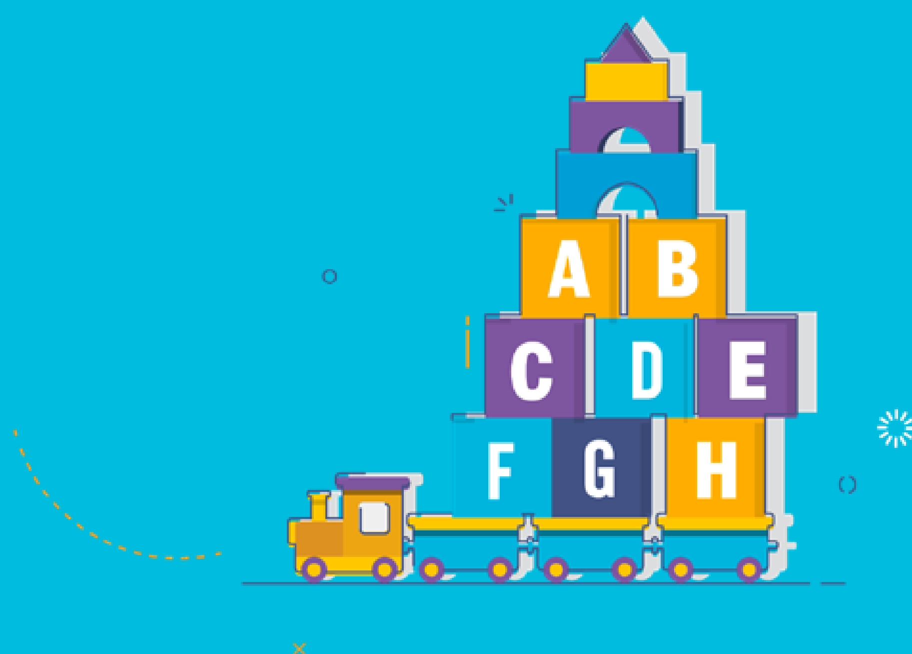
LEARNING TO LEARN

Learning about my mental health programme evaluation report



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JIGSAW
Young people's health in mind

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Acknowledgements

This report describes the findings from an evaluation of the Learning to Learn Programme which was delivered during the 2017/8 academic year.

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The design of the programme and coordination of the project was guided by Siobhán McGrory (Education and Training Manager), with oversight by Dr Gillian O'Brien (Director of Clinical Governance). The programme was designed by Dr Emma Farrell (Education and Training Officer) and Tara Mulhern (Clinical Coordinator) and delivered by Dr Emma Farrell (Education and Training Officer), Tara Mulhern and Jen Trzeciak (Clinical Coordinators).

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Introduction

It is well accepted that the number one health issue for young people is their mental health. The *My World Survey* (Dooley & Fitzgerald, 2012) revealed that many young people who are experiencing mental health difficulties do not look for support. Barriers to help-seeking amongst this age group include poor service knowledge, concerns about confidentiality and shame around help-seeking (Brown et al., 2010). Good mental health literacy has been found to act as a key facilitator for help-seeking amongst young people (Kelly, Jorm, & Wright, 2007). This report describes key findings from an evaluation of the Learning to Learn programme which aims to improve mental health literacy amongst college students. The programme was delivered to first year B.A. (Hons) in Social Care Practice students at IT Tallaght during the 2017/8 academic year.

Mental Health Literacy

The concept of mental health literacy has its origins in general health literacy, which is defined by the World Health Organisation (1998) as “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” (p.10). Centred on skills such as the ability to maintain health and identify illness, as well understanding how to properly apply and adhere to prescribed treatments, health literacy is considered “a stronger predictor of an individual’s health status than income, employment status, education and racial or ethnic group” (WHO, 2013, p.7). Mental health literacy evolved from this context and was initially conceptualised as the “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997, p.182). Although Jorm (2012) later expanded this definition to include the concepts of stigma and self-help strategies, traditionally, mental health literacy has tended to align with more biomedical conceptualisations of mental health.

More recently, Wei, McGrath, Hayden & and Kutcher (2017), in a meta-analysis of mental health literacy measures, conceptualised mental health literacy across four domains: 1) understanding how to obtain and maintain good mental health; 2) understanding mental disorders and their treatments; 3) decreasing stigma against mental illness; and 4) enhancing help-seeking efficacy. They define mental health literacy as comprising of three inter-related concepts: (i) knowledge of mental illness and positive mental health, (ii) attitudes and (iii) help-seeking efficacy. This definition was adopted for the current study but adapted slightly to focus on: students’ knowledge of positive mental health; help-seeking intentions; and beliefs about mental health (particularly stigmatising beliefs).

Mental Health Knowledge

Mental health knowledge, stemming from mental health literacy’s alignment with health literacy, has typically focused on knowledge about mental disorders, which aid[s] their recognition, management or prevention (Jorm et al., 1997). As a result, measures of mental

health knowledge have tended to centre on an individual's ability to identify illness as well as their factual knowledge of mental disorders and associated terminology, aetiology, diagnosis, prognosis, and consequences (Wei et al., 2017). However, in a later paper elaborating upon the concept of mental health literacy, Jorm (2012, p. 231) highlights how mental health literacy is also linked to the possibility of action to benefit one's own mental health. Jigsaw's conceptualisation of mental health knowledge recognises that everyone has mental health and that there is much we can do to support and build our own mental health and wellbeing.

Help-seeking intentions

As previously highlighted, research including the *My World Survey* (Dooley & Fitzgerald, 2012) suggests that young people who share their problems enjoy better mental health than those who don't. The survey also reveals that 20% of young Irish adults, who are in distress, do not seek help and that not talking about problems is linked to suicidal behaviour (Dooley & Fitzgerald, 2012). Help-seeking has been described as the behaviour of actively seeking help from other people. This help may be formal, from professionals who have a recognised role or specialist training in providing help or advice, or informal, from social relationships such as friends and family. Young adults (17-25) who participated in the *My World Survey* (Dooley & Fitzgerald, 2012) listed the internet (55%), friends (52%) and parents (45%) as the top three sources they had actually used to obtain information or support about their mental health and wellbeing. Regardless of whether the source of help is formal or informal we know that 'the help-seeking behaviours of young people are fundamental to their mental health and wellbeing' (Rickwood, Deane, Wilson, & Ciarrochi, 2005, p.3).

Mental health beliefs

The attitudes and beliefs individuals have about mental health are shaped by many factors such as personal knowledge about mental health, knowing and interacting with someone living with mental health difficulties, cultural stereotypes and the media (Choudhry, Mani, Ming, & Khan, 2016). Stigma, often associated with 'the core experiences of shame (to oneself) and blame (from others)' (Thornicroft, 2006, p.11), persistently emerges as a main barrier to mental health help-seeking (Brown, Conner, Copeland, Grote, Beach, Battista & Reynolds, 2010; Gulliver, Griffiths & Christensen, 2010; Lally, O'Conghaile, Quigley, & Bainbridge, 2013). Stigma has been described as comprising both public and self-stigma (Loreto, 2017). Public stigma involves attitudes of fear and anger that members of the public have concerning people with mental illness, while self-stigma occurs when individuals internalise negative attitudes toward mental health and begin to manifest behaviours that support the negative perceptions (Corrigan & Rao, 2012; Corrigan, Watson, & Barr, 2006). Mental health literacy involves an understanding about stigma and the value of seeking help/early intervention for a mental health problem (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). Emerging research is providing evidence that improving mental health

literacy via education programmes in schools and communities has a positive effect on stigma reduction (Busby, Bruce, & Batterham, 2015; Milin et al., 2016; Rodgers, Paxton, & McLean, 2015; Wei et al., 2013).

The Learning to Learn Programme

While issues relating to behaviour are unlikely to be comprehensively addressed over the course of a four week programme, issues related to knowledge and negative attitudes can be influenced. The Learning to Learn programme aims to do this by increasing mental health knowledge and exploring, as well as challenging, common myths surrounding mental health. The programme seeks, not to increase students' ability to recognise and identify mental disorders, but rather to identify that we all have mental health and there is much we can do to support and build our own mental health and wellbeing. The programme also aims to increase students' knowledge about how to manage their own mental health and how they might recognise when they could benefit from further formal or informal support. Breaking down stigma and encouraging early intervention for students to seek help if they experience mental health problems can lead to better recovery outcomes and healthier trajectories (Loreto, 2017).

Spread across four weeks of the academic term, each one-hour session explores a different component of mental health literacy. The first session explores student's beliefs about mental health.

Students' knowledge of, and attitudes towards, mental health is explored in a walking debate during this session. The second session aims to improve their knowledge of what mental health actually is and how it shapes our overall wellbeing and capacity to do the things we want to do with our lives, such as study or socialise with friends. Session three focuses on practical skills students can use to build and maintain their own mental health, while the fourth session centres on the theme of help-seeking. In this final session students explore the barriers that might prevent them from seeking help if they needed it, factors that might make it easier to seek help and sources of support, both formal and informal, within the students' own community. This session includes a carousel activity, which involves students generating ideas in pairs into a prompting statement and then feeding their ideas back to the larger group for a broader discussion. Students are divided into small tutorial groups for the first and final sessions of the programme, while the second and third session are delivered as lectures.

Aim of Current Research

Although we know that mental health literacy is a key element in mental health help-seeking and general wellbeing, Kelly, Jorm, and Wright (2007) point out that 'few interventions to improve mental health literacy of young people…have been evaluated, and even fewer have been well evaluated' (p.26). Thus, the purpose of this evaluation was to evaluate whether the Learning to Learn programme can improve students' mental health

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knowledge, reduce stigma about mental health difficulties, and promote better help-seeking intentions.

Method

Participants

Participants (n = 55) were first year students on the B.A. (Hons) in Social Care Practice course at the Institute of Technology Tallaght (ITT) who completed Time 1 and Time 2 questionnaires.

Almost all students identified as female cisgender (94.5%), with a remaining two identifying as male (3.6%) and another as a transgender male (1.8%). As shown in Figure 1, the age range was 17 to 25 years, with most students aged 18 and 19 years (74.6%).

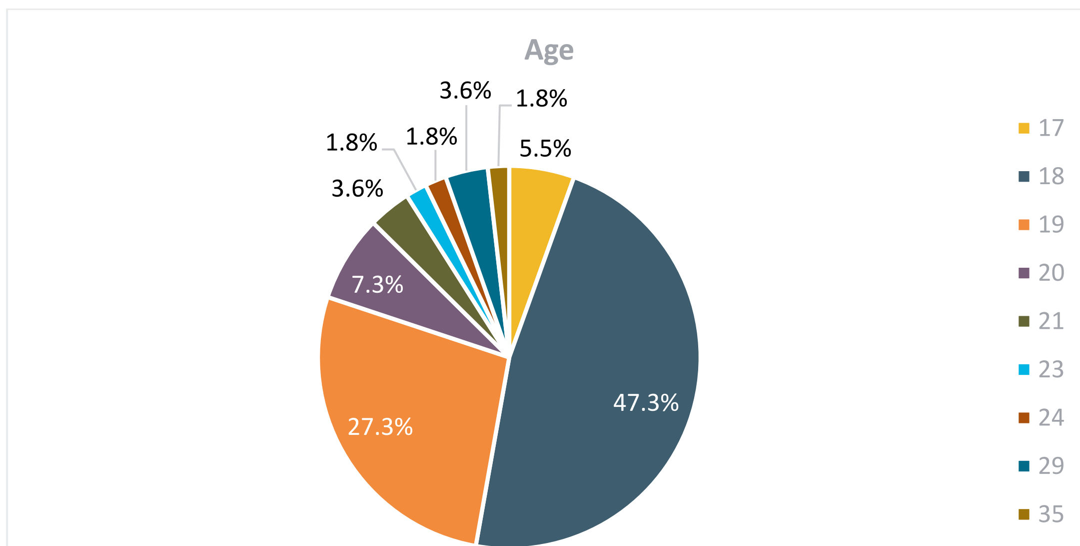

Figure 1. Age of students

Most of the students identified as White Irish (81.8%), with a remaining 9.1% identifying as any White background other than Irish, 7.3% identifying as Black or Black Irish and 1.8% identifying as mixed background. Other backgrounds specified by students included Polish, Nigerian, Spanish (3.6% each), French and Togolese (1.8% each). Four students (7.3%) were parents, becoming parents at ages 18, 19, 20, and 28.

