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Welcome to the first issue for 2013. We continue with the proud tradition of independent publishing and offer an eclectic mix of articles. Contributions come from those working with young people and we welcome the interest from around the world. Developments in open access publications mean that articles from this journal are available in most places where there is Internet access.

The journal, published since 1983, is aimed at those involved with education and health who are concerned with the health and wellbeing of young people. Readers, in the UK, come from a broad background and include: primary, secondary and further education teachers, university staff, and health-care professionals working in education and health settings. Readers outside of the UK share similar backgrounds. The journal is also read by those who commission and carry out health education programmes in school and college.

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Contributors (see a recent list) Do you have up to 3000 words about a relevant issue that you would like to see published?

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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
The Welsh Assembly Government’s Sexual Health & Wellbeing Action Plan for Wales, 2010-2015, (SHWW) released in November 2010, highlights the importance of prevention, education, individual responsibility and access to healthcare services. The plan also aims to promote a culture where people feel able to discuss and ask questions about sexual health and relationships openly. All of these features are particularly relevant within the field of community based Sex and Relationships Education (SRE).

The Action Plan introduced a number of projects and initiatives to be delivered by the All Wales Sexual Health Network. As part of the SHWW, the All Wales Sexual Health Network has led, or contributed to, the development of standards for the delivery of C-Card Schemes in Wales; the development of downloadable resources to support parents in the delivery of sex education; and explored with young people how better to actively involve them with the All Wales Sexual Health Network. The development of guidance for community based sex and relationships education in Wales is another of these projects.

The All Wales Sexual Health Network is a professional network for practitioners working within the field of sexual health in Wales. As part of the earlier action plan to implement the Welsh Assembly Government’s ‘A Strategic framework for Promoting Sexual Health in Wales’ (Welsh Assembly Government, 2000) the Network was originally established in 2000, as part of the SHWW, the All Wales Sexual Health Network has led, or contributed to, the development of standards for the delivery of C-Card Schemes in Wales; the development of downloadable resources to support parents in the delivery of sex education; and explored with young people how better to actively involve them with the All Wales Sexual Health Network. The development of guidance for community based sex and relationships education in Wales is another of these projects.

The Network currently has approximately 800 registered individual members, who come from a variety of professional backgrounds, for example the academic sector, primary care, the third sector, public health and the private sector. It is important to note at this point that the Network does not have a direct remit for providing advice and guidance to the general public, yet much of its work, including the projects discussed within this article, is produced with the improved sexual health of the Welsh populace in mind.

Wider Policy Context

Shortly before the release of SHWW, in September 2010, the Welsh Assembly Government’s Education Department released Sex and Relationships Education in Schools (Welsh Assembly Government, 2010). This guidance provides advice to schools on how they should develop their sex education policies, plan and deliver their sex and relationships education provision and work in partnership with others. Under the Education Act 2002, SRE became a compulsory part of the basic curriculum in all secondary schools in Wales. Primary schools are also required to have a policy on SRE, outlining details of their SRE programme or explaining their decision not to provide SRE. The Welsh Government recommends that primary schools have a graduated programme of SRE tailored to the age and emotional maturity of the children.

The Network aims to provide a discussion forum for a range of agencies involved in promoting better sexual health, and to be a means of promoting good practice and increasing public understanding of sexual health issues.

The Welsh Assembly Government is committed to the principles of the United Nations Convention on the Rights of the Child (UNCRC), and this is demonstrated through the development of the policy Children and Young People: Rights to Action (2004). This promotes seven core aims for children and young people, including the entitlement of children and young people to a range of sexual health services.

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people to access educational and health services, and addresses their right to be listened to and to participate in the decisions that affect them, including them being given the necessary information to make choices. This policy has been followed in recent years by the Children’s Rights Scheme (Welsh Government, 2011), implemented following the ‘Rights of Children and Young Persons (Wales) Measure’ being passed in the National Assembly for Wales in 2011. This Scheme places a duty on Welsh Ministers to have due regard to the rights and obligations within the United Nations Convention on the Rights of the Child (UNCRC) and its optional protocols.

Existing Evidence Base

After accessing a Public Health Wales literature search on the effectiveness of SRE in community based settings, the existing evidence base was found to be inconclusive in most of its results, although many studies did make recommendations for good practice which are in line with the guidance produced. However, key evidence shows that sex and relationships education is most effective when it is delivered through a partnership of education from home, community and school, a key message this guidance promotes and mirrors in the schools SRE guidance.

The community based SRE guidance sets out current good practice recommendations and acknowledges the ongoing and developmental nature of this work.

Project Initiation

FPA (Family Planning Association) is a UK sexual health charity. It provides straightforward information, advice and support to all people across the UK on all aspects of sexual health, sex and relationships.

FPA has established projects and developed guidance and resources for SRE in community based settings throughout its existence, examples of which include Beyond Barbie (Brown-Simpson, 2003), The Boys are Avo’right (Street et al, 2006) and Jiwsi: A Pick ‘N’ Mix of Sex and Relationships Education Activities (Gadd & Hinchliffe, 2007).

Jiwsi is a FPA community based project delivering targeted SRE to groups of vulnerable young people, under 25 years of age, in community settings throughout North Wales. It has been in operation for over ten years, having been established in response to the Welsh Assembly Government’s ‘A Strategic framework for Promoting Sexual Health in Wales’ (Welsh Assembly Government, 2000). The name Jiwsi is a Welsh take on the word ‘Juicy’ and was chosen as the project title in consultation with a group of vulnerable young people.

Vulnerable young people often miss out on SRE that meets their needs. They are at increased risk of unintended pregnancy, sexually transmitted infections or other sexual health problems. Jiwsi works with these groups of young people, who are identified as being vulnerable and at increased risk of sexual health problems now or in the future and delivers developmental programmes of SRE concentrating on issues identified by the young people themselves. Jiwsi’s groups include, but are not limited to: looked after children and young people who are about to leave or who have left care; young people with physical or learning disabilities; young people with behavioral problems; socially disadvantaged young people; rurally isolated young people; young offenders; minority ethnic groups, including young refugees and travellers; lesbian, gay, bisexual, transgender or questioning (LGBTQ) young people; homeless young people; young people with mental health issues; young parents; and young people who have been or are at risk of being abused or abusing others.

In parallel to its work with young people, Jiwsi also runs a popular North Wales SRE practitioners’ network and trains practitioners from a range of disciplinary backgrounds in effective and engaging community based SRE delivery.

With all of this in mind, it was considered by the All Wales Sexual Health Network management that the FPA was best placed and suitably experienced to produce a comprehensive guide for delivering SRE in community based settings in Wales. To make a comprehensive guide formed from the existing knowledge base, the Network envisaged a document that incorporated aspects of the three resources referenced above and other relevant work, such as FPA’s Core competencies in sexual health for youth workers training course.
The project specification for the community based SRE guidance highlighted the key content requirements, including for example an overview of the policy and legal context in Wales, advice on how SRE programmes should be developed, engagement with young people in the development of community based projects and anecdotal examples from the field.

The main vision for the guidance was that it should be a reference point for services to develop and maintain their community based SRE programmes, and also provide a personal reference point for an individual’s career development, through matching content to the core competencies.

**Developing ‘Out in the Field’**

‘Out in the Field’ was developed as a title for the guidance document to reflect the settings experienced by a varied range of community based SRE practitioners.

FPA has a good sense of what SRE practitioners find useful and what key questions and concerns may be. FPA is also familiar with the unique opportunities and challenges that working in community based settings such as local community centres, youth clubs, street-based work, etc can present.

Using the key content requirements as a base, FPA worked to develop the guidance into an easy to use ‘route map’ for sexual health education practitioners of all levels, whether an occasional volunteer or a full-time manager. Experienced in delivering practitioner training, FPA designed the guidance as if it were delivering training: guiding a participant through various stages of professional development including values awareness, critical thinking, information and skills acquisition and the confidence-building that equips a practitioner to deliver SRE to varied client groups. Also asking the questions; what would be most useful for them and what are common worries and questions?

Early on in the guidance, Section One sets the scene, is inclusive and deals with practitioner wellbeing. Within Section One, a definition of what is meant by ‘community based’ is provided, explaining that, “community based refers to work that takes place in informal settings, usually within the client’s local community and not part of mainstream school curriculum (but it could sometimes involve work taking place in schools) … Although this guidance is not intended for mainstream education settings we recognise this work can often take place in settings such as special schools and pupil referral units.” (Gadd, M (2012) pg. 3). Within the wider definition, it is acknowledged that “Working with young people within community settings usually means that participation is voluntary, unlike school. Barriers to access and participation are often reduced and effective participation can take place” (Gadd, M (2012) pg. 3).

A comprehensive Section Two; ‘Am I Allowed to Deliver This Work?’, focuses on the ‘rules’ associated with SRE delivery in community settings, such as confidentiality and child protection, and is designed to be enabling rather than put practitioners off. It includes guidance on how to work in partnership with parents/carers as young people tell FPA they want parents/carers to be a primary information source. This section has links to relevant current guidance in Wales such as schools SRE guidance, SRE and youth and community work and the recent All Wales C-Card Standards.

Section Three then addresses practitioner competencies, based on FPA’s **Core competencies in sexual health for youth workers** training course, and explores what young people tell us they want from their SRE provider. This section also explores the responsibility being a positive role model, managing professional boundaries and distancing techniques and the importance of continual professional development, training and support.

Section Four focuses on delivery. This section of the guidance doesn’t give sex and relationships education content - there are plenty of fantastic resources around that can offer that and the links to these are included in the guidance - rather it gives tried and tested methods for planning and delivering effective, engaging SRE. Methods such as undertaking needs assessments, adapting for different groups and settings, setting good learning outcomes, using active learning techniques, participation, safety, inclusive practice, gender issues, using appropriate resources, working in partnership and meaningful monitoring and evaluation are covered. There is also a handy
section on common problems and suggested solutions.

The final section, Section Five, contains some SRE activities from *Jiwsi: A Pick 'N' Mix of Sex and Relationships Education Activities* (Gadd & Hinchliffe, 2007) and a glossary of common abbreviations and terms; SRE contains as much jargon as any other field! All the way through the guidance are quotes and case studies from practitioners who deliver SRE in community based settings in Wales to keep the guidance grounded and relevant to day to day practice. Links to relevant documents and resources are also included for ease of use by the practitioner.

**Using ‘Out in the Field’**

A guidance document, however relevant, is only useful if it is accessible and is used by practitioners. Its launch has been promoted through the Public Health Wales website, Public Health Wales’ internal and external stakeholder e-bulletins, and the All Wales Sexual Health Network’s ‘Week in Review’ e-bulletin and quarterly publication *Intersexion* (All Wales Sexual Health Network, 2012). The guidance will also be presented at a parallel session at the All Wales Sexual Health Network Annual Conference, in February 2013, where delegates in attendance will learn about the guidance and participate in some of the activities presented within it. Feedback on the guidance to date from practitioners in the field has been entirely positive.

‘Out in the Field’ Delivering Sex and Relationships Education in Community Based Settings is available as a free download from the All Wales Sexual Health Network website and has been one of the most downloaded documents available on the site since its launch in September 2012, attracting (as of 4th February 2013) 462 views for the English-language version of the guidance and 161 views for the Welsh-language version of the guidance.

We are sure that the guidance could be of use to community based practitioners not just in Wales but also those outside of Wales, and encourage readers to download it and let us know what you think.

**References**

This article is concerned with the mounting evidence that examination and assessment pressures have caused a rise in mental health problems in some countries and that this may be a growing contributive factor in increasing suicidal behaviour among young people.

Definition

Suicidal behaviour has been defined as an ‘act of deliberate self-harm with at least some intent to die’ (Silverman et al., 2007: 264). The risk factors which may lead to suicide are many, and it is accepted that there may be overlapping causes. They include mental disorders, (particularly depression), substance use, stressful life events, social isolation, a family history of suicide, loss (social, financial, or relational), physical illness, low educational achievement and an unwillingness to seek help, (perhaps because of the stigma attached to mental illness) (Hawton et al., 2012). The literature on the subject has demonstrated the complexity of the issues involved, but some clear patterns have been recognized which appear to be specific to different cultures, geographical regions and to different age groups. (Hawton et al. 2012).

Statistical limitations

Statistics show that suicide rates are high in some countries, e.g. Lithuania, and lower in others, e.g. Australia, (World Health Organization, 2012). Some of this variation is unrelated to the risk factors that may lead to a person taking their own life. Reporting restrictions, cultural taboos, and even different definitions of what actually counts as suicide are a cause of substantial discrepancies in reporting (Silverman, 2006). Coroners may not know if a death was accidental, has multiple causes or is the result of suicide and may often offer an undetermined/open verdict when causes are uncertain. Major religions and philosophies oppose suicidal behaviour and in some countries it remains illegal: this also compounds under-reporting.

Understanding the causes of suicidal behaviour in young people and children remains a major challenge. For young people the data define children/adolescents in different ways, with different age cut-offs, so statistics have to be treated with some caution. Making comparisons year-on-year or between countries can be difficult. However, there is sufficient information to make some general comments. I briefly summarize significant details below and where possible relate these to examination or school performance.

Suicide and self harm in the young

Worldwide, suicide has been stated as the leading cause of death among females aged 15-19 and is third for males of the same age. Figures indicate that around the world at least 164,000 adolescents kill themselves every year and an estimated four million attempt suicide. Youth suicide, worldwide, is increasing at a greater rate than other age groups (Wasserman, 2005). Younger people are at a higher risk of suicide than older people (Patton et al., 2009).

In the UK, suicide rates are not published at all for those under 15. In 2011, for young adults 15-19, suicide is the second most common cause of death after road traffic accidents (ONS, 2011). The number of children and young people who talked to ChildLine UK about suicide (either as their main problem or as an additional problem) more than doubled in the five years 2004-2008. 2,291 young people called because they were feeling suicidal and this was their main reason for calling. 93% of these were aged 12-18. (NSPCC, 2009a).
between 50 and 100 times (Hawton et al., 2003b). Fox and Hawton (2004), estimate that between 40 to 100 times as many young people have engaged in self-harm than rather actually end their lives (NSPCC, 2009b).

ChildLine has reported a 59% increase in the number of self-harm callers in 2010-2011 compared to the previous year. 86% of the respondents admitted that depression was the main reason for calling. They also admitted to hurting themselves as a way of 'coping'. (NSPCC, 2012). The statistics on self-harm for young people in the UK are unreliable for a number of reasons. Many young people who self-harm will treat themselves or will be treated at home and will not reach the attention of services or professionals (Mental Health Foundation, 2006).

Suicidal behaviour and self-harming have multiple causes. Very little has been done to investigate any direct connection to school performance or examination stress, and indeed it would not be reasonable to look for single causes. However, school performance stress may be a contributing factor.

In a survey of 6020 students in 41 schools in England, it was found that 70% of those self-harming, with accompanying suicidal thoughts, had stated that this was because of worries about school work and exams. This figure was much higher than other stated problems; relationships, parents, bullying etc. (Samaritans, 2002). A survey by the UK Association of Teachers and Lecturers (2008) also found increasing mental health problems. 89% of teachers surveyed felt that tests and exams were the main cause of student stress. Other reports concur with this view. West and Sweeting (2003) found that school performance stress was having a profound affect on mental health, particularly among girls in the UK. Young Minds (2011), the UK mental health charity, is currently involved in a two-year project looking directly at the damage being done to children by the target-driven curriculum in England.

