MENTAL HEALTH LITERACY: 
A REVIEW OF THE LITERATURE

EXECUTIVE SUMMARY

Mental Disorders

Mental disorders range from mild to severe. They differ from normal human distress because they are characterized by specific symptoms and signs and, without intervention, tend to follow a predictable course. Mental disorders are influenced by a combination of biological, psychological and social factors, although there is continued debate about the relative weight of these factors and exactly how they interact to lead to the onset of mental illnesses. It is clear however that social determinants of physical health such as poverty, education and social support, also influence mental health. Approximately one-quarter of all people will be affected by a mental disorder at some time in their lives and the associated global burden is considerable: mental disorders represent four of the ten leading causes of disability worldwide.

Mental Health Literacy

The term mental health literacy was first introduced in Australia by Anthony Jorm. It is derived from the term health literacy, originally defined as a functional capacity related to basic literacy skills and how these affect the ability of people to access and use health information. In recent years, the definition of health literacy has expanded to include the development of increasingly complex and interactive cognitive and social skills, which are related to personal and collective empowerment for health promotion. At the 5th WHO Global Conference on Health Promotion it was noted that health literacy is not only a personal characteristic, but also a key determinant of population health.

Mental health literacy has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. More recently, researchers have suggested that mental health literacy is not a single dimension but rather represents knowledge and beliefs about mental health disorders that emerge from general pre-existing belief systems. Mental health literacy represents a relatively new area of investigation. Compared to health literacy, researchers and policymakers have not yet articulated a comprehensive model that organizes mental health literacy along a gradient of evolving skills and capacities that build empowerment for mental health promotion. Recent work in the field however, such as the beyondblue campaign in Australia, shows the effectiveness of adopting a broad, multi-level approach across several domains. This paper applies the conceptual model for health literacy to mental health literacy on the assumption that the skills and capacities that lead to personal and collective empowerment for health promotion are no different from those needed for mental health promotion.

Knowledge and Beliefs about Mental Disorders

Much of the literature suggests that laypeople generally have a poor understanding of mental illness: they are unable to correctly identify mental disorders, do not understand the underlying causal factors, are fearful of those who are perceived as mentally ill, have incorrect beliefs about the effectiveness of treatment interventions, are often reluctant to seek help for mental disorders, and are not sure how to help others. The ability to
recognize mental disorders is thought to be important because the inability to recognize a disorder in oneself or others could result in delays seeking appropriate treatment, utilization of inappropriate remedies, or difficulties communicating with health professionals. Over the past few years, recognition and awareness appears to have increased in countries such as Australia, which has invested heavily in public awareness initiatives, although researchers still see need for improvement.

In the West, most people believe that psychosocial factors such as environmental stressors or childhood events, are the primary causes of mental disorders.

Attitudes towards mental disorders often involve negative stereotypes and prejudice, or stigma. People with mental health problems frequently fear stigma and this can influence help-seeking behaviour or cause failure to adhere to treatment. Stigma and discrimination in the workplace is common: many employers will not hire persons with mental health problems, and disclosing mental disorders can undermine career advancement. Stigma and discrimination are associated with fears of unpredictability and dangerousness although the risk of violence from persons with mental illness is generally no higher than from other persons. Research indicates that fear and perceptions of dangerousness related to mental illness have increased over the past few decades, largely in relation to serious mental illness such as schizophrenia and many people consider persons with serious mental illness as potentially violent and dangerous.

Laypeople have become somewhat more socially accepting of less severe mental health problems such as depression and anxiety but are generally reluctant to label these common psychiatric symptoms as mental illnesses. They are more inclined to attribute genetic causes to, and to identify serious mental disorders, as medical illnesses and these are still associated with significant stigma in the public mind. Indeed, having a medical understanding of mental disorders appears to increase stigma and social distance, perhaps because the illness is perceived as fixed and chronic.

Some research shows that the numbers of people seeking professional help has increased over the years although these still represent a minority of those with mental health problems. The prevalence of mental disorders in the general population means that most people will have close contact with someone with a mental health problem at some point, but they often lack the knowledge and skills to provide helpful responses. Help seeking appears to be influenced by how people define the problem, what they perceive to be the cause and the anticipated prognosis. Those who have a medical understanding of mental disorders, for example, are more likely to recommend medical interventions, such as medication and hospitalization, but they are also more pessimistic about treatment outcomes. In general, people prefer self-help, lay support and lifestyle interventions for mental disorders, and they are uncomfortable with medical, and especially pharmacological, interventions. Some studies show public attitudes about treatment becoming more akin to those of mental health professionals over the past few years, perhaps because of public education initiatives.

Research indicates that the range of attitudes among mental health professionals in relation to stigma is similar to that found among members of the public, and that discriminatory behaviour from professionals towards persons with mental illness does occur. Medical training, including psychiatric training, rarely addresses the issue of stigma directly. The attitudes of mental health professionals towards the prognosis and
long-term outcomes of mental disorders and the likelihood of discrimination are generally more negative than those of the lay public. Mental health professionals vary considerably in their attitudes toward interventions and this variability tends to relate to professional orientation. Medical professionals prefer medical interventions, for example, while psychologists prefer psychotherapeutic approaches.

The Role of the Media

The media may bear some responsibility for the reported increase in public fear and perceptions of dangerousness. Although the relationship between the media and personal attitudes and beliefs is complex, the media does appear to exert some effect, particularly on perceptions of dangerousness related to serious mental illnesses like schizophrenia. Negative media images are of concern because they increase psychological distress and fear of stigma for persons with mental disorders, and they may influence the adoption of punitive legislation or regressive policies.

