SECTION 2: CONTENT OF THE PROGRAM

PROGRAM OUTLINE

Teachers can adapt the format of the program to suit their classroom and the amount of time they have available. This chart provides a template from which teachers can select learning activities that address the educational components around which the program is based.

The structure of each component is flexible. Each one contains activities and resources that can be adapted for use in a number of courses. The way teachers use the activities and resources will depend on several things: which course the program is being incorporated into; how much time the teachers have available; and where they are in the course outline when they take part in the program.

PROGRAM COMPONENTS

Day 1 **Component 1: Stigma: What is it? How does it affect people's lives?**

- involves a discussion of stigma and its impact on the lives of people with mental illness

Day 2 **Component 2: What is mental illness?**

- provides a basic overview of the major mental illnesses, their causes and treatment

Day 3 (or 3 and 4) **Component 3: The presentation**

- organized by the local committee
- conducted within the classroom or secondary school setting
- consists of a variety of speakers, including people with different types of mental illness

Day 4 (or 5) **Component 4: Follow-up activities and resources**

- provides a number of suggestions for: debriefing the presentation, encouraging students to take action, and finding additional information.

Note to teachers

The "Talking about Mental Illness" program aims to provide the kind of information that helps to break down stereotypes and stigmatization of all of the major mental illnesses. Teachers have expressed a strong need for this kind of information because the secondary school years are often the time when major mental illnesses begin to develop.

In our experience, the discussion of some of these topics, particularly eating disorders and suicide, tends to elicit a strong reaction from students and needs to be handled carefully.

Before implementing any of the program-related activities, we suggest you read the following recommendations and best advice we have gathered for navigating these issues in the classroom. For more specific recommendations on preparing your students for the presentation, please see Component 3: The Presentation.

Eating disorders

Eating disorders are not always subject to the same kind of stigmatization as other forms of mental illness, and may, especially among secondary school girls, be perceived as glamorous. We have received some feedback questioning the appropriateness of treating eating disorders in the same way as other forms of mental illness that are included in the program.

The following are a few recommendations gathered from teachers who have implemented

the program, as well as experts on eating disorders, that may help to ensure discussion is informative and constructive.

· It is important to clarify that "eating disorders" refers to a broad spectrum of behaviours that ranges from eating-disordered behaviour to full-blown eating disorders.

· Eating disorders should be viewed as a broad social issue, within the context of a culture that promotes unrealistic and unhealthy standards of beauty, as depicted in the mass media.

· Adolescents are particularly vulnerable to these images and unrealistic expectations because of peer pressure, as well as the contextual pressures of adolescence (such as physical changes that come about as a result of puberty, and changing expectations of social roles).

· Attempts to provide education around eating disorders should therefore take a comprehensive approach, and focus on the broader levels of the school environment, the community and society at large.

· It may be helpful to ask students to share some of their perceptions and beliefs around eating disorders before the presentation. This would allow the presenters to tailor their talk to address some of the issues and myths that students mention.

· A dietitian or nutritionist could be invited to the classroom to provide information about nutrition and eating disorders before the presentation takes place. It may be helpful for this person to stress that dieting and restricted eating can, for some people, start slipping beyond the person's control into an eating disorder. Introducing the potential medical implications of eating disorders (e.g. that women/girls with anorexia can lose the hair on their heads and grow more hair on their bodies and faces; that the disorder can cause disruption to menstruation and fertility, loss of bone mass, changes in brain structure, and heart complications) might help emphasize that they are serious illnesses, and not at all glamorous.

· Emphasize to presenters that their presentation should focus on their emotional, physical, and spiritual experiences with the illness, but that it should not provide specifics around the methods of weight loss, such as purging.

· Include a discussion about the influence of media on eating/dieting behaviours and self-image. Provide students with information about the ways in which body images are distorted and edited by the media. It might help shift students' ideas about the "ideal" body shape and the glamorous images that may be attached to eating disorders.

Suicide

Although "Talking About Mental Illness" is not a suicide prevention program, we recognize it is important to address the issue of suicide, both in its relationship to mental illness and as an issue

surrounded by stigma. Additionally, because suicide continues to be the second most common cause of death among Canadian youth, it is important to include information about suicide among the range of topics addressed in the program.

The following are a few recommendations gathered from teachers who have implemented the program, as well as experts on adolescent suicide prevention. They may help ensure the discussion is informative and constructive.

· Emphasize that diagnosis and treatment of mental disorders has been, and continues to be, a cornerstone of suicide prevention. A percentage of people who take their lives appear to have been suffering from depression when they committed suicide. However, not all people who choose to end their lives are mentally ill or display symptoms of their distress before they commit suicide.

· Ensure there are close links with professional mental health resources in the community. The local organizing committee will be able to provide teachers with a list of mental health professionals and services available in the community. The committee can also help arrange for a service provider to attend the presentation to provide information on local mental health services, and to respond to students who may be upset as a result of something they hear in the presentation. For example, a student might have a concern about his or her own well-being after hearing presenters discuss the symptoms of their mental illness and/or the circumstances associated with the onset of symptoms. Having a mental health professional available to answer questions during the presentation and afterwards can help answer students' concerns and steer them toward additional sources of information and support.

· Adolescents need to be reassured they have someone to whom they can turn — be it family, friends, school counsellor, physician, or teacher — to discuss their feelings or problems. It must be a person who is very willing to listen and who is able to reassure them that depression and suicidal tendencies can be treated. Teachers can play a role in this area by reminding students of the resources within the school and the community and highlighting how these services can be accessed. It is a good idea to prepare a handout for students, containing the phone numbers and addresses of local mental health services and help lines. Then, if students feel uncomfortable talking about their concern in front of their peers, they will have information about how to connect with a service provider at a time that is better suited to them.

· Presenters will be instructed to avoid providing any detailed information about their suicidal feelings or attempts. Presenters will be asked to keep their account focused on how the symptoms of their mental illness were related to their suicidal ideation, and that once their symptoms were treated, their suicidal feelings were relieved. Presenters should be encouraged to speak about their treatment in concrete terms, such as by saying, "I went to see my family doctor/counsellor, and began to feel better…", "Attending my weekly support group really helped me…", or "It also helped to talk about my feelings with my friends/family/counsellor...".

- Schools should have in place a protocol for suicide prevention that is well communicated to staff, health professionals and speakers participating in the awareness program. The protocol should be explicit and include how to talk to someone who appears to be upset by the presentation and possibly "at risk" of suicide. The protocol should also identify the appropriate person to make the intervention, under what circumstances the contact should be made, how confidentiality and its limits should be discussed, and how to ensure a safe hand-off to a mental health professional if necessary. Another very important component that should be covered is post follow-up — what action should be taken after the intervention to ensure the individual gets appropriate help and support.