There are indications of rising cases of depression, self harm and suicidal behaviour in countries outside of the UK which also have a strong exam culture. Lee et al. (2009), in a survey of 3383 school students in Hong Kong, found a strong correlation between suicidal feelings and school failure and the pressure of exams. A Social Welfare Department of Hong Kong Report (2010) concurred with this finding. The Hong Kong government has recently commissioned a report to investigate the issue because of a spate of school-age suicides. Seven of these suicides were identified as being related to school performance problems (Hong Kong Government, 2012). In mainland China, 24% of the 2500 middle school students surveyed in Shanghai had contemplated killing themselves, many stating that this was because of the stress of exams (Moxley, 2010). Suen & Yu (2006), report on exam-induced psychological and pathological problems in China, Hong Kong and other Asian countries. Hesketh, Ding & Jenkins (2002), also in China, note direct links between depression and suicidal feelings and fear of exams. Zeng & Le Tendre (1998) found a similar connection in a Japanese study.

In the UK, and in other countries around the world, indications are that the pressure from a developing exam culture appears to be putting increasing stresses on the young, stresses not felt to the same degree by previous generations. Greydanus & Calles (2007: 61) have reported that the mental health of the world's children has worsened, with “overall increases in stress and related problems ... school failure is seen as important factor in this”.

The increase in management-based accountability systems in schools has been a developing phenomenon. The educational process in some countries has become almost synonymous with the process of testing and examination preparation. England may be at the forefront of this (House of Commons, 2007). Current trends in some countries for the ‘corporization’ of education in the name of efficiency and accountability may have altered views of education and its purposes in many countries (Kamens & McNeely, 2010).

The possible connection between increased exam pressure and mental health issues is something that has not yet been adequately researched. Suicidal behaviour, depression and self-harming have multiple causes which are biological, psychological and environmental. It is not always possible to see direct cause and effects links between exam stress and suicidal behaviour. However, the suggestion that the pressure of high-stakes exams is a contributing factor has to be given greater credibility.
The testing regimes, which have become prevalent in many countries in recent decades, have been given credit for the rise in education standards. We may also have to accept that test-driven education must take some of the blame for inducing behavioural and psychological problems.

**What can be done?**

In general terms, there is certainly an argument for moving away from what I call the 'business model' of education, with its stress on regulation, provable progress and league tables. Moving away from measurement-driven instruction to a more humanistic view of educational ideals would help. In this view, teaching the young to live happier and healthier lives, while promoting intellectual and emotional development are what matters.

A number of school-based programmes have been offered over the last 30 years to improve emotional health and knowledge about suicidal behaviour and depression. However, the success of these programmes has sometimes been seriously questioned. In some instances, evaluations have confirmed that students have attained an increased knowledge about suicidal behaviour, but concede that there is no evidence that there has been a drop in suicide rates amongst the youth groups involved (Mazza, 1997). It is clear that such evidence would be hard to obtain: if a fall had been observed it might not have been related to a school's suicide prevention programme. There have also been suggestions that such programmes have made matters worse because programmes have 'normalized' suicidal behaviour by suggesting it occurs as a result of stress, rather than emphasizing that it is often a mental health issue. Stress, including stress about exams, may lead to suicidal behaviour, but education programmes have not given sufficient recognition to the mental issues involved.

Other critics have noted that the short programmes offered are wholly ineffective (some have been given only a 2-hour time slot in the whole of a student's school life). It has also been suggested that screening students for those most likely to be at risk would be helpful, rather than offering programmes to everyone.

In some states in the US suicide prevention programmes are required by law and this has led to more time being allotted to programme development. The Signs of Suicide programme (SOS, 2012), reports significant success for its curriculum, begun in 2000. “Significantly lower rates of suicide as well as more adaptive behaviour in attitudes to depression and stress” were reported (Aseltine et al., 2007). Grades 6-12 students involved in the programme learn about depression and suicide warning signs, risk factors, and how to get help. The programme seems to makes it clear that depression is recognized as a treatable illness and so perhaps removes the criticism that programmes normalize suicidal behaviour. Students are also screened for depression / suicide ideation and where necessary follow-up assessments are made.

Recent research in Japan found that around 40% of adolescents, who self-harmed in the previous year, did not seek help. Those who self-harmed were more likely to consult school nurses, which are present in all junior and senior high schools in the Japanese school system. It was recommended that school-based mental health should screen students at risk of self-harm, and educate school nurses about preventative care (Watanabe et al., 2012).

Another recent study, in the US, found that combining a youth suicide prevention curriculum with a home-based programme significantly reduced risk factors for suicidal behaviour. In this programme, 615 young people and their parents were involved. The combined method produced “significantly greater reductions in suicide risk factors and increases in protective factors...” (Hoover et al., 2012: 233).

Some practical ways in which help may be offered have been suggested by the DEAL support programme in the UK (Samaritans, 2012). This programme promotes emotional health and develops coping skills (problem solving, conflict resolution, communication, stress management etc.). It also offers lesson plans on understanding depression and suicidal feelings. The effectiveness of this programme has yet to be evaluated.

Also in the UK, approaches based on the tenets of positive psychology have also been used by Young Minds (2012a, 2012b) and by Wellington College (2012). Both include teaching materials to help students with
'resilience', 'character strength', 'meaning and purpose' and 'mental health'. Wellington College also states they have linked with parents to introduce this curriculum.

Knowledge of the issues often helps teachers, students and parents deal with the effects of stress, whatever form it may take. Peer support training may be particularly effective: we know young people more often talk to each other about personal problems rather than an adult (Sharp, et al., 2008). Talking about these issues will increase teacher and student awareness of suicidal behaviour risk factors.

Within school, we know that students are often resistant to asking for help. Worries about confidentiality are among the main reasons for this resistance. There is still a long way to go to overcome the stigma attached to talking about emotional and mental health. Talking more openly about suicidal behaviour is, I believe, a first step in helping. (The SOS evaluation mentioned above found that 'asking for help' was the one feature of its programme that did not change student behaviour.)

Evaluating the effectiveness of prevention programmes has produced some contradictory conclusions. Some clear indications of success come from the SOS programme. Further successful indications have been seen when there is parental involvement and where students are screened for depression or suicidal ideation so that further help can be offered.

**Conclusion**

The risk factors associated with suicidal behaviour are complex. The growing importance given to exams in many countries is well documented, although making direct links between these developments and suicidal behaviour is not always easy. There are clear indications however, that the pressure to overcome the stigma attached to talking about emotional and mental health. Talking more openly about suicidal behaviour is, I believe, a first step in helping. (The SOS evaluation mentioned above found that 'asking for help' was the one feature of its programme that did not change student behaviour.)

Evaluating the effectiveness of prevention programmes has produced some contradictory conclusions. Some clear indications of success come from the SOS programme. Further successful indications have been seen when there is parental involvement and where students are screened for depression or suicidal ideation so that further help can be offered.

More research should be done on this issue. School programmes which offer help should identify exams and school performance as contributory indicators of stress and suicidal behaviour. Advising students on coping skills as part of these programmes is becoming increasingly necessary.

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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
In recent years the increasing global burden of cardiovascular morbidity and mortality associated with obesity has placed this issue at the top of the health policy agenda (Chopra et al, 2002). Numerous health promotion and education initiatives have taken place targeting various risk groups. According to the Centers for Disease Control and Prevention (CDC), rates of childhood obesity have been increasing at an unprecedented rate as they state that, “since 1980, the percentage of children who are overweight had more than doubled, while the rates among adolescents have more than tripled” (Weschler et al, 2004). One health education initiative has concentrated on targeting children before their development of obesity as a tactic of promoting the future health of North Americans. The researchers Ohinma et al (2011), examined the costs of implementing the widely promoted “comprehensive school health programme” that supports nutrition and exercise within schools in Alberta to be cost-effective, at a total of under half a million dollars in public funds.

The purpose of this paper is to review the literature showing the strengths and weaknesses inherent in various health education campaigns targeted at primary and secondary school children. Knowing the strengths in each campaign will enable the development of best practice guidelines for future healthy eating and activity campaigns. This will ensure that public funding will be allocated only to the most efficacious health education initiatives. The second section of this paper will concentrate on establishing a framework founded on the best evidence that could be implemented in schools in the Vancouver and Burnaby areas.

Several studies within North America and Europe were selected for review that met the criteria of, having been published within the past ten years and, involved an intervention that lasted over a month with a comparison group. The rationale was to ensure relevance to contemporary nutritional issues facing school children which are increased by changing marketing regimes. Another criterion was to ensure that sufficient time had been allocated to observing properly and recording quantitatively, changes between intervention groups.

Preliminary Literature Search: Devault

The preliminary literature search generated several important studies that are worth discussing. One study, conducted by Devault et al (2009), sought to address the public health problem of childhood obesity by implementing a comprehensive physical activity and nutrition programme in schools within the Tulsa district of Oklahoma. The target population consisted of 140 children in grades 1-5 who were exposed to a variety of nutrition education initiatives. One particular strength of this study is that it integrated experiential learning which has been shown to be an effective educational approach exemplified by research in Simon Fraser University's Professional Development Programme. The students in the Devault et al., study were not only educated about healthy eating but were directly involved in making nutritious meals in class. One may suggest that involving the students in participatory exercises increased the relevance of the subject of nutrition to their daily lives and had the advantage of making learning fun. Moreover, involving their student peers in healthy eating

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may have had the advantage of instilling positive peer pressure.

The researchers found significant differences in the level of knowledge acquisition and positive attitudes towards healthy eating between the intervention and control groups. Thus, an important inference may be drawn from this study. Combining theoretical knowledge through traditional lectures, in tandem with directly involving students in making healthy food choices, will have a longer lasting effect on changing unhealthy behavioural risk factors in children. Whilst the above study had certain strengths, listed above, one weakness that this study does not address is the ability of children to eat healthy meals once they leave the school environment. Although children may have more positive attitudes and greater knowledge acquisition after the educational initiative, scarce family resources may act as significant barriers towards translating knowledge into one’s daily practices.

**Preliminary Literature Search: Carlson**

Although the direct student involvement model has many strengths, several other models of interest have been implemented in health education initiatives that are worth considering. One particular model adopted by Carlson et al (2008), pertains to the involvement of health professionals in training as educators in schools. The study involved both kinesiology and dietician university students as a central part of the health education initiatives in primary school children in Michigan. This approach centered around acquiring knowledge of nutrition through student-led mentoring via goal-setting online, in tandem with traditional lectures. The main advantage of this technique, as discussed by the researchers involved, is the low economic cost of programme implementation. It thus provided the benefit enabling students to train while providing the younger students with education from health professionals in training. One weakness of this study is the lack of direct student involvement in the learning process akin to the earlier study conducted by Devault et al (2008). It may be argued that the web-based goal setting programme was a form of direct student learning. However, this initiative could have been strengthened by expanding on the goal-setting component to weekly detailed journal entries composed by students. Another weakness is that the study similarly did not address the SES status of students and the barriers which may arise when seeking to eat nutritious meals in the home environment.

**Preliminary Literature Search: Stock**

A third model has involved student peers as educators. The UBC health education initiative, “healthy buddies” to prevent childhood obesity, used a peer-led approach to promoting healthy nutrition (Stock et al. 2007). This programme was unique in that elementary school students mentored their younger peers in their school about healthy eating. The older students were essentially trained in aspects of nutrition, setting positive examples for their younger counterparts. One feature of this approach, rather than the university student approach, is that it enables students to learn about healthy lifestyles while they act as leaders and role models within their schools by promoting healthy eating and physical activity. It also has the advantage of economic sustainability that was present in their earlier study. Learning from someone who is within your school may motivate students who do not tolerate instructions well from authority figures. However, a disadvantage is that elementary school students may not be adequately prepared to grapple fully with the inherent complexities of nutrition and obesity in the same way that university health programme students can. Having health professionals monitor and assist with the educational interventions would likely maximize the benefits accrued with this form of health promotion. The researchers found that students, who were in the intervention, had improved biological markers and physical measurements associated with healthier nutritious choices, such as reduced weight and systolic blood pressure. Quantitatively assessing the impact of this health education intervention is a strength of this study as previous studies mostly examined self-reported knowledge acquisition rather than physiological findings suggestive of intervention success.

Although there is a need to educate young children and their families about nutrition and to find the most efficacious modes of translating
this knowledge (such as experiential learning, health professional interventions, or peer led approaches), there is also a need to examine social, economic, and environmental barriers.

Social, economic, and environmental barriers

None of the above studies examined the roles of the welfare state in creating opportunities for low-income families to be able to purchase nutritional meals for their children. Indeed, the CDC article, on obesity prevention and the role of schools, promoted strategies to prevent obesity which were seen in all of the studies. However, there was no mention of the role that social structures play in reinforcing inequity in healthy nutritional meal access nor a plan that may ensure equity in accessibility for all families.

Riches (2002) has criticised Canada’s dependence on the food bank as social safety nets, when in fact it demonstrates a failure of the government to enforce work and welfare policies supportive of mothers and low socioeconomic status groups. Riches argues that food banks do not enable children to receive all of the nutrients necessary for healthy development and may serve as stigmatizing points of contact for families who cannot provide for their children. Thus, in order to attenuate the obesity epidemic, there is a need for health promotion strategies in schools to be partnered with health policy initiatives that may enable children to eat healthy meals in both the school and home setting. There needs to be a clear outline that sets goals for schools, families, and welfare policies that will demonstrate how the goals of equity and accessibility will be reinforced. Gaps that exist between the school and home environment need to be addressed by ensuring continual access to healthy meals and green space for sufficient exercise. Often inequity in exercise amongst children from disadvantaged families is overlooked by many studies and policy analyses. Promoting government subsidised after-school sports programmes in recreation centres, that are safe, will ensure that children from all (socioeconomic status) backgrounds will receive sufficient exercise after school. This will maximize the efficacy of health education initiatives within schools.

Furthermore, these programmes should offer choices in exercises in order to ensure maximum student participation. None of the above studies demonstrated a curriculum that had sufficient diversity that would represent all the sports interests of students. Funding dance classes, gymnastics, and synchronized swimming alongside traditional ball game competitive sports, both in the school environment and after-school park recreation centres, will ensure that all children will be able to select exercises that they feel most comfortable. Integrating facilities for students with disabilities into the built environment will also ensure that equity and accessibility to exercise activities will be reinforced.