Cultural and Social Considerations

There are significant cultural variations in how people recognize, explain, experience and relate to mental disorders and treatment. These variations are closely connected to social and environmental conditions. For most mental health problems, social context and related personal beliefs appear to be of significance in shaping the form, expression and recognition of the disorder.

Culture is highly influential in the experience and course of mental disorders. For example, depression often presents in the form of somatic symptoms in developing countries, and it is well documented that schizophrenia has a better course of outcome in the developing world. Stigmatizing attitudes towards severe mental illness such as schizophrenia seem to be less common in non-Western cultures, including small Aboriginal and Inuit communities in Canada.

Within and across cultures, social, economic and political factors profoundly influence mental health. There are multiple socioeconomic and environmental determinants of mental health and mental illness, just as there are for physical health and physical illness. Social determinants of physical health including poverty, education and social support also influence mental health. Feelings of powerlessness and low self-esteem are linked to depression and, in all countries, women and immigrant and refugee populations suffer higher rates of depression. Around the world, despite their diverse cultures, Indigenous people have similar mental health problems, which diminish when they regain control of local governments, services and cultural activities.

Research on Change Strategies

There is some evidence that people who have information about mental illness may be less stigmatizing and more supportive of others who have mental health problems, and a number of change strategies have been applied to enhance the mental health literacy of health professionals and of the public with varying degrees of success.

Because of the public’s resistance to associate common mental health problems with illness, public campaigns appear to benefit from reducing the use of language that links common mental health problems with illness and emphasizing prevalence and shared
responsibility. Educational initiatives that provide evidence-based information about which interventions work, how to help oneself and how to help others, represent promising practices.

The most comprehensive national campaign to date is beyondblue: the national depression initiative in Australia. It involves multiple targeted initiatives to raise community awareness, support national consumer and caregiver advocacy, promote prevention and early intervention, promote primary care training and partnerships for service reform, and increase strategic and applied research. Program evaluations show several positive outcomes:

- increase in community awareness about depression
- increase in the number and range of early intervention and prevention programs, improved engagement of consumers and caregivers
- increase in depression-related research.
- reduction of service-related and social barriers to accessing primary care
- increase in the capacity of primary care providers.
- reduction in stigma (indirect evidence).

Most of the research on stigma reduction pertains to serious mental illness and not to common mental health problems. Disclosure (of mental health problems) and exposure (to people with mental disorders) may be effective in modifying attitudes and reducing stigma, under certain circumstances. Direct experience with a person with a mental disorder improves attitudes and reduces stigma, but is most effective if prolonged, under friendly conditions, and the parties are equal status. Adult education programs, sometimes combining contact with a person with a mental illness who is presenting factual information, have shown improvements in attitudes. Because contact is so powerful, it is important that consumers participate in de-stigmatization campaigns.

Collective empowerment is a key factor in health promotion. There are direct benefits in terms of social support and mutual empowerment for mental health consumer groups who come together for social action. Activities can include training in communication and advocacy, and employment reintegration programs. Targeted initiatives in schools can be helpful in reducing stigma and supporting empowerment. National and international alliances, including consumer and caregivers, may be able to exert some influence on the media.

Advocacy for social and political change involves engaging politicians and policymakers for health reform and action on the broad social and economic determinants of mental health. These are especially pertinent issues for minorities, women, immigrant and refugee populations, and Aboriginal peoples. Specific targets for advocacy involve improving the quality and quantity of mental health services, and eliminating discrimination in the workplace, insurance industry, and housing.

**Toward a Comprehensive Model of Mental Health Literacy**

The mental health literacy of the public is often assessed in terms of how closely public knowledge and beliefs mirror professional knowledge and beliefs. Medical professionals sometimes assume that people are reluctant to seek treatment for mental disorders and hold negative perceptions of mental illness because they have not acknowledged that mental disorders are medical illnesses. From this perspective, changing public thinking to correspond with professional thinking about mental disorders may reduce stigma and
lead to improvements in help seeking and treatment outcomes. This approach does appear to have resulted in some improvements to mental health literacy, i.e. public attitudes have become more consistent with the medical model in some cases, possibly because of public education campaigns, and the social acceptance of milder mental health problems has increased. However, it is not without limitations and risks.

While people have become more accepting of common mental health disorders, this may be because they have come to view them as normal problems of living rather than as medical illnesses. Indeed, having a medical understanding of mental disorders increases stigma and social distance, and reduces optimism about treatment outcomes, perhaps because the disorder is viewed as fixed and chronic. Stigmatizing attitudes remain common among mental health professionals for example, who are assumed to have high mental health literacy. For serious mental disorders, which are more likely to be labeled as medical illnesses, stigma and discrimination remain problematic and may in fact have increased.

For the most part, laypeople continue to resist medical explanations and treatments for common mental health problems, and to prefer psychosocial, lifestyle and self-help interventions. Some of these beliefs and preferences are supported by research evidence and do not necessarily connote poorer mental health literacy. For example, there is evidence of social and environmental causal factors for many common mental disorders, including adverse life events and early experience. Social and cultural factors influence the expression and course of mental disorders. Broad determinants of physical health influence mental health also including life stress, education and social support. In addition, mental health professionals often differ with regard to opinions about interventions and some of the psychosocial, self-help and alternative interventions preferred by laypeople are evidence-based. In addition, concerns about disclosing mental health problems for fear of stigma and discrimination, may be legitimate. Mental health professionals tend to have negative attitudes about the possibility of long-term recovery compared to the public, and stigmatizing behaviour from mental health professionals does occur.

