Received 20 May 2008
Revised 2 March 2009
Accepted 11 March 2009

"Crazy? So what!":

A school programme to promote mental health and reduce stigma – results of a pilot study

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Abstract

Purpose – The purpose of this paper is to evaluate the health-promoting and stigma-reducing effect of the German school-based programme "Crazy? So what!".

Design/methodology/approach – A quasi-experimental longitudinal control-study was carried out with assessments one week prior to the school programme, immediately after it and three months later. A total of 210 Year 9 and 10 students (aged 13-18 years) were surveyed in four schools in Saxony, Germany. Data analysis was done descriptively based on frequency distributions. Random effects regression models for unbalanced panel data were used to estimate the change of the outcome variables over time.

Findings – At baseline, only 5.2 per cent of the intervention group would talk with their teacher about a mental health problem. Immediately after the programme, this number increased to 10.6 per cent and after three months to 17.9 per cent. There was also a positive, short-term effect on students' social distance, i.e. an increase in positive attitudes towards those with a mental illness, but this was not sustained over time. By contrast, self-efficacy proved resistant to change.

Originality/value – This school programme is successful in that the "experts on their own behalf" (young people, who have gone through mental illness) were able to encourage and reassure others on how to face a mental health crisis with more confidence, which also contributes to strengthening students' resilience. The results of this study indicate the importance of sensitising children and youth, but also teachers and other adults to mental health.

Keywords Mental health services, Promotion, Schools, Children (age groups), Adolescents, Germany

Paper type Research paper

Health Education
Vol. 109 No. 4, 2009
pp. 314-328

0965-4283
DOI 10.1108/09654280910970893

Introduction

Mental disorders are widespread and have far reaching consequences. Three of the ten leading causes of burden of disease (disability-adjusted life years – DALYs) in high-income countries in the world are mental disorders (Lopez *et al.*, 2006) and one in every four people is affected by mental disorder or will experience mental health problems at some point in their lives (World Health Organization, 2003). Many mental disorders start during childhood and adolescence. Major depressive disorder, for instance, often has an onset in adolescence and is associated with substantial psychosocial impairment and an increased risk of suicide (Weissman *et al.*, 1999). In recent years, mental health problems among children and adolescents appear to have increased, with a growing number of students experiencing them during their school years today: In Germany for example, according to the WHO 2001/02 survey "Health behaviour in school-aged children (HBSC)", symptoms of mental disorder are discernable in up to 20 per cent of children and adolescents, 5 per cent are in urgent need of professional help, and 7 to 13 per cent show signs of psychological problems for which counselling is required or which should be watched with attention (Hurrelmann *et al.*, 2003). In addition, more than 1.5 million children in Germany have parents who are suffering from a serious mental illness (Bundespsychotherapeutenkammer, 2007).

Mental health problems can be linked to poor academic performance, behaviour problems, violence, dropping out, losing a job or job training position, substance abuse, suicide and criminal activity, and a decreased ability to lead a self-determined life (e.g. BPD, 2007; Fryers and Brugha, 2006; Lehr *et al.*, 2004; Samhsah's National Mental Health Information Center, 2003; US Department of Health and Human Services, 1999; WHO, 2003). The European Commission's Green paper "Improving the mental health of the population: towards a strategy on mental health for the EU." (European Commission, 2007), the Mental Health Declaration and the Mental Health Action Plan for Europe (WHO, 2005) therefore have called on member states to promote emotional well-being in education and to address the specific needs of children and young people.

One of the mental health promotion efforts in Germany is the school-based programme "Crazy? So what!", which was developed and implemented in 2002 by Irrsinnig Menschlich, the first German association for public relations in psychiatry. The programme aims to promote mental health in the young and to reduce prejudices toward people with mental illness, to sensitise students to mental health/mental illness, to encourage them to explore their personal views of life and to increase their resilience. The aim of the programme is to contribute to primary prevention by strengthening students' resources and life skills (social competence) in order to increase resilience, secondary prevention by increasing awareness for mental health problems and improving help-seeking strategies and tertiary prevention in terms of a reduction of stigma, social exclusion and discrimination of mentally ill people and empowerment of "the experts on their own behalf", i.e. young people who have experienced mental illness.

