Universitat de Girona
Facultat de Medicina

LOOKING BEYOND: Informative community intervention reduces the stigma that adolescents have about psychiatric institutions.

Final degree project

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Abstract

Title: LOOKING BEYOND: Informative community intervention reduces the stigma that adolescents have about psychiatric institutions.

Background: Stigma is an important issue that affects all aspects of our life and everybody, being in one side or the other. Mental health has been for long the target of stereotypes, rejection behaviours, negative attitudes and even myths due to ignorance about mental health, being these three elements (knowledge, attitude and behaviour) what compounds stigma. It has also been proved that stigma is one of the barriers for help seeking. Therefore, people with mental health disorders must confront their disorder but also stigma and all what it involves. As a result, this project might help population to change their mind about mental health. Perhaps that change in society will allow people who need mental health care to look for help earlier or without that fear that nowadays seems to be extended in population about psychiatric institutions.

Aim: The objective of this study is to determine whether an informative community intervention is an appropriate way to change stigma upon psychiatric institutions and to reduce barriers to access to mental health care.

Method: This will be a longitudinal, prospective, community intervention study. Participants will be the students in 3rd of ESO from Girona and it will be set in high schools. Questionnaires (CAMI, RIBS, MAKS, BACE, GHSQ) will be given for the students to fill before the intervention, at the end of 3rd of ESO and two years later in 2nd of baccalaureate to measure the impact of the intervention and to compare the results with the non-intervention group. Only the intervention group will do educative activities related to mental health and mental health resources which include: definition and introduction to mental health as a general concept that involves everyone, mental health care resources (Xarxa de Salut Mental i Addiccions de Girona) explained by the professionals who work daily on it, debates about movies and series which talk about mental health and first person witnesses about mental health (including disorders and institutions) who can talk from experience to the students.

Keywords: Mental health, mental health resources, psychiatric institutions, Xarxa de Salut Mental i Addiccions de Girona (XSMiA), stigma, behaviour, attitude, knowledge, barriers, help-seeking.

Abbreviations

AMMFEINA Salut Mental Catalunya – Current name of the Catalan grouping of entities for the labor insertion of people with mental disorders.

AU – Authoritarianism.

BACE – Barriers to accessing care evaluation.

BE – Benevolence.

CAMI – Community attitudes toward mental illness.

CAP – Primary health care centre [Centre d'atenció primaria].

CAS – Drug addiction care and monitoring centres [Centres d'atenció i seguiment a les drogodependències].

CDIAP – Child development and early care centres [Centres de desenvolupament infantil i atenció precoç].

CEIC – Clinical research ethics committee [Comité d'ètica d'investigació clínica].

CMHI – Community mental health ideology.

CRPS – Psychosocial rehabilitation centre [Centre de rehabilitació psicosocial].

CSM – Mental health care centre [Centre de salut mental].

CSMA – Adult mental health care centre [Centre de salut mental per adults].

CSMIJ – Child and youth mental health care centre [Centre de salut mental infantil i juvenil].

CT – Therapeutic community [Comunitat terapèutica].

EAP – Counselling and psycho-pedagogical orientation teams [Equips d'assessorament i orientació psicopedagògica].

EIPP – Psychosis early intervention team [Equip intervenció precoç en la psicosis].

ESO – Secondary education [Educació secundaria obligatòria].

ETAC- COmmunity assertive treatment team [Equip de tractament assertiu comunitari].

GAM – Mutual help groups [Grups d'ajuda mútua].

GHSQ – General help-seeking questionnaire.

GP – General physician.

IAS – Institute of health care [Institut d'assistència sanitària].

IdIBGi – Girona's biomedical research institute [Institut d'investigació biomèdica de Girona].

ISMI – Internalised stigma of mental illness.

MAKS – Mental health knowledge schedule.

OCD – Obsessive compulsive disorder.

PSALL – Home autonomy support program [Programa de suport a l'autonomia a la llar].

PSI - Individual monitoring program [Programa de seguiment individual].

RIBS – Reported and intended behaviour scale.

SESM-DI – Specialised service on mental health and intellectual disability [Servei especialitzat en salut mental i discapacitat intel·lectual (Servei ambulatori)].

SR – Social restrictiveness.

TCA – Eating behaviour disorder [Trastorn de conducta alimentària].

TMS – Label for the building where the psychosocial rehabilitation service is placed (Subacute and long stay units are placed in it).

UHA – Adult psychiatry hospitalization unit [Unitat d'hospitalització de psiquiatria d'adults].

UHEDI – Hospitalization unit specialised in intellectual disability [Unitat d'hospitalització especialitzada en discapacitat intelectual].

UHSubaguts o UHSubacute – Subacute hospitalization unit [Unitat d'hospitalització de subaguts].

UNICEF - United nations international children's emergency fund.

UPD – Detoxification and dual patohology unit [Unitat de desintoxicació i patologia dual].

URPI-UCA – Reference unit for child and adolescent psychiatry [Unitat de referència per a psiquiatria infantil i juvenil].

WHO – World health organisation.

XSM o XSMiA – Mental health care resources and addictions services of Girona [Xarxa de Salut Mental i addiccions de les comarques de Girona].

Introduction

Stigma

Stigma is an ambiguous word, such as everyone knows about this concept but hardly anyone can define it with detail. It is indeed a difficult task, but this text will try to shed light on it. It will be explained the relation between other words that sometimes are used in a similar context as ignorance, prejudice, stereotypes and discrimination.

The definition of stigma by Oxford dictionary is "feelings of disapproval that people have about particular illnesses or ways of behaving". However, it is much more: it is the experience of shame or disgrace that sets people apart and identifies them as being different or undesirable. All these circumstances lead to negative consequences such as preventing people for seeking help, delaying treatment, impairing recovery, excluding people from daily activities and isolating them, stopping people from getting jobs… sometimes, just the fear of stigma can be as harming as actual experiences of discrimination. Having a mental health difficulty from a young age is associated with educational underachievement, family disruption, substance misuse and violence, poorer physical and sexual health, increased mortality rates (1–7).

Stigma is a mark or sign of disgrace usually eliciting negative attitudes to its bearer. This term contains three elements: ignorance (problem of knowledge), prejudice (problem of negative attitudes) and discrimination (problem of rejecting and avoidant behaviour) (8). In order to measure these 3 elements, MAKS, CAMI and RIBS questionnaires will be used.

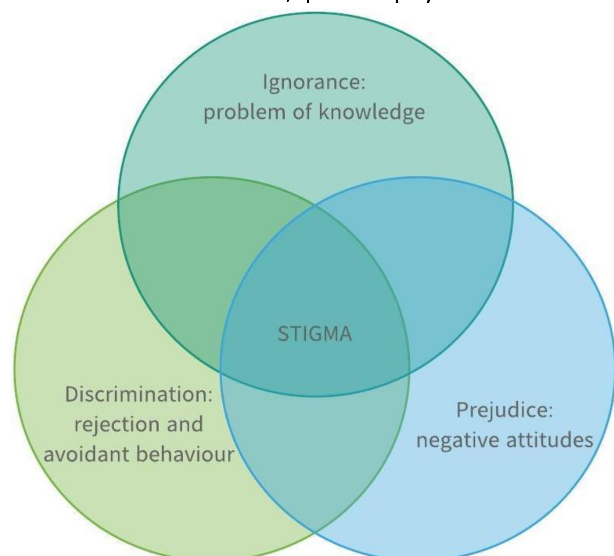

Figure 1: Stigma and its three elements. Source: author

Stereotypes are learned, oversimplified and often negative attitudes embedded in society, which allow individuals to generate quick impressions of specific subgroups, without necessarily believing in them. Prejudices are endorsed stereotypes, meaning they are accompanied by negative emotional reactions. This inevitably leads to avoidance and social distancing, resulting in discrimination. Stigmatising views in teenagers are believed to develop as an assimilation of parent/carer views, media representation and cognitive development; blaming views were associated with a desire for greater social distance (4).

Beside the enormous volume of public information these days, the level of accurate knowledge about mental illnesses (also called "mental health literacy") is meagre (8). Many articles report the benefits of increasing the public knowledge of the mental disorders, their symptoms and psychiatric treatments. Stigma has been associated with low learning about mental health. In this context, there are two types of knowledge: people's familiarity with disorders and educational level related to less prejudice and segregation towards mentally ill patients (9,10).

It is highly reported (2,9,11) how the familiarity with mental illness decreases stigmatization. Being in contact with people suffering from mental health disorders influences behaviours, emotions and attitudes. Therefore, increasing the familiarity with mental health such as with contact-based interventions, seems the main way for potential effectiveness of anti-stigma initiatives. This kind of integrative programmes that mix people with and without mental health disorders reduces stigma for much more time and more significantly than other kind of programmes. It must be taken into account that contact is not just being side-by-side without any plan, it consists on techniques of cooperative learning and social participation like in artistic disciplines which favour communication and contact (3).

Statistics also confirm the high incidence and prevalence of mental illness, so it is important to battle myths for the large amount of people affected by them. One in four people overall will experience a mental health problem in any given year (12). Mental health difficulties in children and young people are prevalent, estimated to affect 10-20% of 5-18 years old; it is estimated that 75% of all people suffering from a mental health disorder experienced the onset before 25 years old, and 50% during adolescence. Therefore, adolescence is a crucial development moment in which a mental health disorder can represent a significant problem for the biological, psychological and social evolution of young people. Untreated, they present a profound and longstanding impact on the individual and society (4,10).

There are not many articles reporting how people see the use of psychiatric institutions. Moreover, the few that talk about this aren't quite favourable. Mental health resources have the aim to equally take care of the biological, psychological and social dimension of the treatment. The most serious obstacle for treatment initiation is stigma due to the experience of shame, embarrassment, negative social judgement and employment-related discrimination (5,6,13). Less help-seeking has been related to stigmatising attitudes and meagre knowledge of mental health disorders and resources. According to Sowislo et al (2), a possibility to reduce stigma upon psychiatric institutions is that they were integrated in general hospitals, as opposed to specialised psychiatric hospitals. This study also explains the importance of education about dangerousness (or lack of it) of the mental health patients. This knowledge must be included in the initiatives because it is wrongly extended that people with mental disorders are violent, when they are usually the target of these inadequate behaviour. A systematic review of barriers and facilitators to mental health help-seeking in young people showed the key barriers are stigma, confidentiality issues, lack of accessibility, self-reliance, low knowledge about mental health services and fear/stress about the act of help-seeking or the source of help itself.

According to a systematic review (4), one in ten children and adolescents suffer from mental health difficulties at any given time but less than one third seek treatment, and stigma is an especially important barrier. Untreated mental illnesses predispose to longstanding individual difficulties and suppose a great public health burden. However, early intervention can result in long-term benefits, which highlights the importance of accessing early effective care.

Another aspect of stigma which shouldn't be forgotten is internalised stigma (1,3,4,14,15) that implicates self-stigma (internalising negative stereotypes), perceived stigma (rejection perception) and experienced stigma (discrimination experiences). Self-stigma has been highly reported in schizophrenia studies but not only, most of which use the ISMI scale to measure it. All this personal stigma produces a great impact in the life of people with a mental health disorder, as it is related with self-esteem loss, profound psychological adversity, demoralisation, promoting aggravation of psychiatric symptoms, reducing psychiatric medication adherence, worsening social and labour functionality and worse life quality. Self-stigma increased in adolescents who perceived less control over their mental health difficulties and believed their problems to be lifelong. Perceived causal explanations for illness that correlated with increased self-stigmatisation were social problems, family problems, trauma, personality/way of thinking and biological causes. It can also become a barrier to recovery: internalised stigma can produce iatrogenic effects and a reduction in use of mental health care services.