Environmental and political forces

In order to maximize the efficacy of health education in schools there is a need to examine environmental and political forces that may limit the efficacy of these programmes. According to Thayer et al. (2012), environmental exposures may act as obesogens by affecting the proper functioning of cells in fat synthesis in tandem with affecting one’s neurological system that regulates appetite. Specifically, a study by Kelishadi & Poursafa (2012) has demonstrated that air pollution is associated with childhood obesity and problems with fat synthesis. Educating children about healthy nutrition should only be one part of a complex strategy that has many components. There is a need to legislate environmental policies that limit childhood exposure to agents that promote obesity. Constructing schools from materials that are safe and in greener spaces is one way to complement health education strategies. Whilst obesity prevention in schools is rightfully a public health priority, there is also a need to achieve a balance between promoting reduced caloric intake with ensuring sufficient caloric intake. The researcher O’dea (2005), argues that health promotion initiatives seeking to reduce obesity in schools may have negative repercussions even though they are intended to have positive impacts on students. O’dea posits that health promoters in schools may not recognise that health education may pressure students to lose excessive weight during critical developmental periods. She argues that, “it is a common myth that overweight children and adolescents are unconcerned about their weight.
and make little effort to control their weight. One of the most concerning findings of the study was that 85% of the teachers reported recommending strict caloric-controlled diets to their overweight students, many of whom were in the middle of their adolescent growth spurts” (O’dea, p.261, 2005).

**Complementary programme**

In addition to the potential psychological harm to overweight children, a lack of a complementary programme targeting students with eating disorders perpetuates and allows this issue to permeate when not taken into account during the design stage of health promotion programmes. In other words, obesity is a public health problem that exists alongside anorexia nervosa and bulimia. Haines et al. (2011), found that high school students across the United States have a high prevalence of eating disorders, according to a national survey, as they argue that, “nearly 12% of females and 3% of males reported vomiting to control their weight and 17% of females and 10% of males reported binge eating 1 or more times a month. Approximately 24% of females and 8% of males report being preoccupied with being thinner” (Haines et al., 2011).

We find fewer initiatives to combat anorexia than obesity. Research by Torres-Mcgee (2011), has demonstrated that not only are dancers unaware of the signs of eating disorders, but that their coaches and school administrators also lacked knowledge in this topic despite ranking themselves as being knowledgeable of the signs of eating disorders. This is particularly disturbing if one considers the fact that dancers are twice as likely to suffer from eating disorders, according to a study by Herbrich et al (2011). Furthermore, the lack of knowledge about eating disorders extends beyond specialized schools and pertains equally to regular high schools. According to a study by Harshbarger et al (2011), the majority of school counsellors are not prepared for dealing with students who suffer from eating disorders. They argue that, “of the 109 respondents, 55% felt eating disorders were a problem in their school. Very few felt “very competent” identifying (6%) or helping (2%) students with eating disorders” (Harschbarger, p.1, 2011). Thus, it appears that health education resource personnel in schools are less trained in dealing with anorexia and bulimia than they are with obesity. There is a need for health promotion campaigns to promote body holism rather than support obesity prevention while allowing anorexic and bulimic students to be excluded from public health prevention, intervention, and education strategies.

One alternative model in health promotion, which Bacon & Aphramor (2011) describe, involves a campaign that supports adequate nutrition and exercise without placing any pressure on obese students nor triggering the symptoms of students with pre-existing eating disorders. It is called “health at any size” and its central tenet is that individuals should eat whenever they feel hunger and can integrate activity into their daily activities without feeling the pressure to engage in excessive exercises in the gym. However, this model does not offer exciting exercise choices for young students who need to first need to learn about different exercise modalities in order to be able to integrate them into their daily lives. Furthermore, it does not address the complex social and cultural forces that both promote obesity and anorexia. One programme in Spain, produced by the researchers Gonzalez et al. (2011), integrates media literacy with health education which has the benefit of empowering students and making them cognisant of the ideal body image types that the media wrongfully propagates.

**Summary**

This literature review has demonstrated that health education campaigns targeted at primary and secondary school students should include social, political, economic, and environmental dimensions. There is a need to integrate obesity prevention programmes with anorexia and bulimia prevention campaigns into a holistic health promotion intervention that may be universally disseminated across schools. There is also a need to improve the awareness of counsellors, school administrators, and sports coaches of the signs of eating disorders in tandem with supporting social intervention training within schools. For if counsellors are unable to effectively deal with anorexia then whom may these students count on for help? Counsellors should act as first points of contact
for both social intervention and primary healthcare referrals. Other lessons from health education initiatives are that an ideal programme should involve many stakeholders and professionals. While peers may promote health nutrition effectively, there is a need for dieticians, trainers, psychologists, social workers, health policy analysts, environmentalists, health scientists, and politicians to be involved in the promotion of healthy nutrition and exercise among school-aged children. Social inequities in accessibility to nutritious meals and exercise programmes need to be addressed. Health education initiatives need to integrate ways to ensure that parents will be able to send their children to sports programmes and purchase healthy meals irrespective of their socioeconomic status.

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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
On Sunday February 9, 1964, The Beatles made their debut on US television. Their appearance on the *Ed Sullivan Show* drew an estimated audience of 73 million people. One of the most quoted consequences associated with this particular show was that between 8pm and 9pm when the show was aired, a number of news reports claimed (without any supporting evidence and so almost certainly fallaciously) that there was no reported incidence of juvenile crime across America during the time of the broadcast. Moreover, the editor of Newsweek, B.F. Henry, went as far as to claim that “there wasn’t so much as a hubcap stolen” during the hour that The Beatles were on the show (Bell, 2011). This apocryphal tale, at the very least, shows the apparent compelling logic in the argument that when an activity is so engrossing it has the capacity to stop people engaging in other types of activity such as crime. Inspired by a speculative blog post on the topic (Sutton, 2010) and supported by some very recent research by Cashmore (2012), which failed to disconfirm what we refer to in this paper as the Crime Substitution Hypothesis, this article briefly examines the extent to which popular youth activity (namely video gaming and social networking) may be having an effect on youth offending and victimization.

**Adolescent media use in a multi-media world**

In contemporary society, television does not have the same pulling power that it had back in the 1960s. Work and leisure have become increasingly technologised and remote for both adults and children (Griffiths, 2010). Activities that were once done in a dedicated external environment (e.g., an amusement arcade, cinema, chatting to friends) can now be done in the home or the workplace. This has led to ‘cocooning’ where a majority of activities can be done without ever having to leave the home and/or the work desk (Griffiths & Wood, 2000; Griffiths, 2002). Paradoxically, this cultural shift in increased technology has also led to an increase in leisure on the move (e.g., mobile gaming) that again may have implications for the activities such as crime.

Young people’s use of technology (the so called ‘screenagers’ and ‘digital natives’) has increased greatly over the last two decades and a significant proportion of daily time is spent in front of various screen interfaces most notably videogames, mobile phones (e.g., SMS) and the Internet (e.g., social networking sites like Bebo, Facebook) (Griffiths, 2010; Griffiths & Kuss, 2011; Kuss & Griffiths, 2011a; 2011b). These ‘digital natives’ have never known a world without the internet, mobile phones and interactive television, and are therefore tech-savvy, have no techno-phobia, and very trusting of these new technologies.

Technologically-based activities such as video gaming and social networking have been accused by social science researchers of many things both positive and negative. One of the most empirically researched areas is in the area of adolescent video gaming. Negative consequences of gaming have included addiction (Kuss & Griffiths, 2012), increased aggression (Anderson, Shibuya, Ihori et al., 2010), and a variety of medical consequences, such as repetitive strain injuries, obesity, and photosensitive epilepsy (Griffiths, 2005a). There is certainly evidence that, when taken to excess, videogame playing can in some cases be addictive, especially online videogame playing.
where the game never pauses or ends, and has the potential to be a 24/7 activity (e.g., Ng & Weimer-Hastings, 2005; Grüsser, Thalemann & Griffiths, 2007). However, there are many reported benefits that adolescents can get from playing videogames. These can be educational (e.g., Griffiths, 2010; de Freitas & Griffiths, 2008), social (e.g., Cole & Griffiths, 2007; Hussain & Griffiths, 2008; 2009) and/or therapeutic (e.g., Griffiths, 2005a; 2005b). Another positive benefit of playing video games along with activities like social networking may be the capacity to reduce youth crime.

**Video games and cognitive distraction**

One innovative application of videogames that may have implications for crime reduction is their use as ‘distractors’ in the role of pain management. The reasoning is that ‘distractor tasks’ consume some degree of the attentional capacity that would otherwise be devoted to pain perception. Griffiths (2005b) noted that the main reasons that videogames make good distractors are because they:

1. Are likely to engage much of a person’s individual active attention because of the cognitive and motor activity required.
2. Allow the possibility to achieve sustained achievement because of the level of difficulty (i.e. challenge) of most games during extended play.
3. Appear to appeal most to adolescents.

One study (Philips, 1991) reported the case of an eight-year-old boy with neurodermatitis being given a handheld videogame to prevent him from picking at his face. Where previous treatments had failed, the use of the game kept his hands occupied and within two weeks the affected area had healed. A number of studies have demonstrated that videogames can provide cognitive distraction for children undergoing chemotherapy (e.g. Kolko & Rickard-Figueroa, 1985; Redd et al., 1987; Vasterling, Jenkins, Tope, & Burish, 1993; Kato, Cole, Bradlyn & Pollock, 2008) or for those with sickle cell disease (Pegelow, 1992). All these studies have reported that distracted child patients report less nausea after treatment (when compared with control groups), and that playing videogames reduced the amount of painkillers the children needed during treatment.

The very reasons why video games may be of benefit therapeutically may also be applied to video games in a crime reduction context (i.e., the playing of video games is so cognitively distracting that that there is little time to do or think about anything else).

**Adolescent video game playing, social networking and crime reduction**

One of the most frequent accusations made against video games is that they may make players more violent and cause an increase in violent crime (Anderson et al., 2010). This debate has been reported extensively elsewhere (see Anderson et al., [2010] for a recent review of the literature) and beyond the scope of this particular article. However, there is also a developing school of thought arguing that peoples’ participation (especially excessive use) in video gaming and social networking may be contributory factors that may partly explain the fall in crime rates in recent years.

Clearly, there are a variety of reasons for the continued decrease in crime rates including advanced policing techniques and technology. However, the economist Katz (2010) suggests that the playing of video games may also play a role in crime reduction. Katz’ reasoning is simple – keeping people busy keeps them out of trouble. There appears to be some statistical support for such a hypothesis as the decrease in US crime rates appears to show an inverse correlational relationship with increased sales of video game consoles and video games (Game Politics, 2008). Clearly, this correlational evidence should be treated with caution as it says nothing about causation. However, it does provide a hypothesis that could be the subject of future empirical testing. Crime has been falling in the US and UK but, as yet, there is no particularly compelling or well evidenced cause. Could adolescent video game playing and/or social networking be unexplored contributory factors?

**Routine activities theory**

According to Felson and Boba (2010), ‘routine activities theory’ is a "theory of how crime changes in response to larger shifts in society. The key to such change is the technology of everyday life, which organizes where we are, what we do, and what happens to us. That
technology governs how crime carves its niche into everyday life". Furthermore, and according to Willison (2000): "This theory has its intellectual roots in the human ecology work of Amos Hawley which recognises the importance of the timing of different activities by hour-of-day and day-of-week for understanding human society. This last point is central to routine activity theory, which addresses changes from moment to moment and hour to hour in relation to what people are doing, where they are, and the consequences of these as a result."

With the advent and increasing popularity – indeed, necessity – of the Internet, and the huge rise in mobile communications technology since the mid-1990s, we might have expected crime to rise dramatically as cyberspace grew as an environment to be exploited by the criminal fraternity. Routine activities theory (RAT) certainly sees that it should be that way. As Felson and Boba (2010) note: "The age of speedy Internet communications provides new options for youths to break laws, often operating out of their homes. They can produce their own pornography. They can view pornography by others. They can sell themselves as prostitutes. They can make sexual liaisons with those of their own ages or well beyond their own. They can send and/or receive threats via the Internet and buy or sell contraband goods. They can, at a young age, learn how to hack the computers of others or distribute computer harm in various ways. They can participate in cyber chat rooms to discuss all of this" (p. 111)

Strangely, Felson and Boba appear not to have considered that RAT would suggest that all the time spent online must equate to less time on the street leading to less potential offending time and a smaller population of available victims of violence and robbery.

Could the rise in video game playing and social networking be a major cause of what criminologists claim is an unfathomable drop in crime, and if not, then why not? RAT predicts that if substantial numbers of young people are not on the streets either as victims or offenders then overall high volume ‘crime opportunities’ would diminish, resulting in an overall drop in high volume crime rates. We have no idea yet whether what we might call the ‘crime substitution hypothesis’ is plausible. So we thought we would set out some ideas that support it as something possibly worthy of further exploration.

As highlighted earlier in this article, research suggests some young people are spending many hours playing video games or social networking (Kuss & Griffiths, 2011a; 2012). Research also suggests that video games can be engrossing, addictive and in some cases compulsive (Griffiths, 2008). Additionally, research has failed to establish that violent media are either a necessary or sufficient condition for causing crime. Therefore, taking a Routine Activity Approach, it would seem that an increase in video gaming might feasibly lead to a rise in the illicit market for stolen computers and games consoles. However, there might be fewer thieves to supply it if:

- Fewer potential offenders are getting addicted to opiates and other drugs, and/or misusing alcohol out of boredom because they have escaped boredom in the real world by entering the more exciting world of cyberspace to play and interact with others.
- Potential offenders and victims are gaming excessively and/or compulsively checking Facebook and/or other social networking sites.
- The game players and other "netizens" are playing at home so (a) fewer potential offenders on the streets and fewer potential victims, and (b) houses are occupied for longer and so less susceptible to burglary.
- Immersion and gaming prowess and reputation may be sufficient substitutes for the same things in the offline (real) world.
- The Internet allows more people to work from home so teleworking may reduce the pool of "available" victims on the street and also ensure fewer homes are empty during the day.

Ferell’s (2004) work on boredom does not examine this issue. Instead, he focuses upon how boring modern life is caused by workplace and urban planning that forbids spontaneity. Spontaneity leads to friction with the criminal justice system. Here, the ‘system’ offers us places of entertainment such as shopping malls, cinema and nightclubs – all to be used only in prescribed ways, which leads therefore to expressive offending or else boredom that is one
cause of drug misuse leading to addiction. But gaming and social networking is a manufactured entertainment virtual space. Ferrell’s argument might explain why virtual vandalism is committed. But Ferrell does not consider how a manufactured environment – online or offline – might reduce crime. The Routine Activities Theory is a theory of how crime shifts and changes in relation to changes in society. The key to such changes is the technology of everyday life.

Conclusions

In this article, we have speculatively argued that one of the reasons for falling crime rates may be an increase in adolescent gaming and social networking engaged in by young people (the ‘crime substitution’ hypothesis). The evidence provided was anecdotal and/or correlational in nature but we would argue that this would provide a fruitful avenue for further research. Such research into ‘crime substitution’ and gaming/social networking might involve: (i) measuring time spent gaming and social networking by groups that empirical research predicts are at greater risk of becoming offenders, (ii) conducting ethnographic studies with young people to gauge whether, and if so to what extent, gaming and social networking are used as a substitute for risky activities in the offline (real) world, and do this in relation to both potential offending and victimization, (iii) examining issues of offline and online peer status and how this may impact on consequent behaviour (including criminal activity), and (iv) further examining the correlation between console and game sales – and any data on playing time and type of games – with the general crime trend over the past 20 years.