Suicide prevention is a complex area. A number of organizations and agencies offer information and training on this issue that is geared to the needs of teachers, counsellors, nurses and other caregivers. For a list of these resources please see Appendix G.

COMPONENT 1 — STIGMA: WHAT IS IT? HOW DOES IT AFFECT PEOPLE'S LIVES?

Rationale

It is helpful to introduce the concept of stigma to students before the presentation, and to brainstorm about the ways mental illness is stigmatized in our society. The tools and activities in this section challenge students to examine their own biases and stigmatizing attitudes, and prepare them to listen to the presentation with open ears.

This introductory session may also be a good opportunity to view one of the audiovisual resources that are available from the National Film Board. Please see Appendix F for further details.

Overview of Educational Activities

1) Free association activity

2) What is stigma?

3) Case studies that examine the impact of stigma

4) Art and literature activity

5) Famous people with mental illness

Overheads and handouts needed

Overhead 1 — What Is Stigma?

Overhead 2 — Terms Related to Stigma

Overhead 3 — Famous People with Mental Illness

Handout 1 — Case Study

Examples of works of literature written by people with mental illness, or in which major characters are affected by mental illness. See Appendix B for sources.

Educational activities: Descriptions, instructions and tools for Component 1

> Activity 1: Free association exercise

(adapted from the "Face to Face with Mental Illness" program, developed by the Canadian Mental Health Association, London-Middlesex Branch and St. Thomas Aquinas Catholic School, London, on.)

PURPOSE: To get an idea of students' knowledge about mental illness and what their fears and misconceptions might be. It is also an icebreaker to encourage students to participate in the discussion.

It is important to emphasize there are no wrong answers — the exercise is all about opening up a discussion. Tell students they don't have to believe in, or agree with, the ideas or names they offer.

MATERIALS: Cue cards, masking tape and markers.

TIME: 15–20 minutes.

INSTRUCTIONS: Ask students about the first things that come to mind when they think of mental illness or a person with mental illness. Get them to write these ideas down on cue cards. Be sure to tell them there are no right or wrong answers; that it is an opportunity to bring up anything that comes to mind. Encourage them to write down as many ideas as they can, then stick the cue cards on the walls.

Once all the responses are on the wall, the teacher facilitates a discussion about which of the following categories each one fits into:

· myth (widely held, but false idea)
· misconception or misunderstanding
· hurtful or disrespectful language
· factual information.

Typically, the majority of responses will fit into the first three categories. Grouping the responses into the categories will reveal common themes. Some common themes that may emerge will be myths and misconceptions, such as the idea that people with mental illness are dangerous.

It is important to address all of the students' comments in the context of stigma by demystifying myths, addressing fears and misconceptions, and examining their underlying causes. Ask students to think about where such ideas come from — for example, the roles that media, movies, books and personal experience play in forming thoughts, attitudes and beliefs about mental illness. Many of the issues that come up will be addressed in the Fact or Fiction? activity that is included in Component 2.

> Activity 2: What is stigma?

PURPOSE: To get students to explore the concept of stigma, its causes and its impact. The definitions provided on the overhead may stimulate discussion about the origins of stigma and the use of the term in relation to mental illness.

MATERIALS: the discussion guide below, Overhead 1 — What Is Stigma?, Overhead 2 —Terms Related to Stigma, overhead projector.

TIME: 10–15 minutes, depending on the size of the audience.

INSTRUCTIONS: Ask students the following questions. If they are slow to respond, try to make connections between this topic and their responses to the free association exercise.

1) Can anyone tell me what stigma is?

Possible answers include: labels like crazy, psycho; stereotyping or discrimination.

· Use Overhead 1 — What Is Stigma? and Overhead 2 — Terms Related to Stigma to define and discuss stigma and related terms. Tell students everyone has had discriminatory or stigmatizing thoughts or attitudes. Remind them the important things are: to recognize discriminatory or stigmatizing thoughts and attitudes; to examine where they come from; and to work toward controlling and changing the hurtful behaviours they may cause.

2) What are some of the negative things you have heard about people with mental illness?

· If not mentioned by the group, repeat any examples from the responses to the free association exercise at the beginning of the presentation.

3) What are some of the positive things you have heard about people with mental illness?

· Some people say those with mental illness are creative and artistic. While this may seem positive, you may want to remind students it is also a form of stereotyping.

4) Why do you think people with mental illness are stigmatized?

Possible answers include: They are seen as being different; People don't understand what mental illness is.

5) Can you think of any other health conditions or social issues that have been stigmatized throughout history?

Possible answers include: homosexuality, leprosy, unwed motherhood, divorce, aids.

6) What kinds of factors have contributed to changing public perceptions around some of these conditions or issues?

Possible answers include: education, public policy, open dialogue, scientific research, changing social mores.

7) What do you think influences perceptions about people with mental illness?

Possible answers include: the media — news, newspaper headlines and stories that associate people with mental illness with violence or suicide; the fact that people with mental illness sometimes behave differently and people are afraid of what they don't understand.

8) How do you think stigma affects the lives of people with mental illness?

Possible answers include: It makes them unhappy; They may not be able to get a job or find housing; It may prevent someone from seeking help; It may cause them to lose their friends; It can negatively affect the whole family.

WHAT IS STIGMA?

The following are definitions of "stigma" taken from different sources and from different historical periods:

"A mark or sign of disgrace or discredit."

"A visible sign or characteristic of a disease."

— The Concise Oxford Dictionary, 1990

"An attribute which is deeply discrediting"

— Goffman, E., Stigma: The management of spoiled identity. 1963

"A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria."

"A mark made upon the skin by burning with a hot iron, as a token of infamy or subjection; a brand."

"A mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing."

— The Shorter Oxford English Dictionary

TERMS RELATED TO STIGMA

stereotype

"a person or thing that conforms to an unjustifiably fixed impression or attitude"

prejudice

"a preconceived opinion"

discrimination

"unfavourable treatment based on prejudice"

— The Concise Oxford Dictionary, 1990

> Activity 3: Case studies

PURPOSE: To illustrate different ways we treat people with mental versus physical illnesses and the impacts our attitudes and assumptions have on other people's lives.

MATERIALS: Handout 1 — Case Study and discussion guide on the following pages

TIME: 10–15 minutes.

INSTRUCTIONS: Distribute Handout 1 — Case Study to the students and give them five minutes to read it. You can choose whether you want the students to work in small groups or individually. When students have read the handout, use the questions in the discussion guide to explore different assumptions made by community members, employers, medical personnel and family members toward Frank's versus Alice's illness.

QUESTIONS FOR DISCUSSION:

1) If both suffer from chronic biological illnesses, why did Frank lose his job, his apartment and his friends while Alice's situation remained relatively unchanged?

2) What kinds of assumptions underlie the actions of health professionals, family and friends in each situation?