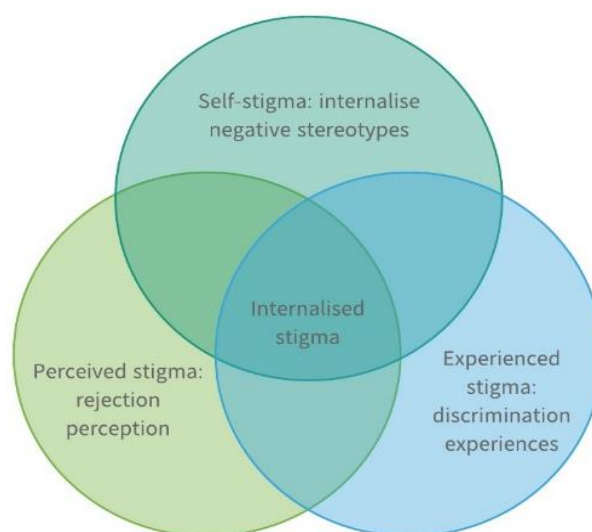

Figure 2: Internalised stigma. Source: author

We can see stigma in something as daily as movies or any other media. They can be a reservoir of prejudice, ignorance and fear that feeds and perpetuates damaging stereotypes about people with mental health problems. The two major stereotypes of contemporary films still comprise mental illness as violence or comedy. Filmmakers seem unable to understand characters with mental health problems; even more, comedy can be based in that lack of understanding. A distorted image is given, and the same wrong characteristics repeat in other films so that, for instance: 68% of the British public still wrongly believe that schizophrenia is a split personality or the characteristics that seem to define film characters with mental illness are violence, weirdness and likelihood to kill violently; nevertheless, this is really far from true (15,16).

As Lancet's editorial publishes (11), mental health stigma is becoming a health crisis because many people with mental health experience shame, ostracism and marginalisation due to their diagnosis but, not being this enough, most of the affected people feel worse the consequences of stigma than the condition itself. Mental health disorders are a wide range of conditions of mental health that affect temporarily and substantially the ability to face the daily demands. This condition can modify thoughts, perception, mood, personality or behaviour, even though sometimes it is invisible and not obvious in front of the others. A mental health disorder does not reduce or deteriorate the mental faculties, it just changes them sporadically. Treatment and recovery are possible and a lot of people with a mental health disorder live a normal life. (17)

The governmental institutions, WHO, specifically the health department, raised the alarm about some facts in the 2013-2020 action plan, specifying that people with mental health problems should be able to fully participate in

society and work, being free of stigma and discrimination (3). On the one hand, stigma is one of the most important social barriers that hinder the search for help and recovery of the person and, on the other hand, prevalence of mental health disorders will increase in children and adolescents by up to 50% for the next years and will be the leading cause of disability among young people. According to UNICEF, one in five adolescents presents mental health problems; the early age, regarding the onset of the mental health problem, is a risk factor for suffering stigma and self-stigma. Stigma must be fought. Children as young as 6 appear to grasp everyday terms associated with mental illness and are well familiarised with cultural stereotypes by the age of 10, or even earlier if they themselves form part of a stigmatised group. Due to all these social consequences and WHO announcements, many countries, for the better of their population, have started many campaigns anti-discrimination around the world (3,4,9,18).

In the United Kingdom, a powerful anti-discrimination organisation, "Time to change", was created and works upon stigma and mental health since 2009. They have many campaigns, programmes and projects not just in a theorical aspect. It is practical: it is working right now and in many different ambits so it can mean a real change. They also provide information to make others aware about which are the problems that must be faced, the solutions they propose and the evolution of the situation (19,20). According to "Time to change", there are 6 main myths that contribute to stigma and are false (21).

1. Myth: Mental health problems are rare → Fact: 1 in 4 people will experience a mental health problem, which means someone you know may be struggling with mental illness.
2. Myth: I can't do anything to support someone with a mental health problem. → Fact: There are lots of things you can do to make a difference to their life: Listen and don't judge, treat them in the same way, ask twice.
3. Myth: People with mental illness can't work. → Fact: People with a mental illness can hold down a successful job. We all probably work with someone experiencing a mental health problem.
4. Myth: You can't recover from mental health problems. → Fact: They might not go away forever but lots of people with mental health problems still work, have families and lead full lives.
5. Myth: People with mental illnesses are usually violent and unpredictable. → Fact: Most people with mental health problems, even those with severe ones like schizophrenia, are not violent. Someone with a mental illness is more likely to be a victim of violence than inflict it.
6. Myth: Young people just go through ups and downs as part of puberty – it's nothing. → Fact: 1 in 8 young people will experience a mental health problem.

Similar campaigns have been launched in New Zealand: "Like minds like mine"; Denmark: "One of us"; Canada: "Opening minds" and "In one voice"; Scotland: "See me"; Spain: "Soy como tú", "obertament", "espaijove.net"…

Mental health care resources (Based on Claudi Camps' bibliography(22–24))

Mental health resources in Girona, expressed as "Xarxa de Salut Mental (XSM)" from now on, are all the integrated resources related to mental health that can need any person affected with a mental health disorder. They work in a net form in order to be able to cover all the areas to give the most integrated service to the patient. The resources are interconnected with a good relationship between professionals and units, as they must be coordinated to offer the best service for the patient. The professionals must involve patients and carers in all the process including treatment, recovery, quality of life and many other circumstances individually treated such as a specific scale in housing commission making a system much more agile.

In Girona, there is only one provider IAS (Institut d'Assistència Sanitària), which manages all mental health resources. It is a global net which can give a global answer to patients. In order to be able to handle all these services, a monthly meeting is done. All agents are present in the meeting: people responsible from each XSM unit (representing psychiatrist, psychologist, social worker, nursery) and families, users, tutelar foundation, and foundations to achieve work normalisation such as Drissa or La Fageda.

Girona is one of the first European places to change their psychiatric institutional model. From the 1980's, IAS have been doing changes to stop new admissions in long-term service and try to rehabilitate and give abilities to patients who were there for many years, so they could re-join society in residences, tutelar flats or other community resources with just a support from psychiatric institutions, but not confined in them permanently. Girona closed the psychiatric hospital and replaced the resources in rehabilitation programmes and community support resources. Girona's new model for psychiatric institutions includes much more changes, beginning with a smaller number of beds per 1000 habitants and more collaboration between different resources. As an example of this collaboration there is a support program in primary attention, meaning psychologist in CAP centres; the main reason for this program is the reported 25% of consultants at CAP about mental health.

Three of the main ideas which make the Girona's model successful are coherence, continuity and coordination.

In 2004, the Sta Caterina's Hospital moves into Parc Hospitalari Martí i Julià and the psychiatric emergency room and mental health hospitalization were integrated in a general hospital.

In 2010, Girona represented Spain in a European study: "REFINEMENT: Research on the financing systems effect on the quality of mental health care" is a collaborative and comparative study between nine countries: Italy, Austria, Spain, England, France, Finland, Sweden, Estonia and Romania. This study is a systematic, exhaustive evaluation, both qualitative and quantitative during 3 years and let by experts. In 2013, Girona's XSM is pointed as the most efficient resources provider. The comparison results show that Girona's XSM has the lowest number of hospital resources (1.17 x 1000 inhabitants in Girona vs 3x 1000 inhabitants in Europe) and the lowest mean hospital stay of Europe, the highest proportion of community resources vs hospital ones in Europe (70/30), the highest European assistance continuity tax (90% in Girona vs 57% Europe mean, meaning, 90% of the patients admitted in acute or subacute unit of mental health, continue the treatment in mental health community centres) and the lowest

percentage in Europe of rehospitalisation (18% in Girona vs 40% in Europe). It seems quite clear the bound between mental health services and the low rate of readmissions in hospital. The study demonstrates Girona has the best accessibility to its centres with good proportion of labour insertion.

From the 2005-2012 period, despite the important increase in population, there was a 17% reduction of psychiatric emergencies and 20% decrease in acute unit admissions, achievement the lowest hospital admissions from Catalonia, 1.2x1000 habitants, less than half of the rest of the country. All these data allow to have a tax of 6.2 beds in acute unit per 100000 habitants, what means 50% less than the tax of the rest of Catalonian tax and allows to move resources to community attention. The same thing can be extrapolated to other mental health units as the subacute unit: it has 8.5 beds per 100000 habitants, meaning 20% less beds than the rest of Catalonia in similar units. The mean stay at subacute unit is 38.9 days; it is crucial to be the minimum days possible in hospitalisation to avoid regressive attitudes, with just 1.2% of readmissions in 90 days. So, even with less beds, there has not been a collapse of these units until now. According to the patients' characteristics and available beds, patients are admitted in acute (UHA) or subacute (UHSubacute) units. It has not been needed to send out patients from the sanitary region, and everyday there are 4 free beds in the acute unit for possible admissions. All this is possible thanks to the integrated work with all community resources and between hospital resources, based in the psychosocial rehabilitation methodology.

The weekly professional presential coordination from the different mental health centres with hospital units is a crucial factor to give coherence to the whole system.

In 2016, XSM received from the Government the Josep Trueta medal to sanitary merit and the award to the best innovative experience in mental health in the 25 years of the "Servei català de la Salut" history.

Then, in 2017, the Catalonian parliament decided that Girona's mental health model should be expanded to the rest of Catalonia. For this reason, the IAS had the assignment to develop the global criteria to plan the resources needed according to the expected necessities in Catalonia. This order recognises the courage and quality of the Girona's professionals work and the straight collaboration with all the community resources needed for a successful evolution.

The province of Girona is divided into sectors to increase the functionality of the mental health network, where the correspondence of the sectors is like that of the counties.

