4

The concept of mental health literacy

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Introduction

In a 1993 Australian government report, *Goals and targets for Australia's health in the year 2000 and beyond*, Nutbeam and colleagues defined health literacy as 'the ability to gain access to, understand, and use information in ways which promote and maintain good health' (Nutbeam et al, 1993, p 151). They then proposed a range of goals and targets concerning literacy for various physical diseases. Curiously, they omitted any mention of health literacy for promoting and maintaining good mental health. Spurred on by this omission, Jorm and colleagues (1997a) subsequently proposed the concept of 'mental health literacy' that they defined as 'knowledge and beliefs about mental disorders which aid their recognition, management and prevention' (1997a, p 182). They further proposed that mental health literacy includes 'the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking' (1997a, p 182).

More recently, Jorm (2012) distinguished a number of components of mental health literacy, including:

> (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis. (2012, p 231)

A notable feature of how this concept has been defined is that it is not simply knowledge of mental disorders or mental health, but rather knowledge that a person can use to take practical action to benefit their own mental health or that of others. For example, knowledge of the genetics of schizophrenia or the distinction between bipolar I and bipolar II disorders would not constitute mental health literacy under this definition, because this knowledge does not underpin any potentially beneficial action.

The intention in proposing the concept of 'mental health literacy' was to draw attention to an area neglected by both health literacy researchers and by the mental health sector. At the time the concept was defined (the mid-1990s), the notion that members of the general public needed an understanding of mental disorders that could empower them to take action was novel. The emphasis within the mental health sector was very much on extending professional training, particularly of the mental healthcare skills of primary care professionals such as GPs. Members of the public with mental disorders were very much seen as passive recipients of professional actions (Goldberg and Huxley, 1992). The introduction of the concept of 'mental health literacy', by contrast, portrayed the person affected as the primary agent managing their own symptoms, with seeking professional help being one of a range of strategies they might try (Jorm, 2000).

While the concept of 'mental health literacy' was originally developed for adults, it has since been extended to adolescents, as this is an important phase of life for first onset of mental disorders. For more information on the mental health literacy of adolescents, see Chapter 19, this volume. Less attention has been given to the mental health literacy of children.

This chapter looks at what community surveys have shown about these components of mental health literacy, and examines the measurement of mental health literacy at both the population and individual level. It argues for the necessity of having a concept of 'mental health literacy', which is additional to the broader concept of 'health literacy', and considers proposals to extend the concept to include non-stigmatising attitudes and wellbeing literacy.

What community surveys reveal about mental health literacy

The concept of 'mental health literacy' led to an initial Australian national survey of adults in 1995 (Jorm et al, 1997a). Similar surveys were carried out independently in Germany and Austria in the mid-1990s, although unknown to each other at the time (Jorm et al, 2000a). These surveys involved presenting a vignette describing a person with symptoms of a mental disorder (see Table 4.1 for examples), and then asking the respondent a series of questions about the person. The vignette-based method has become the standard for studying mental health literacy in community surveys in many countries.

When studying the mental health literacy of the public, it is helpful to have a standard of ideal responses against which to compare. Various methods have been used to do this. In some cases it is possible to judge responses against the published evidence or against existing professional guidelines. However, another method that has been used is to ask similar questions to various groups of mental health professionals and to examine discrepancies between public and professional beliefs, for example, about what treatments are likely to be helpful (Lauber et al, 2005; Jorm et al, 2008; Morgan et al, 2014). The Delphi method has also been used to reach a professional consensus on appropriate public actions, for example, to develop guidelines on appropriate mental health first aid strategies (Kelly

Table 4.1: Examples of vignettes used in community surveys of mental health literacy

Type of problem	Vignette
Depression	John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity.
Schizophrenia	John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because the neighbour is spying on him. They realise he is not taking drugs because he never sees anyone or goes anywhere.