3) Are friends, work, independence, recreation and family support equally important for people with mental illness and people with other chronic illnesses?

CASE STUDY

FRANK JONES

Frank Jones had been released from a provincial psychiatric hospital after having been admitted recently for intense psychotic symptoms. At the time of admission, Frank was highly agitated, yelling that the police were going to harm him because he's the Boston Strangler's brother. In the emergency room, Frank told the on-call psychiatrist that he was hearing voices of the devil preaching about his murderous relatives.

This was the patient's third hospitalization since schizophrenia was first diagnosed 12 years earlier at age 22. Frank had made an excellent recovery from previous hospital stays: He had been working as a salesman at a hardware store for the past six years, and lived nearby in a small but comfortable apartment. He visited a psychiatrist at the community mental health centre for medication about once a month. He also met with a counsellor there to discuss strategies to cope with his mental illness. Frank had several friends in the area and was fond of playing softball with them in park district leagues. He had been dating a woman in the group for about a year and reported that he was "getting serious." Frank was also active in the local Baptist Church, where he was co-leading Bible classes with the pastor. The reappearance of symptoms derailed his job, his apartment and his social life.

Recuperating from this episode involved more than just dealing with the symptoms of his illness. The reaction of friends, family members and professionals also affected what happened to Frank. The hardware store owner was frightened by Frank's "mental hospitalization." The owner had heard mentally ill people could be violent, and worried that the stress of the job might lead to a dangerous outburst in the shop. Frank's mother had other concerns. She worried the demands of living alone were excessive: "He's pushing himself much too hard

trying to keep that apartment clean and do all his own cooking," she thought. She feared Frank might abandon his apartment and move to the streets, just like other mentally ill people she had seen.

Frank's doctor was concerned his hospitalization signaled an overall lack of stability. His doctor believed schizophrenia was a progressively degenerative disease, a view first promoted by a renowned psychiatrist in 1913. In this view, psychiatric hospitalizations indicated the disease was worsening. The doctor concluded Frank's ability to live independently would soon diminish; it was better to prepare for it now rather than wait for the inevitable loss of independent functioning. So the doctor, with the help of Frank's mother and boss, talked him into leaving his job, giving up his apartment and moving in with his mother. Frank's mother lived across town, so he stopped attending the Baptist church. Frank was unable to meet with his friends and soon dropped out of the sports league. He stopped seeing his girlfriend. In one month, he lost his job, apartment and friends.

ALICE JOHNSON

Like Frank Jones, Alice Johnson had been diagnosed with a significant and chronic disease: diabetes. She had to carefully monitor her sugar intake and self-administer insulin each day. She watched her lifestyle closely for situations that might aggravate her condition. Alice also met regularly with a physician and a dietitian to discuss blood sugar, diet and exercise. Despite these cautions, Alice had an active life. She was a 34-year-old clerk-typist for a small insurance broker. She belonged to a folk-dancing club she attended at a nearby secondary school. She was engaged to an accountant at the insurance company.

Despite carefully watching her illness, Alice suffered a few setbacks, the last occurring about a month ago when she required a three-day hospitalization to adjust her medication. The doctor recommended a two-week break from work after her discharge, and referred her to the dietitian to discuss appropriate changes in lifestyle. Even though diabetes is a life-threatening disease (in her

most recent episode, Alice was near coma when she was wheeled into the hospital), no one suggested she consider institutional care where professionals could monitor her blood sugar and intervene when needed. Nor did anyone recommend Alice give up her job to avoid work-related stressors that might throw off her blood sugar.

Case studies adapted from Corrigan, P. (1998). The Impact of Stigma on Severe Mental Illness. Cognitive and Behavioral Practice, 5*, 201–222.*

> Activity 4: Art and literature

PURPOSE: Exposing the audience to the art and literature of people with mental illness will present different perspectives of the experience of mental illness as it is expressed creatively. This activity provides an opportunity to examine changes in society's understanding and acceptance of mental illness and those who are affected by it.

MATERIALS: There are examples throughout the secondary school curriculum of works of literature written by people with mental illness, or in which major characters are affected by mental illness. Some of these include: William Shakespeare's *Macbeth* and *King Lear*, J.D. Salinger's *The Catcher in the Rye*, Emily Brontë's *Wuthering Heights* and Sylvia Plath's *The Bell Jar*.

A list of resources for consumer-survivor art and literature can be found in Appendix B. Use overheads to display visual art. Literature can be read out loud or even performed.

TIME: It can take as little as five minutes to read a selected poem and discuss its possible meaning with the students.

INSTRUCTIONS: Be creative.

> Activity 5: Famous people with mental illness

PURPOSE: To emphasize that mental illness is not a barrier to achievement.

MATERIALS: Overhead 3 — Famous People with Mental Illness, listing famous people — artists, politicians, writers, historical figures, etc. — who experienced mental illness is located on the next page.

TIME: 5–10 minutes

INSTRUCTIONS: Explain the purpose of showing students the names of famous people with mental illness.

Emphasize that just like the rest of us, people with mental illness live ordinary lives: they have families, jobs, bills to pay, talents, challenges, and so on. There are also people who have a harder time dealing with their mental illness and don't function as well as the presenters or the famous people on the list. This may be due to factors such as lack of support, lack of affordable housing or treatment as well as stigma.

Read through the list or just leave the overhead up for students to pick out the names they recognize.

FAMOUS PEOPLE WITH MENTAL ILLNESS

(Diagnosis or believed diagnosis of mood disorder, unless otherwise indicated)

ACTORS/ENTERTAINERS/DIRECTORS

Marlon Brando

Drew Carey

Jim Carrey

Dick Clark

John Cleese

Rodney Dangerfield

Richard Dreyfuss

Patty Duke

Frances Ford Coppola

Audrey Hepburn

Anthony Hopkins

Ashley Judd

Margot Kidder

Vivien Leigh

Joan Rivers

Roseanne

Winona Ryder

Charles Schultz

Rod Steiger

Damon Wayans

Robin Williams

ARTISTS

Paul Gaugin

Vincent van Gogh

Michelangelo

Vaslov Nijinski (schizophrenia)

Georgia O'Keefe

Jackson Pollock

ATHLETES

Lionel Aldridge (schizophrenia)

Oksana Baiul

Dwight Gooden

Peter Harnisch

Greg Louganis

Elizabeth Manley

Jimmy Piersall

Monica Seles

Darryl Strawberry

Bert Yancey

AUTHORS/JOURNALISTS

Hans Christian Andersen

James Barrie

William Blake

Agatha Christie

Michael Crichton

Charles Dickens

Emily Dickinson

William Faulkner

F. Scott Fitzgerald

John Kenneth Galbraith

Ernest Hemingway

John Keats

Larry King

Eugene O'Neill

Sylvia Plath

Edgar Allen Poe

Mary Shelley

Neil Simon

William Styron

Leo Tolstoy

Mark Twain

Mike Wallace

Walt Whitman

Tennessee Williams

Virginia Woolf

BUSINESS LEADERS

Howard Hughes (depression & OCD)