In figure 3, the resources integrated in XSM are exposed, as well as how they work together. All the participants in the network are described below:

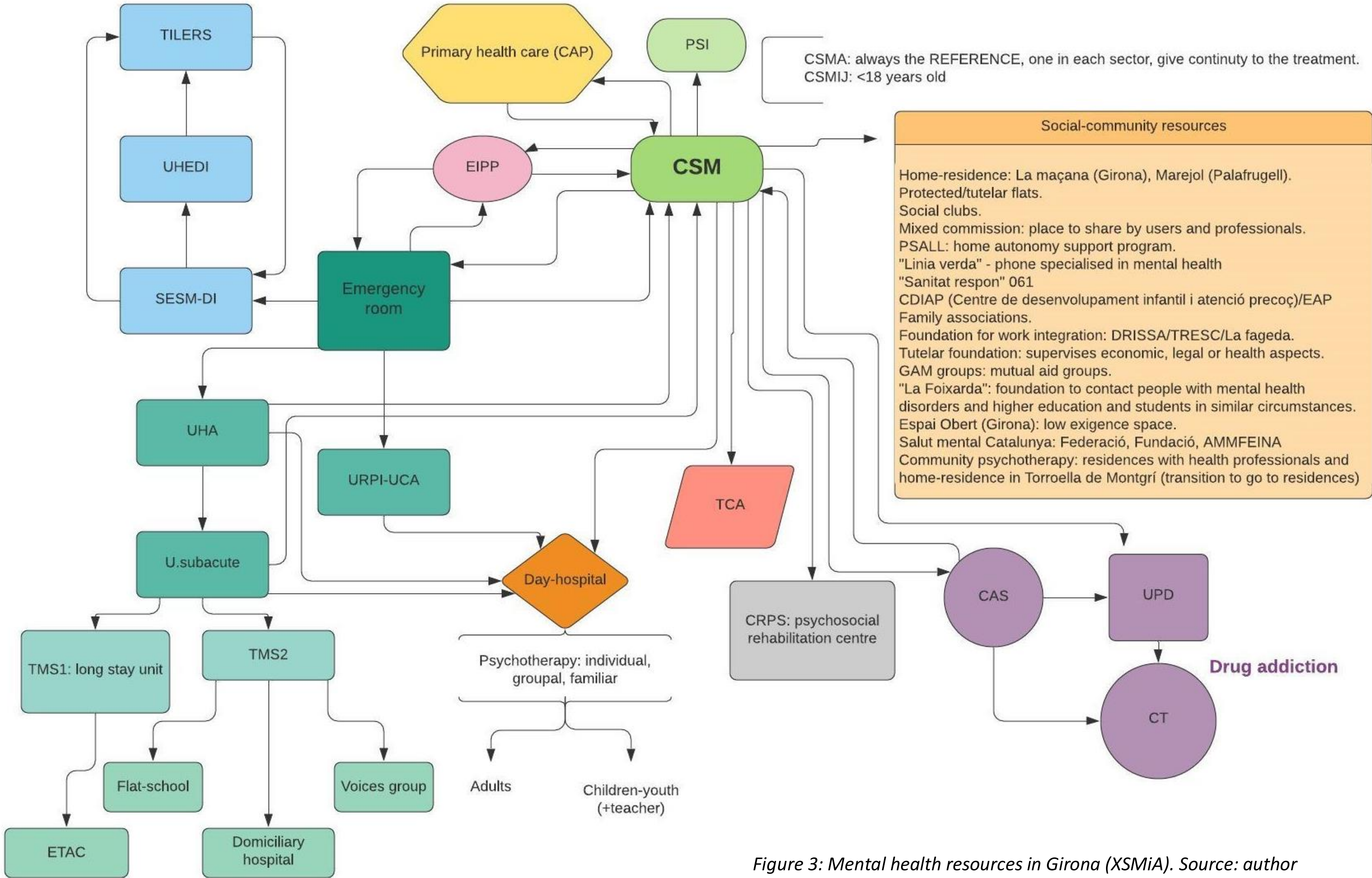

Figure 3: Mental health resources in Girona (XSMiA). Source: author

Mental health care centre (CSM)

CSMA - Adult mental health care centre: It is always the reference unit for the patient, where the continuity of the treatment will be done with a longitudinal vision. There is one in each sector.

PSI-Individual follow-up program: nurse, nurse assistance, social worker or educational assistant. They manage cases which are difficult to link to mental health resources, giving them support with an intensive follow-up to change it. It is a bridge resource to link the patient outside with CSM. This person only has up to 15 cases at the same time.

CSMIJ – Infant and youth mental health care centre: similar to CSMA but for people below 18 years old.

Young adults (<18years old) do not go to CAS. In CSMIJ they have once a week someone from CAS to be their referent for addiction problems.

CSMIJ gives service to other centres: special education centre (once a week); CARAIS (tutelar children centres) or youth justice centre for instance.

Parc hospitalari Martí i Julià (psychiatric hospital institutions)

Emergency room

Acute hospital unit: hospital unit dedicated to recovery and rehabilitation. Even labeled as "acute", people who are admitted can be in there for weeks.

Subacute hospital unit: TMS1: long-stay unit, whose last admission was more than fifteen years ago; it is one of the differences with the rest of Catalonia. Community retirement home with the help of mental health professionals could assume people who have been for many years in the long stay unit. There is also a transition residence in Torroella de Montgrí for the cases which could be more difficult. TMS2: flexible and dynamic space with different workshops, where they can start learning self-medication.

Domiciliary hospitalisation team: in crisis situations they go to the person's home. They handle the situation in situ. They can work with the familiar dynamics and social situation.

Voices group: space out of the hospital to express extracorporeal feelings. It allows to link people with these experiences between them and with mental health resources. In the future, it will depend from CSM, but for now it depends on the rehabilitation unit (subacute).

Flat-school program: 6 sessions in 3 weeks with a social worker or a nurse and a nursery assistance. Resource to gain autonomy, reinforce abilities and reduce difficulties in a different atmosphere.

ETAC- Assertive community treatment team: team formed by a nursing assistant and a nurse from TMS1 who give an active follow-up; it is a specific program to make the transition and be out of the long stay unit. When the patient is out of the hospital, they support them in their home or residence and can give support in individualised circumstances; they are flexible.

URPI-UCA: Hospital unit for children and young people until 18 years old.

Day-hospital: It has two sections, one for adults and another for infant and young adults. This unit gives resources and abilities. It works only during the day, users sleep at home, this unit is an ambulatory service. Psychotherapy is given in three forms: individually, in groups and with family. In the case that the child is still in education system, a teacher will be provided. It is a different resource to a community rehabilitation centre: the users are younger, with sever disorders and difficult life expectancies. They are given an intensive psychotherapeutic treatment.

UPD – Dual pathology unit: Hospital unit dedicated to drug addiction, to allow sobering up. The admission must be willingly, usually scheduled previously by CAS.

Specific units of intellectual disability and mental health disorders: All units in Parc Martí Julià, which are usually collapsed. They must assume a more extensive area that just Girona, since, for other areas of Catalonia, this section is not as developed as in Girona.

SESM-DI: Specialised service on mental health and intellectual disability; ambulatory service.

UHEDI: Acute hospital admissions unit.

TILERS: Hospital unit for mid-long term, like a residence resource, but in high complexity cases. In less complex cases, other residential resources can be considered.

Other IAS mental health care resources

EIPP – Early intervention psychosis team: It is a multidisciplinary team: psychiatrists, psychologists, nurses, nursery assistants, social workers. They work in the early psychosis treatment and EMRAS (high risk mental state). After 5 years of follow up from EIPP, they move on to CSMA. The target population ranges from 16 to 25 years old; if they needed its services in people under 16 years old CSMIJ and EIPP collaborate, depending on the territory one team or the other leads the patient. This kind of team is more informal and closer to the patient; it is different from going into a CSM. The main aim is to support the patient and link them to the mental health care resources. In addition, they inform and form centres in any aspect they think it is important. They work in an ultrafast action: evaluating in less than 48h to determine prognostic factors and evolution.

TCA – Eating behavior disorders unit: They are resources of high implication. Every CSMA or CSMIJ has a psychologist specialised in TCA. They are more accessible, closer and they are meant to be preventive. One of their aims is to be able to intercede in a moderate-mild stage, trying to avoid limit situations. They also have specific places in day hospital for TCA but not different places, as this could give a bad message: they are not so much different from other mental disorders. Patients with TCA do part of the therapy as patients with other disorders and a specific part.

CRPS- Community rehabilitation centre: There is one in each sector. Psychosocial rehabilitation is an important item to increase autonomy and social, family and conflict resolution abilities.

CAS – Drug addiction attention and follow-up centre. Community resource for people whose main problem is consuming substances. It is a multidisciplinary team: psychiatrist or GP, nurse, psychologist and social assistant.

Community resources depending on IAS:

Home-residence: 24h supervised by health professionals. "La maçana" (Girona) and "La marejol" (Palafrugell).

Protected and tutelar flats: There are few of them in each sector with professionals to supervise. The visits in them are regulated.

Social clubs: There is one in each sector. The goals for people at socials clubs are to achieve a good link with CSM, make the patients aware of the disorder, avoid isolation. The activities in there are: courses, workshops neurocognitive stimulation, etc

Penitentiary team: Psychiatrist, psychologist and PSI. PSI works only in the open section which corresponds to the old Girona's prison; the main aim for PSI is to make prisoners avoid relapse in the transition moment.

Homeless team: psychiatrist, social worker and nurse. They work in conjunction with "La Sopa", a community resource, this team must be activated by social services. They have a specific formation. Their aim is to bound with mental health services.

Progressive system: "espai obert" (low exigence space, it belongs to the foundation but receives daily support from mental health resources. It is used for homeless people or people with difficult link to mental health resources) → hostel (everyday there is ETAC support) → flat with support.

Process to recovery autonomy but with mental health care support: home-residence → flats with mental health care support → flats from the foundation with less mental health care support → flat with no mental health support. Flats with mental health support and "home-residence" are financed by "Departament de Benestar".

Resources independent from IAS but in relation with Girona's mental health resources (XSM)

CT – Therapeutic communities. Drug addiction resource to allow dishabituation, a space to reeducate conducts and habits to avoid consuming again.

GAM groups: Mutual help groups driven by "Activament". No professionals, only users are in there, so a different atmosphere is created. They do some activities to empower the user one of them are excursions. It is out of the network, but it does not go against the system.

Family associations

Foundation for work integration/protected work: DRISSA/TRESC/La fageda. Special work centre, prelaboral service, orientation service for regular business, formation service, regular business insertion. Protector factor.

Tutelar foundation: In case of legal incapacity (and not familiar tutela), the tutelar foundation supervises economic, legal or health aspects; they give support. There is one per sector; for example, Arep in Palafrugell is a foundation which has a "home-residence" with psychiatrist and nurse. It also has supervised flats.

"**La Foixarda**": It tries, by working in a network, that adolescents and young people with mental disorders, despite them and other impediments and barriers, obtain an education that facilitates the access to an inclusive and qualified employment in the ordinary job market, so that they have an activity and an economic base that favors their recovery, emancipation and participation in society.

Espai Obert (Girona): It is a low exigence space which offers a place to personal and clothes hygiene, meals, medication and some activities. Some professionals work in it as nurse assistants, nurses and social workers.

Open crisis groups: Psychotherapy groups in primary health attention.

Justification of the study

Mental health disorders affect a great number of people. According to "Departament de Salut de la Generalitat", 23.7% of the Catalan population over 18 years old will have a mental disorder throughout their lives (25). The general population has a bad image of mental health and psychiatric institutions, and also widespread stereotypes are mostly negative, since all this leads to stigma. Due to current rise in prevalence of mental health disorders in our society, there is a high risk of stigma in all these patients, what can lead to dire consequences in their treatment and future lives. There are so many people involved, we cannot allow to exclude people or reject them, even less for something as a mental health disorder. We do not treat someone different just because they have diabetes, we should not do it if they have a mental health disorder such as depression, bipolar disorder or schizophrenia. This intervention can allow familiarity and proximity to mental health community, which is a pillar to include people with mental health disorder in our society and for their treatment. There are so many dire outcomes due to stigma, stereotypes and prejudices. All these social consequences are not immovable; on the contrary we must work to change these adversities, which are unnecessary and only damage people.

Another important point to consider is that stigma prevents from seeking mental health care, hinders the access to psychiatric institutions and harms the prognosis of patients. The aim of the intervention is to change that: reduce stigma and barriers to access to mental health care, looking beyond the first impression.

Hypothesis

Informative community intervention reduces the stigma that adolescents have about psychiatric institutions.

Objectives

Informative community intervention reduces the stigma that adolescents have about psychiatric institutions on short and mid-term follow-ups (8 months – 2 years).

Barriers to access to the mental health system will be reduced as a result of this informative community intervention.