None of the students reported that they had left school early. Students reported that they were experiencing a variety of conditions and difficulties (see Figure 2 on the following page), with 18.2% reporting experiencing mental health difficulties and 12.7% reporting learning difficulties. The highest proportion of participants rated themselves as a 5 (n = 13; 23.5%) or 6 (n = 24; 43.6%) on the MacArthur Scale of Social Status.

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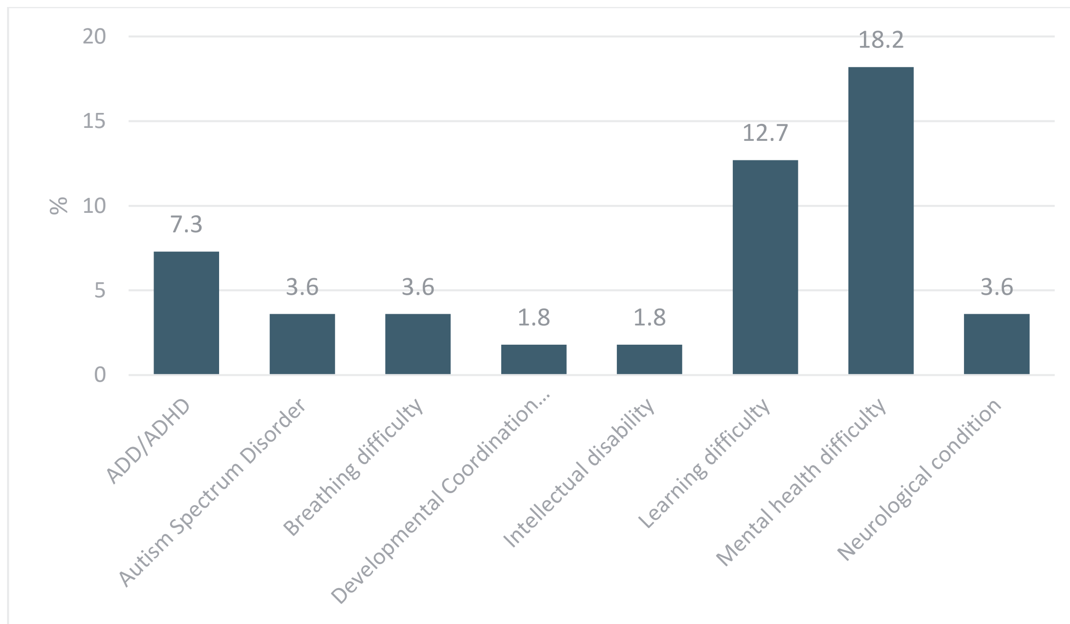

Figure 1. Participants' Conditions or Difficulties

Procedure

Ethical approval for this research was granted by Jigsaw's Ethics Committee and the study was carried out in accordance with the 2013 Declaration of Helsinki. Students on the B.A. (Hons) in Social Care Practice course were provided with information sheets in advance of the first day of the programme and verbally reminded of the programme's aims, the purpose of its evaluation, their rights as participants (including the right not to participate) and their anonymity. Students interested in taking part in the evaluation then completed and signed a form to confirm that they understood the above and consented to participate in the study. This form was separated from any evaluation questionnaires so as to protect the students' identity.

Participants completed questionnaires on the first day of the programme (i.e., Time 1) and two weeks after completing the programme's fourth and final day (i.e., Time 2). Both Time 1 and Time 2 questionnaires began with a matching question where students were asked to identify the first letter of their first name, the first three letters of the month they were born and the date of their birthday in order to allow for anonymous matching across the two time points. These questionnaires were administered by a member of the research team who was not involved in the delivery of the Learning to Learn programme. Students were also asked to record a brief (500 word) journal entry reflecting on their experience of each of the programme's four sessions. A total of 52 participants submitted 113 entries describing their thoughts on and experiences of the programme.

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Measures

At Time 1, the questionnaire given to participants included a demographic section in which they were asked questions about:

- Age
- Gender
- Ethnicity
- Presence of physical, intellectual, learning or mental health difficulties
- Parental status
- Education (i.e., whether they left school early)
- Perceived social status

Participants' social status was assessed using the single item MacArthur Scale of Social Status (Adler, Epel, Castellazzo, & Ickovics, 2000). Here, students were presented with a ladder with 10 steps and asked to rank their standing in their community on this ladder from 1-10, where higher scores indicate higher self-rated standing. These demographic categories were chosen to capture what the literature suggests can influence an individual's mental health knowledge, attitudes and help seeking behaviours (e.g., Cauce et al., 2002; Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Gonzalez, Alegria, & Prihoda, 2005; Kim & Zane, 2015; Rüsch et al., 2014; Vogel & Wei, 2005).

At Time 1 and 2, participants were asked to complete an author designed seven-item questionnaire assessing their **mental health knowledge**. This questionnaire comprised of items relating to 1) understanding mental health ('everyone has mental health', 'only people with problems need to look after their mental health', 'good mental health is largely a matter of luck'), 2) knowledge of the prevalence of mental health problems ('only a small number of people will ever have mental health problems') 3) negative beliefs about mental health problems ('people with serious mental health problems are more likely to carry out crimes than people who do not have serious mental health problems'), and 4) knowledge of how to manage mental health ('only doctors know how to help with mental health', 'in general, talking about worried or problems can make things worse'). Students were asked to rate their agreement with each of these statements on a five-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. Higher scores indicated higher levels of mental health knowledge.

Second, participants were asked to complete a short questionnaire about their **help-seeking intentions** (adapted, with permission, from the *My World Survey*, Dooley & Fitzgerald, 2012). This questionnaire offered a list of formal and informal sources of support and students were asked to rate their likelihood of using these services or supports if they were

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'feeling stressed, worried or down' on a five-point Likert scale (from 'very unlikely' to 'very likely'). Higher scores indicated a higher likelihood of seeking support.

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

At Time 2, participants were also asked a number of questions about their participation on the Learning to Learn programme. Specifically, they were asked to rate their level of enjoyment of the programme, how well the programme was facilitated, whether the content was useful for them, and if they understood the material. They were also asked to comment on what aspect of the programme they found most useful, what they took as the key message and if they had any other comments/suggestions about the programme.

In addition to completing the questionnaires, students were invited to submit a reflective journal entry for each of the programme's four sessions. At the end of each session, the students were given a prompt and to write an approximately 500 word reflection using this prompt for guidance. These were as follows:

- Session One – One thing I will take from today's session
- Session Two – What helps and hurts my mental health
- Session Three – Try out the 5-a-day framework[1] and reflect on whether this has an impact on your mental health
- Session Four – What are they key learning points I will take away from the programme?

These journals were submitted directly to the course leader via the college's electronic learning platform. Entries relating to the four weeks of Jigsaw input were forwarded, with student consent, to the lead researcher upon completion of the programme.

Data Analysis

Quantitative data were analysed using SPSS version 25. Frequencies were explored and differences in pre/post matched questions were examined using non-parametric Wilcoxon

[1] The 5-a-day guide for minding mental health outlines five things to do to support mental health: connect, be active, take notice, keep learning and give (www.jigsaw.ie)

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signed-rank tests. Effect sizes for significant effects were also calculated (>0.1, small; >0.3 medium; >0.5 large). Qualitative data from the students' reflective journals were anonymised and analysed using thematic analysis (Braun & Clarke, 2006).

Findings

Mental Health Knowledge

Qualitative Findings

Analysis of the qualitative data gathered suggested an improvement in students' knowledge about mental health. Many students, in writing in their journals about session one, reflected on how they now realised mental health was something everyone has, just like physical and dental health. For example:

> *"We all have mental health, just like we have dental health and physical health. So why would we not look after our mental health?"*

Students' reflective journals showed students pausing to consider the need to look after their mental health. As one student stated:

> *"Mental health was compared to other aspects of health a number of times such as dental health making many of us realise that we all take time out of every day to look after our teeth and gums, but many of us do not take any time at all to look after our mind and sometimes can go as far as forgetting about our mental health completely"*

Students also acknowledged how they had to come to the realisation it was not just medical professionals who are responsible for looking after mental health. For example:

> *"Understanding…that it's not only doctors that could help someone with mental, people with mental health could also do with love and care from family and friends around them"*

As part of the walking debate exercise in session one, students were asked to reflect on whether people with mental health difficulties were more likely to commit crimes. This typically led to a wider discussion about where our understandings and attitudes about mental health come from and how, as well as why, forces such as the media can be so influential in shaping these understandings and attitudes. As one student stated:

> *"For example with the statement 'Do you think people with mental health issues are more likely to commit crimes?' I was somewhere in the middle I said that it depends on the mental health issue. However after we discussed it <names facilitator>said that figures show that those with mental health issues are more likely to be the victims of crime. This shocked me and really made me think about how we can have prejudice to those with mental health issues"*

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The walking debate exercise which feature in session one appeared to stimulate much reflection among students. The activity really encouraged them to think about mental health, and the factors that shape and influence individual thinking, and they enjoyed hearing others' opinions. For example:

> *"The questions were thought provoking and there wasn't always a straight "I agree" or "I disagree" answer. Mental health is clearly not a black and white area. I realized that there were few questions that I had definitive answers to. Most of them I answered by standing a little bit over to the "agree" side or a little bit over to the "disagree" side"*

However, one area that students remained unsure about after taking part in the Learning to Learn Programme related to talking about mental health difficulties. While most agreed that 'a problem shared is a problem halved' others felt that talking about a problem could make it 'real' or could elicit an unhelpful response. As one student stated:

> *"What stood out to me was that some people honestly felt that talking about a problem can make it worst [sic]. I personally feel that a problem shared is a problem halved. If there are people who feel like this no wonder people don't want to go out and seek help with their mental help"*

Quantitative Findings

- There were significant changes in some aspects of students' mental health knowledge:
    - At both Time 1 and 2, there was some uncertainly among students about whether **people with mental health problems are more likely to carry out crimes**. Prior to the module 47.3% disagreed/strongly disagreed and 41.8% were not sure. After the module there was an increase to 59.2% in disagreement, with 37% unsure. This increase in levels of disagreement was moderately significant (z=-2.248, p=0.025, r=0.306; *Mdns* pre = 3, post = 2).
    - The majority of students disagreed that **only doctors know how to help with mental health** pre-module (89.1%), and post-module (94.5%). Significantly more, with moderate effect size, strongly disagreed post-module (z=-2.359, p=0.018, r=0.318; *Mdns* pre = 2, post = 1)
    - Pre-module most students disagreed/strongly disagreed that **talking about worries or problems can make things worse** (89.1%). However students were not as sure post-module with 72.8% disagreeing and 23.6% neither agreeing nor disagreeing. This increase in uncertainty was small to moderately significant (z=-2.092, p=0.036, r=0.282; *Mdns* pre = 1, post = 2).
- There were other areas where the changes were not significant:

- Prior to the module, most students (87.2%) agreed/strongly agreed that **everyone has mental health**. After the module the majority (85.5%) strongly agreed. The difference was not significant (z=-1.930, p=0.054; Mdns pre/post = 5).
- The majority of students pre-module disagreed/strongly disagreed that **only people with mental health problems need to look after their mental health** (94.5%). Post-module, 80% strongly disagreed however the difference was not significant (z=-1.930, p=0.125; *Mdns* pre/post = 1).
- The majority of students pre- and post-module disagreed/strongly disagreed that **only a small number of people will ever have mental health problems** (90.9%), without a significant difference (z=-1.111, p=0.266; *Mdns* pre = 2, post = 1).
- Students varied in opinions at both time points in relation to whether **good mental health is largely a matter of luck**. While prior to the module most disagreed/strongly disagreed (69.1%), 23.5% neither agreed nor disagreed. While disagreement was lower post-module (54.6%), most students were unsure (34.5%) and differences were not significant (z=-1.032, p=0.302; *Mdns* pre/post = 2).