The unique core of the school programme is the direct contact between students and these young "experts on their own behalf" who have experienced mental illlness. Many studies have shown that direct contact with a person who has gone through mental illness can reduce prejudices and stigmatising attitudes and can result in a decrease in social distance, e.g. (Desforges *et al.*, 1991; Meise *et al.*, 2000; Sulzenbacher *et al.*, 2002; Holzinger *et al.*, 2008).

The first evaluation after the launch of the school programme "Crazy! So what?" showed a decrease of negative stereotypes (Schulze *et al.*, 2003). Since then the programme has been modified. The aim of the second evaluation, described in this paper, is to evaluate the programme in its new form and to establish a foundation for the implementation of "Crazy? So what!", by providing the scientific evidence of its health-promoting and stigma-reducing effect on the students who have participated in the project. The following questions will be answered:

- Has students' social competence (self-efficacy) increased?
- Have students learned more about help-seeking strategies and have they been sensitised to mental health problems?
- Have attitudes toward people with mental illness improved and has there been a reduction of stigmatisation and discrimination?
- Have students learned more about mental health? Which topics were addressed during the discussions?

Methods

Description of the school programme "Crazy? So what!"

"Crazy? So what!" is designed for 15- to 20-years-olds. This school based project takes the needs of young people as a starting point from which to explore the topic of mental health and illness and promote holistic learning. A team, made up of a moderator (drawn from professions such as social work, journalism and those who work in psychiatric institutions) and young people, who have gone through mental illness, come to the school for one day. The experiences the adolescents have had in the past, curiosity, suspense and fun are the hallmark of the project. Education as well as the contact with young people who have experienced mental illness are the strategies of the programme.

We will now look at the programme in more detail. Working with the visiting team, the school students are first sensitised to the topic mental health and illness. They talk about their experience of life (such as taking exams, looking for a job, working in a home for senior citizens, problems at home, experience with drugs, alcohol and so on). They discuss who or what they think of as crazy, what they think about people with mental illness and psychiatry and where these opinions and perceptions are coming from. They explore their own attitudes and begin to question whether their sources of information can be reliably trusted and whether they have any gaps in their knowledge.

In the second part of the programme, which is called "Good times and bad times are part of all people's lives", students deal with their self-perceptions and perceptions of life in small groups. They try to answer questions like "Do I feel comfortable in my class? How can I contribute to improving the class climate? Who can help me when I am in a crisis? What do I wish for in my life? What are the burdens that can throw me off the track? What is good for me?". Finally, each group presents the answers to these questions for discussion in the class.

In the final part of the programme, the students talk to the young people from the team who have gone through mental illness. This is also the first time in the course of the project that they are told that this person has experienced mental illness. By talking to this person, the students can think about their attitudes and perceptions and they

can also try to understand how a mental illness affects people's lives. Furthermore, the students receive information about the illness (causes, prevalence, treatment, etc.) and learn that there is a wide-ranging help system for people in a mental crisis (www.verrueckt-na-und.de/).

The experts who worked on these projects were 25 to 35 years old. They had experiences with drugs and psychoses (e.g. schizophrenia), depression and bipolar disorder. Their illnesses usually started during military service or during their time at university in their early twenties. Their motivation to work as an expert was their regret for not having had this kind of project back in their days at school. They felt that if they had received all the information about mental health and illness much earlier in their lives, they could have met the illness with less fear, they would have talked to someone much earlier and also would have looked for help much earlier.

Before the experts start their work in the school project, they receive a two-day training. There is further coaching in the teams and meetings are conducted on a regular basis, where larger groups of moderators and experts are exchanging experiences they have had in the school project (such as how to handle disciplinary problems during the school project). Some of the experts have worked in the school project for six years, with 10 to 15 project days per year. According to what students have said who participated in the school project, the experts are "teachers for life".