Methodology

Study design

Clinical community intervention trial; it will be performed as a longitudinal, prospective, analytic, experimental study.

This trial is community-based designed, so general adolescent population will be studied.

Study subjects

The subjects we will include in our study are all teenagers from high school, specifically those on the 3rd year of ESO high school students (13-14 years old approximately).

Adolescents at this age are building their personality and values, which may affect their future attitudes. Normalising people with mental health disorders by including them in our society can make a huge difference into the present and future society.

Table 1: Inclusion and exclusion criteria. Source: Author.

Inclusion criteria	***Exclusion criteria***
- Students of 3rd of ESO from Girona high schools. - Girona high schools which have authorised and signed the consent to participate in the study. - Students must assent and their families consent the participation in the study.	None.

Because it's a population-based study, no exclusion criteria will be used.

Randomisation

The selection method with less bias is random selection. Therefore, it will be used to divide Girona's secondary school list (15 centres) into two groups: control and intervention group.

The project will be exposed to all the potential participant centres. An information sheet and informed consents will be given, first to the centres and afterwards to families and students (Annex 1-4). When consents are accepted and signed, the randomisation will be done according to an online software with the centres that agree to participate. Below is the randomisation if the fifteen centres accept to be in this study. In case one of them refuses

to be in the study, there will be 14 centres to distribute. If more centres do not accept, the randomisation will be done to balance both groups. In the following example, “Research randomizer” was used (www. randomizer.org):

Table 2: Example of randomisation of the 15 centres. Source: Author.

Control group	Intervention group
Institut Jaume Vicens Vives	Institut Ermessenda de Girona
Institut Santa Eugènia	Escola La Salle
Institut Carles Rahola i Llorens	Escola Vedruna
FEDAC Sant Narcís	Escola Montessori Palau
Montjuïc Girona International School	Institut Santiago Sobrequés i Vidal
Escola Maristes-Girona	Escola Bell-lloc del pla
Institut Narcís Xifra i Masmitjà	Escola Les alzines
	Institut Montilivi

The randomisation allows the control and balances the influence of covariates.

Sample size

By bilateral contrast it is calculated the sample size needed to reduce stigma about psychiatric institutions. The calculation is done by accepting the next parameters: an alpha risk of 5%, power of 80%, with a moderate effect expected which would be a reduction of stigma around 25% (equivalent to a Cohen’s d equal to 0.3). It has been anticipated a drop-out rate of 20%, as the follow ups extend until two years ahead, it is not a compulsory course and some of the students who complete the questionnaire at 3rd of ESO will not refill the questionnaires at 2nd of baccalaureate.

With all these characteristics, the minimum sample is 209 students for each group, which means 418 students included into the trial. Having all consents, this minimum number will be accomplished because there will be around 1320 3rd of ESO students in Girona city, according to the Education Department statistics from the Generalitat de Catalunya (data from the 2018-2019 academic year) (26).

Computations were carried out with Prof. Dr. Marc Saez’ software, based on the library pwr of the free statistical environment R (version 3.6.2).

Study variables

Dependent variables

1. STIGMA: Stigma is a term that contains three basic elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination). These three elements have specific questionnaires that will be used to measure stigma in our study.

2. ATTITUDE: Negative attitudes towards people with a mental health disorder can lead to prejudice, which involves from negative thoughts to emotions. In fact, prejudice may more strongly predict discrimination than stereotypes do.
   Attitudes will be evaluated by CAMI (Community Attitudes towards Mental Illness)(27–29).
3. BEHAVIOUR: Social distance, rejecting and avoidant behaviour leads to discrimination, while familiarity and experience seem to be crucial in determining our behaviour.
   Behaviour will be evaluated by RIBS (Reported and Intended Behaviour Scale)(28,30).
4. KNOWLEDGE: The level of accurate knowledge about mental illnesses (also called "mental health literacy") is meagre. In addition, the mental health resources must be interconnected, but sometimes this is quite chaotic. Thus, it is important to explain to the general public how to access to these resources and the profit to use them.
   Knowledge will be evaluated by MAKS (Mental Illness Knowledge Scale)(28,30).
5. ACCESS to psychiatric institutions: It is important to be able to achieve the most appropriate mental health resource for what the situation requires.
   Barriers to accessing mental health care will be evaluated by BACE (Barriers to Access to Care Evaluation)(31). How likely it is to look for help to the different proposed people is asked in GHSQ (General help-seeking questionnaire)(32).

Independent variable

Intervention: Multidisciplinary, informative and with an educative aim intervention. The intervention will last several days throughout the academic year, with different activities including a wide range of aspects: general information about mental health, information about the mental health resources, myths and facts about mental health, debates about series and movies with characters that have mental health disorders and their role in them, first person witnesses to explain their experience with psychiatric institutions and mental health disorders, etc.

Covariates

1. Sex (male or female) – dichotomic qualitative variable.
2. Socioeconomic variables: they will be built based on parents' education and occupation by following Domingo et al (33,34) – polytomic ordinal qualitative variable.
3. Mental health personal diagnosis (yes or not) - dichotomic qualitative variable.
4. Family background of diagnosed mental health problems (yes or not) - dichotomic qualitative variable.
5. Name of the secondary education centre – polytomic nominal qualitative variable.
6. Public or private character of the secondary education centre (public or private) - dichotomic qualitative variable.
7. Parents birth country - polytomic nominal qualitative variable.
   a. In case of immigrant parents, number of years parents have been living in Catalonia – quantitative variable.

Table 3: Summary of the variables of the project. Source: Author.

Variables		Type	Measured
Independent	Intervention		Intervention/control
Dependent	Stigma	Qualitative, ordinal, politomic	
	Attitude	Quantitative discrete	CAMI
	Behaviour	Quantitative discrete	RIBS
	Knowledge	Quantitative discrete	MAKS
	Access to psychiatric institutions	Quantitative discrete	BACE, GHSQ
Covariates		Vary	Questionnaires: socio-demographic and students and their parents' characteristics

Intervention

First, information sheet and consent forms must be understood and signed by centres, families and students.

The first round of questionnaires will be done during the first week of the third year of ESO: all students taking part into the study will fill the questionnaires (sociodemographic characteristics and CAMI, RIBS, MAKS, BACE and GHSQ questionnaires). These questionnaires will be displayed in Catalan language and auto administrated. All these data will show the basal status of stigma and barriers about mental health and psychiatric institutions.

During this academic year (3rd of ESO), the control group will not do any specific activity related with mental health stigma, while the intervention group will do some activities with the intention to improve behavior, attitude and knowledge in relation to stigma and access to mental health resources. For the minimum disturbance of the academic year, these activities will be done in "tutorial" classes. These activities will consist on:

- Mental health: general introduction, myths and facts, statistical data. Recommended resources for that session are available at "Obertament"(25).
- Mental health resources: explanation about all the mental health net, their interconnections and how the resources are used. The whole activity will last two hours: one with a psychiatrist and a social worker and another hour with a psychologist and a nurse.
- Debates about movies and series that have characters with a mental health disorder and/or have a mental health resource as a main scenario. In table 4 are the main recommendations for this project, but there are many other films that can be played, some of which are listed in the appendix 11 with a little information about all of them. The important point is to talk about mental health, so other media can be used if they are thought to be appropriate.

  The last session of debate will be done with a psychiatrist or psychologist, in order to express all the doubts found in the debates.

Table 4: Main movies and series recommended for the intervention. Source: author.

Movies	Comment
Joker (2019)	Film which explains the story of a man who loses his job, his mother and his mind. There are so many circumstances around him that make him act like he does, that it is difficult to affirm if there was an option to prevent him from ending this way.
Toc toc (2017)	Spanish comedy, people with different mental health disorders are forced to be in the same room, leading to absurd comic situations due to the exaggeration of the disorders.
It's kind of a funny story (2010)	An adolescent feeling blue with autolytic ideas is admitted into a psychiatric unit. The time spent there changes his point of view and allows him to reflect on his situation.
A beautiful mind (2001)	J. Nash, an excellent mathematic, starts experiencing delirium and paranoid schizophrenia, despite which he continues with his work.
Butterfly effect (2004)	A man finds out he can travel through time with his old diaries, but if he changes anything that happen, then that changes all the future events.
The Danish girl (2015)	Based in a true story of a Danish couple of painters. The man feels different from the day his wife asks him to pose as a ballerina, a feeling which is difficult to understand for everybody.
To the bone (2017)	An adolescent diagnosed with anorexia is proposed for a full-time treatment in a residence. She is not willing to do it, but there, she meets people who make her think about what she is doing with her body.
Patch Adams (1998)	In relation to this project, the first part of the film is the most interesting one, as reflects the possibility to help that everybody can bring to other people.
Take shelter (2011)	Explains how a man starts dreaming, feeling weird, having hallucinations and erratic behavior and how he reasons it for himself. It also shows, how his family have to deal with it.
Elling (2001)	Norwegian movie, talking about a man going out of a psychiatric institution.
Series	
The good doctor (2017)	Shows the good points and difficulties for a surgeon resident who also has high efficiency autism.
Spinning out (2020)	Relates the adversities of a family to achieve their figure skating dreams while dealing with bipolar disorder.
Atypical (2017)	The series talks about the evolution and growth of a high-school boy with autism, the difficulties with daily activities and how he adapts his strengths to deal with his life.

- First person witnesses who can explain their experiences in mental institutions and with mental health disorders. The number of sessions will change according to the availability of volunteers to explain their experiences.

At the end of the year, all the questionnaires will be refilled by all the students of the study. Short-term impact will be measured and also a comparison between intervention and control group will be done.

Two years later, during the 2nd of baccalaureate year, the questionnaires will be refilled. Due to the noncompulsory status of this course, not all the students will refill the questionnaires and some sample will be lost.

Data collection

Data collection will be at different times. Consecutive phases will be needed to collect the information before and after the multidisciplinary intervention.

First phase:

Participant recruitment will start by presenting the programme to the potential candidate centres with an informative sheet (Annex 1) that should be distributed to the families involved. Informed consent (Annexes 2-4) must be signed by all the centres taking part on the study, students and their legal tutors.

Second phase:

During the first week of the 3rd course of ESO, some questionnaires will be filled by the students participating into the study, who will all be students from 3rd course of ESO at secondary schools in Girona city.

Data will be collected using questionnaires, detailed below and attached at "annexes" section of this project. The questionnaires will have different parts. The first one covers socio-economic and demographic characteristics: age, gender, socioeconomic variables, mental health diagnosis (personal or about a relative), name of the secondary school and private or public status, parents birth country and number of years living in Catalonia in immigrant cases. The second part covers questionnaires used to evaluate stigma and based on the three elements (attitudes, behaviour and knowledge) that define stigma. Then, there are two other questionnaires about the barriers found to access to mental health care and the intention for help-seeking. All of them are described below and attached at Annex 5-10:

1. Attitudes will be evaluated by CAMI (Community Attitudes towards Mental Illness)(27–29): Developed by two researchers at a Canadian university (9). It is used to measure public stigma attitudes towards mental illness. CAMI is a forty-item scale divided in 4 subscales of 10 items each: Authoritarianism (AU) ("view of the mentally ill person as someone who is inferior and requires supervision and coercion"), benevolence (BE) ("humanistic and sympathetic view of mentally ill persons"), social restrictiveness (SR) ("the belief that mentally ill patients are a threat to society and should be avoided") and community mental health ideology (CMHI) ("the acceptance of mental health services and the integration of mentally ill patients in the

community"). Higher AU + CMHI scores, and lower BE + SR scores will indicate higher stigma. The addition of subscales allows an overall stigma image: higher scores indicate less stigma attitudes against patients with mental illness.