J.P. Morgan

Ted Turner

SCIENTISTS

Charles Darwin

Sigmund Freud

Stephen Hawking

Sir Isaac Newton

COMPOSERS/MUSICIANS/SINGERS

Irving Berlin

Ludwig van Beethoven

Karen Carpenter (anorexia)

Ray Charles

Frederic Chopin

Eric Clapton

Kurt Cobain

Leonard Cohen

Natalie Cole

Sheryl Crow

John Denver

Stephen Foster

Peter Gabriel

Janet Jackson

Billy Joel

Elton John

Sarah McLachlan

Charles Mingus

Alanis Morissette

Marie Osmond

Charles Parker

Cole Porter

Bonnie Raitt

Axl Rose

Robert Schumann

Paul Simon

James Taylor

Peter Tchaikovshy

POLITICAL FIGURES/WORLD LEADERS

Alexander the Great

Napoleon Bonaparte

Barbara Bush

Winston Churchill

Diana, Princess of Wales

Tipper Gore

Thomas Jefferson

Ralph Nader

Florence Nightingale

George Patton

George Stephanopolous

(Taken from the Mood Disorders Web site: www.ndmda.org)

COMPONENT 2 — WHAT IS MENTAL ILLNESS?

Rationale

Many students do not know basic facts about mental illness; furthermore, they may have misconceptions that need to be corrected. They benefit from learning about the causes of mental illness and the kinds of treatments available to people with mental illness.

Understanding some of the basic terms related to mental illness helps students get the most out of presenters' stories. A basic familiarity with some of the language used by presenters helps students tune into the personal aspect of the presenters' experiences. It also makes students feel more comfortable and encourages them to ask questions.

The specific content of the pre-presentation lessons in Component 2 include: definitions of the major mental illnesses; incidence of different kinds of mental illness in the population; causes of the most common mental illnesses; and treatments currently available.

Because of the somewhat technical nature of the information contained in this component, teachers often request the support of local mental health professionals to help them deliver this information. Members of the organizing committee can put teachers in touch with local mental health professionals (often members of the committee themselves) who would help in the classroom.

Overview of Educational Activities

1) Fact or fiction?

2) Mental illness statistics for Ontario

3) Understanding mental illness: Definitions, possible causes and treatment

4) Auditory hallucinations

Overheads and handouts needed

Overhead 4 — Fact or Fiction?

Overhead 5 — Mental Health Statistics for Ontario

Overhead 6 — Definition of Mental Illness

Overhead 7 — Factors that May Contribute to the Development of Mental Illness

Overhead 8 — Treatment of Mental Illness

Handout 2 — "Voices" Script (two copies)

Educational activities: Descriptions, instructions and tools for Component 2

> Activity 1: Fact or fiction?

PURPOSE: To debunk some of the myths about mental illness.

MATERIALS: Overhead 4 — Fact or Fiction? and answer key located on the next few pages.

TIME: 15–20 minutes.

INSTRUCTIONS: Use Overhead 4 — Fact or Fiction? to test students' knowledge of the facts about mental illness. Read each of the statements, one by one, asking whether the statement is true or false. Use the answer key (page 42) to discuss the students' responses and the correct answers.

FACT OR FICTION?

1. One person in 100 develops schizophrenia. True or False
2. A person who has one or two parents with mental illness is more likely to develop mental illness. True or False
3. Mental illness is contagious. True or False
4. Mental illness tends to begin during adolescence. True or False
5. Poor parenting causes schizophrenia. True or False
6. Drug use causes mental illness. True or False
7. Mental illness can be cured with willpower. True or False
8. People with mental illness never get better. True or False
9. People with mental illness tend to be violent. True or False
10. All homeless people are mentally ill. True or False
11. Developmental disabilities are a form of mental illness. True or False
12. People who are poor are more likely to have mental illness than people who are not. True or False

Fact or fiction? — answer key

1. One person in 100 develops schizophrenia.

True. One per cent of the general population develops schizophrenia.

2. A person who has one or both parents with mental illness is more likely to develop mental illness.

True. Mental illness can be hereditary. For example, the rate of schizophrenia in the general population is one per cent. This rate rises to to eight per cent if one parent has the disorder and to 37–46 per cent if both parents have it. One in 10 people in the general population has experienced depression, compared to one in four for people whose parents have experienced depression.

3. Mental illness is contagious.

False. Mental illness is not contagious. Heredity can, and often does, play a factor in the development of the disease.

4. Mental illness tends to begin during adolescence.

True. The first episode of a mental illness often occurs between the ages of 15 and 30 years. Early intervention is currently thought to be one of the most important factors related to recovery from mental illness. Embarrassment, fear, peer pressure and stigma often prevent young people from seeking out help.

5. Poor parenting causes schizophrenia.

False. Childhood abuse or neglect does not cause mental illnesses such as schizophrenia. However, stressful or abusive environments may seriously impair a person's ability to cope with and later manage the illness.

6. Drug use causes mental illness.

True and False. Alcohol and other drugs sometimes play a role in the development of some symptoms and disorders, but do not usually cause the illness. However, long-term drug and alcohol use can lead to the development of drug-induced psychosis, which has many of the same symptoms of organic mental illness. Alcohol and drugs are often used as a means to cope with the illness, although using alcohol and drugs can make the symptoms of mental illness worse.

7. Mental illness can be cured with willpower.

False. Mental illness is associated with chemical imbalances in the brain and requires a comprehensive treatment plan.

8. People with mental illness never get better.

False. With the right kind of help, many people with a mental illness do recover and go on to lead healthy, productive and satisfying lives. While the illness may not go away, the symptoms associated with it can be controlled. This usually allows the person to regain normal functioning. Medication, counselling and psychosocial rehabilitation are treatment options that can help people recover from mental illness.

9. People with mental illness tend to be violent.

False. People who experience a mental illness acutely sometimes behave very differently from people who do not. While some of their behaviours may seem bizarre, people with mental illness are not more violent than the rest of the population.

10. All homeless people are mentally ill.

False. Although studies have shown that between 17 and 70 per cent of people who are homeless have mental illnesses, it is clear that being homeless doesn't automatically indicate a mental illness.

11. Developmental disabilities are a form of mental illness.

False. Mental illness is often confused with developmental disabilities, even though the two conditions are quite different. Mental illness does not affect an individual's intellectual capacity, whereas developmental disabilities do. However, people with developmental disabilities are more susceptible to developing mental illness.