Participants

All four schools in Saxony where the school programme had been implemented between July 2006 and October 2006 were asked to participate in the evaluation. The two Gymnasien[1] (grade 10) and the two Mittelschulen[2] (grades 9 and 10) agreed to participate (response rate students 100 per cent). A total of 210 students were questioned between July 2006 and February 2007 in the scope of the pilot study. 120 of these students participated in the programme (intervention group) and 90 were in the control group in the other grade classes. 48.6 per cent of the students were attending a Gymnasium, 51.4 per cent a Mittelschule. Gender distribution was also well-balanced (49.3 per cent girls, 50.7 per cent boys). The students were aged between 13 and 18, with the majority (91.9 per cent) being 15 and 16 years old. The schools were located in both urban and rural areas.

Procedures

In the run-up of the evaluation, the respective regional education authorities were informed about the study and were asked to give their written informed consent to carry out the study. The teachers whose classes would participate in the programme obtained informed consent from their headteachers. Students' parents also received written information about the study and were asked to give their written informed consent. Finally, students were also asked to give their consent.

The questionnaires were handed out to all students from the intervention and control group at three different points in time: one week prior to the school programme, immediately after it and three months later. The questionnaires were given an alias in order to allow the assignment of the questionnaires to the individual students.

Prior to answering the questionnaires, the students were asked to read a comic strip, showing either a girl or a boy who is experiencing a mental health crisis. After they

had read the comic strip, students were asked who they would talk to if they themselves were in this situation.

Instruments

The following instruments ere used in the questionnaires (Table I).

Self-efficacy. The Generalized Self-Efficacy Scale is a ten-item psychometric scale that is designed to assess optimistic self-beliefs to cope with a variety of difficult demands in life. In contrast to other scales that were designed to assess optimism, this one explicitly refers to personal agency, i.e. the belief that one's actions are responsible for successful outcomes. Perceived self-efficacy is a prospective and operative construct (Schwarzer and Jerusalem, 1999). Self-efficacy is an important personal and health-promoting resource. As a protecting factor in a salutogenetical sense, self-efficacy can strengthen resilience due to acquired competences and attitudes (Scheithauer and Petermann, 1999; Laucht *et al.*, 1997). Example items of the Generalized Self-Efficacy Scale: I can always manage to solve difficult problems if I try hard enough. When I am confronted with a problem, I can usually find several solutions. (Response format: 1 = Not at all true, 2 = Hardly true, 3 = Moderately true, 4 = Exactly true).

Help-seeking behaviour. This questionnaire inquires into the ways in which young people seek help when they are having problems. For example, students were asked who they would talk to in case of a mental crisis. Other questions were: How likely would it be that you would use tobacco/alcohol/other drugs to help you to cope with stress or other problems?

Social distance. This questionnaire covered the topic social distance, i.e. the students' readiness to enter different types of social relationships with someone who has had a mental illness. The instrument follows the logic of the stigma process, in which undesirable characteristics are stereotypically linked to a condition and serve to justify negative social reactions, i.e. stereotypes form the basis of behavioural intentions (Schulze *et al.*, 2003). Example statements from the questionnaire: I would feel embarrassed or ashamed if my friends knew that someone in my family had a mental illness. I would never fall in love with someone who has had a mental illness.

Evaluation of the school project (intervention group only). Immediately after the project, the students were asked whether they had learned more about mental health

Table I.
Instruments used in the questionnaires

Assessment of instruments	
Self-efficacy (all three points in time)	General self-efficacy expectation (Schwarzer and Jerusalem, 1999)
Help-seeking behaviour (all three points in time)	Help-Seeking Questionnaire (Wilson *et al.*, 2005; Australian Government Department of Health and Ageing, 2007)
Social distance, negative stereotypes and perceived stigmatisation (all three points in time)	Questionnaire on social distance (Schulze *et al.*, 2003)
Socio-demographic characteristics (all three points in time)	Age, gender, type of school
Feedback and evaluation of school project at post test (intervention group only)	Evaluation sheet: Assessment of project as a whole and subparts, questions on experts on their own behalf

and illness, and whether they would have liked to learn more about special topics (in case of yes, they were asked to name these topics). Four final questions addressed the discussion with the "expert on their own behalf" to evaluate the effect of the direct contact approach of the school project on the students' attitudes. Students were asked, if:

- they were surprised to learn that the young people they had been talking to had gone through mental illness;
- the "expert on their own behalf" has encouraged them and has given them hope that they can overcome a crisis;
- the "expert on their own behalf" could be a good role model for them in a crisis situation;
- they now felt better informed how to behave when they encounter mental health problems.

Analysis

The analysis of data, which had been collected with standardised questionnaires, was done descriptively based on frequency distributions, with the aim of identifying differences in attitudes which might be resulting from the intervention.

In addition, regression models for panel data were used. These models allow distinguishing between effects, which can be traced back to differences between students' characteristics (between effects) and effects, which can be attributed to changes of students' characteristics in the course of time (within effects). Social distance toward mentally ill people and self-efficacy expectation were used as independent variables. The point of time of assessment was included into the model in the form of dummy variables as independent variable.

The X_t-regression for self efficacy (high value = high self-efficacy expectation) was carried out controlling for the following variables:

- group (0 = control group; 1 = intervention group);
- point of time (0 = t1; 1 = t2; 2 = t3);
- gender (0 = female; 1 = male);
- type of school (1 = Mittelschule; 2 = Gymnasium).

The X_t-regression for social distance (high value = high social distance (SD), i.e. strong desire for social distance toward people with mental illness) was carried out controlling for the following variables:

- group (0 = control group; 1 = intervention group);
- time (0 = t1; 1 = t2; 2 = t3);
- gender (0 = female; 1 = male);
- type of school (1 = Mittelschule; 2 = Gymnasium).

Results

Students were asked whether they had heard or read anything about mental illness in the past – 66.5 per cent said "yes" and there were no significant differences between

intervention group (IG) and control group (CG). The majority had heard or read something about mental illness on TV, in movies, on the internet, and in magazines.

A total of 62.3 per cent from the CG and 53.9 per cent from the IG said that they knew someone who is mentally ill. 75.7 per cent from the IG said that they would like to learn more about mental illness, from CG, 56.9 per cent said that they would like to get more information.

Self-efficacy

Self-efficacy proved resistant to change. Though a lower self-efficacy was measured in the IG in comparison to the CG (see Table II), over time there have been no significant changes. This is shown by the neglectful and non-significant regression coefficients for both dummy-categories of the time variable (t2 versus t1: −0.33; t3 versus t1 0.055). Thus, the programme did not have an effect on students' self-efficacy. In addition, there were no significant regression coefficients for the variables gender and type of school.

Help-seeking behaviour

Before the intervention, 80.4 per cent of the male students and 81.5 per cent of the female students who participated in the programme would talk to their best male friend or their best female friend, respectively. Next came mother (53.3 per cent of the girls, 39.8 per cent of the boys) and father (20.7 per cent of the girls, 32.3 per cent of the boys). Sisters and brothers and grandparents were also named, however, less frequently then the other relatives. Teachers (6.0 per cent), doctor (4.9 per cent), school counsellor (1.6 per cent), professional counsellor outside of school (2.2 per cent) or the Kids Help Line or other telephone counselling services (2.7 per cent) were of minor importance.