Widening the lens through which people view mental health literacy, to include diverse perspectives and multiple determinants of mental health and mental illness could be the basis for an expanded model, similar to the model for health literacy. Such a model could accommodate a diversity of attitudes and beliefs about mental health and mental disorders, insofar as these differences represent valid but divergent points of view. It could also accommodate the development of a broad range of strategies to enhance personal skill and capacity for informed choice, and critical analysis and collective empowerment for action on the social determinants of mental health. It would lead to social as well as individual benefits, such as increased social capital, and social and economic development. Ultimately, it is expected to improve individual and population mental health outcomes.

Strategies to Enhance Mental Health Literacy

Within a comprehensive model of mental health literacy, strategies would aim to enhance functional literacy, communicative literacy, and critical literacy skills. At the most basic level, mental health literacy is connected to general literacy. Problems with low literacy are prevalent in the developing and developed world and these issues must be considered in all strategies to enhance mental health literacy.
Enhancing interactive mental health literacy focuses on building personal skill and knowledge, and is expected to result in an increased personal capacity to act on knowledge. It involves effective health communication strategies including public education and social marketing to support skill development and informed choice. It includes education to advance understanding at all levels: how to prevent mental health problems, how to intervene early, and how to manage a mental disorder. Mental health care providers can facilitate the development of mental health literacy by developing partnerships with clients and supporting informed choice.

Enhancing critical mental health literacy builds the capacity to critically analyze information and to use it to mobilize for social and political action as well as individual action. Enhancing critical mental health literacy supports collective empowerment and the development of social capital. Because it exerts influence on determinants of mental health, it can result in benefits to mental health at a population level. It includes community development, self-help and peer support initiatives, and alliances and partnerships for advocacy work.

SEARCH STRATEGY AND LIMITATIONS OF THE REVIEW

Multiple databases were searched for the following terms and combinations of terms: health literacy, mental health literacy and promotion and evaluation; mental illness, depression and stigma, prevention, treatment, public education and campaigns, perceptions, attitudes and attitude change and the media. Databases included Medline and Cinahl (Medicine), Social Sciences Abstracts, PsychInfo, Sociological Abstracts and Social Services Abstracts (Social Work). Other relevant journal articles in the reference list were found as cited references in the journal articles obtained through database searches, and through internet searches.

Literature relating directly to mental health literacy mostly emanates from Australia and Europe. Mental health and mental illness are extremely broad terms, and a great deal of research in the field is about stigma, public attitudes and perceptions, and public education about mental illness and mental health. For the most part, the research focuses on depression and schizophrenia, with a smaller number of research articles relating to other mental disorders, such as substance abuse or anxiety disorders. The literature review is a broad overview of the research on mental health literacy and related topics of investigation and it did not involve an analysis of research methodologies.

LITERATURE REVIEW

MENTAL HEALTH DISORDERS

Mental disorders range from mild to severe, but differ from normal human distress in that they are characterized by specific symptoms and signs. Without intervention they tend to follow a predictable course (WHO, 2001). Diagnostic criteria for these disorders have been standardized internationally and are now considered as reliable and accurate as those for physical disorders (WHO, 2001). While there is continued debate about the relative weight of biological and psychosocial factors in the onset of mental illnesses (Arben, 1996; Harris, 2001), it is not an either/or question (WHO, 2001). Exactly how the pathways interact to lead to the onset of mental illnesses is still being assessed, but it is
clear that mental disorders are influenced by a combination of biological, psychological and social factors (WHO, 2001; WHO, 2004). Mental health and mental illness are determined by multiple socioeconomic and environmental factors, as are physical health and physical illness (WHO, 2004b).

Mental illness constitutes a huge and growing worldwide problem (WHO, 2001; WHO, 2004a). The World Health Organization estimates that 450 million persons suffer from a mental or behavioural disorder, yet only a fraction of these are receiving treatment. While prevalence rates vary from country to country, mental disorders are highly prevalent and often go untreated (WHO, 2004a). Approximately one-quarter of people will be affected by such a disorder at some time in their lives and one in four families has a member who is affected. The global burden of these disorders is considerable; currently mental disorders represent four of the 10 leading causes of disability and the number of sufferers is expected to increase (WHO, 2001).

Although the exact causal mechanisms remain unclear, there is a higher prevalence of certain mental disorders among specific groups. For example, depression is more common in women and all mental disorders show higher prevalence rates among people living in poverty, (Harris, 2001; WHO, 2001; WHO, 2004b). Contrary to common perceptions the elderly are not more likely to be depressed than other age groups (Goldney and Fisher, 2003). However depression in the elderly often goes undetected, although it is two to three times more common than dementia (Anderson, 2001). Mental health problems affect people of all regions, cultures and socioeconomic levels, are present throughout the life cycle and show similar prevalence rates for men and women (WHO, 2001). Mental disorders are truly universal.

HEALTH LITERACY AND MENTAL HEALTH LITERACY

Health literacy was originally defined as a functional capacity, in terms of basic literacy skills and how these affect the ability of people to access and use health information. For example, Black (2002) cites the U.S. National Library of Medicine definition of health literacy as “the degree to which people can obtain, process and understand basic health information and services they need to make acceptable decisions.” This includes the ability to read and comprehend written health-related information and materials, such as prescription bottles and appointment slips (Hixon, 2004). Low levels of health literacy are related to low levels of general literacy and as such operate as a barrier to people finding and using health information and services.