Source: Jorm et al (1997a)

et al, 2008a, b, 2009, 2010; Hart et al, 2009; Kingston et al, 2009, 2011; Ross et al, 2014). Some results from community surveys of adolescents and adults are reported below to illustrate the various components of mental health literacy, particularly where there are commonly deficiencies.

Knowledge of how to prevent mental disorders

While some important risk factors, such as traumatic life events, may be outside of an individual's control, there are other lifestyle factors that can be modified to reduce risk. For example, to determine what adolescents can do to reduce their risk of depression, Cairns and colleagues (2014, 2015) carried out a systematic review of longitudinal risk and protection factors and a Delphi study to establish expert consensus on preventive strategies. The found a large number of strategies to have preventive potential, including strategies to develop mental fitness and life skills, fostering healthy relationships and adopting healthy lifestyles.

A survey of Australian young people aged 12–25 assessed their beliefs about a number of prevention strategies for depression, psychosis, social phobia and post-traumatic stress disorder (PTSD) (Yap et al, 2012). There was a high level of agreement by the young people that physical activity, regular contact with family and friends and relaxing activities were protective, which is consistent with both the available evidence and professional consensus. However, a major discrepancy between the young people and professionals' beliefs occurred for the strategy of avoiding stressful situations. Whereas most of the young people endorsed this strategy, few professionals did. The professionals' views are consistent with the evidence that avoidance is associated with the maintenance of anxiety disorders,

and that dealing with stressful situations provides an opportunity to learn effective coping strategies.

Because some risk factors for mental disorders occur early in life, preventive action needs to be taken by parents or other carers. In order to guide what parents can do, a number of systematic reviews have been carried out on longitudinal studies of parenting factors associated with depression and anxiety and in children or adolescents (Yap et al, 2014a; Yap and Jorm, 2015) and alcohol misuse in adolescents (Yap et al, 2017). Delphi expert consensus studies have also been carried out on preventive strategies that parents can use for reducing the risk of these problems (Yap et al, 2014b, 2015b). However, parents often do not know what to do or how to act optimally in these areas. For example, when parental beliefs about reducing the risk of alcohol misuse were examined in an online survey, many parents had deficiencies in their knowledge and actions about modelling responsible alcohol use and in setting appropriate family rules (Yap et al, 2015a).

Recognition of when a disorder is developing

It can be useful for members of the public to be able to recognise when mental health problems are reaching the threshold that warrants intervention, and to conceptualise what they are experiencing in ways that facilitate appropriate help-seeking. Lack of recognition of a person's problem as a mental disorder may contribute to the long delays that often occur between reaching the threshold for a mental disorder and seeking help (P.S. Wang et al, 2007). Community surveys of mental disorders in many countries have found that many people do not seek professional help, and even those who do eventually seek help may delay for many years. Longer delays between onset and professional help-seeking are associated with worse outcomes, so it is important that these delays be reduced. While there are many factors that can lead to these delays, an important one is that the person does not conceptualise what they are experiencing as a mental disorder. This can be seen in an Australian study of people who sought professional help for anxiety or mood disorders. The average delay was 8.2 years, but most of this was the delay between onset and recognition (average of 6.9 years), with a much shorter delay between recognition and help-seeking (average 1.3 years) (Thompson et al, 2004).

In community surveys of mental health literacy, recognition can be assessed by presenting vignettes like those in Table 4.1, and asking the respondent what, if anything, they think is wrong with the person. For example, in the first Australian national survey of mental health literacy carried out in 1995, it was found that while most adults could recognise some sort of mental health problem, some categorised the problem as a physical disorder or saw it as a personal or employment issue. For the depression vignette, 39 per cent used the label 'depression', while for the schizophrenia vignette, 27 per cent used the labels 'schizophrenia' or 'psychosis'. Recognition of the problem typically varies between vignettes, and there is variation between countries. Studies of non-Western countries often

find that recognition is poorer than in Western ones (Jorm et al, 2005b; Atilola, 2015). Recognition has also varied over time in some countries (Reavley and Jorm, 2012; Schomerus et al, 2012).