Help-seeking Intentions

Qualitative Findings

In their reflective journals students expressed that they had learned more about the type of supports available to young people experiencing mental health difficulties. As one student noted:

> *"[Name] made a list on the whiteboard to which we all added a place we know is near us and is cheap or free….she then told us to take a picture of this list to keep for ourselves or for someone we know that may need it. I found this very useful as now I know who I could turn to If I needed such help"*

Some students were surprised at how many services were actually available to them, while others spoke about the particular services they felt they would use, if they needed to seek help for mental health difficulties. For example:

> *"We learnt[sic] about some sources of support and I personally did not know some of them such as Jigsaw or helplines. From my point of view, all of them can be very helpful if you feel down or even if you do not as a method of precaution to feel good about yourself. But I truly think counselling services or visiting a psychologist would be the best ones for me because I feel the need of talking when I notice something is wrong with me"*

Indeed, a number of students mentioned Jigsaw as a service they would engage with. As one student noted:

> *"Jigsaw have a very strong attitude towards talking about our problems and creating an aim to help us deal/solve with anything that may be on our minds. Jigsaw is a colourful, 'non-office like' building. It has bright colours and comfortable chairs, which is welcoming and provides a feeling of security"*

Some students referenced barriers to help-seeking and how feelings of embarrassment or shame prevented young people looking for help. Other barriers mentioned included availability of services and cost. As one student summarised:

> *"Some of us do not want to talk about our mental health problems as we may feel embarrassed, guilty for having someone else feel bad for you, we may not want to talk about it and feel texting is easier, we may feel that some people such as our parents are not educated enough … and may not take us seriously…. Availability is one of the biggest issues. This is because we may want to speak to someone about this but there might not be a specialist anywhere near us or we simply may not have the money for such services"*

Quantitative Findings

- The top sources from which students were most likely to seek help were friends, parents/guardians, and relatives. Differences in likelihood were not significant across time for friends (z=-0.726, p=0.468; *Mdns* pre/post = 5), parents/guardians (z=-0.213, p=0.831; *Mdns* pre/post = 4), or relatives (z=-172, p=0.864; *Mdns* pre/post = 4).
- There were also no significant differences in likelihood to seek help from the internet (z=-1.912, p=0.056; *Mdns* pre/post = 3), college lecturers (z=-1.650, p=0.099; *Mdns* pre/post = 2), and other sources (pre n=5, post n = 6; z=-0.447, p=0.655; *Mdns* pre/post = 5).
- However, a significant increase in students' likelihood to **seek help from Jigsaw** was observed post-module**,** with a reasonably large effect size (z=-3.980, p=0.000, r=0.547; *Mdns* pre = 2, post = 3).
- Significant differences were also observed for sources that students were least likely to seek help from; that is, students were more likely to seek help from phone helplines (z=-2.318, p=0.020, r=0.315; *Mdns* pre = 1, post = 2), a doctor/GP (z=-2.392, p=0.017, r=0.326; *Mdns* pre = 2, post = 2), and a psychologist/counsellor/therapist (z=-2.890, p=0.004, r=0.393; *Mdns* pre = 2, post = 2.5) after participating in the Learning to Learn programme.

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Mental Health Beliefs

Quantitative Findings

- Overall, while there was a small reduction in in stigma agreement from pre- (*M* = 13.83; *SD* = 2.43) to post-intervention (*M* = 13.22; *SD* = 3.37), this change was not significant, *t*(1.336) = 56, *p* = .187.
- However, there was an improvement on the positive stigma items, with average scores improving from pre- (*M* = 16.79; *SD* = 1.56) to post-intervention (*M* = 17.63; *SD* = 1.69), *t*(-3.901; 51; *p* = .000, CI_{95} -1.28, -.41)
- Further examination of individual items on this scale showed three out of four items changed significantly:
  - Prior to the module, most students were unsure whether they believed it is good to be friends with someone who has mental health difficulties (63%), while 37% agreed/strongly agreed. Following the module most students agreed/strongly agreed (54.6%), however 43.6% were still undecided. The differences were significant, with the median moving to 4 i.e. agreement (*z*=-3.152, *p*=0.002, *r*=0.425; *Mdns* pre = 3, post = 4)
  - The vast majority of students pre- (94.6%) and post- (98.1%) module believed that people with mental health difficulties are just as intelligent as other people, with the increase in complete agreement being moderately significant (*z*=-2.294, *p*=0.022, *r*=0.312; *Mdns* pre/post = 5).
  - Most students believed pre- (89.1%) and post- (94.4%) module that people with mental health difficulties can get good grades in college. This increase in complete agreement was moderately significant (*z*=-2.272, *p*=0.023, *r*=0.309; *Mdns* pre = 4, post = 5).

Student Feedback on Learning to Learn Programme

Students' feedback on the programme facilitation and content was very positive. Most students found the module enjoyable (76%), thought it was very well/well facilitated (91%) and that the content was definitely/probably useful (89%). Most reported that they understood most or all of the material (98%).

Many students commented on how they really enjoyed taking part in the programme. As one student noted:

> *"I really liked how the class went by so quick as everyone was taking part and enjoying themselves. I thought it was very enjoyable and found myself looking forward to the class the week after."*

A number of students commented positively on the facilitators who delivered the module, who they described as professional, friendly and non-judgemental. For example:

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"The speakers were kind and open to any questions which made it a lot easier to get involved and being open with your own views and expressing them. They constructed the class in a calm and confidential manner therefore no one felt judged for voicing their view on the topic of mental health"

Finally, some students commented favourably on the mode of delivery for the Learning to Learn programme, which comprised of tutorials and bigger lectures. They described how they felt more comfortable in smaller groups and how they enjoyed the exercises which were delivered in the tutorials. For example:

"We met as a full class group instead of our smaller separate groups. I found this worked much better for this exercise this week as it was easier to come up with different ideas for the 5 a day as we could share our different opinions with each other"

The qualitative data gathered suggested participants found taking part in the Learning to Learn programme very useful for them in that it provided them with opportunities to learn more about their own mental health and support options. For example:

"I find these classes with Jigsaw very beneficial as not only do I get to hear experts' opinions and studies on mental health but also it allows me to take time to reflect within me and understand where I am"

The module activities were the most commonly reported useful aspects of the programme, particularly the walking debate and group work. Students also valued receiving information on services and resources available, as well as information on minding one's own mental health. As one student commented:

''I felt that speaking out loud about what hurts/helps your mental health useful as I've identified what I can do to boot my mood if I feel low''.

Various other aspects of the content of the module were deemed most useful such as the 5-a-day message, learning about mental health, information on stereotypes and barriers to help-seeking. In addition, a small number of students commented on how learning from others and sharing opinions were useful aspects of the module.

A small number of students did provide some suggestions for improving the module, such as including more activities; for example, *"I'd like more active activities to do like the walking debate and the human carousel''*, while others noted some of the material was repetitive and needed more variety or group work. Other comments suggested a need for greater depth and more learning about mental health, that the information was not useful for people with mental health issues, that the class order should be rearranged, and that there should be less discussion time (although the majority of students had cited the debates and group work as the most useful aspects of the module).

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Discussion

This study aimed to examine whether the Learning to Learn programme for third level students can improve students' knowledge and understanding of mental health, attitudes about mental health and help-seeking intentions.

The findings indicate students' **mental health knowledge** increased in some areas after participating in the Learning to Learn programme. Students demonstrated a particular awareness that mental health is not something that only doctors can support. Although the qualitative data indicated some uncertainty about whether talking about problems was helpful, overall students reported this could be helpful if experiencing mental health difficulties. There was a sense from many students that there was an increase in their understanding that everyone has mental health and needs to look after their mental health, although these improvements were not statistically significant.

Encouragingly, when asked about **help-seeking intentions**, students reported a greater awareness of the formal sources of support for young people in their area, and reflected on what services they would use if they experienced a mental health difficulty. Many students commented on Jigsaw as one of those services, and the quantitative data indicated they were significantly more likely to seek help from Jigsaw as a result of participating in the Learning to Learn programme. The top three sources of support cited by students in this study were friends, parents/guardians and relatives, a slight variation from the top three sources of internet, friends and parents reported by young adults who participated in the *My World Survey* (Dooley & Fitzgerald, 2012). The internet emerged as the fourth most popular source of support amongst students in this study.

Students' **beliefs about mental health** revealed higher levels of positivity towards peers with mental health difficulties as a result of participating in the programme. Indeed, a number of students also reflected on how their opinions of mental health can be shaped by negative portrayals of people experiencing mental health difficulties in the media. Overall, however, there was no significant change on the stigma agreement subscale that was used in this evaluation. Negative beliefs are one component of stigma, which has been described as a complex and critical societal issue where several strategies are needed at the personal, and several strategies may be needed at an organisational and societal level to change people's negative perceptions of about mental health (Loreto, 2017).

Examination of students' feedback indicated students generally found the Learning to Learn programme enjoyable. They liked the interactive nature of the programme and the exercises that were included. Students also thought the programme was well-facilitated, and many found it useful. They commented that they learned more about mental health services in their area and they liked hearing other people's opinions about the topic. A small number of suggestions for improvements to the programme were proffered such as including more activities and allowing more time for deeper discussion on issues raised.

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Limitations

As with any piece of research, it is important to note this evaluation's limitations. The first and most significant is the small sample size which limits the generalisability of the findings. This also limited the capacity to examine differences based on variables such as gender and ethnicity. Second, the programme was partly assessed using the reflective journals submitted by students. While it was made clear to students that Jigsaw was not involved in the module assessment, the reflective journal entries submitted by students were, therefore, particularly vulnerable to response bias. Indeed, social desirability can often influence individuals to present favourable responses about mental health and people with mental health difficulties (Chisholm et al., 2016). Finally, as measures of mental health literacy tend to focus on increasing knowledge and awareness of 'mental disorders,' standard measures were considered ill-fitting for Jigsaw's approach to, and conceptualisation of, mental health literacy. As a result, the measure of mental health knowledge adopted in this evaluation was not a standardised measure.