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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
Since I last wrote on integration in 2005, (Richardson-Todd, 2005), Suffolk has edged nearer to inter-agency working. In May 2011, by leaving the NHS and coming under the auspices of the local authority, health visitors and school nurses joined the integrated children’s service teams within the county council, which also consisted of social workers, family support practitioners and youth support workers education, early years support and wider services to support children and families.

Integration could be defined as a single system of service provision and it is not the same as coordinating separate systems but integrating services for young people. A national policy, is being interpreted differently in different parts of the country. There is a long continuum which ranges from co-location and better links between those delivering services to young people, right through to the delivery of all services to young people through wholly integrated locality-based teams.

According to my local authority, integrated service delivery is "a way of working alongside children, young people, their families and communities where everyone shares responsibility for promoting safety, well-being and learning. All recognize their role in identifying need, meeting challenge and building resilience and will have the confidence and skills to secure best outcomes and opportunities for children and young people" (Suffolk County Council, 2011).

Practitioners should be enabled and encouraged to work together in more integrated front-line services, built around the needs of children and young people, using common processes which are designed to create and underpin joint working and at the heart a child-centered, outcome-led vision.

The local vision is for Children and Young People’s Service to enable all children and young people “to aspire to, and achieve, their full potential, giving them a basis for a successful life as active members of their community” (Suffolk County Council, 2011), and to guide staff, children, young people and their families/carers to realising this vision are the values of empowerment, respect, innovation, collaboration and commitment.

Drivers

Some of the national drivers for change have been the economic climate with a reduction in funding for public services; localism, with the concept of the ‘Big Society’ and building partnerships with communities as well as the growth of Academies and Free Schools.

The following documents (Suffolk County Council, 2010), are also impacting on services for children, young people and families:

- Child Poverty Strategy: “A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families’ Lives” This includes removing financial disincentives to work, encouraging early targeted work with needy families, improving health outcomes and tackling disadvantage.
- Munro review of child protection emphasis on reduction of bureaucracy and reforming social work education, changing the way Serious Case Reviews are undertaken.
- Wolf Review of vocational education including changing the nature and improving the quality of some vocational qualifications pre-16 and allowing FE lecturers and professional to teach in schools.
- SEN and Disabilities Green Paper including proposals to replace the current statements with a single assessment process and a combined Education, Health and Care Plan.
The Review “Early Intervention: the next steps” independent report to Her Majesty’s Government” by Graham Allen highlights evidence-based early intervention programmes and strategies to provide a ‘social and emotional bedrock’ for children and young people before the problems arise.

Education Bill including amongst other elements the removal of the duty on schools and colleges to cooperate with Children’s Trusts and for schools to have regard to the area’s Children and Young People’s Plan

Health and Social Care Bill including proposals that:
- make consortia of GPs responsible for commissioning services
- establish HealthWatch as the national voice of patients and the public
- give Local Authorities responsibility for public health improvement (currently resting with PCTs)
- create Health and Wellbeing Boards (HWBs) bringing together GP consortia, Departments for Public Health, children’s services, adult social services and others and will have a statutory responsibility to develop a ‘joint health and wellbeing strategy’
- abolish Primary Care Trusts (PCTs) (2012) and Strategic Health Authorities (SHAs) (2013)
- create Public Health England

Common Assessment Framework

A vehicle to ensure swift and easy access to services is the Common Assessment Framework (CAF). This is a national initiative to develop common methods and processes for conducting an assessment of the needs of a child or young person and deciding how they should be met. It is designed for use by practitioners in all agencies so they can communicate and work more effectively together and there is less need for the family to repeat their story. As part of this process, appointing a lead professional will support children and young people who have a range of additional support needs. Better service co-ordination and increased communication and information sharing is encouraged where appropriate and more clarity given as to what professionals can share with whom.

The benefits for children, young people and families are the “No wrong door” policy which is a single point of contact giving easier access to the appropriate services, and information to ‘navigate’ services, early identification and resolution to difficulties, faster more co-ordinated and appropriate response and a better service experience for families.

The core professional purpose is to ensure safety, well-being and learning for all children, young people and families. The national expansion of the Health Visiting Service is to ensure, amongst other elements, the delivery of the Healthy Child Programme. By 2015 there should be an extra 1268 health visitors in the East of England and large numbers are being trained over a three year period. The Department of Health document on health visiting, “A Call for Action” (DH, 2011) has a new model for health visiting consisting of community, universal, universal plus, universal partnership plus, safeguarding. This model is also being adopted by school nursing.

The Healthy Child Programme

The Healthy Child Programme (HCP) is for children and young people aged 0-19 and supports a model of progressive universalism – a core programme for all children, with additional services for children and families with particular needs and risks and provide greater emphasis on promoting the health and wellbeing of children in the early stages – pregnancy and the first five years of life.

It focuses services on changing public health priorities by supporting the establishment of healthy lifestyles: reducing obesity by healthy eating and exercise; breast feeding; smoking cessation; parenting groups and support; harm reduction from drinking and substance misuse; sexual health – increase the proportion of 16-25 year olds screened for chlamydia; safeguarding children and their families through early identification and intervention; increasing detection and support for women with mental health needs; social and emotional development; supporting children with additional needs and improving the emotional wellbeing and support for children and young people within schools to reduce absences and improve behaviour.

Working within an inter-agency and multi-skilled team is not without its challenges: there are diverse cultural and working practices
which can impact on information sharing/development of common protocols. This is compounded by geographical distance and fragmentation of services. There may be a lack of knowledge of each others services and roles and how/when to refer and the need to align priorities/resources to address common needs made more challenging at a time of re-organisation/restructuring within partner organisations. On a more basic level, issues such as co-location, work space and hot desking can bring their own problems. It is a new mind set for staff.

We need to appreciate different ways of working and understand different use of language/jargon; we have to establish role boundaries and deal with any power issues. Team members are coming from different backgrounds and the integrated teams will be multi-disciplinary and inter-organisational in their make-up. If workers from different professional backgrounds are to work well together successfully, they need to make an effort to understand others’ professional cultures and be clear about their own role and responsibilities and that of the other members of the team.

Although working in an integrated team, it is vital to establish clear lines of accountability wherein those responsible for tasks, milestones, actions and intended outcomes are visible presences within the team. If there is no ultimate responsibility, individuals are left in a vulnerable position. If the integrated team is to be a success, team members need to have a clear, shared purpose and vision.

**Our promise to children and young people**

Integrated Services provide early help to enable children, families and young people to make things better for themselves. Our promise to children and young people -

**We will:**
- listen to you
- treat you with respect
- treat information confidentially unless we have to share it to keep you or someone else safe
- be honest with you
- do what we say
- keep you informed
- ask you before taking any action
- give you one main person to speak to
- not ask you to repeat basic information
- with your agreement, link with other services to support you
- reply to any messages from you promptly
- ask you whether or not we’ve helped

**Case Study 1**

The school nurse was invited to be part of the Team Around the Child (TAC) meeting which also consisted of parents, teacher, education welfare officer (EWO), outreach worker from the county inclusion support, behaviour support worker and family support worker from children and young people’s services (social care). The issues were around an 11-year old autistic girl in her first term at high school having poor school attendance. Because of her autism spectrum disorder, she did not like change and the transition to high school had been traumatic alongside the added onset of puberty. The school nurse was asked to intervene to give health education, advice and support in order for the girl to deal with, and accept, her changing body and emotions. The girl was very bright but uncommunicative to many staff and even to her mother about personal things. The girl was invited to attend the drop-in or to see the school nurse by appointment but because it takes her a long time to build trusting relationships, she refused to see the nurse. Having looked at the register, there appeared to be a pattern of school absences, and the school nurse realised that the absences were when the young girl had her period.

The nurse gathered relevant information and resources which were age and cognitively appropriate and offered them to the girl’s mother, advising her to place them under her daughter’s pillow. The daughter found them and read them and took on board the information, which she might not have done if it had been offered verbally. Her autistic condition suggested that this was the best way forward. Young people learn in different ways and if one method fails, try another approach. If a young person won’t engage, then support can be offered via the family (with young person’s consent if appropriate) Mother, school and
EW0 were extremely pleased and grateful as the girl is now attending school when she is menstruating and has accepted the changes in her body.

Case Study 2

Working closely with the student managers at a high school, a referral was made concerning a 13 year old girl with complex emotional needs resulting in self-harming. She had older siblings and younger half-siblings and there were unpredictable family routines adding to child’s emotional stability. The intended outcome was to assess the immediate risk to the child, ensure her safety and identify any support systems that are available to her.

The school nurse met the girl in school during a lunch time and the aim of the first meeting was to build trust and develop rapport to enable her to disclose her feelings. It was evident that she found it difficult to vocalise her emotional needs. There was discussion around the past history of her social background and reasons contributing to her self-harming. During this meeting the school nurse discussed with the girl the issues of confidentiality and consent to share information disclosed.

Established practice was to discuss with a person responsible for the child’s wellbeing the events that had occurred. The girl was aware of this and consent was given by her for the school nurse to speak to her parents. This was quite positive as she felt unable to discuss these feelings directly herself and at all stages the child was aware of the actions of the school nurse.

During the discussion with the parent, mother was advised to contact the GP to make an appointment to discuss events as this was highlighted as being of high priority. The school nurse wrote a supporting letter to the GP highlighting the concerns.

The school nurse also spoke to her safeguarding named nurse and she agreed the appropriate action had been taken. The school nurse then discussed the case with the primary mental health worker who re-iterated that the appropriate course of action had been taken. The health professionals were in agreement that a referral to social care via Customer First must be the first intervention taken.

A week later, there was a follow up meeting and the school nurse found the child to be more at ease to discuss the situation. She disclosed she had stopped self-harming and was more able to cope and to talk to parents.

Benefits

The school nurse was able to give support via the student manager and close links with the school. The child was invited to the drop-in to provide ongoing support. The school nurse had open discussions with the parent as to how best to address the child’s needs and was available to talk further if they felt the need. The way was open for closer child/parent communication.

Risks

The child and parent could become over dependant on the support of the school nursing service. When services are withdrawn the child could feel vulnerable again but with the ongoing support of the student manager and school nursing team we will aim for her to maintain emotional wellbeing and equilibrium.

The initial assessment commenced in September and completed in November. The parent felt positive and we had provided a beneficial and supportive service to her daughter. The child said she felt much better in herself and able to cope and would know she can access the school nursing service should she need further advice or support in the future.

The child felt more positive which in turn had a good effect on her social and family relationships.

References


Elisa J. Sobo
High physical activity levels in a Waldorf school reflect alternative developmental understandings

Public education in the USA is infamous - rightly or not - for relatively poor learning outcomes. Standardized testing, meant to correct for this, has exacerbated the problem. For example, the concurrent decrease in time students have for physical activity correlates with lower academic achievement rates (Centers for Disease Control and Prevention, 2010; Donnelly and Lambourne, 2011). The heightened stress and fear that high-stakes testing provokes in students also has undermined the test-centric strategy (e.g., Rushton and Juola-Rushton, 2008).

Increased recognition of the high costs of neglecting students’ physical and emotional well-being has supported a growing call to make more room for physical activity during school (e.g., Robert Wood Johnson Foundation, 2008). The general approach to augmentation is modular, as seen, for instance, in recommendations to take “activity breaks” and related concern for doing so without “disrupting” instruction (Alliance for a Healthier Generation, 2012).

Waldorf or Steiner schools advocate a more holistic approach. In this alternative to the orthodox state education system, movement is not confined to break activities, and bodies—and emotions too—are part of reading, writing, and arithmetic instruction. Yet, in part because Waldorf (Steiner) education bases its promise on a developmental pediatric framework that differs significantly from that of the mainstream, and in part because it is independent and therefore assumed irrelevant to the broader public, university-based researchers and education policymakers have long paid it little heed. Waldorf education’s exponential growth and status as one of the fastest growing independent education movements today (Barnes, 1991; Sagarin, 2011) make such cultivated ignorance tenable no longer. The time has come for close and careful inspection of what Waldorf does and why.

This paper outlines the developmental framework underlying Waldorf education’s approach and then describes how teachers put it to use in relation to the call for getting students moving. The paper identifies classroom practices that might be translated for use in other school settings where ‘whole child’ approaches are valued. It also argues that a body-based conception of “movement” settles for too little; in Waldorf education’s world view, thinking and feeling also must be mobile for children to reach their full developmental potential. This triadic model (body, thought, emotion), with its focus on dynamism, stands in contrast to the dualist model (body, mind), fostered in mainstream Western thought as a legacy of Cartesian dualism and the static focus on the disembodied mind that standardisation relies upon.

Methods and settings
This paper draws on findings from the Healthy Child Development Project, which examines the Waldorf community’s health-related knowledge and practices from a medical anthropology viewpoint. The project included a document-based investigation undertaken to derive a conceptual model of the developmental pediatric framework espoused by Waldorf education’s founder, Rudolf Steiner, and used in Waldorf teacher training today. In addition to Steiner’s works (e.g., Steiner, 2007) relevant secondary sources (e.g., Glöckler, 2002; Schoorel, 2004) were reviewed.

Subsequently, an ethnographically oriented study was undertaken at an accredited Waldorf
school. Data collection focused on teachers, and included unobtrusive classroom observations in two pre-K and two kindergarten classrooms (grouped together in the analysis, as per teacher recommendations, as “early childhood”) and in the classrooms of grades one through three (grouped together, again as per teachers, as the “lower grades”). Grade three provided a natural stopping point due to Waldorf education’s position that a new sub-stage of childhood begins with fourth grade. Thus, the project concerns instruction for the four-to-six age range (pre-K/K) and the seven-to-nine age range (early elementary).

The school is 30 years old and serves 280 pre-K through twelfth grade students whose ethnic mix is 4 percent ‘Asian’, 3 percent ‘Black or African American’, 9 percent ‘Hispanic or Latino’, 60 percent ‘White’, and 24 percent ‘Two or More Races.’ Notably, the latter compares to 2.1 percent county wide. The school does not collect household income data but records show it received 166 tuition assistance applications for 2009-10. Average tuition paid that year was $6,802 (personal communication, May 31 2011)—notably less than the tuition of $16,000 to $28,000 reported for other area private schools (Latrell, 2010) but comparable to the estimated cost-per-pupil at a typical public school in the area (Anonymous, 2011), particularly when underreporting in that system is taken into account (Schaeffer, 2010). School fees are comparatively low in part because classrooms house no technology—partly for reasons related to findings described below.

The study included eighteen participants (seven lead teachers, nine support teachers, and two staff members in teaching-relevant positions). At least one week was spent observing in each class or grade, accounting for a total of about 175 classroom hours. I also undertook individual and group faculty and staff interviews. A grounded theory approach was taken, with analysis ongoing during, and informing, data collection (Glaser and Strauss, 1967; Strauss and Corbin, 1998; see also Sobo, 2009). Emergent themes were identified in relation to on-the-ground practices and teacher reflections on pedagogical choices.

Findings

Developmental Pediatrics of Waldorf Education

Waldorf education is based on a developmental model articulated by its founder, Rudolf Steiner, as part of a broader philosophical platform called anthroposophy (translated as ‘humanity’s wisdom’). Anthroposophy itself is not taught in the schools but teachers’ methods and curricula are informed by the understanding of child development that anthroposophy espouses. The schools thus have “a proven track record [for enabling students] to find their creativity and to become free individuals who can think for themselves, make their own judgements and find their own purpose and direction in life” (Steiner Waldorf Fellowship 2011).