A contributing factor in failure of recognition is that mental disorders often have first onset early in life and young people may have less knowledge in this area. It has been found that young people who can give a psychiatric label for the problem in a vignette have more appropriate help-seeking preferences, while those who used lay labels such as 'stress' and 'shy' are less likely to see professional help as warranted (Wright et al, 2007, 2012). It may be that the use of psychiatric labels activates a schema about appropriate action to take (Wright et al, 2007).

Knowledge of help-seeking options and treatments available

When the threshold for a mental disorder is reached, the person affected needs to know about sources of professional help and effective treatments that are available. However, community surveys of mental health literacy show that many members of the public lack adequate knowledge in these areas. For example, in the 1995 Australian national survey of mental health literacy some major differences were found between public and professional beliefs. Counsellors (who are not a registered profession in Australia) were more often seen as likely to be helpful than psychologists and psychiatrists, while vitamins were more often seen as likely to be helpful than antidepressants (Jorm et al, 1997a). More recent surveys of mental health literacy in Australia have shown considerable changes in these areas, with public views moving to be much closer to those of mental health professionals (Reavley et al, 2013; Morgan et al, 2014). However, there are still some major gaps, with the public more likely than professionals to believe in the helpfulness of close family or friends, a counsellor, vitamins and minerals, a special diet or avoiding certain foods, and having an occasional alcoholic drink to relax. By contrast, professionals showed a greater belief than the public in psychotherapy and cognitive behaviour therapy for depression and anxiety, and antipsychotics for schizophrenia.

Negative views of mental health services have been found to be common in many other countries. For example, a survey of the public in six European countries found that around one in three people believed that professional care for mental health problems was worse than or equal to no help (Ten Have et al, 2010).

Given that beliefs about services and treatments are often less than optimal, it is not surprising that many people with mental disorders in the community remain untreated. While there is no single cause of the low rates of treatment for mental disorders, attitudinal factors are important. An analysis of data from the 24 countries participating in the World Mental Health surveys found that a desire to handle the problem on one's own was the most commonly reported barrier to not receiving treatment (Andrade et al, 2014). Even when treatment is sought, a person's beliefs and attitudes to treatments are an important factor in whether they are continued (Acosta et al, 2013).

Knowledge of effective self-help strategies for milder problems

Surveys of mental health literacy in a number of countries have found that members of the public often believe in the helpfulness of self-help strategies (Jorm et al, 1997a, 2005b; J. Wang et al, 2007), and there is evidence that they commonly use them (Jorm et al, 2000b). Some of these self-help strategies have evidence of effectiveness (for example, physical activity), whereas others are more likely to be ineffective (for example, vitamins) or even harmful (for example, use of alcohol to relax).

Self-help strategies are most often used for milder mental health problems. Jorm et al (2004) have proposed an 'overlapping waves of action model' to account for the role of self-help. According to this model, a person can use a range of strategies to deal with mental health problems, including increasing the use of self-help strategies already in their repertoire (for example, seeking more social support or engaging in more physical activity), taking up new self-help strategies (for example, learning meditation or taking a herbal remedy), or seeking professional help. At the individual level, the person can use these strategies in any order or can use them simultaneously. However, when looking at the population as a whole, existing self-help strategies show peak use with milder problems; this is the first wave of action. New self-help strategies show peak use with more moderate problems; this is the second wave of action. The third wave of action is professional help, which increases in frequency as mental health problems become more severe.

Given that members of the public are often positive about self-help strategies, there is a need to promote those that are most likely to be helpful. Delphi studies have been carried out to find out which self-help strategies experts think would be most likely to be effective for milder levels of depression (Morgan and Jorm, 2009) and anxiety (Morgan et al, 2016).