Conclusion

Findings from this evaluation indicate that Learning to Learn programme can lead to some positive changes in students' mental health literacy. The findings also indicate that participating in the programme increases students' awareness of Jigsaw and the likelihood that they would seek help from the service.

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Appendix A: Mental Health Knowledge % Agreement Charts

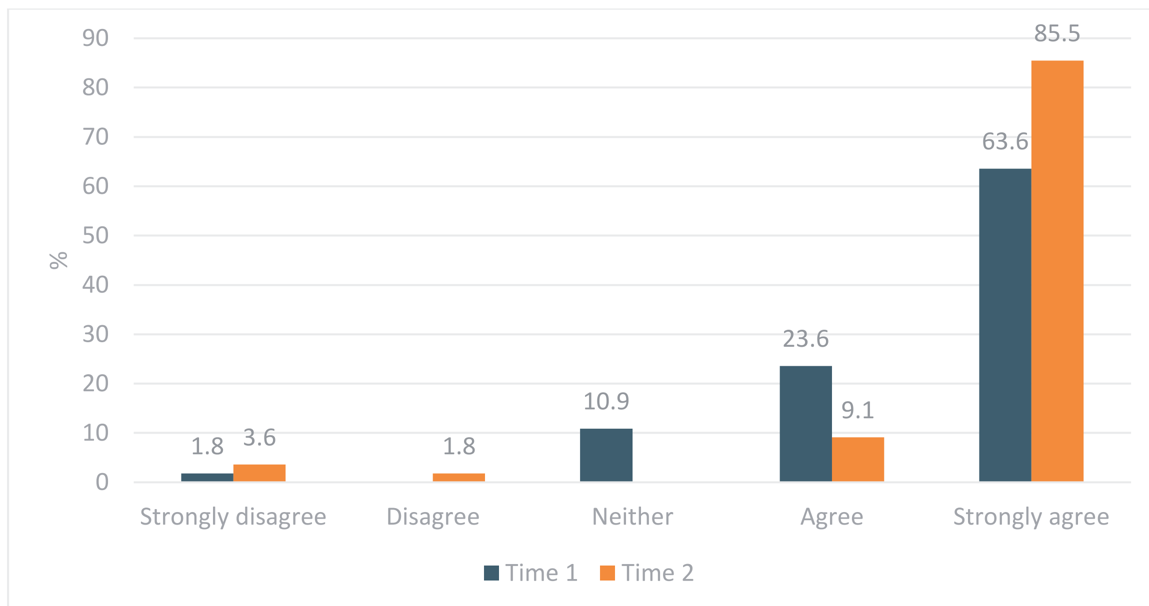

Figure A1. Responses to ''Everyone has mental health'' at Times 1 and 2

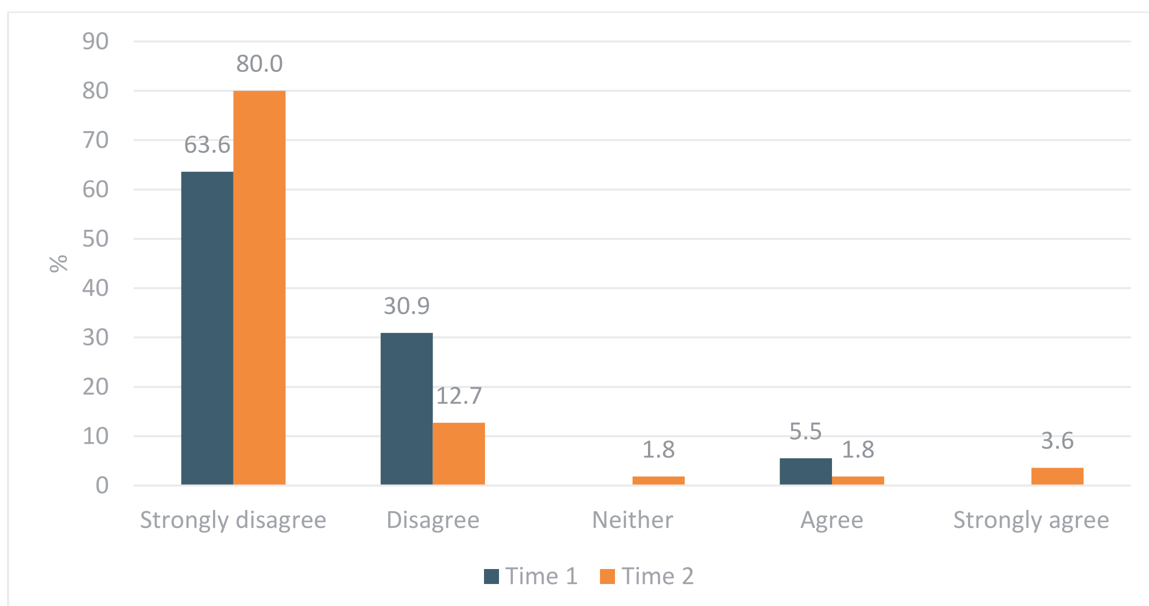

Figure A2. Responses to ''Only people with mental health problems need to look after their mental health'' at Times 1 and 2

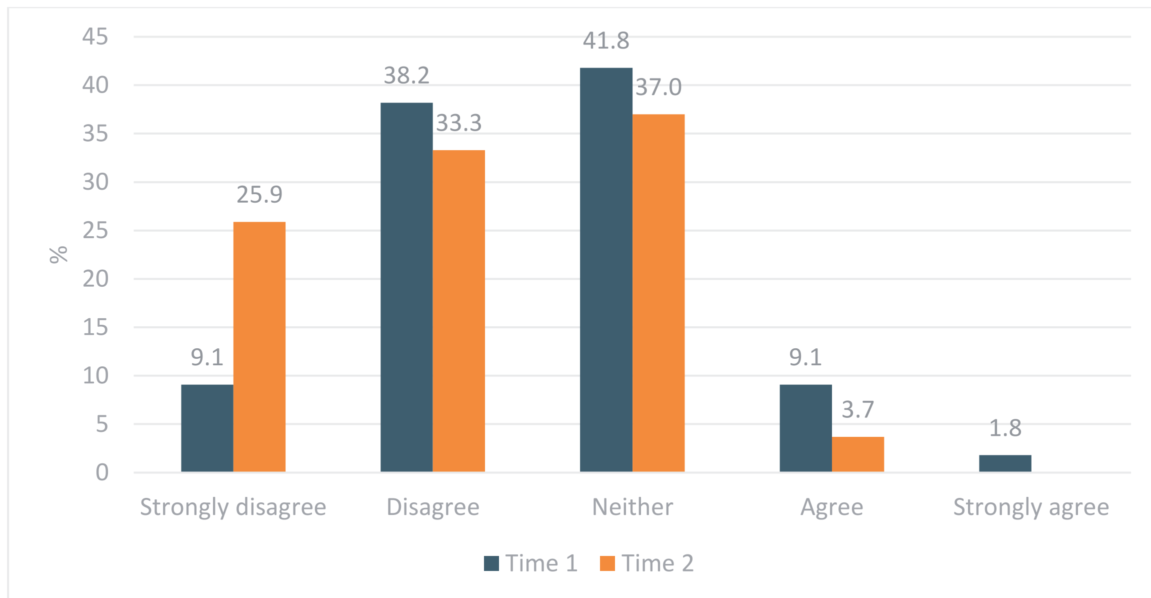

Figure A3. Responses to ''People with mental health problems are likely to carry out crimes' at Times 1 and 2

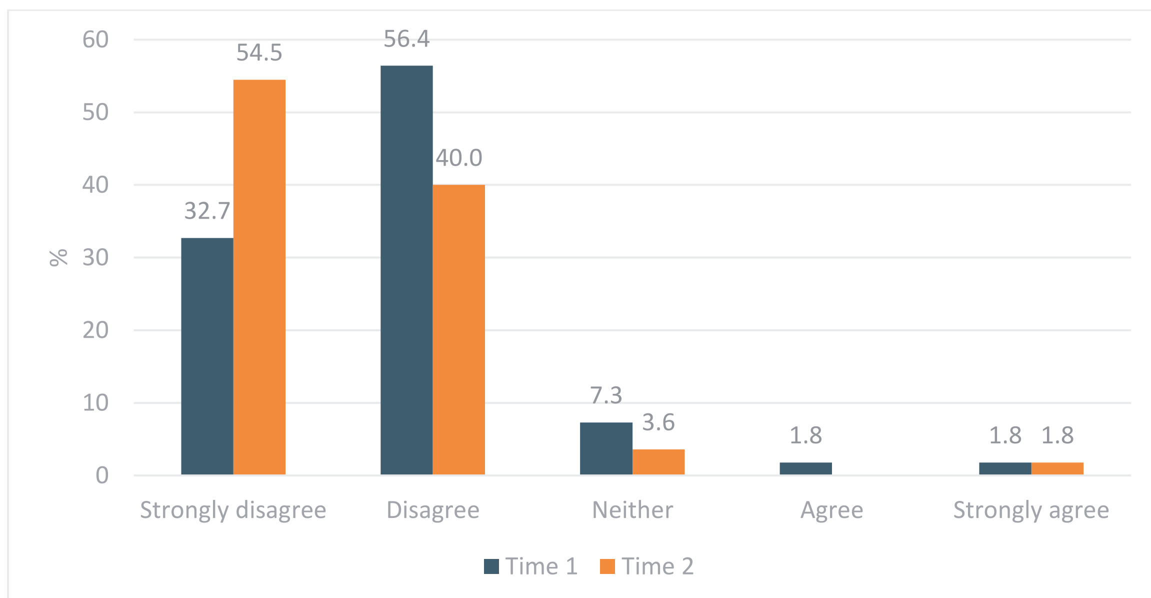

Figure A4. Responses to ''Only doctors know how to help with mental health'' at Times 1 and 2

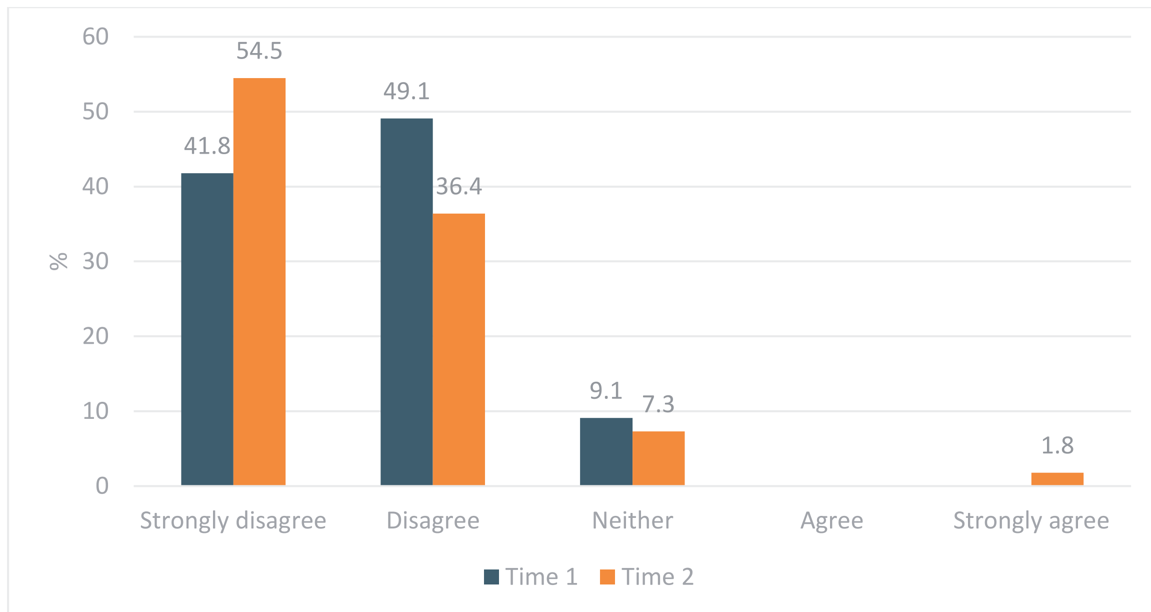

Figure A5. Responses to ''Only a small number of people will ever have mental health problems'' at Times 1 and 2