The extent of limited health literacy and problems associated with it are thought to be considerable. In Canada, four out of ten adults struggle with low literacy (ABC Canada, 2005a). Rootman (2004) cites a U.S. Institute of Medicine report that indicates as many as 90 million Americans lack the literacy skills to use the health system effectively, and that people with limited health literacy tend to have poorer health, are less likely to use preventative services, have less knowledge of health promoting behaviours, and are less able to manage disease. With regard to the elderly, for example, depression has been related to lower levels of mental health literacy, which is in turn related to poor general health status. (Gazmararian et al, 2000).

In recent years, researchers have expanded the definition of health literacy to include complex, higher order cognitive and social capacities that support empowerment. The WHO health promotion glossary defines health literacy as “the cognitive and social skills
which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health" (Kickbusch, 2001; Rootman, 2002). Nutbeam (2000) differentiates three levels of health literacy: functional, interactive and critical. The second two levels extend the concept of health literacy beyond basic reading and writing skills to more advanced and complex cognitive and social skills that allow people at level two to “…extract information and derive meaning from different forms of communication and to apply new information to changing circumstances” and, at level three, “to critically analyze information and to use this information to exert greater control over life events and situations.” Using this definition, health literacy is a gradient of increasingly complex and interactive skills, which relate to personal and collective empowerment for informed choice and action on the social determinants of health.

By expanding the concept of health literacy to include skills and abilities that humans use to create meaning from and exert control over the environment, these revised definitions bring health literacy into the domain of health promotion (Rootman, 2002; Tones, 2002). As such, health literacy may be viewed as a key outcome of health promotion activities that include health education and social marketing (Nutbeam, 2000; Ratzan, 2001). In June 2000, a Health Literacy Workshop at The Fifth WHO Global Conference on Health Promotion concluded that health literacy involves “dimensions of community development and health related skills beyond health promotion…not only as a personal characteristic, but also as a key determinant of population health.” (Kickbusch, 2001).

It has been suggested that the definition of health literacy has now been extended so far that it bears little resemblance to the original meaning of literacy (being able to read and write) and has become a generic catch-all category for concepts already better defined within other fields of study (Tones, 2002). The expanded definition of health literacy is in line however with the field of literacy studies, which is moving toward a broader conceptualization of general literacy as a variety of skill sets (e.g. scientific literacy, cultural literacy) situated along a continuum from basic reading and writing to critical analysis. (Nutbeam, 2000; Kickbush, 2001; Rootman, 2002). It also supports a focus on the broad social and environmental determinants of health, and it leads to social as well as individual benefits such as the development of social capital, and social and economic development (Kickbush, 2002). In this context, enhancing health literacy is expected to improve population health outcomes, just as improving education and general literacy influences the overall health and well being of populations (Nutbeam, 2000; Kickbush, 2002).

The term mental health literacy is derived from the term health literacy, and was first introduced in Australia, by Anthony Jorm. It has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al, 1997a), and it is thought to consist of several components:

- the ability to recognize specific disorders or different types of psychological distress;
- knowledge and beliefs about risk factors and causes;
- knowledge and beliefs about self-help interventions;
- knowledge and beliefs about professional help available;
- attitudes which facilitate recognition and appropriate help-seeking;
- knowledge of how to seek mental health information.
Further research suggests that knowledge and beliefs about mental health disorders may emerge from general pre-existing belief systems about health and health interventions (Jorm et al., 1997b; Jorm et al., 2000a). For example, a belief that physical health problems are caused by lifestyle factors may lead to similar beliefs about the causes of, and appropriate treatments for, mental health problems. Enhancing mental health literacy is important because of the high prevalence of mental disorders—mental health professionals cannot possibly help everyone affected by mental health problems, and therefore knowledge and skills need to be widely distributed in the general population (Jorm, 2000).

Mental health literacy represents a relatively new area of investigation. Compared to health literacy, researchers and policymakers have not articulated a comprehensive model that organizes mental health literacy along a gradient of evolving personal and social skills which can influence modifiable determinants of mental health. Recent work in the field however, such as the beyondblue campaign in Australia, shows the effectiveness of adopting a broad, multi-level approach across several domains. This paper applies the conceptual model for health literacy to mental health literacy, on the assumption that the skills and capacities that lead to personal and collective empowerment for health promotion are no different from those needed for mental health promotion.

PUBLIC KNOWLEDGE AND BELIEFS ABOUT MENTAL DISORDERS IN THE WEST

Recognition/Awareness

Much of the literature suggests that laypeople have a poor understanding of mental illness—they are unable to correctly identify mental disorders, do not understand underlying causal factors, are fearful of those who are perceived as mentally ill, have incorrect beliefs about the effectiveness of treatment interventions, are often reluctant to seek help, and are not sure how to help others (Priest et al., 1996; Jorm, 2000; Lauber et al., 2003a; Jorm et al., 2005a; Jorm et al., 2007).

The ability to recognize mental disorders is thought to be important because the inability to recognize a disorder in oneself or others could result in delays seeking appropriate treatment, utilization of inappropriate remedies, or difficulties communicating with health professionals (Jorm, 2000; Jorm et al., 2006a). Several studies have attempted to gauge the ability of the public to recognize and correctly label mental disorders. Much of the research involves the presentation of a vignette that describes a person with either symptoms of a major mental illness or substance abuse (using ICD-10 or DSM-IV diagnostic criteria). Following presentation of the vignette, respondents are asked a series of questions such as: What, if anything, is wrong with this person? What interventions would be helpful? What is the outcome likely to be? What is the likelihood of the person being discriminated against? (See Appendix for two sample vignettes).