There were no significant changes to this over time, except for willingness to talk to a teacher. Looking at the results over time and differentiating between control group and intervention group, (Figure 1), there is a significant effect: While at t1, only 5,2 per cent from the IG (7,4 per cent CG) would talk with a teacher about their problem, at t2, i.e. immediately after the programme, this number increased to 10.6 per cent in the IG

	Coefficient	$P > \|z\|$	[95 per cent confidence interval]	
Group (CG)[a]				
IG	−0.195	0.001	−0.308	−0.083
Point in time (t1)[a]				
t2	−0.033	0.538	−0.136	0.071
Point in time (t1)[a]				
t3	0.055	0.548	−0.125	0.236
Group × point in time t2	0.107	0.076	−0.011	0.226
Group × point in time t3	−0.045	0.652	−0.242	0.151
Gender (female)[a]				
male	0.065	0.193	−0.033	0.163
Type of school (Mittelschule)[a]				
Gymnasium	−0.063	0.219	−0.162	0.037
Constant	3.191	0.000	3.002	3.380

Note: [a]=reference category

Table II.
X_t-regression for self-efficacy

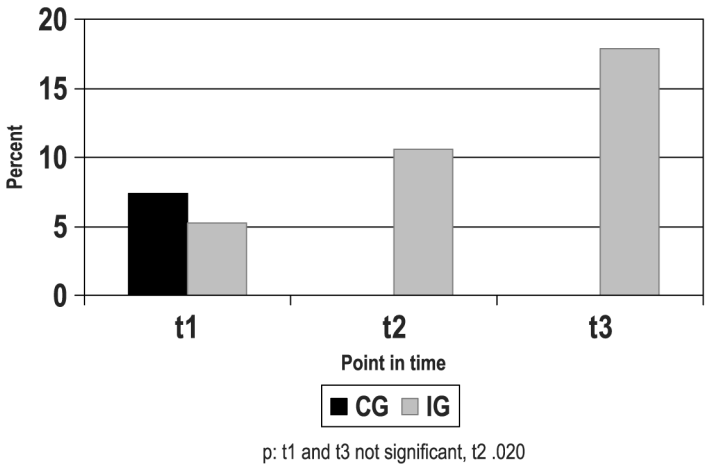

Figure 1.
Percentage of students who would talk to a teacher about their problem

(CG 0 per cent). After three months (t3) 17.9 per cent from the IG would talk with their teacher (CG 0 per cent).

Social distance

The social distance (SD) of the students from the IG was significantly lower immediately after the programme (t2) as compared to the pre-test (t1). This is shown by a regression coefficient of 0.148 for the dummy category t2 versus t1 of the time variable (Table III). Thus, the programme clearly had a positive effect on the desire for social distance, however, at follow-up (t3), this effect no longer existed (three months after the programme). Thus, the results show that a short-term reduction of social distance cannot reduce stigmatisation of mentally ill people on a long-term basis. The

	Coefficient	P > |z|	[95 per cent confidence interval]	
Group (CG[a])				
IG	0.042	0.673	−0.153	0.236
Point in time (t1)[a]				
t2	0.148	0.108	−0.033	0.330
Point in time (t1)[a]				
t3	−0.050	0.755	−0.363	0.263
Group × point in time t2	−0.405	0.000	−0.612	−0.198
Group × point in time t3	0.071	0.684	−0.270	0.411
Gender (female)[a]				
male	0.387	0.000	0.217	0.557
Type of school (Mittelschule)[a]				
Gymnasium	−0.303	0.001	−0.476	−0.131
Constant	2.597	0.000	2.269	2.924

Note: [a]= reference category

Table III.
X_t-regression for social distance

stereotypes still exist, which keep students from wanting to enter different types of social relationships with someone who has had a mental illness.

The analysis showed two significant differences in terms of social distance for the two control variables gender and type of school (Table III): In general, boys have a higher social distance than girls and students from the Gymnasium have a lower social distance than students from the Mittelschule.

The programme from the students' perspective

Immediately after they had participated in the school programme, the students from the IG were asked to assess the intervention. They were asked whether they had learned more about mental illness and 63.2 per cent responded yes to this question, with more girls (81.8 per cent) answering in the affirmative than boys (43.1 per cent). A number of questions referred to the discussion with the "expert on their own behalf". Most of the students were surprised to learn that the young people they had been talking to had gone through mental illness. 84.6 per cent said that the "expert on their own behalf" had encouraged them and has given them hope, and three quarters of the girls and boys said that the "expert on their own behalf" could be a good role model for them. A total of 73.7 per cent said that they would now be able to handle mental health problems in a positive way. Finally, students were surprised to learn that there is help for a crisis or mental illness. Most of them had just heard more or less bad and less-optimistic things about mental illness in the media.