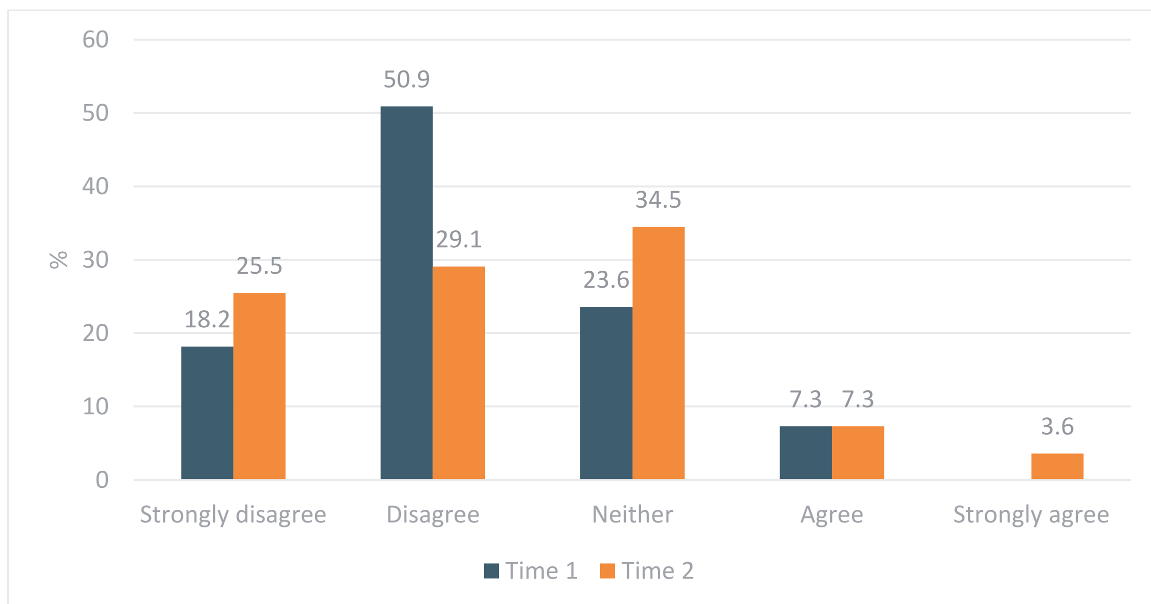

Figure A6. Responses to ''Good mental health is largely a matter of luck'' at Times 1 and 2

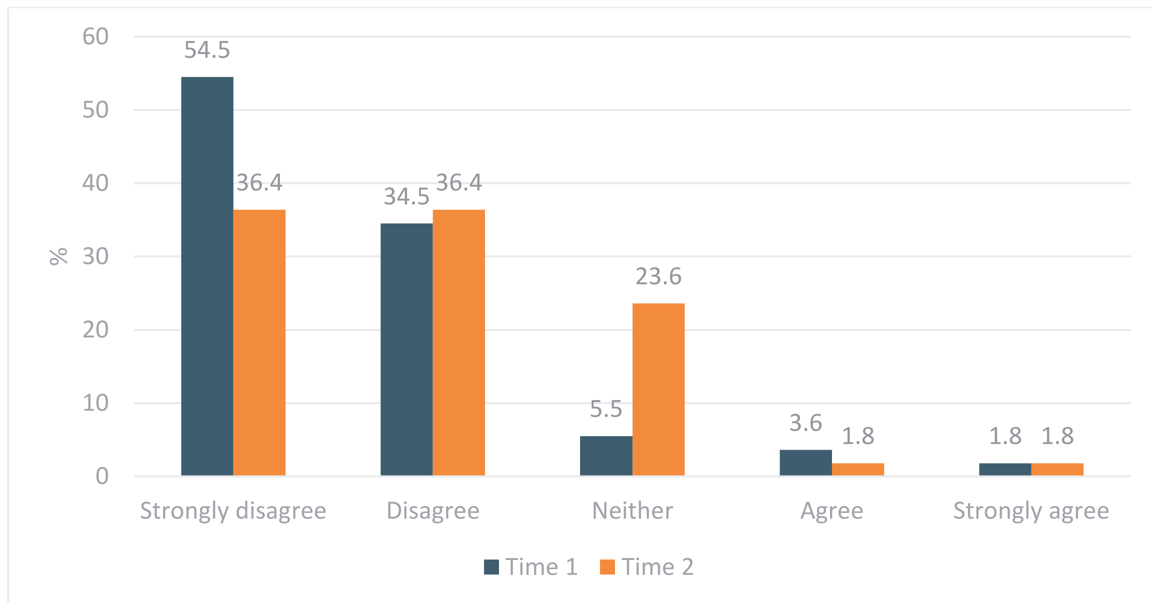

Figure A7. Responses to ''Talking about worries or problems can make things worse'' at Times 1 and 2

Appendix B: Help-Seeking Intentions % Agreement

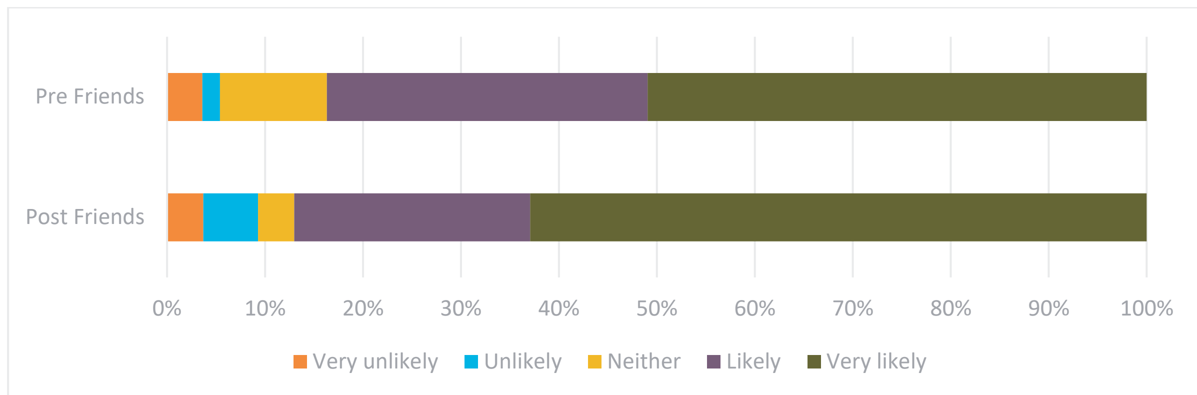

Figure B1. Likelihood of seeking help from friends

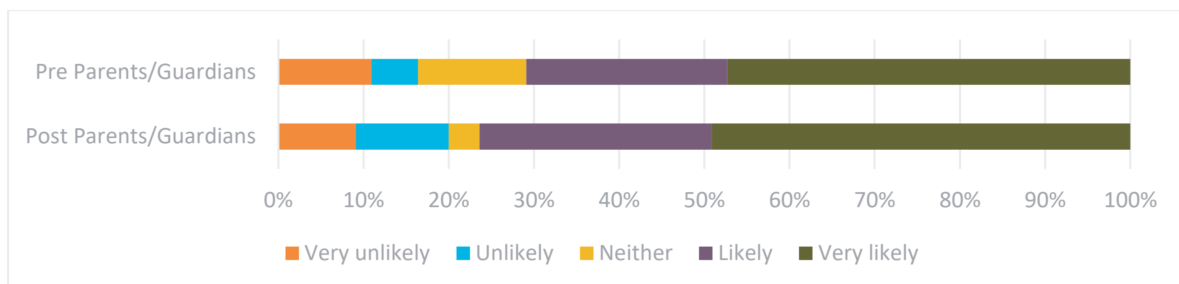

Figure B2. Likelihood of seeking help from parents/guardians

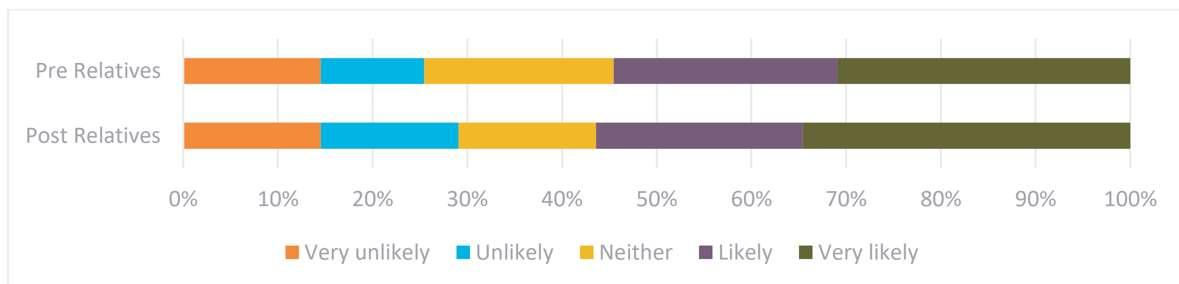

Figure B3. Likelihood of seeking help from relatives.

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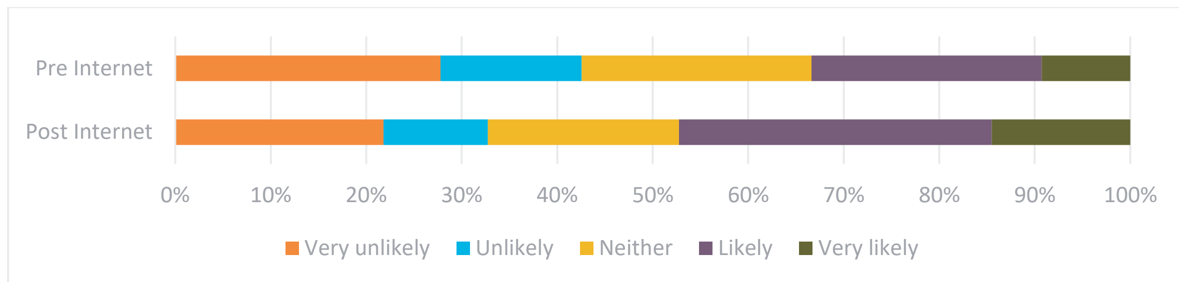

Figure B4. Likelihood of seeking help from the internet.