Generally few members of the public are able to provide the correct diagnostic labels to mental illnesses, although most recognize that the problems as presented involve some kind of mental disorder. In a representative sample of the Australian population, Jorm et al. (1997a) found that depression was correctly labeled by only 39% and schizophrenia by 27% of respondents. In a representative sample of the Swiss population, 74% identified the schizophrenia vignette as an illness, while only 40% identified the depression vignette as an illness (Lauber et al., 2003a). In an American study, a majority
of respondents were able to identify schizophrenia and major depression as mental illnesses when asked specifically how likely it was that the person in the vignette was suffering from a mental illness (Link et al., 1999). Few people identify alcohol and substance abuse as mental illnesses, although clinical evidence suggests that they are (Link, 1999; WHO, 2001). A survey of the Australian population revealed that most people do not view mental disorders as health problems (Highet et al., 2002). When asked specifically to name mental health problems, depression was the most common response, followed by anxiety/stress. Fewer people identified schizophrenia/psychosis, dementia/Alzheimer’s disease, and alcohol/substance abuse as mental health problems.

Recognition and awareness has improved somewhat in Australia since the late 1990’s, following implementation of initiatives to improve mental health literacy, however researchers believe there is still room for improvement (Goldney et al., 2005; Jorm et al., 2005b; Jorm et al., 2006a; Jorm et al., 2006b).

It is not clear what influences recognition. Personal experience may not; people with major depression are no more likely than others to recognize depression in a vignette (Goldney et al., 2001). However, those who have had contact with people who have been depressed are more likely to identify depression as an illness (Lauber et al., 2003a). Age and gender may also play a role. The ability to correctly recognize and label depression in a vignette appears to be higher in younger people (Highet et al., 2002; Fisher and Goldney, 2003), and in women (Highet et al., 2002).

Beliefs about Causes

For the most part, in the West, mental illnesses are thought to be caused by psychosocial factors, such as environmental stressors or childhood events. Biochemical and genetic influences, although recognized as causal factors, are not considered as important as environmental ones (Jorm, 1997b; Link et al., 1999: Jorm, 2000). In a study of the public’s attitudes towards depression prior to the launch of the Defeat Depression Campaign in Britain, a majority identified psychosocial events and situations as the causes of depression, although they did agree that it was a medical condition (Priest et al., 1996). Walker and Read (2002) cite a number of studies that show that the public rejects the medical model and is quite resistant to biogenetic causal explanations for mental illnesses, preferring explanations related to environmental stressors or traumatic childhood events. Some studies suggest that serious mental illnesses such as schizophrenia are more likely to be linked to genetic causal factors compared to common mental disorders such as depression (Jorm, 1997b; Link et al., 1999).

Perceptions/Attitudes towards Mental Illnesses

Negative attitudes and discriminating behaviors towards people with mental illnesses are often referred to as stigma. Stigma involves negative stereotypes and prejudice and is often measured in terms of social distance (the degree to which people are willing to interact socially with others) (Corrigan and Penn, 1999; Corrigan et al., 2003; Phelan et al., 2000; Mann and Himelein, 2004; Lauber et al., 2004). Stigma can be enacted through social rejection and discrimination or felt as the fear of social rejection and discrimination (Scrambler, 1998). The stigmatizing of mental illnesses remains pervasive and problematic and often results in active discrimination (Sims, 1993; Priest et al., 1996; Link et al., 1999; Walker and Read, 1999; Corrigan et al., 1999; Phelan et al., 2000; Martin et al., 2000; Stuart, 2005). This is of concern for a number of reasons. People may be
reluctant to seek treatment for or disclose mental health problems, even common forms of anxiety and depression, for fear of social rejection and discrimination (Priest et al, 1996; Watson and Corrigan, 2001; McNair et al, 2002). Perceived stigma may also result in treatment discontinuation (Sirey et al, 2001; Watson and Corrigan, 2001).

People who do disclose or who are identified as mentally ill have reported discrimination from landlords, employers, physicians and other mental health professionals (McNair et al, 2002; Corrigan et al, 2003; Stuart, 2005). Social exclusion is a common experience (Byrne, 2001). Stigma and discrimination in the workplace frequently occurs: many employers will not hire persons with mental health problems, and disclosing mental disorders can undermine career advancement (Stuart, 2005). People may limit their social interactions with others for fear of experiencing stigma (Perlick et al, 2001).

Stigma can have negative effects on life satisfaction and self-esteem, and the experience of stigma can increase symptoms of anxiety and depression (Sims, 1993; Sartorius, 1998; Markowitz, 1998; Link et al, 2001). It may also influence how policymakers choose to allocate resources to those with mental illnesses (Corrigan et al, 2004).

Perceptions of dangerousness and unpredictability influence the desire to remain socially distant from those with mental illnesses (Link et al, 1999; Read and Law 1999; Phelan et al, 2000; Walker and Read 2002). These perceptions are not based on fact: only a small minority of individuals with mental disorders, primarily those with a specific sub-set of symptoms or co-occurring substance disorders, are actually more prone to violence compared to persons without mental disorders. The risk of violence from other groups such as young male adults is similar or even higher and does not result in broad social stigmatization and desire for social distance (Read and Law, 1999; Corrigan et al, 2003).

Phelan et al (2000) suggest that attitudes towards mental illnesses have taken two trajectories since the 1950’s. The public now accepts less severe problems such as depression and anxiety as more or less normal life events that can happen to anyone, but psychosis remains alien and stigmatized, and fear related to it has increased. Angermeyer and Matschinger (2001) came to a similar conclusion following a study of attitudes towards help seeking among the German population. In Australia, Jorm et al (2000b) found that public attitudes about depression are relatively benign. Mann and Himelein (2004) suggest that reports of broad stigmatization of all mental illnesses are inaccurate and potentially harmful, as there is much more stigma toward severe mental illness, and perceptions of broad stigmatization could deter persons with common mental disorders such as depression from seeking treatment.