Topics addressed during the discussions

The "experts on their own behalf" had experienced schizophrenia, bipolar disorder and depression, and these illnesses were addresses in the scope of lively discussions. During these discussions, students addressed a variety of different topics, which seem to be of importance to students when talking about mental health and illness (Figure 2).

Questions did not only refer to specific mental illnesses, but more often to the experts' relationships, e.g. "How did your parents, family, friends, partners deal with your illness and also with you? How is it now? Do you still have your friends?" Thus, it was very important for the students to hear something about the development of the

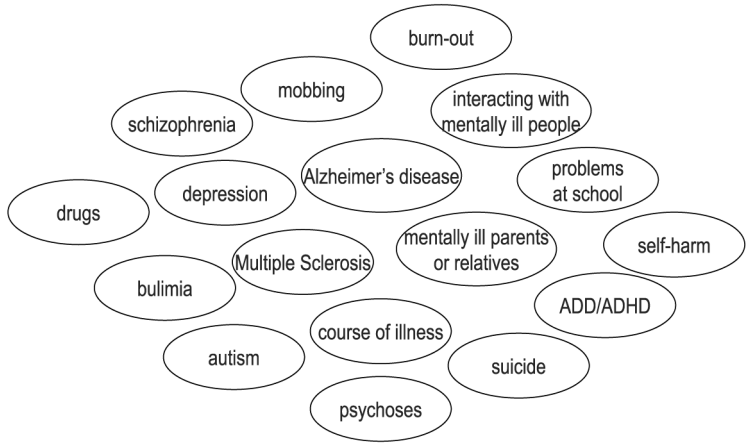

Figure 2.
Topics addressed by students during the discussion

experts' relationships (in the past, present and future), and to be reassured that people are not left on their own in the time of crisis. Other topics, which were raised during the discussions, referred to everyday life in a psychiatric institution, causes of mental illnesses (here social, biological and psychological factors were explained), how it feels when you are suffering from a depression, how to treat a mentally ill person, or who to talk to in school when in a state of crisis. Class climate was an important topic as well, as was relationships to other students and teachers. Thus, it was always of importance to illustrate abstract constructs by breaking them down to the individual person.

Discussion

The aims of the school programme "Crazy? So what!" are to strengthen students' resilience and students' coping ability – and thus to help prevent mental illness in children and adolescents by sensitising students to mental health and mental illness – and to reduce stigmatising attitudes toward people with mental health problems. The present evaluation study investigated whether these objectives are accomplished with the school programme and looked at its potential stigma-reducing and health-promoting effect. Thus, three aspects where at the centre of this pilot evaluation study: self-efficacy, help-seeking behaviour and social distance toward people with mental illness.

Has students' social competence (self-efficacy) increased?

Self-efficacy was quite resistant to change. The programme did not have an effect on students' general self-efficacy. However, looking more closely at the questions that refer to the talk with the "expert on their own behalf", the project seems to have an effect on the self-efficacy expectation: 84.6 per cent of the students said that the expert had encouraged and reassured them. About three quarter of the girls and boys said that the expert could be a role model for them. And 73.7 per cent felt that they could now handle a crisis situation better. Thus, the project has a positive effect on students' self-efficacy expectation with regard to the "expert on their own behalf". This is in line with other studies on school-based programmes referring to students' self-efficacy, which showed positive effects on depressive symptoms (Kahn *et al.*, 1990; Jaycox *et al.*, 1994; Thompson *et al.*, 2000; Quayle *et al.*, 2001; Randell *et al.*, 2001; Peden *et al.*, 2001; Possel *et al.*, 2005) and have increased self-efficacy (Hains, 1992; Orbach and Barjoseph, 1993; Eggert *et al.*, 1995; Cowen *et al.*, 1995; Peden *et al.*, 2001; Flay *et al.*, 2001; O'Kearney *et al.*, 2005; Short, 2006).

