Mental Health Literacy for Students and Teachers: A “School Friendly” Approach

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HEALTH LITERACY AND MENTAL HEALTH LITERACY: AN INTRODUCTION

Mental health literacy (MHL) is the foundation for mental health promotion, effective acknowledgment of prevention of mental disorders, and provision of evidence-based mental health care (Jorm, 2012; Jorm, Korten, Jacomb et al., 1997; Kutcher, Bagnell, & Wei, 2015; Kutcher, Wei, & Coniglio, 2016; Kutcher, Wei, & Weist, 2015; Reavley & Jorm, 2011; McLuckie, Kutcher, Wei, & Weaver, 2014). Anchored in the larger concept of health literacy (HL), which has undergone substantial evolution over time (Nutbeam, 2008; World Health Organization (WHO), 2013), understanding of the nature and impact of MHL has similarly changed from its initial consideration as information about mental disorders to a more comprehensive construct considering MHL as an empowerment competency for people to participate in their own health care (Jorm et al., 1997; Kutcher et al., 2016). Most recently, mental health literacy has been defined to comprise four distinct but related components: understanding how to obtain and maintain good mental health, understanding mental disorders and their treatments, decreasing stigma, and enhancing help-seeking efficacy (knowing when and where to obtain evidence-based mental health care and having competencies to enhance self-care) (Kutcher et al., 2015, 2016).

Historically, HL was initially conceptualized as narrowly constructed within the health care delivery environment and focused primarily on the ability of people to be able to understand and apply medical information
given to them by their health care providers, particularly with regards to improving adherence to treatment (American Medical Association Ad Hoc Committee on Health Literacy, 1992). Soon thereafter, however, this construct was expanded to include key components of health promotion and individual capacity for improvement of health-related behaviors: “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (Nutbeam, 1998).

More recently, understanding of HL has further evolved, now encompassing not only the individual’s capacity to seek health improving and health maintaining interventions but also to include the ability for self-care and for participating in the development of health policy and related activities designed to enhance health outcomes (Kanj & Mitic, 2009; Institute of Medicine, 2012; Schillinger et al., 2003; WHO, 2013). This broader construct is now understood to be a key factor in improving both individual and population health outcomes and has been identified as an important intervention to be applied for the decrease of health inequalities in populations (Berkman et al., 2011; Kickbusch, 2001; WHO, 2013). Indeed, according to WHO (2013), HL is “a stronger predictor of an individual’s health status than income, employment status, education and racial or ethnic group.”

With the increasing application of patient-centered health care interventions (such as the Wagner Chronic Care Model), HL has become an essential competency for health care recipients (Coleman et al., 2009; Schillinger et al., 2005). Educational interventions designed to enhance HL are understood to be an important component of health care capacity-building (Nutbeam, 2008; IoM, 2012; WHO, 2013).

Currently, the construct of HL can be considered to comprise the following components: competencies required to help a person obtain and maintain good health and identify illnesses, understanding of how and where to access and evaluate health information and health care, understanding how to properly apply prescribed treatments, and understanding health-related human rights and how to advocate for health improvements (WHO, 2013). To achieve this, HL needs to be: developmentally appropriate, contextually applied, and widely available through existing institutional and social vehicles such as schools, the workplace, and media (Kanj & Mitic, 2009; Nutbeam, 2008; WHO, 2013).

A similar evolution in understanding of MHL is also underway. The initial important work of Jorm et al. (1997) on an individual’s ability to recognize, manage, or prevent mental disorders, and early evaluations of educational interventions designed to address this focused primarily on one or two mental disorders (such as depression). This early construct was later broadened by Jorm and colleagues (Jorm, 2012; Reavley & Jorm, 2011) to additionally include: recognition of the development of mental
disorders, knowledge of effective self-help strategies, and first-aid skills to assist others who have a mental disorder.

As the HL definition has evolved, so have others contributed to the evolving construct of MHL (Kutcher, Bagnell, et al., 2015; Kutcher et al., 2016). In step with the current conceptualization of HL, MHL is currently conceptualized to address the four constructs presented in the previous section. This approach has integrated historically separate stigma interventions into the broader and more comprehensive construct of MHL. Such integration is supported both by the recognition that knowledge and stigma are not unique and separate constructs, but are related to each other and that knowledge enhancement does impact stigma reduction related to mental health and mental illness (eg, Chan, Mak, & Law, 2009; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Pinfold et al., 2003; Thornicroft, 2006). This evolving understanding also parallels the WHO integration of human rights constructs into HL and other health care frameworks that have integrated health knowledge with stigma reduction strategies in other health conditions, such as HIV/AIDS and epilepsy (Birbeck, 2006; Brown, Macintyre & Trujillo, 2003; Heijnders & Van Der Meij, 2006; Sermrittirong, Van Brakel, & Bunbers-Aelen, 2014).