Although social acceptance of common mental disorders may have increased over the past few decades, fear and perceptions of dangerousness pertaining to severe mental illness have actually increased significantly (Phelan et al, 2000; Walker and Read, 2002). Persons with schizophrenia and with alcohol and drug problems are now more likely to be perceived as unpredictable and potentially dangerous (Pescosolido et al, 1999; Crisp et al, 2000). The reason for the increase in fear related to serious mental illness is unclear, but it does not appear to be due to de-institutionalization (Phelan et al, 2000).

The public is generally reluctant to label common psychiatric symptoms such as depression and anxiety as mental illness and tends to characterize only severe disorders
associated with bizarre or violent behaviour, as mental illnesses (Gray, 2002; Prior et al, 2003). It may be that mental disorders are stigmatized based on perceptions of normalcy: i.e. where they fit on a continuum of experience with which the public is able to relate. For example, attitudes towards obsessive-compulsive disorders (OCD) vary by symptom features, and people are much more socially rejecting towards those with obsessions related to harming than towards those with obsessions related to checking or washing (Simonds and Thorpe, 2002).

It has also been suggested that having a medical understanding of a mental disorder increases negative attitudes because the disorder is then viewed as inherent and chronic (Lauber et al 2004; Phelan et al, 2006). Pescosolido et al (1999) found that respondents who identified a vignette as a “mental illness” were less likely to consider the person competent and more likely to be worried about violence. Lauber et al (2004) report that having a medical understanding of mental illness, identifying the person in the vignette as being “ill” and having a positive attitude to medical treatment, increases social distance. Further, believing that the vignette represents a life crisis reduces social distance, and serious illnesses like schizophrenia predict increased social distance. Martin et al (2000) found that few Americans define depression as a mental illness, those who see stress as the cause of mental health problems show lower levels of social rejection regardless of the specific disorder, and those who label a vignette as a “mental illness” indicate a preference for more social distance from the person. Read and Law (1999) report that having biogenetic causal beliefs about mental disorders increases negative attitudes, particularly with regard to dangerousness and unpredictability. Similar findings emerged from a study by Walker and Read (2002), where providing respondents with a medical explanation for a videotaped scene of a person with psychotic symptoms significantly increased perceptions of dangerousness and unpredictability.

### Attitudes Related to Interventions and Help-Seeking

The use of professional mental health services, at least in the U.S., has greatly increased since the 1950’s (Phelan et al, 2000). The reason for this trend is not clear. At the same time, numerous studies show that a minority of people with mental health problems seek professional help (Angermeyer and Matschinger, 1999; Jorm, 2000; Watson and Corrigan, 2001; Simonds and Thorpe, 2003). The prevalence of mental disorders means that most people will have close contact with someone with a mental health problem at some point, but many of them lack the knowledge and skills to provide helpful responses (Jorm et al, 2005b; Jorm et al, 2007).

The exact relationship between attitudes towards mental illness and help seeking or service utilization is unknown (Phelan et al, 2000; Fisher and Goldney, 2003). While service utilization has increased, attitudes towards interventions are varied and not strongly related to actual help-seeking behavior (Fisher and Goldney, 2003; Jorm et al, 2000a). Beliefs about the helpfulness of interventions do not always predict the use of them (Jorm et al, 2000b).

Greater treatment seeking is not associated with more knowledge about mental health issues; for example, older subjects have less knowledge about mental health issues and less positive attitudes towards professional mental health services, but are more likely to have been prescribed or to be taking anti-depressants (Fisher and Goldney, 2003). This may be related to their having more contact with medical doctors for age related health
problems. Attitudes towards interventions vary by age, education and gender, with younger people, women and those with more education more likely to perceive mental health professionals as helpful (Angermeyer and Matschinger, 1999; Fisher and Goldney, 2003). Women are more likely than men are to use a range of interventions, including various self-help and life-style interventions (Jorm et al, 2000b).

Generally, people prefer self-help, lay support and lifestyle interventions for mental disorders, and they are uncomfortable with medical, and especially psychopharmacological, interventions (Angermeyer and Matschinger, 1996; Priest et al, 1996; Jorm, 2000; Angermeyer and Matschinger, 2001; Hoencamp et al, 2002; Highet et al, 2002; Hegerl et al, 2003; Jorm et al, 2005a). Some studies show that psychotherapy and counseling are rated by the public as more effective than medical help for mental disorders (Angermeyer and Matschinger, 1996; Priest et al, 1996).

Findings are mixed with regard to attitudes about the helpfulness of general practitioners for mental health problems. Some studies show that GPs are rated highly, especially for depression, but this is not universal (Jorm, 2000). In Britain, for example a public survey revealed that 60% of respondents would be reluctant to consult their family physician for depression for fear the doctor would regard them as unbalanced or annoying (Priest et al, 1996). Psychiatrists are generally seen as less helpful than GPs, except for schizophrenia (Angermeyer and Matschinger, 1999; Jorm, 2000; Goldney et al, 2005).

