisingly under-utilized potential resource. On average, only 20% of participants said they would be 'likely' or 'very

likely' to use the internet when feeling stressed, worried or down. This is in contrast with previous Irish studies (Chambers et al., 2017; Dooley & Fitzgerald, 2012) where internet was a popular choice among teenagers. Perhaps terminology other than 'internet' could be used to differentiate between different types of online support such as social media or mental health apps (Chambers et al., 2017). Formal sources of support (GP, psychologist, and help-line) were not popular choices in the current study whereas availing of support from school guidance counsellors and teachers was more accepted. It is noteworthy that, although young people are aware of formal mental health services, it seems they might be unlikely to avail of them.

With regards to mental health knowledge, following attendance at the ITTST workshop, participants displayed a greater understanding that mental health is not the same as mental illness and that everyone has mental health. In addition, participants learned that mental health problems are more prevalent than they previously thought. This information may aid recognition of mental health difficulties in oneself as well as in others. A minimal improvement on the item 'only people with mental health problems need to look after their mental health' was observed. However, disagreement was already high prior to the workshop. This is an encouraging finding but one which could be improved upon in order to facilitate the prevention and management of mental health difficulties. The workshop helped dispel the belief that people with mental health difficulties are more likely to carry out crimes, hence potentially decreasing the stigmatising stereotype that people experiencing mental health problems are dangerous (Corrigan & Shapiro, 2010). Following the workshop, participants were better able to identify things they can do to make themselves feel better when stressed. In addition, they were less likely to believe that talking about worries or problems can make things worse. These findings indicate that the workshop successfully informed participants of ways to cope with mental health difficulties. Overall, the improvement in mental health knowledge is a very positive outcome from this evaluation of the ITTST workshop.

This evaluation provided evidence that the ITTST workshop promotes more positive attitudes towards people experiencing mental health difficulties. For example, following attendance at the workshop, participants were more likely to believe it is good to be friends with someone who is experiencing mental health difficulties. Furthermore, educating these young people about common negative stereotypes led to a reduction in personal endorsement of stigmatising statements. For example, after the workshop, participants were less likely to believe that teenagers experiencing mental health difficulties are to blame for their difficulties. Reduced stigma may lead to young people more openly discussing their mental health difficulties and has the potential to improve help--seeking behaviour (Rickwood et al., 2005). The overall reduction in stigma here observed illuminates the value of mental health education and provides evidence in support of the ITTST workshop.

The findings from this evaluation endorse Jigsaw's work in the community and illustrate that Jigsaw's work in schools is beneficial to young people. As a result of the finding that participants were mostly unsure of whether they would avail of the Jigsaw service, facilitators will be encouraged to remind those in attendance that Jigsaw is a service which is available to them. As the ITTST workshop encourages young people to seek help for mental health difficulties from both informal and formal sources it is important that parents and other members of the community are supported to develop their capacity to provide support. To this end, Jigsaw provides the workshop 'Supporting Young People's Mental Health' to parents, guardians and other interested adults.

Conclusion

Educating young people about mental health has the potential to improve the quality of their social support and may make them more willing to use that support when needed (Ciarrochi, Deane, Wilson & Rickwood, 2002; Yap & Jorm, 2011). The importance of educating young people about mental health is widely acknowledged and school mental health programmes are the ideal vehicle through which young people are educated about mental health (*Guidelines for Wellbeing in Junior Cycle*, 2017). It is imperative that such programmes are evaluated in order to establish an evidence base for their effectiveness (Jorm, 2012). This evaluation has provided evidence that the ITTST workshop positively influences help-seeking intentions, increases mental health knowledge and decreases stigma.

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