In Waldorf educators’ view, as per Steiner’s, the human body comprises three systems: the head system, the chest or cardio-pulmonary system (also called the rhythmic system due to the rhythmic activity of the heart and lungs), and the limb system. The limb system is said to extend somewhat into the abdomen, as it includes non-rhythmic, metabolic organs such as the liver and intestines and it sometimes is informed also by knowledge gained through my direct participation in the system as a Waldorf school parent. I thereby stand in relation to my topic just as do all state education system researchers whose children go or went to, or who themselves have been educated in state school settings and, indeed, to all researchers who study things like eating, sleeping, reproduction, and death.

A real limitation, however, was that the research involved no children. As such, children’s experiences of moving and being moved remain unknown. As well, teacher training was not taken into account ethnographically. Moreover, the study focused on one school only; despite programmatic and aesthetic similarities between Waldorf schools worldwide, meaningful differences in how the basic developmental pediatric framework is construed and applied may exist. Notwithstanding, the paper helps fill the wide gap in our scholarly knowledge about Waldorf education as well as providing ideas for how movement could be enhanced in other school settings.
called the metabolic-limb system after this fact. A major task of Waldorf educators is to ensure that the three systems, and all that they pertain to, get the environmental support necessary for their healthy development.

The three systems are said to express three modes of engagement: thinking, feeling, and willing. These are all “soul activities.” Although soul forces per se are most firmly at home in the chest, they permeate our whole being, with willing or doing most active in the limbs and metabolism, feeling or experiencing most active in the mediating chest, and thinking most active in the somewhat distanced head. The limbs are thought to act as conduits through which soul and spiritual forces enter children.

In Steiner’s view, at different phases in the life course, different systems and so different soul activities dominate. From birth until age six, a time when so much physical growth occurs, the metabolic-limb system dominates as does the activity of willing or doing (following through). From seven through thirteen, we are chest-ruled creatures, with feeling at the forefront of how we engage with the world. And at puberty, our head and other hardened parts, such as the intellect, become mature enough to be put to work. In keeping with this trajectory, pedagogy begins with a focus on encouraging physical imitation, then strives mainly to mobilize imagination, and later on will include lessons that use analytic logic or independent judgement (see Table 1 below).

This triadic model challenges, in Steiner’s words, the “erroneous conception of the twofold division of the human being” (2007, pp.41-42). Indeed, Steiner viewed Cartesian dualism, in particular, as “one of the great mistakes… of the last few centuries” (p.27)

Early Childhood: Ages Four through Six

Waldorf education does not displace active learning in early childhood classrooms with sedentary academics as many other systems have done. This is because pre-K and kindergarten-age children are seen as “incarnating”—entering, developing, and learning how to live with and through their bodies—and so stilling them would be unhelpful and unhealthful. The will needs to penetrate the body to the fingertips and toes, and productive work that engages the hands and legs, keeping them moving—digging, sanding, kneading dough, sweeping—is best for this. Keeping the limbs in movement likewise, it is believed, helps to spiritualize the body in a broader sense, drawing in spiritual substance into the child’s being from the universal sphere.

No attempt is made of formal instruction in early childhood classrooms, for this would cause premature hardening of the intellect, leading to inflexible thinking in adulthood. Rather, teachers leverage young children’s imitative tendency; they strive to set good examples and engage their charges actively to do as they do: to chop carrots for soup, knead bread, sweep the floor, and sew. They encourage them also to use their bodies in creative play; classroom furnishings can be moved all about, piled up, and turned over as boats, dragons, houses and other structures; as well, children are taken out to play even in inclement weather. Props used in play outside are mainly tools (e.g., watering cans, shovels, buckets) and natural objects (e.g., stones, found bugs, bits of wood).

Engaging children in whole-body activities is said to promote the full development of proprioceptive, balance-related, and gross and fine motor skills—upon which later learning and academic success will depend. Teachers say sweeping, for example, allows children to gain mastery in crossing their vertical midline, key to the kind of right-left integration that skillful writing demands.

The Lower Grades: Ages Seven through Nine

Once in the lower grades, teaching by allegory joins teaching by example. Teachers strive to provide children with lots of imagery now to drive learning; they use words poetically to create engaging “pictures” that, once children

<table>
<thead>
<tr>
<th>Stage of childhood</th>
<th>Primary force to be awakened</th>
<th>Corresponding system</th>
<th>Primary mode of engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 years</td>
<td>Willing (‘hands’)</td>
<td>limb system</td>
<td>Imitation</td>
</tr>
<tr>
<td>7-13 years</td>
<td>Feeling (‘heart’)</td>
<td>chest system</td>
<td>Imagination</td>
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<tr>
<td>14-20 years</td>
<td>Thinking (‘head’)</td>
<td>head system</td>
<td>Judgement</td>
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take them into their imaginations, mobilize further inquiry or contemplation by fueling a sense of connectedness to subject matter. Wet-on-wet painting, in which watercolors are applied to wet paper so that mobile interaction of the paints occur, also is used to stimulate children’s “feeling life.” In this and other chest-focused ways, teachers move children to learn.

Teachers encourage students to move their limbs during lessons too. For instance, in one class observed, students practicing spelling some new words were directed to rise. In single file according to seat, they walked toward the far wall chanting one letter with each step: “M, O, N, K, E, Y!” They did not stop there. Backward they marched: “Y, E, K, N, O, M!” Not all children got the letters right coming back, but they would work on the words repeatedly in the weeks to come.

The next word was ‘their,’ and the children stumbled a bit. “Stop,” said the teacher. “That was not so good and I’ll tell you part of the problem. People are taking silly, too big steps.” They tried again, organizing themselves a bit better this time, calling the letters out now in order for the most part as they stepped: “ R, I, E, H, T! T, H, E, I, R!”

Math lessons also involve movement. For example, students may toss bean bags back and forth, clap, or even do “donkey kicks” (very fast handstands) or jump rope while reciting times tables. One teacher had students create a “number sidewalk” by drawing numbers on large pieces of paper and then laying these out in a line, zero through twenty. One by one, the children were called up to the number sidewalk to work out an equation each, after which they were to recite the entire equation and then write it onto the board. The first child to go, a volunteer, was given the equation “four plus two equals what?” and led to the four by the teacher, who again said “four plus” and then “one, two” as the boy walked forward two spaces. Ending on six, the boy announced “four plus two equals six!” Smiling, he recorded this on the board as the next student came to the sidewalk.

These students first worked their equations out physically; only later did they write them on the board. The learning happened, the teacher said, through moving and speaking; writing “brings it to consciousness,” helping students become conscious of what they have learned while the hand and arm embody it. Some think, the teacher lamented, that “our bodies are there to get our heads around from one meeting to another”—but Waldorf education “is not a head to head education.”

Like math, subjects labeled by the mainstream as non-academic incorporate movement too. Music, for example, inherently involves the body: students finger a flute and blow into it, and use breath to sing. They clap and stomp in rhythm; they move their bodies when songs have associated dances or ring games. Even foreign language classes entail movement, for example through songs in which students march and use their arms and hands to indicate story lines or ideas (a bunny hopping across a field, a wolf’s long nose).

Teachers often used beanbags in lessons, asking students to pass them in various ways around their bodies, such as from left to right hand in a rainbow arch made over the head while repeating a verse, or in a figure eight around marching legs while counting. Teachers say that physical skills translate into academic skills both through imputed neurological channels, such that what appears to be play facilitates sitting squarely on one’s chair by enhancing right-left integration and knowledge of one’s balance points; this in turn leads to academic success. Similarly, the finger and hand dexterity encouraged in handwork class via knitting facilitates writing skills; nimble fingers also are said to help build nimble minds. And, for handwork as for other productive endeavors undertaken during schooling (e.g., gardening, cleaning, building), the act of making useful objects or doing useful and therefore meaningful work with one’s limbs is itself spiritualizing and healthful (see Steiner 2007, pp.176-178). A child at home in his or her body is better prepared to do well in academically (see McAllen 2004; Blythe 2005).

Conclusion

The scientific literature associates increased physical activity with academic gains and myriad policy briefs endorse increased movement (Centers for Disease Control and Prevention, 2010; Donnelly and Lambourne, 2011), as do Waldorf educators. This does not mean that Waldorf education follows a dualistic
mind-body model. On the contrary: Waldorf education’s ‘whole child’ approach includes a third component: feelings. Like the limbs, which Waldorf education strives to keep in movement (first to educate the will and spiritualize the child, then to cement learning), the feelings or chest system should be mobile also. Teachers strive to stimulate children emotionally, engaging them not only with subject matter but also with the world as a whole, fostering in each student a deep sense of connectedness to beings beyond him- or herself. Waldorf education’s developmental pediatrics support the incorporation of physical activity directly and seamlessly into classroom-based lessons rather than saving it for breaks or offering it as an add-on. These examples help to broaden our thinking about increasing movement in the classroom.

References


Mental health-related stigma is a global predicament, since it causes social exclusion for people with mental health problems (Thornicroft, 2006). It might also prevent people from accessing mental health services, since they expect discrimination in society against people who have a diagnosis of a mental health condition (Thornicroft et al., 2008). Considering the fact that many individuals have an onset of psychiatric symptoms during their adolescence (Costello et al., 2006), mental health-related stigma amongst young people is one of the central issues related to psychiatry, health and education.

A recent media campaign in Canada called In One Voice, on the Mind Check website (Mind check, 2012), has addressed this issue. The campaign included a 2-minute public service announcement featuring a popular Canucks’ player speaking about his teammate, discussing mental health issues, and promoting mindcheck.ca. The campaign also aimed to: 1) increase activity on an interactive and youth-focused website as a vehicle for improving mental health awareness, and 2) improve attitudes and behaviours towards people with mental health problems (Livingston et al., 2012). The campaign was an original way to focus on youth awareness, and to employ online social media such as Facebook, Twitter, and YouTube rather than traditional media (e.g. newspaper and radio).

Livingston et al. (2012), have carried out an interesting study examining the effects of this Canadian campaign awareness, attitude, social distance and behaviour towards people with mental health problems. The authors concluded that the campaign could raise awareness, but did not improve attitudes, social distance and behaviour towards people with mental health problems (Livingston et al., 2012). The findings of this study give us valuable insights that we shall discuss. We will base our commentary upon recent systematic reviews including our own work as well as using recent studies related to large-scale mass media campaigns.

What types of stigmatisation are targeted for mass media campaigns?
Mental health-related stigma normally involves three dimensions (Jorm, 2000; Thornicroft et al., 2007); problems of:
1. knowledge (ignorance) including own mental health awareness, mental health literacy and help-seeking interventions,
2. attitudes (prejudice) including behavioural intentions and social distance,
3. behaviour (discrimination).

While the Canadian online media campaign successfully improved mental health awareness, it was not effective in improving attitudes and behaviour towards people with mental health problems (Livingston et al., 2012). This concurs with findings from previous studies. Both our narrative and systematic reviews of stigma reduction interventions amongst young people found that the programmes, which mainly aimed at increasing mental health awareness, could enhance help-seeking intentions, but often did not improve their attitudes and behaviour towards people with mental health problems (Yamaguchi et al., 2011; 2013).
Conversely, the reviews also found that interventions such as having social contact and media-based social contact are effective in changing attitudes and behaviour towards this group. But, such interventions could not always yield significant changes in help-seeking intentions (Yamaguchi et al., 2011; 2013).

These differences seem to be attributed to the primary aim and contents of the interventions. Theoretically, the goal of improving mental health awareness amongst young people includes the maintenance of mental health and prevention of mental health problems (Tennant et al., 2007; Lloyd-Evans et al., 2011). In this context, an intervention implicitly describes that young people should avoid mental health problems, and often provides the knowledge about mental illness itself and information of available and accessible services related to mental health (Tennant et al., 2007; Lloyd-Evans et al., 2011; Yamaguchi et al., 2011; 2013). Contrary to awareness (knowledge), the goal of improving attitudes and behaviour towards people with mental health problems is to eliminate discrimination and to promote social inclusion (Huxley & Thornicroft, 2003; Thornicroft, 2006). This encompasses (young) people including and involving those with a mental health diagnosis as members of our society, as opposed to excluding them due to their ill health.

A campaign may need to determine whether an intervention intends to improve mental health knowledge/awareness, attitudes or behaviour towards people with mental health problems. For example, the national media campaign, Time to Change in England - which has employed online social media (e.g. YouTube) as one of the campaign tools - reported significant positive changes in perceived discrimination amongst service users (Henderson et al., 2012). Its primary aim has been to counteract discrimination against people with mental health problems displayed through social contact or media-based social contact (Schachter et al., 2008; Thornicroft et al., 2008; Corrigan, 2011; Corrigan et al., 2012; Schomerus et al., 2012; Yamaguchi et al., 2011; 2013). A consensus between 32 experts in mental health-related stigma found that recovery-oriented, personal messages from people with mental illness; social inclusion and highlighting the prevalence of mental illness are keys to relay stigma-related messages (Clement et al., 2010). Essential contents of mass-media campaigns focus on a more personal message and show that having a mental health problem is not a barrier to participate in society, showing people with mental health problems working and living in the community.

Evidence on stigma reduction interventions accumulated over two decades has suggested some effective content in anti-stigma campaigns. One particular effective intervention amongst a younger population was a presentation on the social recovery process (e.g. having a job) for people with mental health problems displayed through social contact or media-based social contact (Schachter et al., 2008; Thornicroft et al., 2008; Corrigan, 2011; Corrigan et al., 2012; Schomerus et al., 2012; Yamaguchi et al., 2011; 2013). A consensus between 32 experts in mental health-related stigma found that recovery-oriented, personal messages from people with mental illness; social inclusion and highlighting the prevalence of mental illness are keys to relay stigma-related messages (Clement et al., 2010). Essential contents of mass-media campaigns focus on a more personal message and show that having a mental health problem is not a barrier to participate in society, showing people with mental health problems working and living in the community.

What information in mass media campaigns enhances attitude and behaviour?

If the primary goal of the Canadian campaign was to improve young people’s attitudes and behaviour towards people with mental health problems, what aspects are important to create change? The messages in large-scale mass-media campaigns are of great interest where their impacts are closely monitored, especially as they portray specific information to the public within a very restricted time frame. The Canadian campaign illustrated a male sport player speaking about his teammate and discussing mental health problems (Livingston et al., 2012). Is this an effective approach, to reduce prejudice and discrimination against people with mental health problems, amongst young people?

Evidence on stigma reduction interventions accumulated over two decades has suggested some effective content in anti-stigma campaigns. One particular effective intervention amongst a younger population was a presentation on the social recovery process (e.g. having a job) for people with mental health problems displayed through social contact or media-based social contact (Schachter et al., 2008; Thornicroft et al., 2008; Corrigan, 2011; Corrigan et al., 2012; Schomerus et al., 2012; Yamaguchi et al., 2011; 2013). A consensus between 32 experts in mental health-related stigma found that recovery-oriented, personal messages from people with mental illness; social inclusion and highlighting the prevalence of mental illness are keys to relay stigma-related messages (Clement et al., 2010). Essential contents of mass-media campaigns focus on a more personal message and show that having a mental health problem is not a barrier to participate in society, showing people with mental health problems working and living in the community.