2. Behaviour will be evaluated by RIBS (Reported and Intended Behaviour Scale) (28,30): RIBS assesses and tracks mental health related behavioural discrimination among the general public, which allows documenting trends. RIBS is an eight-item scale divided in 2 groups of four items: the first one focuses on reported behaviours (past and current) while the second group focuses on future intentions in the same areas. Items are coded on an ordinal scale (1= strongly disagreed, 5= strongly agreed, while "don't know" is coded neutral). High values correspond to more favourable expected behaviours (9).
3. Knowledge will be evaluated by MAKS (Mental Illness Knowledge Scale)(28,30): It has been widely used to develop interventions that effectively reduce stigma in combination with other instruments which assess attitudes and behaviour. MAKS was developed to measure mental health-related knowledge among the general public. Its twelve items are coded on an ordinal scale (1-5); higher total scores correspond to greater knowledge.

   There are many other questionnaires based on myths that can be easily found, for example at "Time to change" website, an English programme to end discrimination (Also in appendix 10(35)).
4. Barriers will be evaluated by BACE (Barriers to Access to Care Evaluation): It is a 30-item scale which measures barriers to accessing mental health care. BACE has a special focus on stigma-related barriers(31).
5. GHSQ (General help-seeking questionnaire): It is a 20-item questionnaire divided in two questions of 10 items each, in which it is asked how likely it is to look for help to the different proposed people according to personal or emotional problems in the first question and suicidal thoughts in the second one. Each item is answered in a 1-7 ordinal scale (1= extremely unlikely, 7= extremely likely). Higher scores indicate higher help-seeking intentions(32).

Third phase:

The centres assigned to the control group will not do any activity specifically oriented to reduce stigma or reduce barriers to access to mental health care.

In the secondary education centres from the intervention group, there will be activities related to stigma and barriers during some days, distributed throughout the course. They can be complemented with other projects with the aim to illustrate the meaning of mental health to the teenagers and, especially in this project, information about psychiatric institutions.

The intervention must be multidisciplinary, including a wide range of aspects: general information about mental health, myths and facts about mental health, statistical data to make students aware of its proximity, information about the mental health resources, debates about some movies and series related with mental health and first person witnesses to explain their experience.

Fourth phase:

At the end of the course, having finished all the activities, all the questionnaires will be refilled to study whether there have been any changes according to the previous data. This intermediate data collection will give a short-term idea of the consequences of the intervention or no-intervention process.

Fifth phase:

A couple of years later, at 2nd of baccalaureate, the questionnaires filled in 3rd of ESO should be refilled. Then, the mid-term impact could be measured. This outcome will be particularly interesting for the intervention group; even for the control group, it will be interesting to know if there has been any change in comparison to the first data collected and the short-term results. It could also be seen whether there are other methods which could have informed the control group.

Clearly, as some students won't continue with post-obligatory courses, part of the sample will be lost; this factor was anticipated when the sample was calculated.

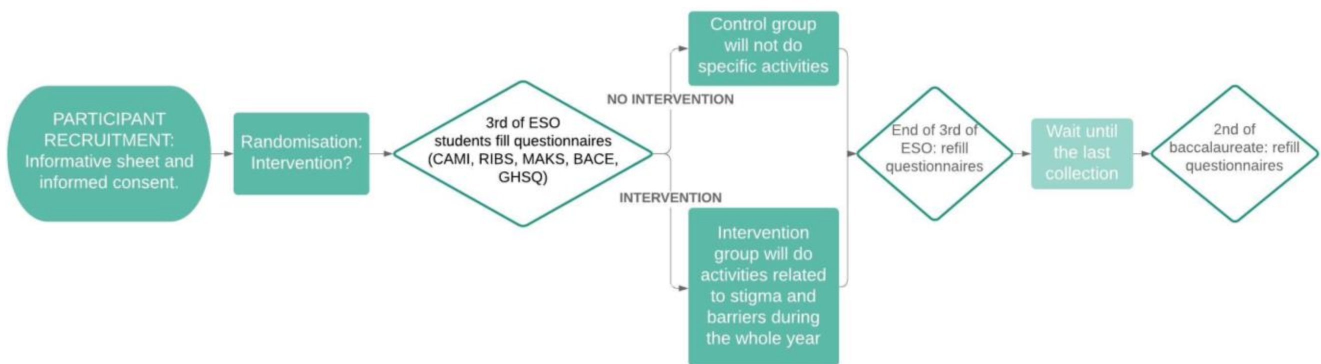

Figure 4: Flow chart about data collection. Source: author.

Safety

No side effects are expected. Nonetheless, some activities could hurt the sensitivity of some students; before these activities, the pupils will be alerted about this possibility.

Statistical Analysis

Descriptive analysis

Discrete variables (the CAMI, RIBS, MAKS, BACE and GHSQ scales) will be summarised using median and interquartile range, stratifying by control or intervention group.

Stigma will be constructed assessing CAMI, RIBS and MAKS questionnaires. For descriptive and bivariate analysis, it will be categorised as: low, medium, high stigma.

Once categorised, stigma will be summarised using proportions in a contingence table stratified by control and intervention group.

These analyses will also be stratified for the covariates. The number of years in Catalonia will be categorised in quartiles.

Bivariate inference

The difference of medians in the scales between the control/intervention groups will be tested by using Mann-Whitney's U test.

The difference of proportions in the variable stigma (once categorised) will be tested with Chi-square test. If there was less than 5 expected in any of the cells, Fisher's F exact would be used.

These analyses will also be stratified for the covariates. The number of years in Catalonia will be categorised in quartiles.

Multivariate analysis

Association between scale/ discrete variables and the intervention will be adjusted in a Poisson's regression, controlled by the covariates.

For multivariate analysis, we categorised stigma in low and middle/high. Once categorised, the association between stigma and the intervention/control variable will be adjusted using logistic regression controlling for covariates.

Existence of interaction will be assessed between intervention and covariates, especially sex, socioeconomic variables and family background of mental health problems.

Ethical and Legal Considerations

This study will be conducted according to the basic ethical principles: autonomy or people respect, beneficence, no maleficence and justice. Also, according to the national and international ethics guidelines and laws, following detailed:

Once the research protocol is written, it will be presented to the Clinical Research Ethical Committee (CEIC, "Comitè Ètic d'Investigació Clinica") of Hospital Josep Trueta and Institut d'Investigació Biomèdica de Girona for its approval, whose recommendations will be considered before starting the study. CEIC has the purpose of ensuring the projection of the rights, security and well-being of the subjects participating in clinical trials and other research projects that are evaluated according to RD1090/2015. Once approved, the permission of the directions of the secondary school centres and the mental health unit will be asked for.

The study will be led according to the requirements expressed in the *Declaration of Helsinki of Ethical Principles for Medical Research Involving Human Subjects* signed by the World Health Association in 1964 and last reviewed in October 2013.

Before secondary education centres, families and students are included in the study, following the "Ley 41/2002 Básica Reguladora de la Autonomía del Paciente y de Derechos y Obligaciones en materia de información y documentación clínica"; they will receive the necessary information about the procedures through an information sheet (see Annex 1). Afterwards, they will be asked to sign voluntarily the written informed consent (see Annex 2-4). Participants have the right through all the duration of the study to withdraw the consent with no negative impact on the quality of healthcare that they will receive. Even though, no side effects are expected.

According to "Ley Orgánica 3/2018, de 5 de diciembre, de Protección de Datos Personales y garantía de los derechos digitales (BOE núm. 294, de 6 diciembre de 2018)", the personal and clinical information of patients will be kept confidentially, and this data will be analysed and published anonymously. What is more, the patients information will only be used with the purpose of research.

The investigators of this project declare that there are no conflicts of interests, and that they do not receive any economic compensation to collaborate in the study.

Study limitations and strengths.

The first drawback we will encounter when conducting the study is the translation of the questionnaires (CAMI, RIBS, MAKS, BACE and GHSQ) into Catalan and their validation, because they haven't been used in this language before, which can take a while. The process is quite long, as the translation must sometimes be back and forward until it gets the most appropriate and precise to the original. In addition, in order to validate the scales, a trail must be done in the target population.

A possible limitation is that not all the fifteen centres agree to participate in this study, but even in that case, randomisation can be balanced. In case only one refuses to participate, the fourteen centres could be distributed in two balanced groups; if more centres do not agree to be part of the study, the randomisation will be done trying to balance intervention and control group.

Another possible limitation will be the reminder bias that we can find in the case of data collection 8 months after the first one (at the end of the 3rd year of ESO), because they could remember what they answered due to the short time between the first round of questionnaires and this second one.

For the duration of the study and considering that the last collection of data (2nd of baccalaureate) is not a compulsory course, part of the sample will be lost. For this reason, the sample was calculated with a possible drop out of 20%.

In contrast, this is a clinical community intervention trial, so it has a good external validity, as it is a very robust type of study.

Impact on the National Health System

The aim of this programme consists on raising the awareness about mental health, mental health disorders and people with these disorders as well as endear society to people with mental health disorders. People with mental health disorders are part of our society, so we cannot exclude them and we should understand them, which is difficult keeping the current social distances.

On the one hand, the purpose of this study intervention is to reduce stigma about mental illnesses and rejection about psychiatric institutions, change attitudes and behaviours towards people with mental health disorders, lessen fear from people with mental health disorders, change stereotypes and break myths related to people with mental health disorders, mental illnesses and psychiatric institutions, which are mostly far from true.

As mentioned before, the terrible consequences of stigma have been proved, so if this programme was carried out, there would be also benefits for the patients of mental health units, such as: less readmissions in mental health care units, better life quality, more success in rehabilitation and recovery, etc.

On the other hand, more knowledge about mental health resources (XSM) can reduce barriers to access to mental health care, including stigma barriers. Therefore, a better contact and relationship with mental health units can increase early diagnosis, which usually implies better prognosis and better recovery, which leads to better quality of life.

Work plan

Stage 1: Protocol design and acceptance

Period: 8 months

Personnel: Main investigator, CEIC, philologist

Description: Review Mental Health Literacy related to stigma and barriers to access to mental health care resources to be able to design the study protocol. Translate and validate scales in Catalan needed in the study (CAMI, RIBS, MAKS, BACE, GHSQ), which could last a while. Submit the documentation to CEIC in IdIBGI of Hospital Josep Trueta, to be accepted and carried out.

Stage 2: Coordination and organisation

Period: 4 months

Personnel: Investigators, XSM unit involved, informatic, personnel from educative centres.

Description: The informatic will pass the questionnaires to a digital platform so that all students can easily enter the answers and to facilitate the analysis. Make meetings to organise all the members of the multidisciplinary unit of the XSM to be able to accomplish all the planned activities. A day formation for each centre link-person to give them resources to do the activities the best way, including solving doubts they could have.

Stage 3: Participant recruitment

Period: 3 months

Personnel: Investigators, XSM unit involved, secondary education centres, families and students.

Description: Present the project to all the potential centres -giving the informative sheet (Annex 1). Time will be given so they can think about it, after which they must sign the consent (Annex 2). Each centre that agrees with the project will designate a person to be responsible, who will be formed and will link XSM unit with the educative centres. The centres that agree will be randomised. Regardless of what group they are assigned to, the information sheet and informed consent will be given to be distributed to the families and students involved.