Mental health first aid knowledge

Mental health literacy is not only important to protect one's own mental health, but also for the capacity to support others with mental health problems. The term 'mental health first aid' has been used to refer to 'the help offered to a person developing a mental health problem, experiencing the worsening of an existing mental health problem or in a mental health crisis' (Kitchener et al, 2015, p 12). To find out what are appropriate actions to take for mental health first aid, a number of Delphi studies have been carried out with professionals, consumers and carers to develop guidelines on how to assist people with various mental health problems (for example, psychosis, depression, eating disorders), and experiencing a range of mental health crises (for example, suicidal, self-harming, experiencing a traumatic event) (Kelly et al, 2008a, b, 2009, 2010; Langlands, 2008a, b; Hart et al, 2009; Kingston et al, 2009, 2011; Ross et al, 2014).

Mental health first aid knowledge has been assessed in a number of mental health literacy surveys by asking respondents what, if anything, they would do to

assist a person in a vignette if it was someone they knew and cared about. Expert-consensus guidelines have been used as a standard to judge the adequacy of public responses. In Australian surveys of adults, the quality of responses overall has been found to be poor (Rossetto et al, 2014). While respondents often say that they would listen to the person, provide support and information, and encourage the person to seek appropriate professional help, other actions, such as assessing and assisting with any crisis, are rarely mentioned, even when the person portrayed in the vignette is suicidal. This lack of knowledge can have an impact on actions actually taken to provide mental health first aid in the community. Longitudinal studies show that intentions to provide help to a person in a vignette are a predictor of later providing mental health first aid to someone who has a mental health problem (Yap and Jorm, 2012; Rossetto et al, 2016).

Measurement of mental health literacy

The term 'mental health literacy' was originally proposed as a convenient label to draw attention to a neglected area. It was not intended to define a psychological construct. Much of the research that has been carried out on mental health literacy has involved community surveys aimed at describing various components of mental health literacy at the population level rather than to provide an assessment of individuals. However, some researchers have been interested in scale score measures to quantify mental health literacy, or some aspect of mental health literacy, at the individual level. O'Connor and colleagues (2014) carried out a review of scale-based measures and identified 13 relevant studies. They concluded that there was limited psychometric data on these scales and that most measured some component of mental health literacy rather than all of those proposed by Jorm et al (1997a).

Another 'scoping review' of mental health literacy measures has been carried out by Wei and colleagues (2015). They broadened the concept of mental health literacy for their review to cover mental health knowledge (including knowledge of positive mental health), knowledge of mental illness and treatments, and stigma/attitudes towards mental illness and help-seeking. In adopting such a broad definition, they found 401 studies, which included 14 knowledge measures, 65 stigma/attitude measures and 10 help-seeking measures that had some validation.

Kutcher and colleagues (2016) have argued for the virtues of measuring the much broader concept of mental health literacy that was used in the Wei et al (2015) review. They further argued that measures used in evaluation studies of mental health literacy interventions should simultaneously address all the components of this broader definition and be relevant to a wide range of mental disorders. However, it is not clear how practical such a measure would be, given the number of items that would be required to cover the knowledge, attitudinal and behavioural components of each mental health literacy dimension and the complexity of the scoring. Stigma alone is quite complex and multidimensional. Cross-cultural portability may also be difficult to achieve for an omnibus measure,

given differences in health systems. An alternative approach is to base measurement on the specific aims of an intervention rather than try to measure a wide range of outcomes that are not necessarily the target of intervention.

If 'mental health literacy' were a psychological construct, one might expect to find a broad general factor reflecting correlations between a wide range of items tapping into the definitions of Jorm et al (1997a) or Wei et al (2015). At one extreme of this dimension might be mental health professionals, while at the other end might be children who are completely ignorant of the area. On the other hand, if 'mental health literacy' is simply a term to draw attention to an important area, one would not necessarily expect any underlying factor.