The socio-demographic factors (e.g. ethnicity, age and sex) of the characters introduced by mass media campaigns may also influence the
results. The public are more likely to empathise with someone similar in socio-demographics to themselves but with a diagnosis of a mental health condition. With the study by Livingston et al. (2012), males took more notice of the campaign than females where the short video consisted of a male sports player. The national media campaigns in England and Scotland (See Me), which significantly improved public attitudes and behaviour, have several videos introducing a variety of people with mental health problems from various demographic backgrounds and employment status (Mehta et al., 2009; Henderson et al., 2012). Since large-scale mass media campaigns generally target a diverse population including young people, the campaigns would be expected to have a range of visual materials for the public to be empathic towards people with mental health problems.

**Does the length of the mass media campaign period affect the results?**

The relatively weak impact of the Canadian campaign on improving attitudes and behaviour amongst young people may be due to the short length of the campaign period (approximately 2 months). A similar finding has been reported from the 4-week pilot project of the UK national media campaign. The evaluation of the pilot project shows that the rate of market penetration (23%) peaked in the final week, and that only knowledge about mental health was significantly improved, as opposed to an increase in attitudes and behaviour towards people with mental health problems (Evans-Lacko et al., 2010). Conversely, the successful national media campaigns in England and Scotland spanned a number of years. Not surprisingly, people get more results from a longer campaign about mental health problems which may alter their attitude and behaviour. These limitations are common in short-term mass media campaigns. Sartorius (2010), pointed out that maintenance of mass media campaigns is important and should be addressed with some urgency, although keeping these media campaigns large scale definitely adds up the costs. In other words, the Canadian campaign may have the potential to change young peoples’ attitudes and behaviours, if it runs for a longer time.

**How do we determine the impacts of mass media campaigns?**

How do we consider the effects of a large-scale mass media campaign including the online social media campaign in Canada? The traditional methods for evaluating the outcome of a mass media campaign are: 1) to assess the market penetration (e.g. number of people who see the campaign during the study period), and 2) to compare the mean scores of the scales for mental health-related stigma between pre and post surveys to find statistically significant differences determining the impacts. Livingston et al. (2012) also evaluated the Canadian campaign using these traditional methods, and concluded that their campaign had moderate penetration (24% of participants remembered the campaign) and insufficient magnitude to reach the statistically significant changes in attitudes and behaviour towards people with mental health problems.

However, we may not be able to determine the impact of large-scale mass media campaigns using the traditional evaluation methods. A major strength of a large scale mass media campaign is that it can concurrently deliver specific information to a large number of people. On the other hand, because they usually have very limited time to present their information to the public, they need to direct audience members to places where they have more information, such as relevant websites. It may be difficult to deliver information to people who are less likely to be interested in mental health problems; therefore although the market penetration is high, the impact of it will be low. The Canadian campaign had the same strength and difficulty, and these features pose a threat in accurately assessing the market penetration. In other words, studies did not actually identify the differences in how long or how many times individual participants have seen or recognised the campaigns, yet, they asked participants to recall from them, (Corrigan, 2012), which can ultimately skew results.

With the variety in intervention penetration levels between individuals, direct comparisons of mean scores of some stigma scales, and trying to find statistically significant differences, may not be appropriate for evaluating large-scale mass media
campaigns, while the direct comparison of mean scores appear to be the proper way to evaluate interventions in a small group (Yamaguchi et al., 2011; 2013). Therefore, relatively small changes in attitudes and behaviour towards people with mental health problems, produced by these large campaigns, may be seen as an important achievement. This is because such changes may offer a chance to help people to learn about mental health problems and to achieve greater changes in their attitudes and behaviour in the future. For example, a 5% reduction in perceived discrimination was the final goal in the UK national media campaign (Henderson et al., 2012). Currently, there are no coherent methods to evaluate large-scale mass media campaigns, and further discussion is required.

Conclusion

This paper discusses four points of views on the impact of the Canadian online social media campaign amongst young people. Although Livingston et al. (2012) stressed the limited effects on improving mental health-related stigma, we believe that the campaign has delivered some specific benefits. It depends on the primary goal, content directed towards the goal, evaluation methods used and length of the campaign period. We have evaluated and listed the implication for future studies and future campaigns:

1. The campaign needs to set the primary goal, and develop different approaches to achieve positive changes in mental health awareness, attitudes and behaviours towards people with mental health problems amongst young people.
2. There is a great desire to maintain the campaign and to build evidence on effects of the long-term campaigns amongst young people.
3. Further discussion about evaluation methods for large-scale mass media campaign is needed.

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The article by Livingston et al. (2012) reporting the evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues makes some insightful points regarding the impact of media campaigns on the stigma of mental illness. The particular Canadian campaign evaluated featured a prominent male sports figure talking about mental health issues and used online social media to reach young people. The effectiveness of the campaign was shown to be limited to the proximal outcomes of increasing awareness and use of a mental health website, but did not impact the distal outcomes to improve attitudes toward people with mental illness. The authors acknowledge that these findings are consistent with Corrigan’s recent summary that such campaigns show evidence of penetration but little meaningful impact (Corrigan, 2012). Notably, this campaign used social media rather than traditional media, which would be expected to have a greater impact for young people, but the anticipated outcomes remained elusive. Livingston et al. make the points, however, that increased market penetration is a worthwhile outcome and that improving mental health literacy, rather than reducing stigma, should be the goal of such media campaigns.

Is increased website awareness a worthwhile goal?

The outcome that was successfully achieved by the campaign was market penetration, and Livingston et al. maintain that increased awareness of the website is a valuable outcome. The evidence for increased awareness was that one quarter of survey respondents remembered the campaign and there was an increase of about 10 per cent in website awareness. However, while there was an initial surge of interest in the first week after the campaign launch, attracting more than 55,000 people to visit the website and more than 200 people in the community to upload a personal video pledge, this quickly dropped off. It is well-established that people respond to novelty and this quickly wanes.

The approach taken of using a male sports role model was argued to be particularly effective at reaching young males, which are an important target group due to their reluctance to seek mental health help (Rickwood et al., 2005), although the change in awareness between males and females was comparable, with an increase of 9.3 and 9.6 per cent, respectively. Notably, however, the campaign was not shown to be effective for young people with a mental health issue and non-white respondents, and these are also important target groups. This supports arguments that targeted and tailored approaches are needed for public health campaigns; different population groups require targeted messages and individually tailored messages are even more effective (Noar et al., 2007).

The assumption that directing people to a website makes a difference also needs to be tested. While website traffic increased, this study design was not able to ascertain whether using the website had an effect. In general, there is little evidence available regarding the impact of mental health websites, despite their proliferation. In fact, one relevant longitudinal study revealed that using the internet for health purposes was associated with increased depression, suggested to be due to increased rumination, unnecessary alarm, or over-deplo...
attention to health problems (Bessière et al., 2010). A rigorous study of young adults using health e-cards, which were personal emails containing links to depression information presented on a web page, found no effect on indicators of mental health literacy or changes in help-seeking for depression compared with control conditions (Costin et al., 2009).

Consequently, the assumption that mental health websites are uniformly helpful is not supported. While the evidence shows that many online interventions are effective, there are many for which no evidence exists (Christensen et al., 2010) and basic education offered to people with a mental health condition shows the least effectiveness on most outcomes. Rather, what is required are the very sophisticated ways of tailoring public health messages to individual characteristics and personalised barriers that are increasingly available through advances in technology, including social technologies (Lustria et al., 2009, Cobb and Graham, 2012).

**Does website awareness improve mental health literacy?**

Livingston et al. (2012) claim that rather than change attitudes the campaign encouraged young people to seek out more information on mental health issues, and suggest that such social media campaigns may be more useful to improve mental health literacy than as a vehicle to change attitudes and stigma. This assumes that the campaign did improve mental health literacy and, in this case, the impact appeared to be very weak from the results presented. There were no differences overall in any of the indicators of mental health literacy comparing the sample groups before and after the campaign. Significant differences were only evident between those who indicated they were exposed to the campaign compared with those who indicated they were not exposed on the measures of discussing mental health literacy with others, making an effort to learn more about signs and symptoms, and making an effort to learn more about the availability of mental health services, but not helping someone beginning to experience mental health difficulties.

However, no effect sizes are given for these differences and there is no adjustment made for inflated Type I error rate due to multiple comparisons. With the sample size quite large, trivial differences could be significant at p<.05; although significant, these differences may well be practically meaningless. It is not possible to determine the magnitude of the change that was evident for three out of the four questions measuring mental health literacy.

The evaluation design was, however, only able to compare answers to the mental health literacy questions for those who stated they were or were not aware of the campaign – not those who had visited the website; the design was not able to investigate the effect of the website itself. The question that remains is whether once directed to the website, young people spent much time there, and whether the activities available on the website are effective at improving mental health literacy. The mindcheck.ca website that was the focus of the evaluation is clearly targeted at young people’s mental health and related risk factors in a youth-friendly format and, once at the site, young people can choose the pathways that are relevant to their personal wellbeing, with them being led to evidence-based screening instruments and appropriate follow-up information and support. It would be of interest to investigate the dose-response effect of this website for different groups of young people.

**What is achieved by better mental health literacy?**

Improving mental health literacy is certainly a worthwhile goal. Better understanding of mental health and mental illness, having a positive attitude toward seeking help, and knowing how to find appropriate sources of help, have been repeatedly argued to be important factors in promotion, prevention and early intervention for young people’s mental health. Nevertheless, improving mental health literacy is not a simple task. While different programs and approaches are constantly emerging, for many of these there is little evidence. A program with a strong evidence base is Mental Health First Aid (Kitchener and Jorm, 2011). This program has been shown to improve mental health literacy and increase help-seeking in a range of contexts and with targeted programs for different population groups. It also shows evidence of stigma.
reduction. However, it should be noted that the program has undergone a long and rigorous development process and is an intensive intervention—the youth version takes 14 hours of instruction for delivery (Kelly et al., 2011).

Educational approaches to improve mental health literacy and reduce stigma are common, and often focussed in educational settings such as schools and colleges. However, a recent review of school-based mental health literacy interventions concludes that this field is still in its infancy and that there is insufficient evidence to claim a positive impact of school mental health literacy programs on knowledge improvement, attitudinal change or help-seeking behaviour (Wei et al., 2013).

Is mental health literacy related to stigma?

But a more relevant question in the current context is whether mental health literacy is related to stigma. The main aim of media campaigns, such as that evaluated by Livingston et al. (2012), is reduction in stigma, and the evaluation revealed that this outcome was not achieved.

A large body of research has shown that while education and awareness are recognised as important elements of anti-stigma strategies (Corrigan and Penn, 1999), these alone do not achieve substantial and long-lasting reductions in stigma. Mental health literacy has mostly been shown to be effective in getting people, including young people, to access services (Kelly et al., 2007), but the evidence around its impact on reducing stigma is less clear.

In fact, a recent major meta-analysis (Schomerus et al., 2012) shows that while the general public’s understanding of mental disorders has clearly increased, at the same time attitudes towards people with mental illness have not improved, and have even deteriorated toward people with schizophrenia. In particular, notions of dangerousness have not changed and the social acceptance of people with mental illness has not improved since 1990; instead, acceptance of a person with schizophrenia as a co-worker or neighbour has dropped. The authors maintain that the biological explanation model, which is often the basis of literacy interventions and argues that mental illness is an illness like any other, is questionable; while this approach seems to have helped improve acceptance of medical treatment for mental illness, it has not improved social tolerance. This is in marked contrast to the improved attitudes that have been realised toward people who are same-sex attracted.

Stigma is a complex construct and comprises public stigma, self-stigma, stigma by association, and structural stigma (Bos et al., 2013). Each of these is important, although most public campaigns focus on public stigma. The Livingston et al. (2012) study showed that public stigma, as evident through measures of attitudes toward people with mental health issues and social distance items, was not changed by the campaign. The authors highlight that a substantial proportion of the survey respondents reported positive attitudes toward mental health issues both before and after the campaign—about two-thirds had low levels of personal stigma and just over half desired low levels of social distance. The implication is that there was not much room for change, but this overlooks the third with moderate or high levels of stigma and just under half with higher levels of social distance.

What impacts stigma?

It seems evident that public media campaigns and mental health literacy have, at best, limited impact on stigma. The factors that affect stigma are complex and not fully understood. One of the earliest conceptual notions in this area was that prejudice can be reduced by equal-status contact between majority and minority groups in the pursuit of common goals, proposed by Gordon Allport (1954) in his book The Nature of Prejudice—known as the contact hypothesis.

The contact hypothesis has received mixed support in the literature as it applies for different types of prejudice, but the factors that facilitate effective contact with people with mental illness are becoming clear. Corrigan and Kosyluk (2013) argue that contact works most effectively when it is in vivo, targeted, local, credible and continuous. They also report some evidence for effective virtual contact interventions, although in vivo contact has a stronger impact. Effective elements comprise eliciting emotional reactions, particularly empathy, which can be achieved through the personal stories of those with mental health
problems. It is also important to achieve a sense of self-other overlap, through some identification with the person with mental illness or part of their story (Corrigan and Kosyluk, 2013).

An Australian program based on this premise is Mental Illness Education, for which there is some evidence for their school-based program (Rickwood et al., 2004). The program has people with lived experience of mental illness give presentations to school classes, based on their personal stories and including information and activities to debunk myths about mental illness and encourage students to empathise and connect personally with the stories and information. Students report that the personal stories and points of identification are the most powerful elements. Research supports that eliciting empathy for a member of a stigmatised group can improve attitudes towards the group as a whole (Batson et al., 1997). A growing argument is that interventions that foster the development of empathy are particularly pertinent; rather than one-off, brief interventions based on cognition-focused outcomes like knowledge, attitudes and stereotypes (Schachter et al., 2008).

Conclusion

Reducing the stigma of mental illness is fundamental to mental health strategies in many countries, including the United Kingdom (HM Government, 2011), Canada (Mental Health Commission of Canada, 2012) and Australia (Commonwealth of Australia, 2009), as freedom from stigma is critical to the wellbeing and quality of life of people with lived experience of mental illness. We have much yet to learn in this field and interventions must be carefully planned by being appropriately targeted or tailored, based on a sound conceptual framework and current empirical evidence, clear about the type of stigma and level of intervention, and with a thorough evaluation process instigated at the outset comprising a rigorous design with appropriate measures.

The way forward for young people is likely to be for personalised and individualised interventions that appeal to emotions and elicit empathy through the stories of other young people who are living well with mental health issues. Mental health literacy may help to some extent, but is not the primary intervention point, although it is an essential focus to enable young people to recognise their own mental health issues and seek appropriate help.

We must keep in mind, however, that while ever more sophisticated interventions are being developed to combat stigma and educate young people about mental illness, their impact is constantly undermined by other media exposure—onscreen portrayal of people with mental illness is frequent and mostly negative (Pirkis et al., 2006) and print media portray mental illness as dangerous and a threat to the public, and the mental health system as not able to adequately manage and treat them (Duca, 2012). Stigma needs to be redressed at multiple levels, including where it is structurally embedded within our societies, as well at the very personal level to appeal to the emotions of young people.