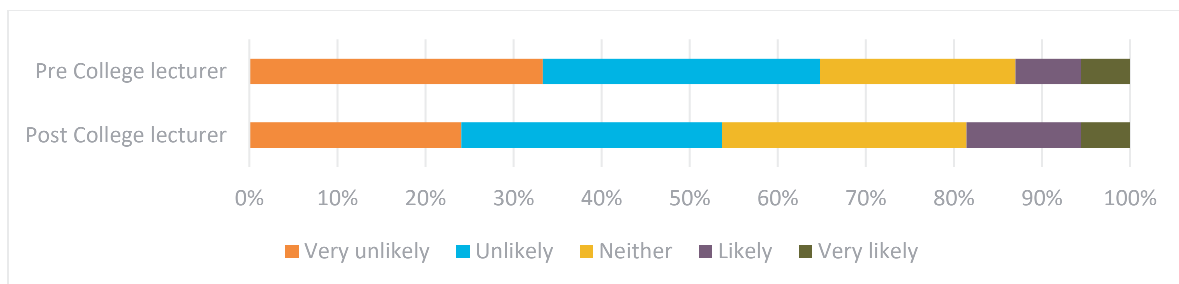

Figure B5. Likelihood of seeking help from college lecturers.

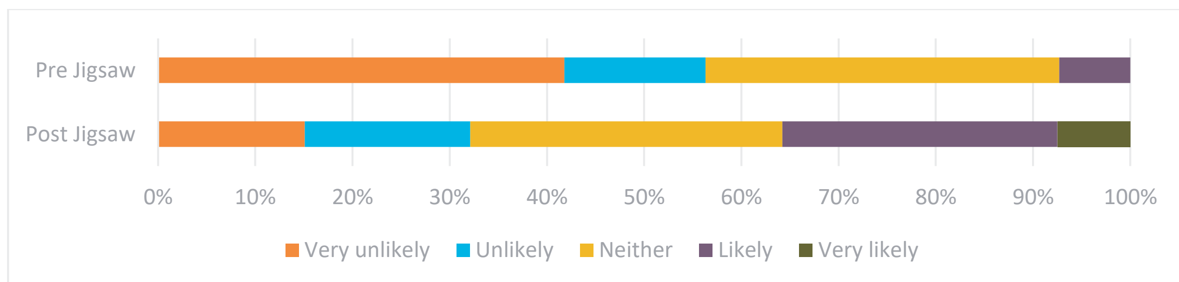

Figure B6. Likelihood of seeking help from Jigsaw.

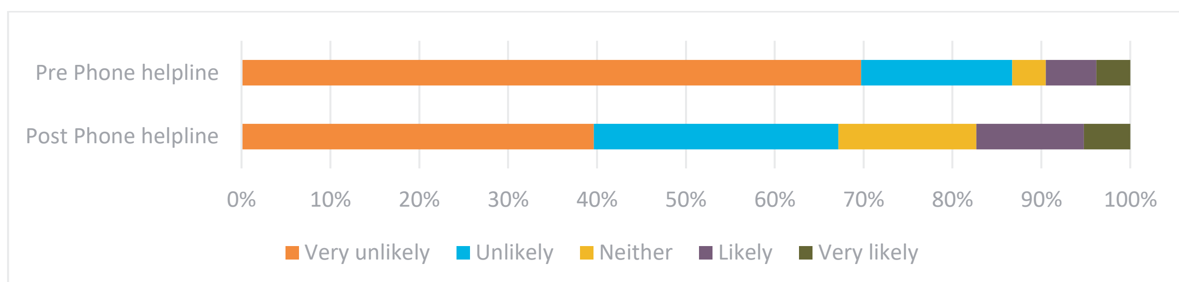

Figure B7. Likelihood of seeking help from a phone helpline.

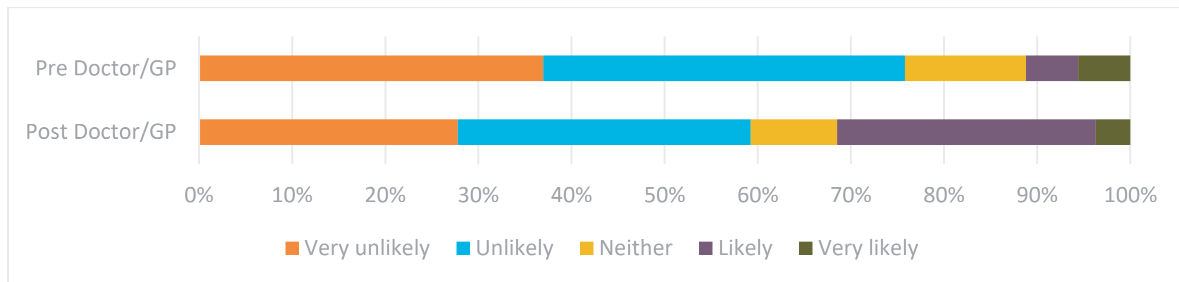

Figure B8. Likelihood of seeking help from doctor/GP.

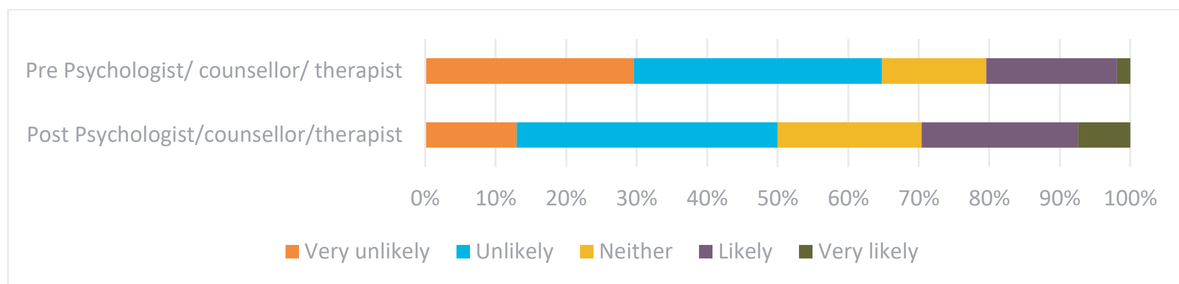

Figure B9. Likelihood of seeking help from psychologist/counsellor/therapist.

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Appendix C: Peer Stigmatisation Scale % Agreement

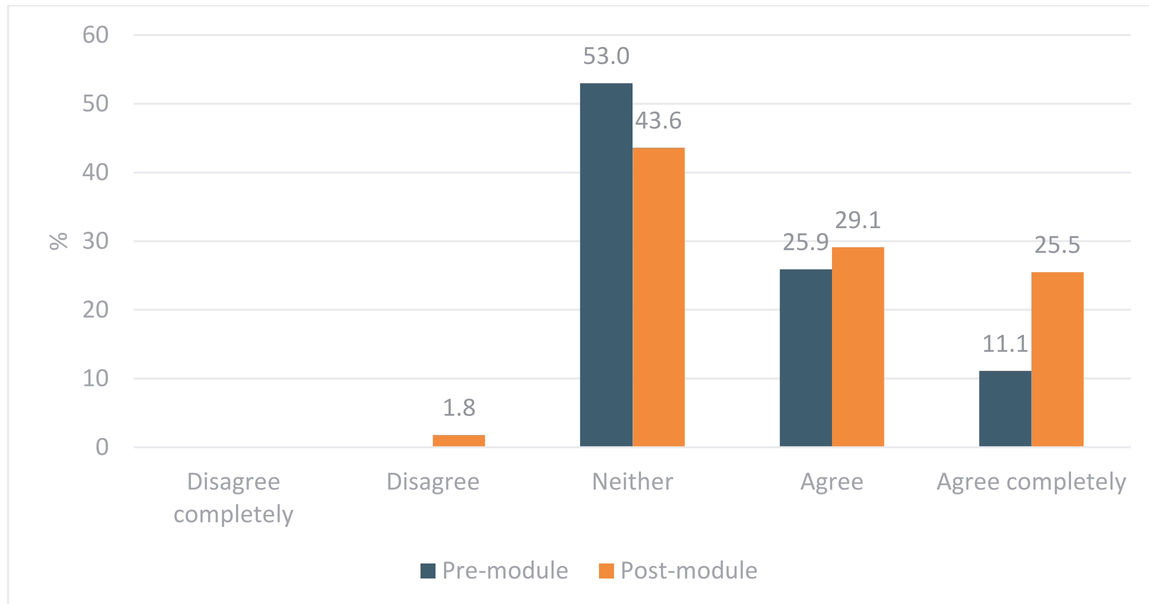

Figure C1. Responses to "I believe it is good to be friends with someone who has mental health difficulties"

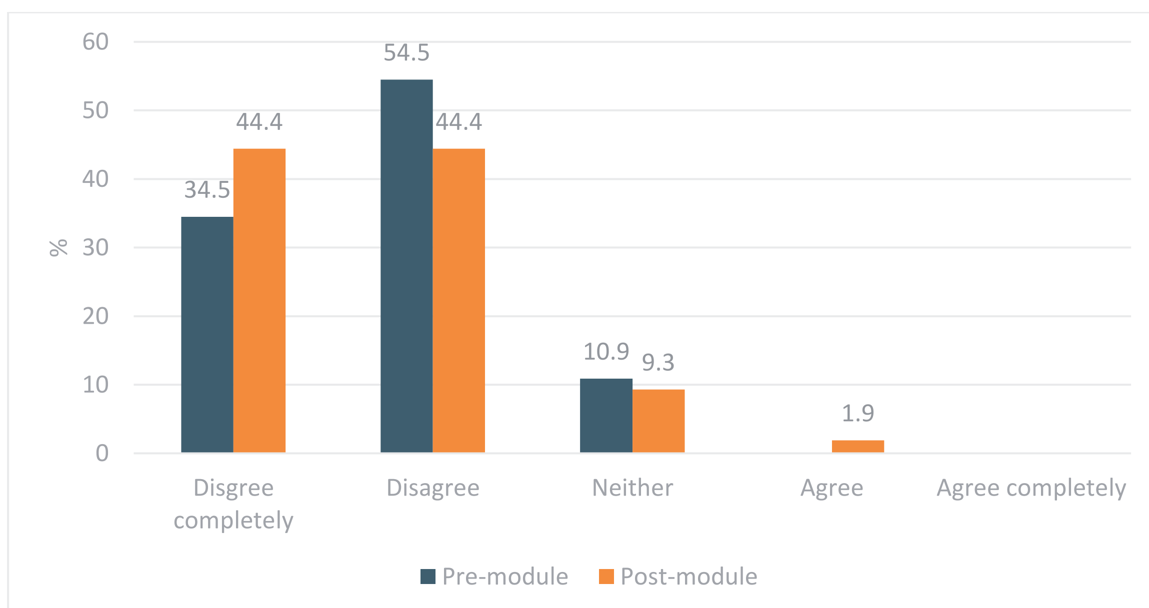

Figure C2. Responses to "I believe people with mental health difficulties are not as trustworthy as other people"