Global interest in school mental health is now becoming more evident (Kutcher, Wei, et al., 2015; Rowling & Weist, 2004). Foundational to all different school mental health approaches is the integration of MHL into the existing school curriculum structure because the school setting is contextually established to deliver interventions using a literacy approach (Jorm & Wright, 2007; Kutcher, Bagnell, et al., 2015). Furthermore, using educational strategies, including school curriculum and various knowledge-based interventions delivered in school settings may be more effective in addressing stigma in young people than other types of interventions (Corrigan et al., 2012; Kutcher et al., 2016; Pinfold et al., 2003). Finally, bringing mental health literacy into the school setting is not only consistent with a core activity of schools, but also fits well with the definition of literacy that is used by the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2006), a construct also consistent with the WHO model for Health Promoting Schools (http://www.who.int/school_youth_health/gshi/hps/en/).

To date, a number of different types of interventions addressing some or all parts of the components of MHL have been reported in the school setting. Broadly speaking, these fall into one of two different strategies. First are strategies that introduce interventions to the school using external resources. For example, Skre et al.’s clinician-led intervention in a Norwegian sample (2013); Pino-Foltz et al.’s application of the In Our Own Voice intervention in two schools in the USA (2011); Stuart’s evaluation of the Reaching Out program in a Canadian setting (2006); and Jorm’s application of the very expensive corporate supplied Mental Health First
Aid program targeting teachers (e.g., Kitchener & Jorm, 2002). Many more examples can be found in a recent systematic review on the effectiveness of school mental health literacy interventions (Wei et al., 2013). Taken as a group, these interventions are added to existing school activities, are usually not delivered by existing internal school resources, are episodic rather than continuous, require fidelity of delivery as a requirement of the intervention, do not usually strengthen existing school resources or communities, often focus primarily on one target group (such as students only), and are not likely to be sustainable, particularly in times of fiscal constraint, due to their costs and add-on nature.

Second, in contrast, are interventions that are substantially different from the above-described externally applied interventions. These are “School Friendly” interventions, designed to be delivered by existing school resources (primarily teachers) within existing school activities (primarily everyday classroom instruction) and have the following characteristics:

1. are designed to be a resource that can be easily integrated into existing school curriculum
2. are designed to be developmentally appropriate and educationally innovative
3. are designed to be learned by and then taught by usual classroom teachers within their usual classroom instruction periods
4. are designed to be pedagogically familiar in content and process
5. are designed to enhance and strengthen existing school systems
6. are designed to be able to fit into existing school mandated curriculum (such as health and physical education or life-skills management), and therefore become embedded and continuous rather than external and episodic interventions
7. are designed to build on the professional ability of teachers to teach, rather than requiring fidelity of implementation
8. are designed to improve MHL outcomes for both teachers and students simultaneously
9. are designed to be cost-effective and sustainable
10. have demonstrated significant and robust impacts on both teacher and student mental health literacy in two or more independent investigations conducted in different settings

As of 2016, these have been applied within a curriculum-based framework, where teachers can learn to apply a mental health literacy resource within the existing school curriculum that is consistent with established pedagogic procedures and existing school structures. For example, Perry et al. in their 2014 study of the Headstrong resource in Australia and McLuckie et al. (2014) in their study of the Guide resource in Canada illustrate this School Friendly approach.
In Canada, there has been increasing recognition of the importance of school mental health. For example, a study by the School Based Mental Health and Substance Abuse Consortium, funded by the Mental Health Commission of Canada, recently reported on the substantial need to address the mental health of students in Canadian schools (Mental Health Commission of Canada, 2013). This work builds on earlier study by Santor, Short, and Ferguson (2009), which came to similar conclusions. Evergreen, the Canadian child and youth mental health framework, identified schools as a key site for the delivery of mental health-related interventions (Kutcher & McLuckie, 2010). The Canadian Teachers’ Federation is a national organization supporting the importance of addressing child and youth mental health in the school setting, and recently, the faculty of education at the University of Western Ontario established a center for school-based mental health to encourage the development of research into various components of this topic (http://www.edu.uwo.ca/).