References


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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
The stigma associated with mental health can have a profound impact on young people. It can put them off accessing services, but it can also have a profound impact on their mental health. So programmes that have been proven to tackle stigma are essential. This article briefly looks at what stigma is and why it is such an issue. It also looks at a number of programmes that have attempted to tackle stigma. In particular, there is a focus on an evaluation of a Canadian campaign, called *In One Voice*, which aimed to reduce stigma and increase awareness about mental health.

**What is stigma?**

The literal definition of stigma means being marked or branded, but in reality it means that a group of people - in this instance, young people with mental health problems - being categorised as different from the social norm, and being shunned and devalued as a result. Therefore, mental health is associated with negative connotations, so people do not want to admit to having mental health problems. Even the word mental carries a considerable amount of stigma. The term mental health is often associated with deviance, and for many conjures up ideas of madness and asylums. By contrast, YoungMinds believe that the following attributes are seen in mentally healthy children and young people:

1. The capacity to enter into, and sustain, mutually satisfying personal relationships.
2. A continuing progression of psychological development.
3. An ability to play and to learn so that attainments are appropriate for age and intellectual level.
4. A developing moral sense of right and wrong.
5. The capacity to cope with a degree of psychological distress.
6. A clear sense of identity and self worth.

Researchers have defined stigma as an overarching term which consists of three elements: (Thornicroft, 2006):

- The problem of knowledge: Ignorance
- The problem of attitudes - Prejudice
- The problem of behaviour - Discrimination

Stigma operates at a number of different levels (Gale, 2007; Hinshaw, 2005; Ben-Zeev et al., 2010), and can have profound effects. These are:

- Public stigma – where large social groups endorse stereotypes about mental illness
- Self-stigma – where people internalise public stigma, which results in a loss of self-esteem and self-efficacy
- Label Avoidance – where people avoid seeking help and thus being labelled with a stigmatising mental health problem

Stigma operates at a number of different levels (Gale, 2007; Hinshaw, 2005) for instance, within the individual, the family, the community, the media and so on. So, tackling stigma requires a multidimensional approach.

People with mental health problems are known to experience more stigma than those with other health problems (Gale, 2006). This may be because young people are likely to face a number of difficulties, such as not having their rights understood and addressed; difficulties in accessing appropriate mental health services; and many people do not believe that young...
people can suffer from mental health problems, so they are often not taken seriously.

**Why is it such an issue?**

The most damaging aspect of stigma is when it is internalised (Green et al., 2003). This results in people believing that they do indeed have undesirable attributes and they are spoiled and of less value than a ‘normal’ person. Many participants in a study by Green and colleagues (2003) had internalised stigma, even though they thought that it was unjustified. According to Gale (2006), stigma has a disabling impact on the individual’s sense of self, including a diminished self-esteem, self-value and confidence.

Stigma causes people to be secretive about their problems, and discourages them from seeking appropriate help. It is thought that, in Great Britain, 1 in 10 children and young people have a mental disorder. However, only about a half of these vulnerable young people access any service, and only a fifth access specialist child and adolescent mental health services (Ford et al., 2005). There are various reasons why this is the case, but it is likely that stigma plays a significant factor.

There are studies which show a link between stigma and not seeking help and adherence to treatments (Corrigan, 2004). There is a growing evidence base for treatments, but if people will not seek help because of the stigma associated with mental health, then these developments will come to nothing. This illustrates how fundamental and crucial tackling stigma is to developing high quality mental health services.

Young people from YoungMinds Very Important Kids (VIK) project have told us why it is so important to tackle stigma (YoungMinds, 2009). The following quote from the Children and Young People’s Manifesto for Change illustrates why it is such an issue:

“We cannot be open about how we feel because we believe we will be judged. Society needs to accept that anyone can have mental health problems and that it is part of life. Our friends, teachers and other adults are scared of our illnesses and that makes us feel we can’t speak out. We have been called ‘attention seeking’, ‘drama queens’, ‘mental’, ‘weird’, and told to ‘shut up, it’s just hormonal’. We all need to talk about how we feel inside. We also want the media to be more educated about mental health problems so they don’t misrepresent us and create fear about us.”

**Young People’s Attitudes to Mental Health**

Studies have suggested that younger people often have very negative attitudes to people with mental health problems (DH, 2010). A survey of 2,629 children and young people aged 9-25, which was commissioned by YoungMinds (2010), found that over half had heard other young people using derogatory language concerning mental health, when a friend or classmate was going through a difficult time; and nearly half had been called names themselves when they were going through a difficult time.

This is connected to a lack of knowledge and understanding of what mental health actually is. A study of young people’s knowledge and attitudes to mental health found that a very high number of derogatory and technically incorrect labels are used to describe mental health (Rose et al., 2007). So there is a need for education, and there is some evidence that lessons in mental health have reduced stigma (Naylor et al., 2009). YoungMinds have called for mental health and emotional wellbeing to be part of a mandatory Personal, Social and Health Education (PSHE) curriculum. Unfortunately, it is currently optional, and is left up to schools to decide whether they provide any lessons on mental health.

**Tackling Stigma**

In British Columbia, Canada, a number of organisations got together to develop the In One Voice campaign, which they define as a social media intervention. The aim of this campaign was to improve attitudes and behaviours towards mental health issues, and increase activity on a young person focused website – mindcheck.ca. The campaign involved a Canadian professional hockey team called the Vancouver Canucks. This was because one of their team members had suffered from depression and had committed suicide.

This campaign has been evaluated by Livingston and colleagues (2012). They used a successive independent samples design to assess market penetration, attitudinal changes and behavioural changes among young people.
aged 13-17 years and young adults aged 18-25 years. They identified 806 young people aged 13-25 to take part in the survey. This group were predominantly white, nearly three quarters were aged 18-25 years, and nearly half had no personal experience of mental health problems. These participants were randomized and split into two groups. One group (T1) completed the survey before the campaign was launched, and the other group (T2) completed it two months after the launch.

One of the main aims of the campaign was to increase awareness of the Mindcheck website. The researchers collected data on the website traffic, and they found that there was a substantial increase in website visits after the launch of the campaign. People also engaged with the campaign by uploading personal pledges and ‘liking’ the campaign on Facebook.

The evaluation found that awareness of this website doubled in the T2 group, who completed their survey after the launch of the campaign. Young men are a particularly difficult group to engage with mental health issues, but possibly the involvement of sport in the campaign managed to increase awareness in males as well as females. This factor is very important as in this country at least the suicide rate in young males is still very high. The campaign also saw a greater increase in awareness amongst white respondents compared to those from other ethnic backgrounds. This is potentially an issue, as people from black and minority ethnic groups also often don’t engage with mental health issues. It is likely that the campaign didn’t do enough to engage this group.

The campaign also aimed to find out whether it enabled young people to help others with mental health issues; and to improve attitudes to mental health issues. The evaluation found that the campaign didn’t really help young people feel that they could help others with mental health issues, and it made very little difference in participants’ attitudes toward mental health. However as the study used a between group methodology, where the T1 and T2 groups included different participants, it is difficult to say whether the campaign improved a given individual’s attitude to mental health. The researchers presumably picked this methodology because they wanted to know whether people had heard of the website before and after the campaign, and you can’t do that with a within group methodology. So, whilst it is understandable, it is a weakness of the study. It possibly might have been better to run two separate studies, where one focused on the website, and the other on the campaign’s impact on people’s attitudes to mental health.

So this evaluation does seem to suggest that the campaign has been successful in reaching young people, which is not always an easy task. The campaign did improve awareness of mental health issues, but unfortunately, it seemed to be less successful in changing people’s attitudes to mental health. The authors of this evaluation do state that whilst education and awareness are important factors in improving attitudes to mental health, they are unlikely to achieve substantial and long-lasting reductions in personal stigma on their own.

Stigma is a global issue and many countries have developed campaigns to tackle stigma. There have been a number of programmes in the UK that have aimed to tackle stigma. In England, the Time to Change Programme, which is run by Rethink Mental Illness and Mind, was set-up in 2007, and is now in its second phase. The evaluation of the first phase found that the campaign is having a positive effect, with the level of discrimination reported by people who experience a mental health problem, dropping by 4% (Time to Change, 2010).

Time to Change, includes a number of different projects, including one on children and young people, which has involved the setting up of a pilot project in Birmingham in 2012, and this is about to be extended to Kent. This project has only just got off the ground, so it is too early to tell how effective it is.

The See Me campaign in Scotland, had a specific programme of work aimed at children and young people called Just Like Me. This award winning campaign worked directly with young people, and involved talking to them about their experiences. The campaign involved a TV advertisement, and the development of a micro site. The evaluation found that, after the campaign, young people were more knowledgeable about specific mental health problems, and would know how to help friends if they had mental health problems (Myers et al., 2009). Also, there were some improvements in
expressed positive attitudes to mental health.

Stigma is a complex issue, and a number of key elements all need to be addressed if it is to be successfully tackled. Also, stigma exists within our culture, and changing social norms is not simple and needs to be continuously chipped away at. This is why there needs to be a number of different projects, which address different elements of stigma. All research studies have their weaknesses and limitations, and despite this, the In One Voice campaign, and all the others covered here are much needed in order to reduce stigma. This is important, because having a mental health problem is hard enough without all the additional difficulties that stigma brings.

References


In recent years the promotion of mental health became a public health priority (World Health Organization, 2005). However, the lack of information regarding mental health issues, and mental illness stigma (Schulze et al., 2003; Dwight et al., 2005; Stuart, 2006; Patel et al., 2007) are significant barriers to such challenge. The recognition of these important barriers led to several mental health promotion and anti-stigma programmes to be launched worldwide (Wyn et al., 2000; MINDSET, 2002; Stuart, 2006; Tacker and Dobie, 2008). In this context, important anti-stigma campaigns were developed in countries such as United States, United Kingdom, Canada, Australia, and Brazil. Nevertheless, other activities to fight stigma of mental illness were carried out in mid-sized European countries like Austria, Czech Republic, Norway, Poland, Portugal, Romania, Slovakia, and Turkey (Beldie et al., 2012).

The In One Voice campaign, a brief social media intervention, was developed in Canada with two main goals: to raise mental health awareness and to improve attitudes of youth and young adults towards mental health issues. The purpose of the Livingston et al. (2012) article was the evaluation of the effectiveness of In One Voice campaign.

The Livingston et al. (2012) study shows an interesting approach to increase mental health awareness. However, a theoretical discussion of some basic concepts underlying the work (e.g., personal stigma, social distance), as well as a reference to other successful relevant campaigns, would have been important. We therefore will proceed as follows: firstly, we will emphasize the importance to promote mental health and to evaluate anti-stigma campaigns, and the relevance to intervene with youth and young adults. Secondly, we will refer different strategies to challenge stigma, and will highlight some results of two important anti-stigma campaigns. Finally, we will analyze some methods used by the In One Voice Campaign and some of the results obtained from the evaluation of its effectiveness. A brief discussion of some complementary interventions, that could be considered, will end the analysis.

The importance of promoting mental health and to evaluate anti-stigma campaigns, and the relevance to intervene with youth and young adults

Why is it important to develop awareness regarding mental health? Is it relevant to assess the impact of anti-stigma campaigns?

Mental health is not merely the absence of mental disorders or symptoms but also a resource supporting overall well-being and productivity of human beings (Social Cohesion, 2008). Therefore, awareness regarding mental health allows people to be actively involved in seeking information about mental health, contributing to the recognition, management and prevention of mental health problems (Jorm, 2000; Kelly et al., 2007). Mental health enables people to experience life as meaningful and to be creative and active citizens. Thus, it is an essential component of social cohesion, productivity, peace and stability in the living environment, contributing to social capital and economic development in societies (RETHINK, 2008; Social Cohesion, 2008).

The goal of the Livingston et al. (2012) study is very relevant, since the evaluation of anti-
stigma campaigns has not been given much attention due to a variety of factors, including methodological difficulties, the scarcity of resources provided to anti-stigma programs, or the absence of the tradition to evaluate programs in the field of health in general and when dealing with subjects such as stigma in particular (Beldie et al., 2012).

**Why this target group?**

The Livingstone et al. (2012) study focused on the evaluation of the effectiveness of a campaign that targeted young people between 13-25 years old. As the authors mentioned, “during early stages of the life span, attitudes are developing and many mental health issues begin to emerge”. Other reasons could be referred to support the importance of developing anti-stigma campaigns that target young people: the youngsters’ natural risk of developing a mental disorder [20-25% of adolescents will experience a mental disorder (Patel et al., 2007)]; and the fact that adolescence is a stage where attitudes can still be changed (Corrigan and Watson, 2002).

Young people are the future generation of doctors, teachers, journalists and the “general public” with the power to sustain and perpetuate stigma and discrimination or to eliminate it (Schulze et al., 2003). Cultural stereotypes of madness are developed in part by media representations that socialize young people into stigmatized views of mental illness (Wahl, 2003). Though these stereotypes are not fully developed, most young people do not have a clear idea about what mental illness actually is and how it presents itself. Therefore, young people are an attractive audience for attitude-change programmes seeking to influence young minds before unhealthy attitudes and beliefs towards mental illness become entrenched (Schulze et al., 2003).

**Different strategies to challenge stigma, and results of two important anti-stigma campaigns**

**How can stigma in young people be challenged?**

Given what has just been mentioned, youngsters are often identified as an important target population for stigma change (Rickwood et al., 2005; Corrigan and Watson, 2007b; WHO, 2010). Regarding stigma challenges, we could foster future generations of adults where the stigma of mental illness is neither so prevalent nor egregious (Corrigan and Watson, 2007b), by helping young generations to have more positive attitudes towards mental health problems.

The most relevant strategies that are usually applied to the referred age group are: (1) education, (2) protest, (3) contact, (4) video and (5) role-playing.

Education requires challenging myths about mental illness with facts (Larson and Corrigan, 2008; Mckinney, 2009). Education is especially appealing because a standardized curriculum can be designed and exported to schools and other educational venues across a country relatively quickly (Corrigan et al., 2001). Several studies, specifically focusing on contact’s effect on mental illness stigma, have produced promising findings (Corrigan and Watson, 2002, 2007b). However, contact-based education is difficult to implement widely because it requires trained individuals with mental illnesses to deliver the intervention (Stuart, 2006). As an alternative to direct contact, video depictions of individuals with serious mental illnesses may be used. Furthermore, Aboud and Levy (2000 cited in Corrigan and Watson, 2007a) argue that role-playing strategies that facilitate empathy for outgroup members have much in common with social cognitive skills training.

Finally, a common approach to mental health promotion and mental illness stigma reduction, that uses the strategies mentioned above, is the campaign’s development. That specific topic will be discussed in the next section.

**How effective are mental health promotion campaigns?**

Worldwide, several campaigns aimed at fighting stigma related to mental health problems have been developed over the last decade. Most campaigns reflect a strong willingness to perform social change. However, not all campaigns are anchored in research projects enabling the evaluation of their impact and designing new and improved campaigns. As good examples of campaigns concerned with
evaluation practices, two programs developed in Europe and Australia stand out – *Time to Change* (2012) and *BeyondBlue* (Morgan & Jorm, 2007).