This issue has been investigated in relation to treatment beliefs in factor analytic studies of data from three Australian community surveys. In these surveys, respondents were asked to rate the likely helpfulness or harmfulness of a wide range of potential interventions for a person in a vignette. These studies found three factors of treatment beliefs: medical (with high loadings on medications, psychiatric ward and ECT), psychological (with high loadings on counsellor, social worker, phone counselling, psychiatrist, psychologist, psychotherapy and hypnosis), and lifestyle (with high loadings on close friends, close family, naturopath, vitamins, physical activity and getting out more) (Jorm et al, 1997b, 2000c, 2005). These same factors are found in relation to a range of different vignettes. One of these studies also found a fourth factor labelled 'information-seeking', which covered getting information from the web, a book, health educator or consulting an expert by email (Jorm et al, 2005). It is notable that the interventions that load on a factor do not reflect greater mental health literacy, as judged by what professionals rate as likely to be helpful. Rather, they include both interventions that have evidence of effectiveness and others that do not. This is seen most clearly in the medical factor, which includes beliefs in psychotropic medications, like antidepressants and antipsychotics, but also in analgesics and antibiotics, which are not indicated for mental disorders. Rather than the ratings reflecting knowledge, or lack thereof, they appear to be based on overarching attitudes to general classes of treatment, which might be applied to any health problem. Members of the public do not appear to be 'empty vessels' waiting to be filled with knowledge provided by experts. Rather, they have pre-existing general attitudes in favour of or against certain broad classes of interventions. These broad general attitudes can be viewed as a type of mental scaffold on which more specific evidence-based knowledge is grafted. Thus, a person with a strong predisposition towards lifestyle interventions might learn to favour physical activity over vitamins for depression, while still retaining the general commitment to that class of interventions.

Challenges and extensions to the concept

While the concept of 'mental health literacy' grew out of the concept of 'health literacy', it has since taken an independent path. Mackert and colleagues (2015)

have expressed concern about the fragmentation of the area of health literacy, including by health domains. They argue that domain-specific health literacy measurements make it difficult to compare findings across domains and to advance the area more broadly. In a commentary on Mackert et al (2015), Jorm (2015) argued that both a broad concept of health literacy and a domain-specific concept of mental health literacy are needed, depending on the purpose. For example, a broad concept would be useful for a community survey investigating health literacy across a number of domains, whereas a domain-specific concept would be appropriate for evaluating an intervention targeting a specific aspect, such as mental health first aid knowledge. Jorm (2015) argued that the concept of mental health literacy has been useful in drawing attention to a neglected field that was being ignored by both mental health and health literacy researchers, that the introduction of the concept had had the desired impact on government mental health policies, that it has led to the development of specific interventions targeting mental health literacy and also to the development of measures that meet the aims of specific interventions. These advances may have been slower to occur without the concept of mental health literacy.

Others have argued that the concept of mental health literacy is too narrow or have proposed extensions (see Chapter 25, this volume). Kusan (2013, p 14) has stated that the original definition of mental health literacy 'effectively translates to knowledge of the contents of the DSM and reflects the dominant biomedical orientation of the mental health field.' He has redefined mental health literacy as 'the self-generated and acquired knowledge with which people negotiate their mental health' (2013, p 14), and included such topics as resilience, salutogenesis and mindfulness, which have been associated with positive psychology. In a similar vein, Bjørnsen et al (2017) have noted that mental health literacy and its measures have focused on knowledge and beliefs about mental ill health rather than on mental health, and have proposed the term 'positive mental health literacy' to refer to the latter. On the other hand, the knowledge proposed by these concepts of positive mental health literacy overlaps considerably with knowledge required for the prevention of depression (Cairns et al, 2015) and for dealing with mild anxiety (Morgan et al, 2016), as proposed in more traditional approaches to mental health literacy that conceptualise mental health as a continuum and call for action at all points on this continuum.

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