To respond to the national considerations referenced in the previous section, a collaboration between the Canadian Mental Health Association (the leading national mental health Non-Government Organization in Canada) and Dr. Stan Kutcher, the Sun Life Financial Chair in Adolescent Mental Health at Dalhousie University, resulted in the development, field testing, and subsequent delivery and evaluation of a “School Friendly” mental health literacy approach (Kutcher & Wei, 2013; Kutcher, Wei, McLuckie, & Bullock, 2013; McLuckie et al., 2014), Mental Health & High School Curriculum Guide (the Guide) (Kutcher & Canadian Mental Health Association, 2009). The Guide consists of six web-based modules addressing knowledge, attitudes, and help-seeking efficacy. This includes: stigma of mental illness, understanding mental health and mental illness, information about specific mental illness, experiences of mental illness, seeking help and finding support, and the importance of positive mental health. Further information about this freely available resource can be found at www.teenmentalhealth.org.

This intervention takes the form of a classroom-ready resource (the Guide) designed to be delivered by usual classroom teachers to students in Canadian schools enrolled in grades 9 or 10 (ages 13 to 15 years). These grade levels were chosen because at this point most young people would still be attending school, they would all tend to be exposed to the same standard curriculum (few, if any, individualized curriculum options), and this period in the life span is the point of departure for the rapid increase in psychiatric diagnoses that occurs prior to age 25 years (Costello, Mustillo, Erkanli, Keeler, & Angold, 2004; Kessler et al., 2005), making the development of mental health literacy at this point an important foundational component for potentially improving mental health outcomes. The Guide
was certified by the Curriculum Services Canada, a national curriculum standards and evaluation agency and was initially field-tested in various provinces across the country (www.curriculum.org). On the basis of that evaluation, curriculum materials were revised, input from students and parents was sought, a new section designed for teacher self-study, a teachers’ self-evaluation test was added, and a teacher training program on how to apply the Guide in the classroom was developed by Kutcher and members of his team. Recently the Guide has been updated by Kutcher and Wei in response to teacher suggestions for improvement and to ensure compatibility with new diagnostic nomenclature. Further development of a train-the-trainer model that can be embedded in schools and school boards maintains the sustainability of the intervention. As a result, teachers and trainers received the Guide in concert with web-based access to all the components of the Guide intervention (teacher self-study, teacher self-evaluation, student evaluation resource, six classroom-ready modules consisting of prepared lesson plans, and in-class teaching resources such as powerpoint slides, animated videos, and print-ready materials).

The initial application of this approach was conducted and evaluated in the Province of Nova Scotia where it was subsequently embedded in the 2012 Provincial education policy framework—Kids and Learning First (Nova Scotia Department of Education and Early Childhood Development, 2012; Wei et al., 2015). Two cross-sectional studies assessing the impact of this intervention specifically on teachers were conducted with educators from the Halifax Regional School Board and from the larger Province of Nova Scotia (Kutcher et al., 2013; Wei, Kutcher, Heather, & Mackay, 2014). Additionally, two cross-sectional cohort studies assessing the impact of this intervention on students were conducted in a number of school boards in the province of Ontario including the largest school board in Canada, the Toronto District School Board (Kutcher et al., 2016; McLuckie et al., 2014), as well as a randomized-controlled trial in the Ottawa District School Board in Canada (Milin, Kutcher, Lewis, Walker, & Ferrill, 2013).

In all of the research and evaluations of the Guide, classroom teachers who were identified as having the responsibility for applying the Guide in their classrooms were provided with a one-day training program designed to be able to fit into existing teacher professional development day sessions. Evaluation of the impact of this simple intervention demonstrated significant and substantial improvements in teachers’ knowledge (Cohen’s effect size: $d=1.48–2.03$) and substantial decreases in teachers stigma as a result of the intervention (Cohen’s effect size: $d=0.21–1.26$) (see Table 8.1) (Wei et al., 2014; Kutcher et al., 2016).

With regards to the impact of this intervention on students’ mental health literacy, research conducted in the three different Canadian school districts at different times all demonstrated similar results. Teachers who
### TABLE 8.1  Research Summary of the Guide Impact