Stage 4: Data collection

Period: 35-45 months

Personnel: Investigators, XSM unit, link-personnel at centres, students.

Description:

1st time filling questionnaires, during the first week of 3rd of ESO. They include sociodemographic characteristics and specific questionnaires about stigma and barriers (CAMI, RIBS, MAKS, BACE, GHSQ). All students must do it.

Control group: No specific activity oriented to reduce stigma or barrier. Intervention group: informative sessions about mental health, XSM, debates about movies and series, first person witness experiences. Professionals such as psychiatrics, psychologists, social workers and nurses will do the interventions.

2nd time filling questionnaires, at the end of 3rd of ESO. They include sociodemographic characteristics and questionnaires about stigma and barriers (CAMI, RIBS, MAKS, BACE, GHSQ). All students must do it.

3rd time filling questionnaires, during 2nd of baccalaureate year. They include sociodemographic characteristics and questionnaires about stigma and barriers (CAMI, RIBS, MAKS, BACE, GHSQ). It is not a compulsory year, so part of the sample will be lost.

Stage 5: Data analysis

Period: 8 months

Personnel: Statistic

Description: Construction of a data base, depuration of it and statistical analysis.

Stage 6: Results interpretation and writing

Period: 6 months

Personnel: Main investigator and XSM unit collaborator

Description: Results interpretation and clinic analysis of the results. Writing the article.

Stage 7: Publication and dissemination

Period: From August 2024

Personnel: Principal investigator and XSM unit collaborator

Description: Publish the article in open access and present the results in a national and international congresses.

Chronogram

		2019		2020												2021							2022	2023					2024												2025							
		N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	A-D	J-D	J-A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A
STAGE 1																																																		
Protocol design	Principal investigator																																																	
Translate and validate scales	Philologist, investigator																																																	
Protocol acceptance	CEIC																																																	
STAGE 2																																																		
Digital platform	Informatic																																																	
Coordination and organisation	Investigators, XSM unit																																																	
Formation course	XSM unit																																																	
STAGE 3																																																		
Participant recruitment	Investigators, XSM unit																																																	
STAGE 4																																																		
Questionnaires 1	Principal and collaborator investigators, personnel from educative centres																																																	
Intervention																																																		
Questionnaires 2																																																		
Questionnaires 3																																																		
STAGE 5																																																		
Data analysis	Statistic																																																	
STAGE 6																																																		
Results interpretation and writing	Principal and collaborator investigators																																																	
STAGE 7																																																		
Publication and dissemination	Principal and collaborator investigators																																																	

Budget

In order to carry out the present longitudinal prospective community study, a substantial budget is needed, but as it could make a difference for the population involved, a grant will be requested. The project involves different departments (health, education, welfare and family), which can be a positive point in its evaluation.

Due to the three years follow-up, the adaptation and validation of the scales and the different resources needed to develop this programme, a 30000€ budget will be needed.

In the first phase, scales must be translated and validated, what presumably could cost around 1000€ per scale; an informatic will be needed to pass all the scales to a digital platform so it will be easier for the students to fill the questionnaires. In the second phase, the protocol is presented to the potential centres, which will be given information sheets and consents to be signed by the centre, families and students involved. It will be also needed some formation for the link-people between centres and mental health care unit, in order to guide the activities in each centre. They will be given a little economic compensation, and the journeys for the professionals who expose the information in the centres will be paid. After the data collection, in the third phase, a statistic will expend some months creating the data base and analysing it. In the last phase, an interpretation of the results will be done, and an article will be written from the conclusions. The article will be translated to English and its correction will be needed. After the article publication, some budget will be for the open access receipt and some conferences will be held: a national one with two investigators and an international one.

All the costs are detailed below:

Table 5: Summary of the budget. Source: Author.

Assets and services	**16000€**
Informatic	5000€
Link-person between each centre and the mental health care unit (15 x 120€)	1800€
Statistic: data base, depuration of the data base, statistical analysis	9000€
Photocopies	200€
Journey and expenses	**6700€**
Coordination and intervention journeys	2000€
Conferences	4700€
National: 2 investigators → 600 (inscription) + 400 (travel)	2200€
International: 1000 (inscription) + 1500 (journey)	2500€
Other expenses	**7300€**
Scales translation [5 (CAMI, RIBS, MAKS, BACE, GHSQ) x 1000€]	5000€
English article correction	500€
Open access payment	1800€
Total budget	**30000€**

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Appendix 1: Information sheet

Títol de l'estudi: LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques.

Benvolgut/da,

Agraïm el seu interès i el convidem a participar en el present estudi portat a terme a través de la Xarxa de Salut Mental de la província de Girona i en els Instituts de la ciutat. La seva col·laboració és de gran ajuda per poder desenvolupar de manera adequada el projecte ideat. A continuació li exposem detalladament els motius del present estudi, així com els detalls sobre els seus drets i deures com a participant, en què consisteix l'estudi i de les possibles conseqüències que pot aportar participar-hi que necessita conèixer. Si us plau llegeixi atentament tota la informació, i no dubti en consultar qualsevol aspecte, si ho considera necessari.

Participació voluntària i compensació econòmica

La seva participació és totalment voluntària i decidirà lliurement, sense influències externes si desitja o no participar en l'estudi. Durant l'estudi es pot negar a continuar-hi sense que comporti cap perjudici per a la seva salut o afectació de la seva atenció mèdica.

Respecte a la compensació econòmica, cap estudiant ni centre en rebrà, sent totalment altruista la seva participació.

Per què es realitza aquest estudi?

La prevalença de trastorns de salut mental està en augment i degut als tabús i estigma sobre la salut mental les persones que els pateixen reben un fort impacte negatiu en les seves vides. Aquest es pot produir tant des del àmbit social i com en la seva evolució del trastorn ja sigui per negar-se a anar a la Xarxa de Salut Mental o per les negatives conseqüències del estigma sobre la recuperació i el tractament. L'objectiu del estudi és que la societat tingui una relació més propera amb la salut mental per tal de que no la rebutgi, integri les persones amb trastorns i en cas de necessitar-ho poder accedir als recursos de la Xarxa de Salut Mental. De forma general, es busca que la població entengui més i per tant rebutgi menys que altres persones utilitzin recursos sanitaris de la Xarxa de Salut Mental, sense que això els comporti una repercussió social.

Qui participarà i quant durarà l'estudi?

Els estudiants de 3r d'ESO dels Instituts de Girona, l'estudi durarà de 3 a 4 anys segons el moment de la recollida de les ultimes dades durant el curs de 2n de batxillerat.

En què consistiria la seva participació?

Si decideix participar a l'estudi després d'haver llegit i entès la fulla d'informació, haurà de signar el formulari de consentiment informat. Un cop fet, l'investigador conservarà el formulari de consentiment informat original signat i datat del centre, de les famílies i dels estudiants.

La seva participació en l'estudi consistirà en emplenar una sèrie de qüestionaris per tal de determinar el grau d'estigma, intenció de buscar ajuda i accés a serveis de salut mental.

També es duran a terme (per la meitat dels centres participants, distribuïts aleatòriament en grup d'intervenció o control) un seguit d'activitats enfocades en la salut mental, per millorar-ne el coneixement tant del concepte de salut mental (introducció, mites, dades estadístiques...), com la xarxa de salut mental de Girona i com accedir-hi explicada pels mateixos professionals que la integren, debats durant el curs de pel·lícules i series que tracten el tema de salut mental, institucions de salut mental i trastorns de salut mental en els quals es podrà analitzar com és aquesta visió, que en pensen els alumnes i si ho farien o no diferent argumentant el perquè de les actituds, comportaments i intentant ampliar els seus coneixements. Per últim hi hauria activitats relacionades amb testimonis en primera persona que poguessin explicar i interactuar amb els alumnes explicant la seva pròpia experiència en salut mental, amb les institucions i quins canvis ha suposat en la seva vida. Si es creu que alguna de les activitats podria ferir alguna sensibilitat s'informaria abans i es donaria una alternativa als estudiants que no poguessin afrontar-la.

Respecte al seguiment, els qüestionaris s'emplenaran al inici de 3r d'ESO, per tenir les dades basals. Al final del mateix curs per poder comparar l'efecte immediat de la intervenció i si hi ha diferències amb el grup control. Per últim, durant el curs de segon de batxillerat es tornaran a emplenar els mateixos qüestionaris per observar l'evolució en les respostes a aquests qüestionaris.

Puc sortir perjudicat al participar en l'estudi?

No. El present estudi esta dissenyat sota uns principis legals i ètics, ha estat aprovat pel Comitè Ètic d'Investigació Clínica i es duu a terme d'acord amb els requeriments de la Declaració de Hèlsinki i la llei orgànica de confidencialitat; garantint que cap participant surti perjudicat pel fet de participar en l'estudi.

El fet d'entrar a l'estudi no modificarà el tipus d'atenció mèdica que pugui rebre durant o després del estudi.

I si canvio d'opinió?

La participació en l'estudi és voluntària i, per tant, els participants poden canviar d'opinió i abandonar l'estudi en qualsevol moment, sense necessitat de donar cap explicació i sense que això repercuteixi ni en l'àmbit educatiu ni sanitari de la persona en qüestió.

Què passarà amb les dades que es recullen sobre mi?

Si decideix participar en l'estudi, tota la informació que s'obtingui de vostè durant aquest es tractarà de manera confidencial segons la "Ley Orgánica de Protección de Datos Personales y garantía de los derechos digitales 3/2018, de 5 de diciembre", conservant sempre els drets de la citada llei que li reconeixen l'accés, rectificació, cancel·lació i oposició respecte les seves dades.

La informació recaptada es conservarà en el Fitxer d'Investigació del Centre i serà accessible per a les Autoritats Sanitàries, Comitès Ètics d'Investigació, auditors i investigador, per a la verificació dels procediments i dades obtingudes durant l'estudi, amb el deure de respectar la confidencialitat. Les dades de l'estudi podran ser publicades en revistes científiques i presentades en congressos i conferències, però sempre garantint l'anonimat dels participants en l'estudi.

Més informació

En cas que desitgi sol·licitar informació addicional, podrà contactar amb l'investigador principal, Dr. _________________________ a través del telèfon _____________ o a través de correu electrònic _______________________.

Amb tot això, el convidem a participar en el nostre estudi. Els resultats que se n'obtinguin poden permetre una millora social per les persones que tenen, poden tenir o tindran un problema relacionat amb la salut mental. Tots tenim salut mental, es cosa de tots preservar-la i poder accedir als serveis sanitaris corresponents sense por.

Other versions will be available in different languages.

Appendix 2: Formulari de consentiment informat pels centres

Títol de l'estudi: LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques

Jo (nom i cognoms), ……………………………………………………………………………………, com a representant del equip directiu de ....confirmo que:

- He rebut, llegit detalladament i comprès tota la informació proporcionada sobre la participació en el present estudi.
- He rebut tota la informació necessària sobre l'estudi i entenc el seu propòsit i els procediments que es duran a terme en el mateix.
- Entenc que les dades del nostre centre i extensivament els alumnes que hi participin seran tractades de forma estrictament confidencial.
- He pogut resoldre tots els dubtes que tenia respecte l'estudi i el paper en aquest.
- Entenc quin serà el paper del nostre centre com a participant de l'estudi de manera clara.
- Comprenc que la nostra participació és voluntària i que podríem retirar-nos de l'estudi si ho creiem precís, sense que això repercuteixi en l'atenció sanitària futura de cap dels implicats.