Have students learned more about help-seeking strategies?

The results referring to help-seeking showed that peers are the first persons students would talk to in the case of a mental crisis. The inner familial circle is also of great importance. Only a few would contact a teacher, doctor, psychologist or counsellor. This tendency is also apparent in other studies (Shafii *et al.*, 1984; Ross, 1985; Hodgson *et al.*, 1986; Brent *et al.*, 1988; Offer *et al.*, 1991; Clark, 1993; Kalafat *et al.*, 1993; King, 2001). However, with this programme, there was a significant effect on students' willingness to seek help from a teacher, a willingness which improved over time after the intervention was over. It seems to be of great importance that class teachers participated in the project and were sensitised to mental health and mental illness. Apparently, this has encouraged some students to see teachers as a person to talk to in

case of a mental health crisis, which makes it even more important to prepare teachers for this situation.

Have attitudes toward people with mental illness improved and has there been a reduction of stigmatisation and discrimination?

There was a positive effect of the programme on students' desire for social distance toward people with mental illness, however, it was only a short-term effect. Three months after the programme, there were no longer any significant effects. This highlights the need for long-term, permanent efforts to reduce stigmatising and discriminatory attitudes.

Demographic differences

The results of the evaluation indicate that there are gender-related differences: Boys have a higher social distance than girls. Girls and boys also differ in their help-seeking strategies: While more girls said that they would smoke to cope with stress and other problems, boys more often said that they would be using alcohol to cope with problems. Thus, introducing adequate help-seeking and coping strategies during the school project could possibly be helpful in reducing tobacco and alcohol consumption in case of mental health problems. In addition, thoughts should be given to the idea of introducing a gender-specific section in the project in order to meet the special needs of girls and boys regarding their help-seeking behaviour in a crisis situation.

Significant differences also showed for the type of school: Students at the Gymnasium (higher level of education) had a lower social distance than students from the Mittelschule (lower level of education). And more students from the Mittelschule would smoke tobacco to cope with problems and stress. These results suggest that particular attention should be paid to students from the Mittelschule (lower education).

Conclusion

The concept of the school programme is successful in that the youth "experts on their own behalf" can encourage and reassure students to face a mental health crisis with more confidence. Other studies have provided evidence that only a few adolescents would talk to an adult person about a friend who is experiencing mental health problems (Kalafat *et al.*, 1993; King, 2001). Again, this indicates the importance of sensitising children and youth to mental health and mental illness. This would be of two-way benefit for the students: they themselves would benefit in case of a mental crisis, but also their friends whom they could talk to and whom they could give support. As a result of the experiences from the school project and also from its evaluation, the association Irrsinnig Menschlich, which developed and implemented the programme "Crazy? So what!", is now developing a new programme, which is focused on peer education and support, guiding students on how to react when friends tell them that they are having problems or when a friend is in a mental crisis.

Although the generalisability of the study is limited due to the small sample size and because it is a sample of convenience, the evaluation of the school projects is very promising and facilitates further implementation and research. The school project has a proven effect on widening young people's thinking about who they could approach for help in a crisis situation and a short-term effect of reducing social distance. The results indicate that permanent long-term efforts are required, which address different

bodies in the school system: local education authorities, school board members, parents, teachers and other adults from the family and outside the family should be sensitised to mental health and mental health problems. These efforts could be even more effective in cooperation with other activities aimed at the promotion of mental health, for instance further education for teachers or other school-based interventions like MindMatters (Wyn *et al.*, 2000; MindMatters, 2007).

Notes

1. Gymnasium (grades 5 to 12, students obtain a certificate of eligibility for training at an institution of higher learning, similar to A-levels or high school – higher level of education).
2. Mittelschule (type of secondary school, grades 5 to 10 – lower level of education).

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