<table>
<thead>
<tr>
<th>Province</th>
<th>Study Type</th>
<th>Year</th>
<th>Participants</th>
<th>Increased Knowledge</th>
<th>Improved Attitudes</th>
<th>Improved Help-Seeking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nova Scotia</td>
<td>Program evaluation</td>
<td>2012–2013</td>
<td>218 educators</td>
<td>Yes $p &lt; 0.0001, d = 1.85$</td>
<td>Yes $p &lt; 0.0001, d = 0.51$</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>RCT</td>
<td>2011–2012</td>
<td>362 students</td>
<td>Yes $p = 0.0001, d = 0.46$</td>
<td>Yes $p = 0.0001, d = 0.30$</td>
<td>Yes $p = 0.01; d = 0.18$</td>
</tr>
<tr>
<td></td>
<td>Cross-sectional study</td>
<td>2012</td>
<td>409 students</td>
<td>Yes $p &lt; 0.001, d = 0.9; p &lt; 0.001^a, d = 0.73^a$</td>
<td>Yes $p &lt; 0.001, d = 0.25; p &lt; 0.007^a, d = 0.18^a$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Program evaluation</td>
<td>2013</td>
<td>74 educators</td>
<td>Yes $p &lt; 0.001, d = 1.48$</td>
<td>Yes $p &lt; 0.03, d = 1.26$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cross-sectional study</td>
<td>2013</td>
<td>175 students</td>
<td>Yes $p &lt; 0.0001, d = 1.11; p &lt; 0.001^a, d = 0.91^a$</td>
<td>Yes $p &lt; 0.001, d = 0.66; p &lt; 0.001^a, d = 0.52^a$</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>Program evaluation</td>
<td>2013</td>
<td>25 educators</td>
<td>Yes $p &lt; 0.0001, d = 2.03$</td>
<td>Yes NS, $d = 0.21$</td>
<td></td>
</tr>
</tbody>
</table>

*Results from three-month follow-up.*
taught the Guide had all received a one-day training session for the classroom use of the Guide resource as part of a professional development program provided by either the Ontario Shores Mental Health Center or the Royal Ottawa Hospital. In all cases, student outcomes demonstrated significant and substantial improvements in knowledge (Cohen’s effect size: \( d = 0.46–1.11 \)) and significant decreases in stigma as a result of the intervention (Cohen’s effect size: \( d = 0.18–0.66 \)) (Kutcher et al., 2016; McLuckie et al., 2014; Milin et al., 2013). These impacts were sustained over a three-month follow-up. The Ottawa study also investigated student self-reported help-seeking efficacy, which also showed significant impact with a more modest effect size (see Table 8.1).

Feedback from teachers using the Guide indicated that it was easy to apply in the classroom, that it did not entail the use of additional resources, and that the students thought that the topic was timely and important, found the material engaging, and enjoyed the various classroom and learning activities supported by the modules.

**DISCUSSIONS AND CONCLUSIONS**

This series of interventions all used the “School Friendly” approach to address MHL. The Guide resource was available at no cost, easily accessible via the web, and teacher friendly. Teachers were able to simply download the various modules and supporting materials and immediately apply them in their classrooms once they had received training on the use of the resource. A simple one-time training opportunity, compatible with existing professional development activities, provided them with the information they required for classroom application and concurrently demonstrated significant and substantial impact on improving their knowledge and decreasing their stigma. This approach used well-understood and historically comfortable pedagogic approaches, which enabled teachers to apply the resource in their own classroom using their own professional skills. This did not require fidelity of delivery (just as no other school curriculum resource—be it mathematics textbooks or geography curriculum—requires fidelity of delivery) and was able to be modified by teachers to fit each of their own teaching styles. Teaching of the resource embedded into usual classroom curriculum demonstrated the positive impact on students’ knowledge, attitudes, and help-seeking efficacy. Additionally, this impact was sustained over time.

Finally, unlike the traditional costly, stand-alone school mental health programs that are added to existing school activities, “School Friendly” mental health literacy intervention is tied into a larger education and health system integrated model that promotes a horizontal and seamless pathway through mental health care for young people who may require
various types and levels of intervention (see Fig. 8.1). Mental health literacy, delivered by a single classroom intervention that enhances both teacher and student knowledge and decreases both teacher and student stigma, may be the first impactful stepping-stone along this pathway to better youth mental health (Wei, Kutcher, & Szumilas, 2011).

Thus, the “School Friendly” mental health literacy approach has the impact of not only effectively addressing the various components of mental health literacy, but it also has the role of enhancing the opportunity for young people to be able to access appropriate mental health care if they need it. In this way, the “School Friendly” mental health literacy approach provides an opportunity to bridge the long-standing gap between public health/population health interventions and clinical interventions, perhaps beginning a new care delivery framework, applicable wherever schools and health providers co-exist in the same community. Additional work by the authors on other components of this framework such as the “Go To Educators” program (Wei & Kutcher, 2014) and child and youth mental health care competency building in primary health care (Garcia-Ortega et al., 2003, 2013) suggests that such an integrated approach, beginning with “School Friendly” mental health literacy may be adapted, modified, and considered for global application (Kutcher, Wei, et al., 2015).
References


III. INTERVENTIONS AND TREATMENTS
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