En conseqüència, dono la meva conformitat a participar en l'estudi: "LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques ".

Signatura representant del equip directiu:

Data i lloc:

Other versions will be available in different languages.

Appendix 3: Formulari de consentiment informat per a les famílies

Títol de l'estudi: LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques.

Jo (nom i cognoms), ………………………………………………………………………, amb data de naixement ___/___/___ i DNI/NIF .... mare, pare, tutor/a legal de...confirmo que:

- He rebut, llegit detalladament i comprès tota la informació proporcionada sobre la participació en el present estudi.
- He rebut tota la informació necessària sobre l'estudi i entenc el seu propòsit i els procediments que es duran a terme en el mateix.
- Entenc que les dades del meu fill/a seran tractades de forma estrictament confidencial.
- He pogut resoldre tots els dubtes que tenia respecte l'estudi i el paper en aquest.
- Entenc quin serà el paper del meu fill/a com a participant de l'estudi de manera clara.
- Comprenc que la seva participació és voluntària i que pot retirar-se de l'estudi quan vulgui, sense que això repercuteixi en la seva atenció sanitària futura o la de la nostra família.

En conseqüència, dono la meva conformitat a participar en l'estudi: " LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques ".

Signatura de la mare / pare / tutor/a legal:

Data i lloc:

Other versions will be available in different languages.

Appendix 4: Formulari de consentiment informat per a l'alumne

Títol de l'estudi: LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques.

Jo (nom i cognoms), ………………………………………………………………………………………, amb data de naixement ___/___/___ i DNI/NIF ....confirmo que:

- He rebut, llegit detalladament i comprès tota la informació proporcionada sobre la participació en el present estudi.
- He rebut tota la informació necessària sobre l'estudi i entenc el seu propòsit i els procediments que es duran a terme en el mateix.
- Entenc que les meves dades seran tractades de forma estrictament confidencial.
- He pogut resoldre tots els dubtes que tenia respecte l'estudi i el paper en aquest.
- Entenc quin serà el meu paper com a participant de l'estudi de manera clara.
- Comprenc que la meva participació és voluntària i que puc retirar-me de l'estudi quan vulgui, sense que això repercuteixi en la meva atenció sanitària futura.

En conseqüència, dono la meva conformitat a participar en l'estudi: " LOOKING BEYOND, mirant més enllà: intervenció informativa comunitària redueix l'estigma que tenen els adolescents sobre les institucions psiquiàtriques ".

Signatura del participant:

Data i lloc:

Other versions will be available in different languages.

Appendix 5: CAMI Questionnaire

Community attitudes toward mental illness (27–29)

Issue	Totally agree	Agree	Neutral	Disagree	Totally disagree
1. As soon as a person shows signs of mental disturbance, they should be hospitalised.					
2. More tax money should be spent on the care and treatment of the mentally ill.					
3. The mentally ill should be isolated from the rest of the community.					
4. The best therapy for many mental patients is to be part of a normal community.					
5. A mental illness is an illness like any other.					
6. The mentally ill are a burden on society.					
7. The mentally ill are far less of a danger than most people suppose.					
8. Locating mental health facilities in a residential area downgrades the neighbourhood.					
9. There is something about the mentally ill that makes it easy to tell them from normal people.					
10. The mentally ill have for too long been the subject of ridicule.					
11. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.					
12. As far as possible, mental health services should be provided through community-based facilities.					
13. Less emphasis should be placed on protecting the public from the mentally ill.					
14. Increased spending on mental health services is a waste of tax money.					
15. No one has the right to exclude the mentally ill from their neighbourhood.					

16. Having mental patients living within residential neighbourhoods might be good therapy, but the risks for the residents are too great.					
17. Mental patients need the same kind of control and discipline as a young child.					
18. We need to adopt a far more tolerant attitude toward the mentally ill in our society.					
19. I would not want to live next door to someone who has been mentally ill.					
20. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.					
21. The mentally ill should not be treated as outcasts of society.					
22. There are sufficient existing services for the mentally ill.					
23. Mental patients should be encouraged to assume the responsibilities of normal life.					
24. Local residents have good reasons to resist the location of mental health services in their neighbourhood.					
25. The best way to handle the mentally ill is to keep them behind locked doors.					
26. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.					
27. Anyone with a history of mental problems should be excluded from taking public office.					
28. Locating mental health services in residential neighbourhoods does not endanger local residents.					
29. Mental hospitals are an outdated means of treating the mentally ill.					
30. The mentally ill do not deserve our sympathy.					
31. The mentally ill should not be denied their individual rights.					
32. Mental health facilities should be kept out of residential neighbourhoods.					
33. One of the main causes of mental illness is a lack of self-discipline and willpower.					

34. We have the responsibility to provide the best possible care for the mentally ill.					
35. The mentally ill should not be given any responsibility.					
36. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.					
37. Virtually anyone can become mentally ill.					
38. It is best to avoid anyone who has mental problems.					
39. Most women who were once patients in a mental hospital can be trusted as babysitters.					
40. It is frightening to think of people with mental problems living in residential neighbourhoods.					

Appendix 6: RIBS Questionnaire

Reported and intended behaviour scale (28,30,36)

Instructions: The following questions ask about your experiences and views in relation to people who have mental health problems (for example, people seen by healthcare staff). For each of questions 1– 4, please respond by ticking one box only.

	Yes	No	Don't Know
Are you currently living with, or have you ever lived with, someone with a mental health problem?			
Are you currently working with, or have you ever worked with, someone with a mental health problem?			
Do you currently have, or have you ever had, a neighbour with a mental health problem?			
Do you currently have, or have you ever had, a close friend with a mental health problem?			

Instructions: For each of statements 5–8, please respond by ticking the appropriate box.

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree	Don't know
In the future, I would be willing to live with someone with a mental health problem.						
In the future, I would be willing to work with someone with a mental health problem						
In the future, I would be willing to live nearby to someone with a mental health problem.						
In the future, I would be willing to continue a relationship with a friend who developed a mental health problem.						

Appendix 7: MAKS Questionnaire

Mental health knowledge schedule (28,30,37)

Instructions: For each of statements 1– 6 below, respond by ticking one box only. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree	Don't know
Most people with mental health problems want to have paid employment.						
If a friend had a mental health problem, I know what advice to give them to get professional help.						
Medication can be an effective treatment for people with mental health problems.						
Psychotherapy (e.g. talking therapy or counselling) can be an effective treatment for people with mental health problems.						
People with severe mental health problems can fully recover.						
Most people with mental health problems go to a healthcare professional to get help.						

Instructions: Say whether you think each condition is a type of mental illness by ticking one box only.

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree	Don't know
Depression						
Stress						
Schizophrenia						
Bipolar disorder (manic-depression)						
Drug addiction						
Grief						

Appendix 8: BACE Questionnaire

Barriers to Access to Care Evaluation (BACE v3)[1](31)

Below you can see a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care we mean care from such staff as a GP (family doctor), community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem?

Please circle one number on each row to indicate the answer that best suits you. For 'not applicable' e.g. if it is a question about children and you do not have children, please cross the Not applicable box.

[1]Barriers to Care Evaluation (BACE) Scale (v3) Institute of Psychiatry, King's College London © 2011. For permission to use and a copy of the manual, please contact Dr Sarah Clement sarah.clement@kcl.ac.uk or Professor Graham Thornicroft, graham.thornicroft@kcl.ac.uk

	Issue	This has stopped, delayed or discouraged me			
		NOT AT ALL	**A LITTLE**	**QUITE A LOT**	**A LOT**
1.	Being unsure where to go to get professional care.	0	1	2	3
2.	Wanting to solve the problem on my own.	0	1	2	3
3.	Concern that I might be seen as weak for having a mental health problem.	0	1	2	3
4.	Fear of being put in hospital against my will.	0	1	2	3
5.	Concern that it might harm my chances when applying for jobs. Not applicable □	0	1	2	3
6.	Problems with transport or travelling to appointments.	0	1	2	3
7.	Thinking the problem would get better by itself.	0	1	2	3
8.	Concern about what my family might think, say, do or feel.	0	1	2	3
9.	Feeing embarrassed or ashamed.	0	1	2	3
10.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies).	0	1	2	3

11.	Not being able to afford the financial costs involved.	0	1	2	3
12.	Concern that I might be seen as 'crazy'.	0	1	2	3
13.	Thinking that professional care probably would not help.	0	1	2	3
14.	Concern that I might be seen as a bad parent. Not applicable □	0	1	2	3
15.	Professionals from my own ethnic or cultural group not being available.	0	1	2	3
16.	Being too unwell to ask for help.	0	1	2	3
17.	Concern that people I know might find out.	0	1	2	3
18.	Dislike of talking about my feelings, emotions or thoughts.	0	1	2	3
19.	Concern that people might not take me seriously if they found out I was having professional care.	0	1	2	3
20.	Concerns about the treatments available (e.g. medication side effects).	0	1	2	3
21	Not wanting a mental health problem to be on my medical records.	0	1	2	3
22.	Having had previous bad experiences with professional care for mental health.	0	1	2	3
23.	Preferring to get help from family or friends.	0	1	2	3
24.	Concern that my children may be taken into care or that I may lose access or custody without my agreement. Not applicable □	0	1	2	3
25.	Thinking I did not have a problem.	0	1	2	3
26.	Concern about what my friends might think, say or do.	0	1	2	3
27.	Difficulty taking time off work. Not applicable □	0	1	2	3
28.	Concern about what people at work might think, say or do. Not applicable □	0	1	2	3
29.	Having problems with childcare while I receive professional care. Not applicable □	0	1	2	3
30.	Having no one who could help me get professional care.	0	1	2	3

Appendix 9: GHSQ Questionnaire

General help-seeking questionnaire – original version (32)

In all questions, items a-j measure help-seeking intentions. Help sources can be modified to match the target population.

1. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people? Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de facto).	1	2	3	4	5	6	7
Friend (not related to you).	1	2	3	4	5	6	7
Parent.	1	2	3	4	5	6	7
Other relative/family member.	1	2	3	4	5	6	7
Mental health professional (e.g. psychologist, social worker, counsellor).	1	2	3	4	5	6	7
Phone helpline (e.g. Lifeline).	1	2	3	4	5	6	7
Doctor/GP.	1	2	3	4	5	6	7
Minister or religious leader (e.g. Priest, Rabbi, Chaplain).	1	2	3	4	5	6	7
I would not seek help from anyone.	1	2	3	4	5	6	7
I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If not, leave blank)__________________________________	1	2	3	4	5	6	7

2. If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people? Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de facto).	1	2	3	4	5	6	7
Friend (not related to you).	1	2	3	4	5	6	7
Parent.	1	2	3	4	5	6	7
Other relative/family member.	1	2	3	4	5	6	7
Mental health professional (e.g. psychologist, social worker, counsellor).	1	2	3	4	5	6	7
Phone helpline (e.g. Lifeline).	1	2	3	4	5	6	7
Doctor/GP.	1	2	3	4	5	6	7
Minister or religious leader (e.g. Priest, Rabbi, Chaplain).	1	2	3	4	5	6	7
I would not seek help from anyone.	1	2	3	4	5	6	7
I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If not, leave blank)__________________________________	1	2	3	4	5	6	7

Appendix 10: TIME TO CHANGE Questionnaire about mental illness knowledge (35)

1. How many people in the UK will experience a mental Health problem every year?
   a. 1 / 4 b. 1 / 8 c. 1 / 2
2. Which of these is a common symptom of schizophrenia?
   a. Split personality
   b. Hallucinations and delusions
   c. Violent behaviour
3. What proportion of people with severe mental health problems have been victims of a crime in the previous year?
   a. 28% b. 12% c. 45%
4. What proportion of people with mental health problems experience stigma?
   a. 10% b. 90% c. 50%
5. How many people will experience suicidal thoughts throughout their lifetime?
   a. 33% b. 2% c. 17%
6. Which country's Prime Minister was re-elected in 2001 after publicly taking time off for depression?
   a. Mexico b. Poland c. Norway
7. What proportion of people with mental health problems believe that workplace stress contributed to their illness?
   a. 1/3 of people b. 1/5 of people c. 2/3 of people
8. How long do the majority of people with a mental health problem wait before telling their closest family and friends about it?
   a. >1 year b. 7 months c. 2 months
9. Which of these UK Prime Ministers experienced mental health problems?
   a. Gordon Brown b. Margaret Thatcher c. Winston Churchill
10. What proportion of young people with mental health problems say the stigma they face has made them want to give up on life?
    a. 52% b. 6% c. 26%

11. Before the Mental Health Discrimination Act was signed into law in 2013, what were some people with mental health problems prohibited from doing?
    a. Represent Britain at the Olympics
    b. Serve as an MP
    c. Be a psychologist
12. What proportion of people with mental health problems reported stigma affecting their friendships?
    a. 65% b. 44% c. 15%
13. Which of these statements is the most accurate?
    a. "Everyone is a little bit OCD"
    b. "People with OCD experience intrusive obsessional thoughts often followed by repetitive compulsions"
    c. "People with OCD just like things to be clean & tidy"
14. The incidence of depression in minority ethnic groups has been found to be how much higher than in the white population?
    a. 60% b. 40% c. 20%
15. What proportion of young people with mental health problems say that fear of stigma has stopped them from applying for a job?
    a. 57% b. 76% c. 29%

Answers: 1a 2b 3c 4b 5c 6c 7c 8a 9c 10c 11b 12a 13b 14a 15a

2: Many believe that people with schizophrenia are likely to commit violence – however, most people with schizophrenia do not commit violent crimes, and are more likely to be victims of violence than perpetrators. Similarly, there is a common misconception that schizophrenia leads people to have split personalities, when this is not the case. In reality, schizophrenia's most common symptoms are hallucinations, delusions and hearing voices.

4: Our research shows that up to 90% people with mental health problems experience some form of stigma, whether from friends and family, at work, in education or during treatment.

6: Norwegian Prime Minister Kjell Magne Bondevik announced in 1998 that he was experiencing a depressive episode, and took three weeks of sick leave, before returning to office. Bondevik said he received thousands of supportive letters.

7: About two thirds of people with mental health problems believe that long hours, unrealistic workloads or bad management either caused or exacerbated their condition.

8: A Time to Change survey showed that 60% of people with a mental health problem waited over a year to tell the people closest to them about it.

9: Churchill lived with depression that he described as his "black dog".

10: One in ten young people will experience a mental health problem, and a survey conducted by Time to Change showed that 26 per cent of those young people felt the stigma around their condition was so severe that it made them want to give up on life.

11: Before 2013, people who had been sectioned for more than 6 months were not eligible to be elected as a Member of Parliament. In addition, before the Act became law, people currently receiving treatment for mental health problems could not serve on juries, and company directors could be removed because of a mental illness

12: Time to Change's 2014 'State of Stigma' survey showed that 65% of people with mental health problems experienced stigma in their friendships. Additionally, 57% reported stigma in their family life, and 38% said they had experienced it in dating and relationships.

13: Obsessive-compulsive disorder is one of the most misunderstood mental illnesses - many people believe that OCD is a character trait that encourages cleanliness and order. In reality, it is a mental illness based on obsessions and compulsions that can have a serious impact on the people that experience it. Around 1% of the population will experience OCD.

Appendix 11: Movies related to mental health disorders.

Affective disorders

The hours [Las horas](2003). USA, 115 min. Director: Stephen Daldry. Cast: Meryl Streep, Julienne Moore, Nicole Kidman. The plot focuses on three women of different generations whose lives are interconnected by the novel Mrs Dalloway by Virginia Woolf. These are Clarissa Vaughan, a New Yorker preparing an award party for her AIDS-stricken long-time friend and poet, Richard in 2001; Laura Brown, a pregnant 1950s California housewife with a young boy and an unhappy marriage; and Virginia Woolf herself in 1920s England, who is struggling with depression and mental illness while trying to write her novel.

Mr. Jones (1994). USA, 114 min. Director: Mike Figgis. Cast: Richard Gere, Lena Olin. It is about a man suffering from bipolar disorder, a disease that causes him periods of intense emotional pleasure and expansiveness, but which also results in periods of suicidal depression. He is eventually taken to a psychiatric hospital where he meets Elizabeth "Libbie" Bowen, a doctor who takes an interest in his condition and they slowly begin falling for each other whilst she tries to treat his condition.

Silver Linings Playbook [El lado bueno de las cosas] (2012). USA, 162min. Director: David O. Russell. Cast: Jennifer Lawrence and Bradley Cooper. Patrizio "Pat" Solitano Jr. is a man with bipolar disorder who is released from a psychiatric hospital and moves back in with his parents. Determined to win back his estranged wife, Pat meets a young widow, Tiffany Maxwell, who offers to help him get his wife back if he enters a dance competition with her. The two become closer as they train and Pat, his father and Tiffany examine their relationships with each other as they cope with their problems.

Psychotic disorders

An angel at my table [Un ángel en mi mesa](1990). New Zeland, 158 min. Director: Jane Campion. Cast: Kerry Fox, Karen Fergusson. It is a dramatisation of the autobiographies of New Zealand author Janet Frame. The film follows Frame from when she grows up in a poor family, through her years in a mental institution, and into her writing years after her escape.

Spider (2002). Canda, UK, 98 min. Director: David Cronenberg. Cast: Ralph Fiennes. Spider is the story of Dennis Cleg, a man who is given a room in a halfway house catering to mentally disturbed people. Cleg has just been released from a mental institution and in his new abode starts piecing together or recreating in his memory an apparently fateful childhood event.

A beautiful mind [Una mente maravillosa](2001). USA, 130 min. Director: Ron Howard. Cast: Russell Crowe. The story begins in Nash's days as a graduate student at Princeton University. Early in the film, Nash begins to develop paranoid schizophrenia and endures delusional episodes while watching the burden his condition brings on wife Alicia and friends.

Fatal attraction [Atracción fatal](1987). USA, 119min. Director: Adrian Lyne. Cast: Glenn Close, M. Douglas. The film centres on a married man who has a weekend affair with a woman who refuses to allow it to end and becomes obsessed with him. [In case to look for a diagnosis it could be erotomania delirium].

Personality disorders

Benny and Joon (1993). USA, 99min. Director: Jeremiah Chechik. Cast: Johnny Depp, Mary Stuart Masterson. The movie is about how two eccentric individuals, Sam and Juniper "Joon", find each other and fall in love.

Leaving Las Vegas (1995). USA, 120 min. Director: Mike Figgis. Cast: Nicolas Cage, Elisabeth Sue. Based on the semi-autobiographical novel of the same name by John O'Brien. Plot: A suicidal alcoholic in Los Angeles who, divorced and recently fired, has decided to move to Las Vegas and drink himself to death. He loads a supply of liquor and beer into his BMW and gets drunk as he drives from Los Angeles to Nevada. Once there, he develops a romantic relationship with a pretty, but hardened prostitute. O'Brien died by suicide after signing away the film rights to the novel.

Sunset Boulevard [El crepúsculo de los dioses](1950). USA, 112min. Director: Billy Wilder. Cast: W. Holden, G. Swanson. Plot: Joe Gillis, an unsuccessful screenwriter, and Norma Desmond, a faded silent-film star who draws him into her fantasy world, where she dreams of making a triumphant return to the screen.

Downfall [El hundimiento] (2004). German, 150min. Director: Oliver Hirschbiegel. Cast: Bruno Ganz, Alexandra Maria Lara. It is set during the Battle of Berlin in World War II, when Nazi Germany is on the verge of defeat, and depicts the final days of Adolf Hitler. [Shows antisocial or psychopathic personality].

A clockwork orange [La naranja mecánica] (1971). USA, UK, 137 min. Director: Stanley Kubrick. Cast: Malcom Mc Dowell. It employs disturbing, violent images to comment on psychiatry, juvenile delinquency, youth gangs, and other social, political, and economic subjects in a dystopian near-future Britain.

Take my eyes [Te doy mis ojos] (2003). Spain, 109min. Director: Icíar Bollain. Cast: Laia Marull, Luis Tosar. Critically acclaimed for its unclichéd treatment of domestic violence.

Anxious disorder

The aviator [El aviador] (2004). USA, 166 min. Director: Martin Scorsese. Cast: Leonardo di Caprio. Based on the 1993 non-fiction book "Howard Hughes: The Secret Life" by Charles Higham, the film depicts the life of Howard Hughes, an aviation pioneer and director of Hell's Angels. The film portrays his life from 1927–1947 during which time Hughes became a successful film producer and an aviation magnate while simultaneously growing more unstable due to severe obsessive–compulsive disorder (OCD).

Zelig (1983). USA, 79 min. Director: Woody Allen. Cast: Woody Allen, Mia Farrow. Plot: Leonard Zelig, a nondescript enigma, who, apparently out of his desire to fit in and be liked, unwittingly takes on the characteristics of strong personalities around him. The film, presented as a documentary, recounts his period of intense celebrity in the 1920s, including analyses by contemporary intellectuals.

As good as it gets [Mejor imposible] (1997). USA, 139min. Director: James L. Brooks. Cast: Jack Nicholson, Helen Hunt. Plot: Melvin Udall is a misanthropic best-selling romance novelist in New York City, whose obsessive–compulsive disorder has him avoiding stepping on sidewalk cracks while walking through the city, and eating breakfast at the same table in the same restaurant every day. He takes an interest in his waitress, Carol Connelly, the only server at the restaurant who can tolerate his uncouth behavior.

Copycat (1995). USA, 123min. Director: Jon Amiel. Cast: Sigourney Weaver, Holly Hunter. Plot: After giving a guest lecture on criminal psychology at a local university, Dr. Helen Hudson, a respected field expert on serial killers, is cornered in the restroom of the lecture hall by one of her previous subjects, who kills a police officer and

brutally attacks her. Helen becomes severely agoraphobic as a result, sealing herself inside an expensive hi-tech apartment, conducting her entire life from behind a computer screen and assisted by a friend, Andy.

Neurocognitive disorders

Memento (2000). USA, 113min. Director: Christopher Nolan. Cast: Guy Pearce. Plot: a man who, as a result of an injury, has anterograde amnesia (the inability to form new memories) and has short-term memory loss approximately every fifteen minutes. He is searching for the persons who attacked him and killed his wife, using an intricate system of Polaroid photographs and tattoos to track information he cannot remember.

Still Alice [Siempre Alice] (2014). USA, 101min. Director: Richard Glatzer. Cast: Julianne Moore. Based on Lisa Genova's bestselling 2007 novel of the same name. The film shows Alice Howland, a linguistics professor diagnosed with familial Alzheimer's disease shortly after her 50th birthday.