12. People who are poor are more likely to have mental illness than people who are not.

False. Income is not a factor in overall rates of mental health problems. However, people with lower incomes experience slightly higher rates of depression. People who live with major mental illnesses often end up in lower social classes because the illness may interfere with their ability to hold a job.

> Activity 2: Mental illness statistics for Ontario

PURPOSE: To provide students with a few basic statistics about the major mental illnesses. The statistics can inspire further investigation and discussion in the classroom.

MATERIALS: Overhead 5 — Mental Health Statistics for Ontario, located on the following page.

TIME: 10 minutes

INSTRUCTIONS: Use Overhead 5 — Mental Health Statistics for Ontario. If students want further information related to these statistics, please refer them to the document from which these statistics were taken, the Health Statistical Sourcebook Vol. 1: An Investigation into the Ontario Mental Health Supplement of the 1990 Ontario Health Survey. (February 1999). It can be found at the Web site of the Ontario Division of the Canadian Mental Health Association, at http://www.ontario.cmha.ca/mhic/omhss_v1.pdf

MENTAL HEALTH STATISTICS FOR ONTARIO

- 22 per cent of Ontarians have experienced at least one mental health problem in their lifetime.
- Women are more likely than men to experience a mental health problem, specifically anxiety or depression.
- Men are more likely to experience antisocial personality disorder.
- 31 per cent of 15- to 24-year olds have experienced a mental health problem:
  - 27 per cent have anxiety problems
  - 7.5 per cent have affective problems
  - 15- to 24-year-olds are more likely to have social phobias and bipolar disorder.
- Older people experience depression more often than younger people.
- Mental disorders (especially depression) are more common among people who are separated, divorced or widowed.
- 52 per cent of Ontarians whose parents have experienced a mental health problem also experience a mental disorder.

Source: Canadian Mental Health Association, Ontario Division, 1999

For further information, please refer the source document of these statistics.

It can be found on the Canadian Mental Health Association, Ontario Division's Web site:

http://www.ontario.cmha.ca/mhic/omhss_v1.pdf

> Activity 3: Understanding mental illness: Definitions, possible causes and treatment

PURPOSE: Most people have heard of at least some types of mental illness, but they may not have a full understanding of those illnesses. The objective of this activity is to inform students about different mental illnesses, as well as to correct misconceptions students may have regarding mental illness and treatment. Members of the organizing committee can be good resources if teachers need support in delivering the content of this component. Local mental health professionals with a clinical background and experience may be able to offer insight into the technical nature of this component.

This section is particularly useful for audiences who have had limited instruction about mental illness. The goal of this material is to offer a common framework for understanding mental illness and the different ways it is manifested in individuals. The amount of time you spend on this exercise will depend on how much formal teaching your students have had in this area.

MATERIALS

Overhead 6 — Definition of Mental Illness

Overhead 7 — Factors that May Contribute to the Development of Mental Illness

Overhead 8 — Treatment of Mental Illness

TIME: About five minutes to go through each overhead.

INSTRUCTIONS: Use Overhead 6 — Definition of Mental Illness to uncover students' knowledge of types of mental illness. Ask students to name some types of mental illness. As you read through the definitions, be sure to remind students of the following:

· Everyone experiences feelings of sadness, agitation or confusion, but people with mental illness experience these symptoms for extended periods of time; they experience a loss of ability to function and they are unable to bounce back without extensive medical attention and social support.

· Culture, age and gender influence each of these disorders, and different people may have different experiences with the illness.

· A person can experience one or more of these disorders at the same time.

Use Overhead 7 — Factors that May Contribute to the Development of Mental Illness and discussion guide (page 54) to discuss the factors related to the onset of mental illness.

Use Overhead 8 — Treatment of Mental Illness and discussion guide (page 56) to discuss the various conventional approaches to treating mental illness.

DEFINITION OF MENTAL ILLNESS

Mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.

DESCRIPTIONS OF MENTAL ILLNESSES — MOOD DISORDERS

Mood disorders are persistent changes in mood caused by biochemical imbalances in the brain. Major depressive disorder and bipolar disorder are two types of mood disorders.

Major depressive disorder is depressed mood accompanied by symptoms such as: loss of interest or pleasure in life; irritability; sadness; difficulty sleeping or sleeping too much; decreased or increased appetite; lack of concentration; sense of worthlessness; guilt; and in some cases, thoughts of suicide.

Bipolar disorder is a cycle of depressed mood, "normal" mood and mania. Mania is an elevated, exaggerated mood accompanied by symptoms such as: inflated self-esteem or confidence; a decreased need for sleep; increased energy; increased sexual drive; poor judgment; increased spending; agitation; non-stop talk; and increased involvement in pleasurable and possibly dangerous activities.

DESCRIPTIONS OF MENTAL ILLNESSES — PSYCHOSIS

Psychosis is the active state of experiencing hallucinations or delusions and can be organic (mental illness) or drug-induced.

Schizophrenia is a disturbance involving delusions, hallucinations, disorganized speech and/or disorganized or catatonic behaviour. Delusions are false beliefs or misinterpretations of situations and experiences. Hallucinations can be auditory, visual, olfactory (smell), gustatory (taste) or tactile (touch), but auditory hallucinations are most common. Schizophrenia is also associated with a deterioration of a person's ability to function at work, school and/or socially.

DESCRIPTIONS OF MENTAL ILLNESSES — ANXIETY DISORDERS

Anxiety disorders are associated with feelings of anxiousness, combined with physiological symptoms that interfere with everyday activities. Obsessive-compulsive disorder, phobias and post-traumatic stress disorder are types of anxiety disorders.

Obsessive-compulsive disorder is marked by repeated obsessions and/or compulsions that are so severe they interfere with everyday activities. Obsessions are disturbing, intrusive thoughts, ideas, or images that cause marked anxiety or distress. Compulsions are repeated behaviours or mental acts intended to reduce anxiety.

Post-traumatic stress disorder is the re-experiencing of a very traumatic event, accompanied by feelings of extreme anxiety, increased excitability and the desire to avoid stimuli associated with the trauma. The trauma could be related to such incidents as military combat, sexual assault, physical attack, robbery, car accident or natural disaster.

Phobias are significant and persistent fears of objects or situations. Exposure to the object or situation causes extreme anxiety and interferes with everyday activities or social life. Specific phobias have to do with objects or situations — for example, germs or heights. Social phobias have to do with social situations or performance situations where embarrassment may occur — for example, public speaking or dating.

DESCRIPTIONS OF MENTAL ILLNESSES — PERSONALITY DISORDERS

A personality disorder is a pattern of inner experience and behaviour that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress or impairment. Personality disorders usually begin in adolescence or early adulthood.