Overall, attitudes towards psychiatric drugs are very negative (Angermeyer and Matschinger, 1996; Jorm, 2000; Lauber et al, 2001; Hegerl et al, 2003). In a survey of the British population, 78% considered anti-depressants to be addictive (Priest et al, 1996). Similar findings have been reported for the German population, where 40% of respondents warned against the use of psychotropic drugs, because of perceptions that the drugs treat only symptoms and not causes and concerns about addiction (Angermeyer & Matschinger, 1996). These negative attitudes are of concern to the medical community as beliefs about anti-depressants are a strong predictor of their use (Jorm et al, 2000b; Lauber et al, 2001). Negative attitudes are quite prevalent even among those who are taking anti-depressant medication (Hoencamp et al, 2002; Lauber et al, 2003b).

Attitudes may have moderated somewhat in recent years, especially in places where public information campaigns to improve mental health literacy have been implemented. For example, a comparison of public surveys in Australia (1998-2004) shows that the number of people who believe psychiatric medications are harmful has dropped and the number who would recommend seeing a GP or seeking counseling for depression has increased. However, people are no more likely to recommend psychiatric help or medication as a treatment for depression than they were (Goldney et al, 2005). Another study shows attitudes towards psychiatric medications becoming more positive over an eight-year period (Jorm et al, 2006b). Where changes in attitudes toward treatment interventions have been observed over time, these are generally ascribed to lay beliefs converging with professional attitudes (Jorm et al, 2000a; Jorm et al, 2006b).

Experience may influence attitudes toward interventions. For example, some consumers and caregivers report having encountered stigma within the health care system, and they perceive health care services as focused more on reducing symptoms or the danger of self-harm than on models of long-term personal recovery (McNair et al, 2002). Other studies indicate that some mental health professionals hold stigmatizing attitudes
towards people with mental illness, especially persons with schizophrenia (Summerfield, 2001; Sartorius, 2002; Gray, 2002; Mazeh et al, 2003; Patel, 2004). Caldwell and Jorm (2000) cite research showing that consumers perceive the quality of care to be higher from psychologists, nurses and case managers compared to medical practitioners and psychiatrists. Resentment against mental health professionals can serve as a deterrent to help seeking (Angermeyer and Matschinger, 1999).

Help seeking is influenced by how people define the problem, what they perceive to be the cause and the anticipated prognosis (Angermeyer and Matschinger, 1999). As Jorm et al (2000a) suggest, there may be underlying belief systems about mental illnesses that influence attitudes to treatment. For example, one study asked adolescent males to free associate regarding the term “mental health counseling” (Smith, 2004). The responses were highly negative, associating the term with “brain problems”, “mentally unstable”, “mental problems”, “crazy people” and the like. However the respondents reported that they would use counseling for life problems, suggesting a clear distinction between perceptions of mental illness and social/emotional problems. In general, those who have a biomedical view of mental disorders (mental disorders as illnesses) are more likely to support the use of psychotropic drugs; those with a psychosocial view (mental illnesses as life crises) are not (Lauber et al, 2003a). Similarly, people who define mental health problems in terms of a psychiatric disorder and see the cause as being external or internal influences that are outside personal control are more likely to advise professional intervention (Angermeyer and Matschinger, 1999). People who attribute genetic causes to mental illnesses are more inclined to recommend medical help, i.e. medication or hospitalization, but are less optimistic about treatment outcomes (Phelan et al, 2006).

Prior et al (2003) suggest that lay people have very different conceptions from professionals as to what constitutes a psychiatric problem. People do not fail to seek help or disclose the symptoms of mild to moderate mental disorders because of fear of stigma, but because they do not view them as medical illnesses and remain ambivalent about the appropriateness and efficacy of medical treatment for what they see as problems of living.

**PROFESSIONAL ATTITUDES TOWARDS MENTAL DISORDERS AND INTERVENTIONS**

The range of attitudes among mental health professionals in relation to stigma is similar to that of the general public and stigmatizing and discriminatory behaviour from professionals is not uncommon (Summerfield, 2001; Sartorius, 2002; Gray, 2002; Mazeh et al, 2003; Patel, 2004). The issue of stigma is not normally addressed in medical, including psychiatric, training even though it is a critical influence on the quality of life of persons with mental illness (Byrne, 2001). The attitudes of mental health professionals towards prognosis and long-term outcomes, and likelihood of discrimination are more negative than those of the public, and most mental health professionals report that their attitudes are related to their experiences working with people with mental disorders (Jorm et al, 1999; Hugo, 2001). Negative outcomes and discrimination are seen as more likely for schizophrenia than depression (Jorm et al, 1999). The attitudes of mental health professionals may be more realistic than those of the public, or they have more contact with patients on the severe/chronic end of the spectrum (Jorm et al, 1999). Given that most people with mental health problems do not seek medical treatment, it is probably the latter.
Mental health nurses – who have the most contact with consumers – have more positive attitudes than other medical professionals (Caldwell and Jorm, 2001). Mental health professionals with a biological perspective assess patients as more disturbed and are less likely to support the involvement of consumers in planning and managing services (Read and Law, 1999).

Like the public, mental health professionals vary considerably in their attitudes toward interventions and this variability is related to professional orientation (Caldwell and Jorm, 2000; Tiemeier et al., 2002). Medical professionals prefer medical interventions; psychologists prefer psychotherapeutic approaches (Tiemeier et al., 2002). There is some evidence that these attitudes may be changing; for example, younger psychiatrists and nurses may be more supportive of psychosocial interventions than their older colleagues (Caldwell and Jorm, 2000). Mental health nurses generally agree with psychiatrists about the most helpful interventions especially for schizophrenia, but they also differ in some ways (Caldwell and Jorm, 2000). Mental health nurses believe a wider range of interventions to be helpful and are more supportive of lifestyle and psychological interventions. Their beliefs about the helpfulness of interventions tend to bridge those of psychiatrists and the general public.