*Time to Change* (2012) is an example of a successful program developed in England to reduce the stigma and discrimination faced by people with mental health problems. The program is run by the charities Mind and Rethink Mental Illness, and funded by the Department of Health and Comic Relief. *Time to Change* has been running since 2007 and has already achieved significant improvements in public attitudes and behaviour among adults, including a 20% reduction in the levels of reported discrimination and a 3% increase in the number of people with mental health problems living lives completely free from discrimination, along with improvements to public attitudes.

Another important program is *BeyondBlue* (Morgan et al., 2007), a national depression initiative launched in Australia. The aim was to address issues associated with depression, anxiety and related substance-misuse disorders. Its five priority areas are community awareness and destigmatization, consumer and carer advocacy, prevention and early intervention, improving training and support for healthcare professionals on depression, and depression-related research. *Youthbeyondblue* (*Ybblue*) is the youth program of *BeyondBlue*, which focuses on youth depression awareness and early intervention. It targets 12 to 25 year-olds and aims to help family and friends identify early warning signs or behaviours and promote help-seeking behaviour. Results showed that 1) around 44% of young people have some awareness of *BeyondBlue* or *Ybblue*, 2) awareness was low in young adolescents, but generally increased with age, and 3) those who were aware of *BeyondBlue* tended to have better mental health literacy, being better able to recognize depression in another person, and less likely to believe that dealing with depression alone is helpful (Morgan et al., 2007).

**The One Voice Campaign, its effectiveness, and some complementary interventions that could be considered.**

The Livingston et al. (2012) study aims to assess the effectiveness of the *In One Voice* campaign. It used an independent sample design aimed at assessing the market penetration and attitudinal changes among young people.

Five important methodological options of the campaign should be highlighted. First, the option for a Canadian professional hockey team underlies the important link between sports and the age of the target group of the campaign; second, the link between this type of sport activity – hockey - within the Canadian community; third, colleagues of someone who suffered from a mental disorder, and speaking about their teammate; fourth, being a male team, opposes the general idea that women are more likely to discuss mental health issues than men (Johansson, Brunnberg and Eriksson, 2007); and fifth, the importance of using attractive and appealing strategies to youth and young adults, such as internet based tools (e.g. website, Facebook, Twitter).

As the authors conclude the proximal outcomes of the campaign to increase awareness (for example, through the creation of the website) were achieved but, on the other hand, the distal outcomes (personal stigma, social distance) of the campaign to improve attitudes towards mental health issues were not successfully achieved.

In fact, after the campaign, one quarter of the respondents remembered the campaign, the awareness of the website increased significantly from T1 to T2, and those who were exposed to the campaign were significantly more likely to talk about and to seek information relating to mental health issues. These results justify the achievement of the first goal of this study - to raise mental health awareness. Indeed, the campaign methods successfully served this goal – using a well-known and popular group of people (the hockey team), media exposure, internet based tools - and showed to be important methods to increase awareness of a particular community regarding mental health issues.

One particularly method used by the campaign should be emphasized: the contact with people with mental disorders. Contact involves fostering interactions between a person with mental illness and the public (Larson et al., 2008). In this campaign, the indirect contact with someone with mental disorder (the colleague of the hockey team members who
suffered from depression) may have significantly enhanced public awareness.

More specifically, some results are interesting like a significantly larger proportion who remembered the campaign were males, and the awareness of the website increased significantly among young adults. These results highlight the importance of adjusting interventions to the target groups, that is, using a team of young adult male hockey players shows to be a correct option when the goals of the campaign are to reach male young adults. However, if the target population is different (for example, female older adults) different choices should be made.

Different target groups demand different strategies. Therefore, projects’ strategies should follow the guidelines suggested by the literature regarding the development of interventions focused on promoting mental health. For example, conducting pilot studies with target groups through focus groups, in order to guarantee message (e.g. “wording”) and methodology accuracy (Campos et al., in press).

Regarding the distal outcomes, the authors conclude there were no significant differences in relation to personal stigma or social distance. In fact, reducing personal stigma and social distance requires long-lasting interventions (Patton et al., 2000; Sartorius, 2006; Jorge-Monteiro and Madeira, 2007), as the change of attitudes and behaviours take time, and could be increased through booster sessions (Botvin et al., 1983). Research has demonstrated that effects are likely to lessen with time, and that the duration and regularity of an intervention is positively related to its long-term effects (Susser et al., 1997 cit in Schulze et al., 2003).

Furthermore, Internet campaigns are very important but should be complemented with specific context-based interventions aimed at reaching the distal outcomes mentioned in the Livingston et al. (2012) paper. For example, simultaneous school-based interventions with students, teachers, and parents could be implemented in association to a general population awareness campaign. Mental health awareness programmes in schools succeed overall mental health awareness campaigns and have been shown to be effective in changing young people’s opinions about mental health matters and help-seeking (Burns and Rappee, 2006; Wright et al., 2007).

In this context, in October 2007, Portugal witnessed the launch of the first national anti-stigma campaign - “UPA’08—United to Help Movement. Stand up against stigma and discrimination toward mental disorders”. This movement aimed at combating stigma and discrimination of mental illness. Since then, several projects have been developed under the UPA movement, focusing on studying stigma related to mental illness and consequent discrimination, on improving awareness about mental health issues, and on combating stigma and discrimination in different population groups (Beldie et al., 2012). These projects include:

- **UPA Makes the Difference**
- **P’UPA United to Help Teachers**
- **Finding Space to Mental Health**

: Promoting mental health in adolescents (12-14 year-olds), directly and indirectly focused on the same target group - young people.

All of these projects included research studies concerned with the evaluation of their impact. Furthermore, the school-based interventions included pilot studies to improve the accuracy of both measures and interventions strategies.

**UPA Makes the Difference** results indicated a very significant increase of knowledge perceptions, and a significant increase of positive perceptions towards mental health problems; **P’UPA’s** results indicated a very significant increase of positive perceptions towards mental health problems, of knowledge perceptions, and an improvement of behavioural intentions (Campos et al., in press). **Finding Space to Mental Health** preliminary results showed a significant increase in knowledge, first aid skills, help seeking and self-help strategies (Campos et al, 2012).

**Conclusion**

There is no doubt that anti-stigma campaigns to raise mental health awareness are an effective strategy and their assessment is crucial. Nevertheless, and as the authors argued, “media campaigns may be most likely to achieve improvements in health literacy outcomes (e.g. improved education and awareness) and less effective in the personal stigma and social distance associated with mental issues” (Livingston et al, 2012). Thus, we consider that other specific strategies, such as
school-based interventions, should be implemented, since “the ideas taught to children during mental health awareness programmes in schools have the potential to infiltrate the community more broadly” (Burns et al., 2006, pp.227).

References


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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
The thoughtful commentaries, provided in this issue of Education and Health outlined numerous technical ways in which the In One Voice campaign would have had greater consistency with an evidence-informed approach. To summarize, the campaign could have: depicted greater socio-cultural diversity (Lavis, 2013; Yamaguchi, Uddin, Mino, & Thornicroft, 2013); run for a longer duration (Campos, 2013; Yamaguchi et al., 2013); used more targeted messages to reach specific populations (Campos, 2013; Rickwood, 2013); been supplemented with specific contact- and school-based interventions (Campos, 2013); and focused more strongly on personal stories of youth (Rickwood, 2013). These are important and useful lessons. However, the degree to which making this combination of changes would have produced larger effects is an empirical uncertainty. As Rickwood (2013) states, there is much to be learned in this field (p. 39). Given the immature state of the research in this area, are we really in a position to proclaim a formula for creating reliable and meaningful change? One of the commentaries suggests that interventions should focus on fostering empathy rather than “one-off, brief interventions based on cognition-focused outcomes like knowledge, attitudes and stereotypes” (Rickwood, 2013, p. 39). Although there is an intuitive logic to the theoretical linkage between empathy and inclusiveness, such an approach lacks robust evidence. Recommending this approach over others requires making assumptions and drawing conclusions about something which we still know very little.

Inspired opportunities

The idea of mass media campaigns that are carefully-planned, evidence-based, and rigorously evaluated (Rickwood, 2013) sounds brilliant. Social scientists dream about being intricately involved in planning, creating, implementing, and evaluating interventions. Unfortunately, this does not always reflect reality. More often than not, media campaigns are developed by people who are not scientists, but who offer inspirational stories, genuine intentions, short timelines, and an abundance of passion and enthusiasm. In this version of reality, considerations about whether or not a campaign is acceptable to social scientists falls fairly low on—or may be omitted from—the priority list. Evaluations sometimes occur only after a researcher receives a last-minute tip about a soon-to-be-implemented intervention or campaign. Such situations present two options for researchers: to refuse to be part of it, or to try to learn from it.

The In One Voice campaign offered an exceptional naturalistic learning opportunity. As was articulated in our original article, the principal goal of this brief, social media intervention was to increase awareness and use of mindcheck.ca, a youth-focused website (Livingston, Tugwell, Korf-Uzan, Cianfrone, & Coniglio, 2012). All other admirable goals, such
as changing the attitudes and behaviours of youth and young adults, were secondary for this particular initiative. The unique power of the campaign was that it was initiated by professional male hockey players—Canadian cultural icons—challenging the stereotypical moulds of masculinity by talking about mental health issues and promoting acceptance of people who live with such conditions. The significance of this should not be lost, as it signifies a dramatic and fundamental shift in the social discourse and collective conscience surrounding mental illness in Canada. A so-called social movement!

Worthwhileness

Our evaluation revealed that the In One Voice campaign increased awareness and use of an educational mental health website. Other than this, very few changes were observed (Livingston et al., 2012). One author ponders whether increasing website awareness is a worthwhile goal (Rickwood, 2013, p. 36). In answering this question, the author makes an intriguing argument that increasing access to mental health information may, in fact, be harmful. We concur that evaluating how people use and responded to the mindcheck.ca website would have generated valuable information about the effects of the campaign. But, we were struck by the author’s use of the term “worthwhile,” which conveys that some things are insufficiently valuable to be worth one’s time, effort, or interest. How do we measure the worthwhile-ness of an intervention or outcome?

Many social scientists would agree with Rickwood’s (2013) framework for determining an intervention’s worth, which includes the following criteria: (a) carefully planned; (b) appropriately targeted or tailored; (c) based on a sound conceptual framework and current empirical evidence; (d) clear about the type of stigma and level of intervention; and (e) uses a thorough evaluation process instigated at the outset comprising a rigorous design with appropriate measures (p. 39). If mass media campaigns fail to meet these criteria, are they worthless? Or even worse: harmful? Should we discourage people and organizations from embarking on activities that are not aligned with a positivist conceptualization of utility and value? The collateral consequence of suppressing grassroots enthusiasm (in the interest of science) may be that social movements lose traction and momentum. We risk inhibiting efforts that symbolize and stimulate broader social change. In addition to being an independent variable (the cause), perhaps these types of campaigns also represent the dependent variable (the effect) of socio-cultural change. They signal that it is happening.

Social context

Mass media campaigns, like In One Voice, do not occur in a vacuum. This fact creates significant problems for evaluations which must treat these “interventions” as though they are isolated events removed from the broader social context. For research, applying a reductionist approach to understand these campaigns (e.g., reducing them to goals, messages, components, costs, start and end dates, and outcomes) is necessary, but undermines their complexity and promise. After our evaluation was completed, we learned that In One Voice inspired the creation of a large-scale follow-up initiative called Hockey Talks (Vancouver Canucks, 2013). Seven Canadian National Hockey League teams were involved in this month-long initiative (February, 2013), which used a variety of novel methods (e.g., in-arena messaging, online storytelling, sharing information and experiences at one of their home games) to increase dialogue and awareness about mental health. Like the original campaign, social media and online educational materials were integral. Our original evaluation did not account for this growth in enthusiasm for mental health awareness. Now, seven male professional hockey teams, not just one, in Canada are talking about mental health and helping to raise funds to support local mental health agencies. Of course, it would be terrific if these novel initiatives used evidence-based approaches so as to maximize their potential to achieve certain goals. But even if they do not, should such activities be disparaged and discouraged? Would progress be made if they disappeared forever?

Future evaluations

The commentaries in this issue of Education and Health provide excellent suggestions for
improving future evaluations of mass media campaigns, including: (a) carefully tracking the campaign messages and ensuring that they align with outcome measures (Yamaguchi et al., 2013); (b) using multiple indicators to assess market penetration (Yamaguchi et al., 2013); (c) investigating the dose-response relationship of mental health websites on different groups of people (Rickwood, 2013); and (d) using different methods (e.g., independent samples plus repeated sample designs) to examine different elements of a campaign (Lavis, 2013; Rickwood, 2013). Adding these elements would increase the precision with which an intervention and its effects are measured. We would also suggest that this field would benefit from research that uses less mechanistic and more sociological or anthropological approaches to understand the connection between mass media campaigns and the larger socio-cultural systems within which they are embedded.

Our evaluation of the In One Voice campaign (Livingston et al., 2012) was guided by frameworks used in similar studies (Corrigan, 2012; Dumesnil & Verger, 2009; Griffiths, Christensen, Jorm, Evans, & Groves, 2004; Reavley & Jorm, 2011; Stuart, 2006; Yamaguchi, Mino, & Uddin, 2011). As was suggested by Yamaguchi et al. (2013), evaluating the effects of mass media campaigns is an imperfect science. The broader goal of our evaluation was to scrutinize the range of effects that a brief, social media campaign, like In One Voice, should reasonably expect to achieve. This guided our selection of measures. However, Rickwood (2013) repeatedly implies that our measures and findings are suggestive of our values and beliefs. In one instance, she indicates the following: “Livingston et al. maintain that increased awareness of the website is a valuable outcome” (p. 36). In actuality, what we indicated was that the goals of this specific campaign were to increase awareness and use of the website, without opining as to the “value” of this particular variable. In other words, we measured awareness of mindcheck.ca because it was the principal goal of the campaign, not because we placed significant value on it. Similarly, the conclusion of our study was framed as follows: “Livingston et al. make the points, however, that increased market penetration is a worthwhile outcome and that improving mental health literacy, rather than reducing stigma, should be the goal of such media campaigns” (Rickwood, 2013, p. 36). This misrepresents our message in two ways. First, we do not posit an opinion as to whether market penetration is a reasonable or “worthwhile” outcome. It is a standard metric for evaluating mass media campaigns (Corrigan, 2012). Second, we do not indicate what should or should not be the goals of media campaigns. Rather, we argue that the available evidence, including the findings of our study, suggests that such campaigns are more likely to impact mental health literacy outcomes as opposed to stigma-related outcomes.

We believe that, despite their limits, mass media campaigns have a role in accomplishing circumscribed goals (e.g., increasing awareness) and objectives that defy measurement. How do you assess whether something has contributed toward the advancement of a social movement? It is wonderful to see that our article has stimulated such rich dialogue among renowned mental health experts. Since mass media campaigns do not appear to be on the decline, there will be plenty of opportunities to dissect them, refine our methods, and test new approaches.

References


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