Dissociative identity disorder, formerly known as "multiple personality disorder," is the presence of two or more distinct identities that alternately control a person's behaviour. It reflects a failure to make connections between identity, memory and consciousness. Known by the general public as "split personality," there is now a controversy as to whether or not it is a real diagnosis.

DESCRIPTIONS OF MENTAL ILLNESSES — EATING DISORDERS

Eating disorders are a range of conditions involving an obsession with food, weight and appearance that negatively affect a person's health, relationships and daily life. Stressful life situations, poor coping skills, socio-cultural factors regarding weight and appearance, genetics, trauma, and family dynamics are thought to play a role in the development of eating disorders.

Anorexia Nervosa is characterized by an intense and irrational fear of body fat and weight gain, the strong determination to become thinner and thinner, the refusal to maintain a normal weight (for height and age) and a distorted body image.

Bulimia Nervosa is characterized by self-defeating cycles of binge eating and purging. Bingeing is the consumption of large amounts of food in a rapid, automatic and helpless fashion and leads to physical discomfort and anxiety about weight gain. Purging follows bingeing and can involve induced vomiting, restrictive dieting, excessive exercising or use of laxatives and diuretics.

(Eating Disorders Awareness and Prevention Web site: http://www.edap.org)

FACTORS THAT MAY CONTRIBUTE TO THE DEVELOPMENT OF MENTAL ILLNESS

The following are factors that may contribute to the development of mental illness:

· chemical imbalance

· substance use

· traumatic life events

· heredity

· other illnesses.

Factors that may contribute to the development of mental illness: Discussion guide

Although there is currently no agreement about the exact causes of mental illness, the following factors are recognized as playing a role in the development of various mental illnesses:

Chemical imbalance

There is growing evidence that mental illness may be partially caused by a chemical imbalance in the brain. Many people respond well to medications that address such an imbalance and many of the symptoms of their illness are reduced or eliminated.

Substance use

There is no clear causal relationship between substance use and the development of mental illness. People who have mental illness may use alcohol and other drugs to relieve some symptoms of their illness. However, substance use may actually worsen symptoms and delay proper diagnosis and treatment. There are also cases in which substance use has induced psychotic behaviour, both because of the chemical effect of the drug and because the drug unmasks a pre-existing mental illness.

Traumatic life events

Similar to substance use, traumatic life events can, in some instances, make people more vulnerable to developing mental illness. Instead of recovering from a situational depression (e.g., grief following the death of a loved one), some people may go on to develop a more profound, clinical depression.

Heredity

We are learning more about the role heredity plays in the development of mental illness. Researchers have found that with certain diagnoses, the likelihood of a child developing a mental illness is greater if one or both parents have a mental illness. Examples of diseases thought to have a genetic component include schizophrenia, bipolar disorder, obsessive-compulsive disorder and depression.

Other illnesses

People with conditions such as Alzheimer's, Parkinson's, dementia and brain damage (from strokes or accidents) experience memory loss and confusion. People can also develop chronic depression in conjunction with debilitating physical illness, or illnesses that alter their level of functioning.

TREATMENT OF MENTAL ILLNESS

Biological treatments

· medication

· electroconvulsive therapy (ECT).

Psychosocial Interventions

· psychotherapy

· self-help groups

· family support and involvement

· community supports.

Treatment of mental illness: Discussion guide

Treatments vary according to the particular illness and the severity of the illness. Different types of treatment include biological interventions, such as medications and electroconvulsive therapy; and psychosocial interventions, such as psychotherapy, family support and involvement, self-help, vocational, recreational and housing support. For most people with a serious mental illness, a combination of approaches tends to be most effective in relieving symptoms.

Biological treatments

Medication

The types of medications most commonly used to treat mental illness fall into four categories: antipsychotics, antidepressants, mood stabilizers, and anxiolytics, or anti-anxiety medication.

Electroconvulsive therapy (ect)

ect, also referred to as "shock therapy," is a long standing, effective and often misunderstood treatment for acute depression. The patient is given an anaesthetic and a muscle relaxant, then an electric charge is applied to the brain, inducing a small seizure.

ect has been both condemned and promoted in the mental health field and the media. In its early days, ect was a cruder procedure, which sometimes resulted in short- and long-term memory loss (although it usually resolved after six months).

Today, ect is a much gentler intervention proven to be an effective treatment for major depression and bipolar depression or mania. Most people are unaware of the newer procedures and remain fearful of ect, so they tend to try several medications before considering ect as a treatment.

Psychosocial interventions

Psychotherapy

Psychotherapy is often used in conjunction with medication to treat mental illness. Psychotherapy is a general term used to describe a form of treatment based on "talking work" done with a therapist. The aim of talk therapy is to relieve distress by expressing feelings; to help change negative attitudes, behaviour and habits; and to promote constructive ways of coping.

There are many different types of therapy, including short-term, long-term, individual and group. An essential component of any psychotherapy is a supportive, comfortable relationship with a trusted therapist.

Self-help groups

Self-help organizations, run by clients of the mental health system and their families, provide an important part of treatment for people with mental illness and their families. Self-help groups offer the chance to meet informally with other people who understand the same issues and

challenges. These groups can reduce a sense of isolation and provide opportunities to learn from other group members' experiences. Volunteering and sharing the wisdom gained by living with mental illness can be an empowering experience for others.

Family support and involvement

Informal relationships with friends, family, co-workers and others play a vital role in supporting and maintaining mental health. Family members and friends of people with mental illness need as much information as possible so they can assist and support their loved ones, and deal with their own feelings.

Community support

People with serious mental illness need access to social services, education, public housing, social support and family services to maintain wellness. In addition to these services, there are networks of community groups and organizations that contribute to community life. Interest-based groups (such as gardening and sports clubs), religious organizations and service clubs (such as Kiwanis and Rotary) also provide the opportunity for meaningful involvement in the community.

> Activity 4: Auditory hallucinations

PURPOSE: To get students to experience the fear, frustration and confusion of auditory hallucinations.

MATERIALS: two photocopies of Handout 2 — "Voices" Script.

TIME: About 20 minutes, including the discussion that follows the activity.

NOTE: This particular exercise has been criticized by some people with mental illness as not being a good representation of what auditory hallucinations are really like. If you decide to do this activity, indicate that it is very difficult to truly feel what it is like to experience auditory hallucinations and that every person will experience them in a slightly different way.

INSTRUCTIONS: Tell students you will be taking them through an exercise that attempts to show them what it is like to experience auditory hallucinations, or hearing voices. Ask for four volunteers from the audience. Ask each person in a group to take on one of the four following roles:

· a person with schizophrenia
· a friend
· voice 1
· voice 2.