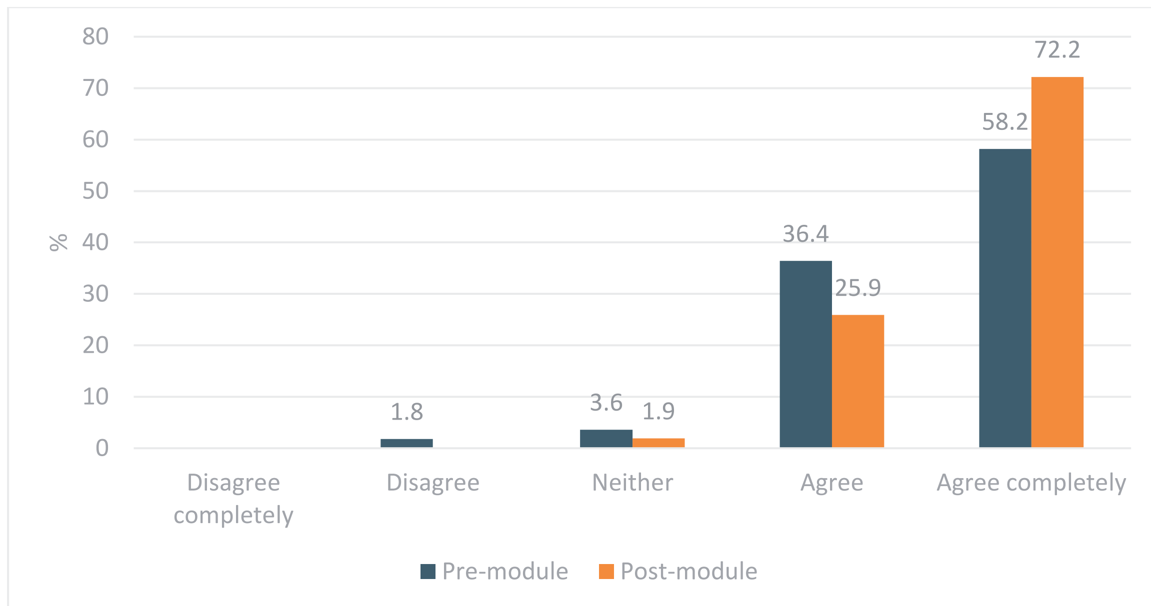

Figure C3. Responses to “I believe that people with mental health difficulties are just as intelligent as other people”

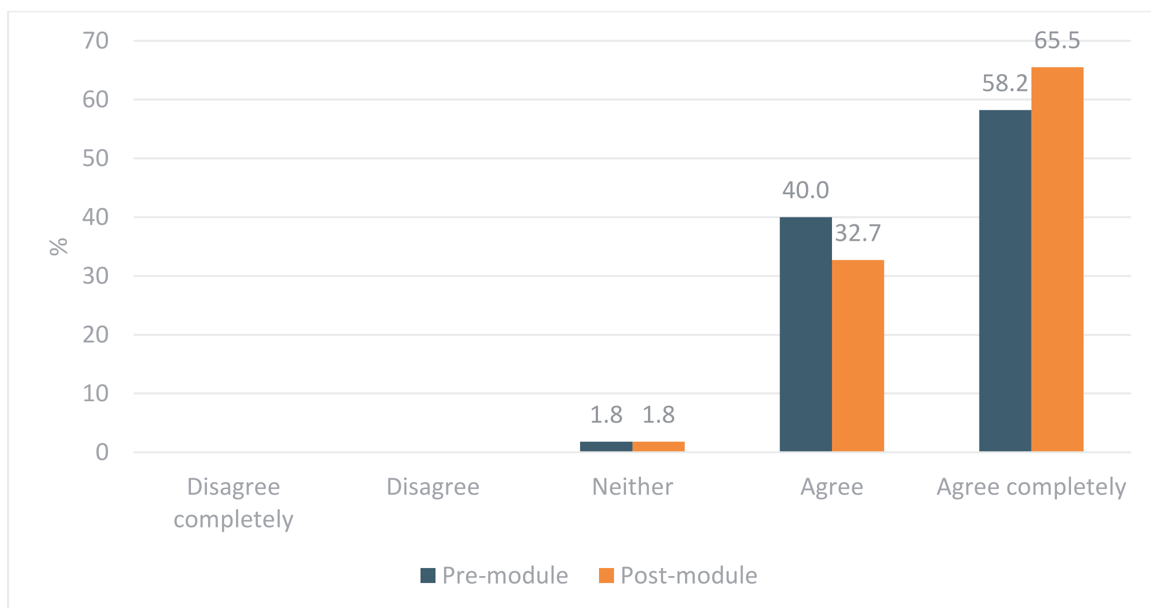

Figure C4. Responses to “I believe people with mental health difficulties can get better”

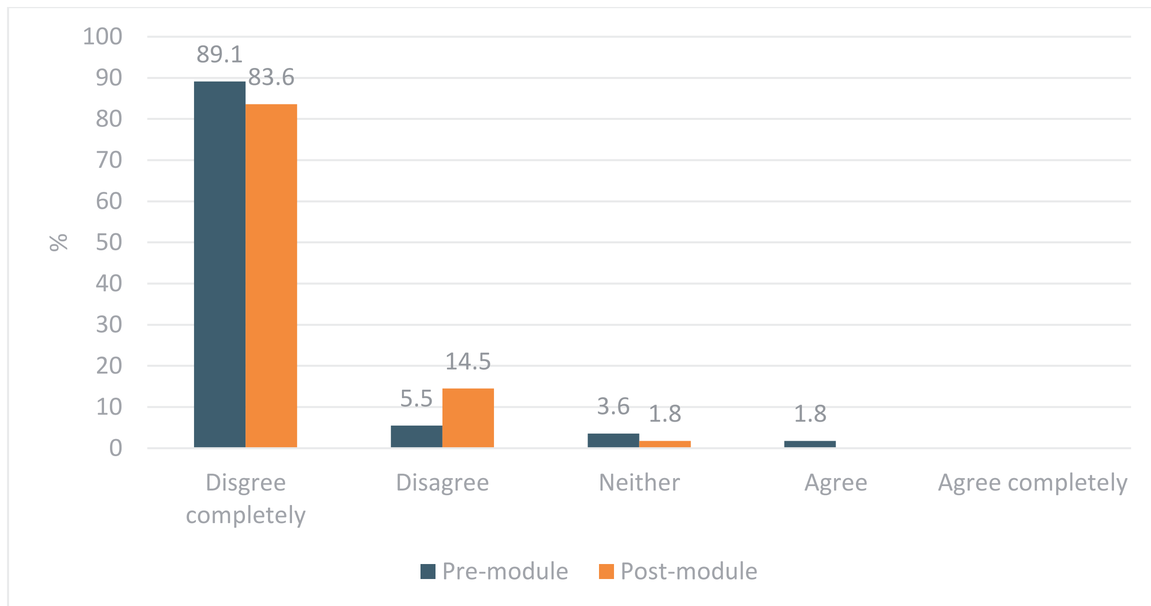

Figure C5. Responses to "I look down on people who visit a counsellor because they have mental health difficulties"

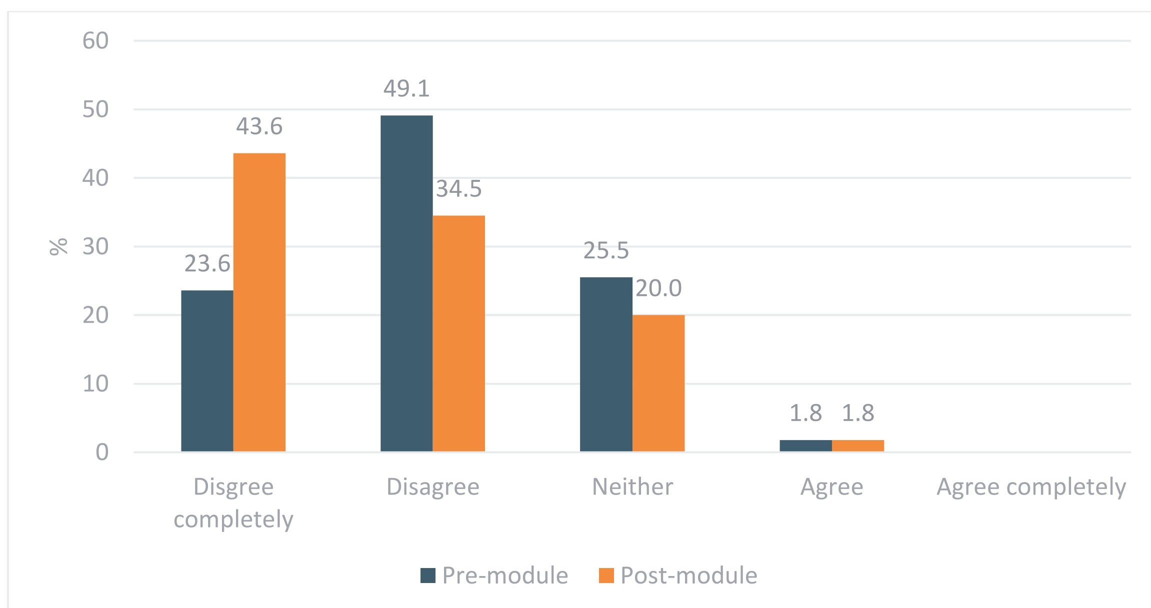

Figure C6. Responses to "I believe that students with mental health difficulties do not behave as well as other students in class"

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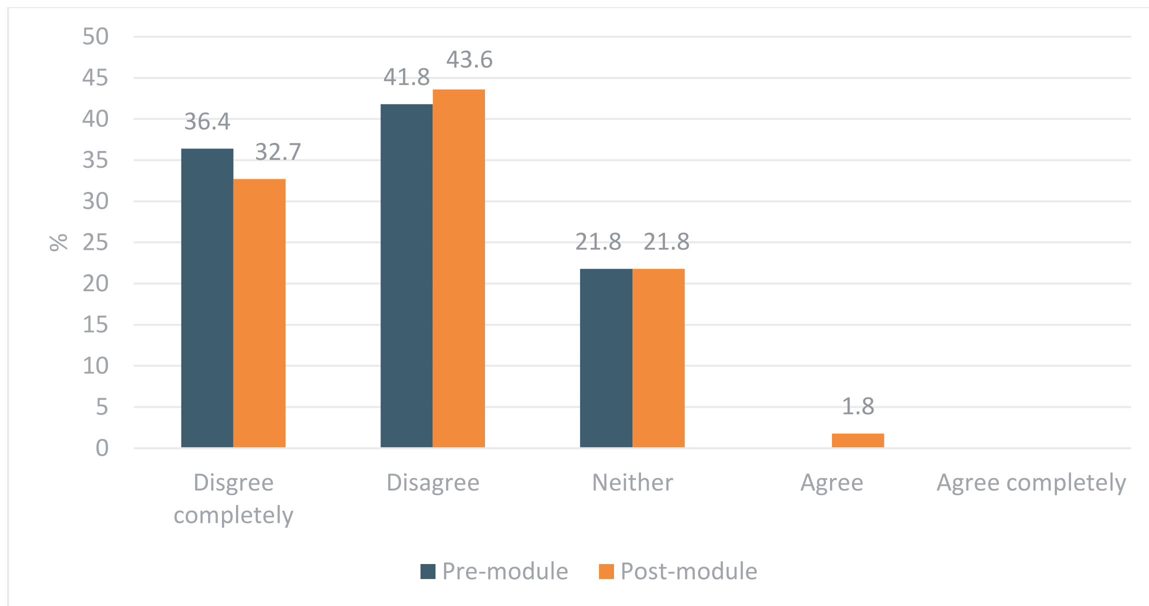

Figure C7. Responses to "I believe that people with mental health difficulties are dangerous"