The people playing voice 1 and voice 2 get a copy of Handout 2 — "Voices" Script and stand on

either side of the student playing the role of the person with schizophrenia. The person playing the "friend" stands across from the "person with schizophrenia." Tell the people who are playing the "friend" and the "person with schizophrenia" to talk to each other about anything — school, what they did that weekend, anything. Tell the people playing the "voices" to read their script to the "person with schizophrenia" at the same time. They should do this quietly but loud enough to be heard by the "person with schizophrenia."

Once you tell the volunteers to begin, let the activity continue for a minute or so. It will probably get very noisy and there will be lots of laughing, but students enjoy this activity and do get the point of the exercise.

Once you've asked them to stop the exercise and they've settled back into their seats, ask them the following questions:

1) What was it like for those of you who were playing the part of the person with schizophrenia?

Typical answers are: confusing, frustrating, hard to focus on what the "friend" was saying, couldn't carry on the conversation, etc.

2) What was it like for those of you who were playing the part of the friend?

Typical answers are: frustrating, the other person wasn't answering their questions.

3) What were some of the things the voices were saying?

The main points are that voices aren't always commanding and that sometimes there are themes to the voices; they can be religious or sexual or punitive and sometimes they don't mean anything.

4) What do you think it would be like to be in a class at school or in a job interview or taking an exam while experiencing auditory hallucinations?

Typical answers include: distracting, hard to concentrate, hard to do well.

“VOICES” SCRIPT

VOICE 1

You jerk!

Stupid!

Everyone knows it

They’re all looking at you

They know you’re stupid

They are laughing at you

You’re ugly

Hide your face

Run away

You’re no good

You lazy, good for nothing

Get a job you bum

Do something

Don’t listen to them

Go for a coffee

Have a cigarette

This is boring

Hurt yourself

You deserve it

You’re useless

No one cares

VOICE 2

Save these people

They’re devils

They must be persecuted

God works through you

You can save the world

You are Jesus, son of God

Cleanse yourself

Save the world

Dirty! Dirty!

Take your clothes off

Purify yourself

Go naked in the presence of God

Naughty! Naughty!

You’re tired

Get out of here

Go to sleep

They’re staring with evil eyes

Run away

Hit them now

Hit! Hit!

Before they hurt you

COMPONENT 3 — THE PRESENTATION

Rationale

Overwhelmingly, teachers and students identified the major strength of the awareness program as the opportunity to interact with people personally affected by mental illness. It provides a unique kind of experiential learning — one that breaks down barriers by bringing the community into the classroom. The presentation is a central component of the program; it helps to put a personal face on mental illness and reminds students that mental illness can happen to anyone.

Preparing for the presentation

Teachers play an important role in making the awareness presentation a positive learning experience for their students. Some simple activities before the presentation (see Components 1 and 2) will make students more comfortable with the subject and engage in meaningful dialogue with the presenters and one another. Following the presentation, teachers play an equally valuable role: they ask students how they felt about the presentation and respond to unanswered questions and issues, including local resources for mental health problems.

The following is a list of tips and recommendations for teachers whose students are going to participate in an awareness presentation. The ideas and suggestions are gathered from a survey and focus group conducted with teachers who participated in the program.

1) Make sure the right people are "in the know."

Ensure the principal and other appropriate personnel and staff members know about the awareness presentation.

2) Have support on hand.

Plan to have a guidance counsellor at the presentation or available afterwards for students' questions.

Consult with colleagues about students who may find the presentation sensitive because of difficulties they, or someone close to them, is having.

3) Find out about details of the presentation.

How long will it be?

How many presenters will there be?

What types of mental illness will presenters be talking about?

Will mental health professionals be involved in the presentation?

4) Arrange for an appropriate space.

The presentation will be most effective if presenters and students are comfortable. It's important to choose a space that is intimate, though not claustrophobic. Often, classrooms are an appropriate venue because they are the right size for a single class and tend to have fairly good acoustics.

You might want to use the school library or another larger space if more than one class is participating. Auditoriums are generally not appropriate. They are so large and formal, they may create a sense of distance between the presenters and the students.

Consider the set-up of the room. Presenters can form a panel at the front of the room or everyone can sit together in a circle.

5) Think ahead about welcoming and thanking participants.

Plan to have a student or teacher welcome the presenter and thank them after the presentation.

Send a thank you note to the presenters and organizers to let them know the students enjoyed the program and learned from their efforts.

Preparing your students

It is important to go over a few basic ground rules with students before the presentation takes place.

Remind students to use respectful language — terms like crazy, mental, psycho, and so on, are not acceptable.

It is important students respect presenters' and other student's privacy. That means respecting the confidentiality of people's personal stories by not discussing them outside the classroom.

Prepare students for different presentation styles. Presenters are sharing their experience, but may not be expert public speakers, or experts on different forms of mental illness. Remind students that presenters are representing their own perspective and that everyone has a very different experience. Tell students presenters will welcome their questions and truly appreciate their sensitivity and interest.

Ask students to phrase questions thoughtfully and reflect on presenters' experiences before they ask deeply personal questions. Tell students if they think a question might make a presenter uncomfortable, they could preface their question with a phrase such as "I'm not sure if you'll want to answer this, but…"

Prepare students for the emotional nature of some of what they may hear. Some discussions may evoke discomfort for some students, and may lead them to question their own functioning. Students need to know this is a natural reaction to the discussion. In the discussion, presenters should establish a clear distinction between distress and illness, and clearly define processes for seeking help.

Preparation checklist for teachers

Before the presentation:

☐ Prepare students in advance by covering material in classroom.

☐ Establish clear ground rules and expectations for students (e.g., respectful listening, privacy and confidentiality).

During the presentation:

☐ Have a guidance counsellor, social worker, or school nurse present.

☐ Observe students' reactions to the material and the speakers.

After the presentation:

☐ Distribute the resource list of local mental health services and supports to students.

☐ Follow up with students who express concerns.

COMPONENT 4 — FOLLOW-UP ACTIVITIES AND RESOURCES

Rationale

Now that students have learned some facts about mental illness and have heard about the experiences of people with mental illness, they are ready to learn how to take action against stigma. The purpose of this section is to show students how to: change their own behaviour; help others learn about stigma and mental illness; be supportive to someone they know who has a mental illness; and how to find help for themselves if they think they have a mental health problem.

Although the presenters' stories reflect their individual experiences, the presentation often raises broader issues about the way society treats people with mental illness. Following up the presentation with discussion and additional information is an integral part of the learning process.

After listening to the presenters' personal stories, students are often eager to talk about what they can do to change the way people with mental illness are treated, and more generally, the way mental illness is viewed. The follow-up session provides an opportunity for students to identify their concerns and identify ways they can work to change attitudes and behaviours.

The follow-up is also important because some students respond emotionally to the presentation. The experiences of the presenters may prompt students to think about their own mental health and that of their family and friends. This may lead students to disclose a mental health problem or concern to the teacher, often in written work following the presentation.

It is a good idea to anticipate potential student disclosures and/or concerns, and to be prepared to deal properly with these situations. Teachers will need the support of school-based resources (such as guidance counsellors, social workers, nurses and chaplains), the organizing committee, as well as local mental health professionals, to ensure a student's confidentiality is respected and they are given support and information about where and how to get help.

Provide students with some general information on ways to get help. The organizing committee will give you a list of mental health resources available in your community. Ask committee members to distribute the list at the presentation. You can also let students know what resources are available within the school (e.g., guidance counsellors, school nurses, teachers).

Teachers can also take advantage of events in their school and community to encourage ongoing thoughtful discussion about mental health and mental illness. This can be an effective way of increasing students' knowledge about mental illness and their awareness that mental illness affects all members of society. Students may want to participate in some of these events, such as Mental Illness Awareness Week and Walk for Schizophrenia. Teachers can contact the organizing committee to find out how to get involved.

Overview of Educational Activities

1) Analysis of media coverage

2) Dos and don'ts brainstorm

3) Support strategies

4) Working and volunteering in mental health

5) Where to get help

6) Awareness posters

7) Class newsletter or magazine

Overheads and handouts needed

Overhead/Handout 9 — Support Strategies (handout copies optional)

Newspaper and magazine articles that discuss mental illness, or provide an account of an incident involving a person with mental illness. (see page 67 for details)

A list of local agencies and organizations that offer volunteer and career opportunities in the field of mental health. The program's local organizing committee will supply this list.

A copy of Where to Get Help; this information sheet will be provided by the organizing coalition in your community.

Educational activities: Descriptions, instructions and tools for Component 4

> Activity 1: Analysis of media coverage

PURPOSE: The purpose of this activity is to highlight the role media plays in influencing public understanding and perception of mental illness, and to help students evaluate media messages about mental illness.

MATERIALS: Collect articles from newspapers and magazines that discuss mental illness, or provide an account of an incident involving a person with mental illness. It is particularly effective if you can find coverage of the same story or event from different news sources. There are a number of resources available on the Internet on the Stigmabusting Web site, such as a sheet of statistics that highlights the prevalence of negative media depictions of people with mental illness (http://mason.gmu.edu/~owahl/media.htm).

TIME: About 20 minutes

INSTRUCTIONS: Ask students to break off into small groups in order to analyze and compare the way each article depicts mental illness or people with mental illness. Ask them to find examples of stigmatizing or stereotypical images and language, and to think of alternative ways of reporting the story that would not perpetuate stereotypes of people with mental illness. Ask each group to share their discussions with other members of the class.

> Activity 2: Dos and don'ts brainstorm

PURPOSE: The purpose of this activity is to encourage students to think about taking steps toward changing their language and behaviour and promoting a more accepting community.

MATERIALS: The Dos and Don'ts Suggestion List located on the next page.

TIME: About 5 minutes.

INSTRUCTIONS: Ask students to brainstorm ideas about ways of talking about, and behaving toward, people with mental illness that are inappropriate, stigmatizing and disempowering. Ask them to come up with a list of suggestions for more respectful language and behaviour and ways of raising awareness about the issue of stigma in the school and the community. If students need some hints, use the suggestions provided.

Make links to the personal experiences of consumer-survivors and/or responses from the free association exercise done before the presentation.

DOS AND DON'TS SUGGESTION LIST

Disempowering language	Empowering language
"the mentally ill"	consumer
victims, suffering	survivor
crazy, wacko, lunatic, psycho, psychopath, demented	people/person with mental illness

Disrespectful language	Respectful language
schizophrenic	person with schizophrenia
manic depressive	person with bipolar disorder
handicapped person	
slow	
retarded	
challenged	
special	
normal vs. not normal	

Don't	Do
refer to people by their illness	put the person first
talk about people	talk with people
be judgmental	become informed about mental illness
	take action in your community and school, e.g. Walk for Schizophrenia

> Activity 3: Support strategies

PURPOSE: The purpose of this discussion is to provide students with strategies for supporting people with mental illness.

MATERIALS: Overhead/Handout 9 — Support Strategies, overhead projector, and enough photocopies for each student (optional).

TIME: About 5 minutes.

INSTRUCTIONS: Ask students to think about how they would hope to be treated if they had a mental illness. Ask for some suggestions. Use the overhead as a starting point to encourage further discussion.

SUPPORT STRATEGIES

Here are some strategies for supporting someone with a mental health problem:

· Be supportive and understanding.

· Spend time with the person. Listen to him or her.

· Never underestimate the person's abilities.

· Encourage the person to follow his or her treatment plan and seek out support services.

· Become informed about mental illness.

· If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.

· Put the person's life before your friendship. If you think the person needs help, especially if she or he mentions having thoughts of suicide, don't keep it a secret (even if the person may have asked you to). Tell his or her parents or someone else who can help.

> Activity 4: Working and volunteering in mental health

PURPOSE: Provide students with a list of local agencies and organizations that offer volunteer and career opportunities in the field of mental health. The program's local organizing committee will supply this list.

MATERIALS AND INSTRUCTIONS: Provide students with lists of mental health careers and volunteer opportunities.

> Activity 5: Where to get help

MATERIALS AND INSTRUCTIONS: Provide students with a list of resources available in your community. A template for creating this list is found in the accompanying *Community Guide.* The list may be provided by the organizing coalition in your community. This list should include phone numbers and addresses and explain what each organization offers. It will be important to tell students that all services are private.

You can also highlight resources present within the school such as guidance counsellors, school nurses, chaplains and social workers, as well as other possible resources in the community, such as hospitals, clergy and family doctors.

> Activity 6: Awareness posters

PURPOSE: To engage the students in a creative response to combating stigma in their school and community.

MATERIALS: Posterboard, newspapers, magazines, paints, glue and other art supplies.

TIME: 30–60 minutes. Could be assigned as homework.

INSTRUCTIONS: Ask students to design a poster that will create awareness about a mental health issue. Possible issues include: the impact of stigma on the lives of people with mental illness; facts about a particular mental illness; the important contributions of people with mental illness; stereotypes of people with mental illness, etc. Ask students to make the posters large, colourful and appealing. Display the posters prominently in different areas of the school.

> Activity 7: Class newsletter or magazine

PURPOSE: To share students' impressions of the program with other members of the school community.

MATERIALS: Computers, magazines and newspapers, students' written perspectives on the program, and/or poetry and artwork created by students in response to the program.

TIME: An ongoing group activity.

INSTRUCTIONS: Ask students to put together a magazine/newsletter about the program. Students can write a short column or report to contribute, or can work on developing graphics, artwork, layout, etc. The finished product can be assembled and given a catchy title and an attractive cover. The newsletter can be reproduced and copies can be distributed to different classrooms and common areas throughout the school.