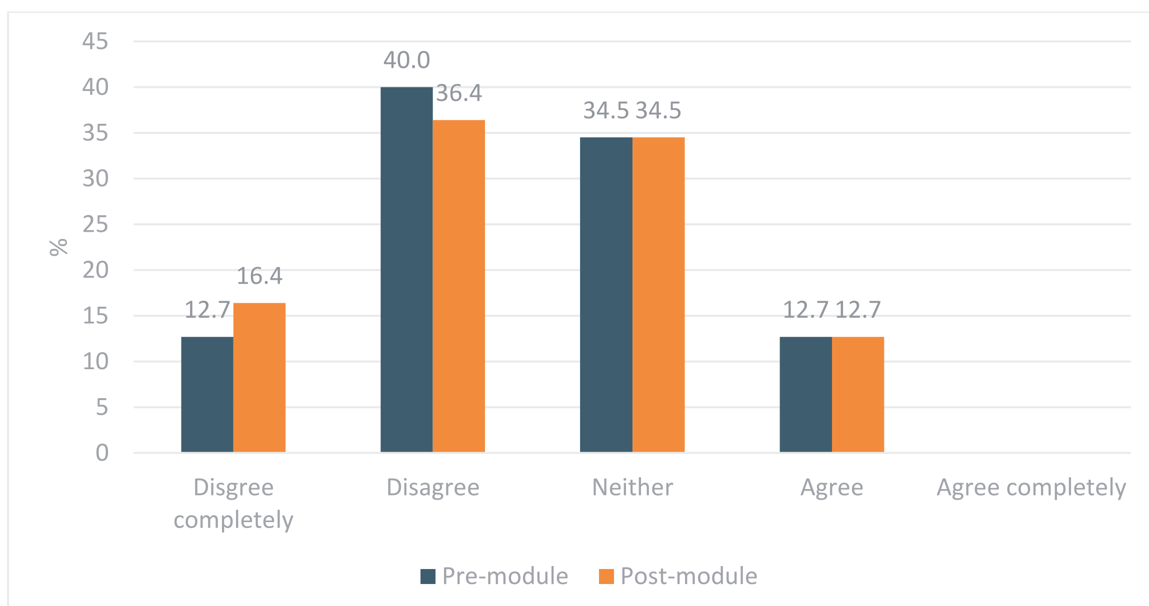

Figure C8. Responses to "I believe that people with mental health difficulties are not as good as other people at taking care of themselves"

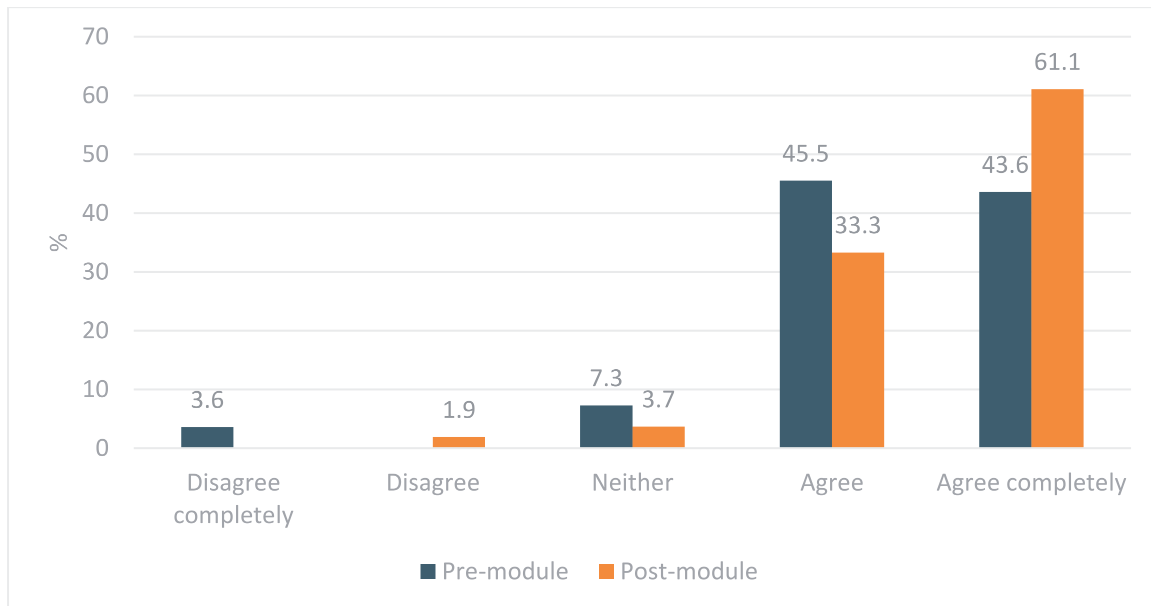

Figure C9. Responses to "I believe that people with mental health difficulties can get good grades in college"

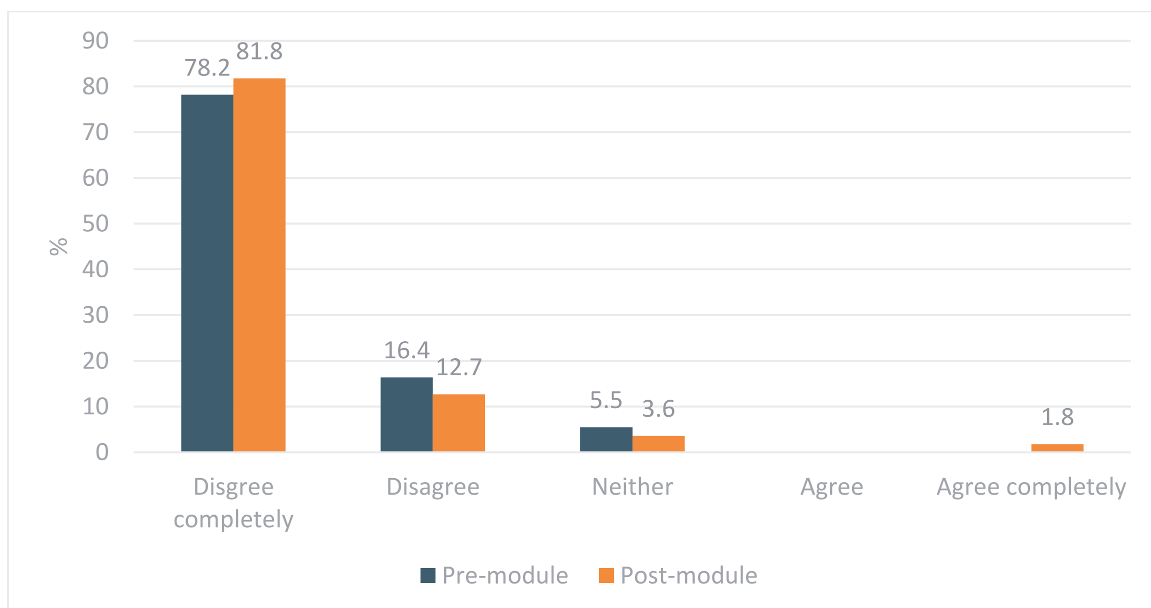

Figure C10. Responses to "I believe that people with mental health difficulties are to blame for their difficulties"

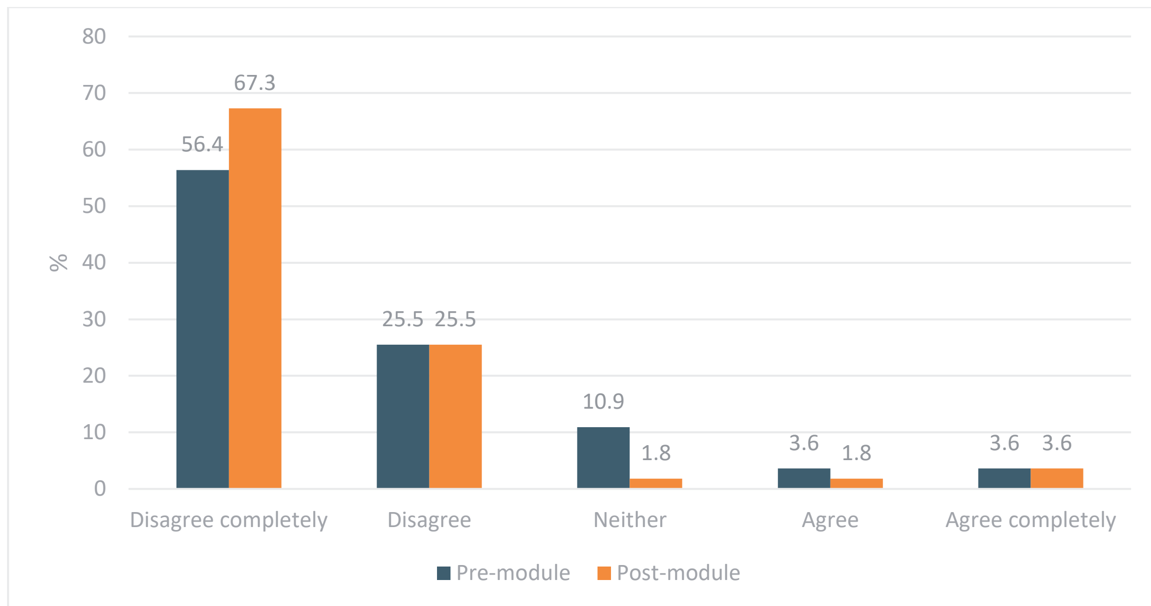

Figure C11. Responses to "I believe that it is not a good idea for employers to give jobs to people with mental health difficulties"

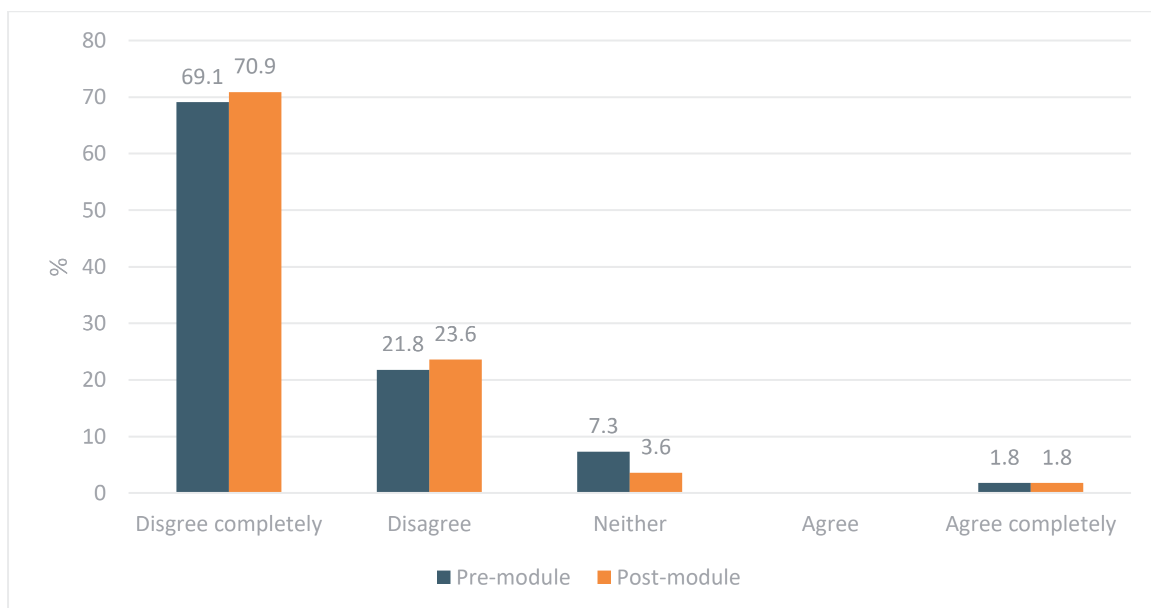

Figure C12. Responses to "I would be afraid of someone if I knew they had mental health difficulties

We're here to make sure that every young person's mental health is valued and supported, providing information and support online, through schools, and our services based in communities across Ireland.

For information and support visit jigsawonline.ie

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