In addition, preferences with regard to interventions vary by patient characteristics and over-treatment, where the risks outweigh the benefits, is not uncommon (Tiemeier et al., 2002).

THE ROLE OF THE MEDIA

The media may bear some responsibility for the reported increase in public perceptions of fear and dangerousness related to those with mental disorders, but the exact effect remains to be investigated (Phelan et al., 2000). Mental health advocates have long been concerned that media images and stories about people with mental illness in the media have an impact on public perceptions. Certainly negative images and stereotypes about mental illness abound in the popular media, and media portrayals of people with mental illness are largely inaccurate (Granello et al., 1999; Olstead, 2002; Anderson, 2003; Clarke, 2004). People with mental illnesses are often characterized as unpredictable, dangerous or violent in films, television and the print media (Granello et al., 1999; Stuart, 2003). Furthermore, the media is a dominant influence in the modern world—it has been identified as the primary source for information about mental illness for Americans (Granello et al., 1999).

Although the relationship between the media and personal attitudes and beliefs is complex (Granello et al., 1999; Olstead, 2002; Anderson, 2003) the media does appear to exert some influence on perceptions of mental disorders. In one study, two-thirds of the respondents who cited the media as the primary source of their beliefs about mental illness associated mental illness with violence (Clarke, 2004). However this effect appears to be related mostly to serious mental illnesses like schizophrenia. Francis et al. (2003) found that media stories that linked mental illness and crime tended to do so for schizophrenia and substance abuse, but not for other disorders. There has also been a general increase in media stories about mental distress in recent years, such as depression and anxiety and related coping strategies, suggesting a greater public awareness of and tolerance for these forms of mental health problems (Clarke, 2004).
Negative media images are of concern because they have a direct impact on people with mental disorders. They can increase psychological distress and the fear of stigma and reduce overall quality of life (Stuart, 2003). They may also influence the adoption of punitive legislation or repressive policies, for example, denying adequate funding for services, or reducing community-based care (Stuart, 2003; Clarke, 2004). Clarke (2004) notes that negative images in the media support a power imbalance between those who are represented (people with mental health problems) and those doing the representing (presumably those with no mental health problems). This maintains an “us versus them” climate of social exclusion.

Olstead (2002) suggests that how the media talks about persons with mental disorders is as important as what it talks about. His review of 195 articles from Canadian newspapers shows that the media uses polarizing language to make a fundamental distinction between “them – the mentally ill” and “us – the world”. As Stuart (2003) states: “the creation and perpetuation of media images stigmatizing people with mental illness is a potent ingredient in a broader social process that denies social and legal entitlements through neglect, avoidance and discrimination.”

**CULTURAL AND SOCIAL CONSIDERATIONS**

Culture may be defined as the set of beliefs, norms and values that shape the networks in which human interactions take place (Moldavsky, 2004). Western psychiatry has been criticized for not attending to cultural influences on mental disorders (Jadhav et al, 2001). Further, it is not unusual for cross-cultural research to assume that white, Western expressions of mental disorders are culture-free and represent “purer” aspects of the underlying pathology when they are themselves culturally constructed (Jadhav et al, 2001). Culture is of particular interest with regard to mental health literacy because there are significant cultural variations in how people recognize, explain, experience and relate to mental disorders and treatment (Littlewood, 1998; Kirmayer et al, 2000; Sheikh and Furnham, 2000; Weiss et al, 2000; Jadhav et al, 2001; Moldavsky, 2004; Jorm et al, 2005a). These are, in turn, closely connected to social and environmental conditions (Kirmayer et al, 2000, Moldavsky, 2004).

Psychiatric disorders as categorized in the West are not recognized universally although research suggests that most cultures recognize a disorder with specific features analogous to chronic schizophrenia (Littlewood, 1998). For other mental health problems, particularly minor psychiatric disorders, the social context and related personal beliefs appear to be of more significance in shaping the form, expression and recognition of the disorder (Littlewood, 1998; Jadhav et al, 2001).

To some extent, causal beliefs and attitudes about mental distress are culturally determined. Non-Western, traditional cultures are more likely to attribute mental disorders to supernatural causes (Sheikh and Furnham, 2000). Stigmatizing attitudes towards severe mental illnesses such as psychotic disorders seem to be less common in non-Western cultures, including small Aboriginal and Inuit communities in Canada (Littlewood, 1998; Kirmayer et al, 2000). Attributions of external causes for mental health problems, more tolerant attitudes towards deviant behavior, and more supportive familial and social environments all appear to play a role (Littlewood, 1998; Kirmayer et al, 2000). Self-perceived stigma varies across cultures as well; in India, people with mental disorders report more concerns about marriage due to stigma compared to British persons (Weiss et al, 2000). Attitudes towards help seeking may also be influenced by culture. In Western countries, people who adhere to traditional causal...
beliefs have less positive attitudes about seeking professional help (Sheik and Furnham, 2000).

Culture is highly influential in the experience and course of mental disorders. For example, depression often presents in the form of somatic symptoms in developing countries (Moldavsky, 2004). This is thought to be related to a Western bias against somatization, a higher tolerance for and less stigmatizing attitudes towards somatic expressions in other cultures (Littlewood, 1998; Moldavsky, 2004). It is well documented that schizophrenia has a better course of outcome in the developing world, and this is thought to be associated with cohesive, supportive extended family and social environments (Littlewood, 1998; Moldavsky, 2004).

Within and across cultures, social, economic and political factors profoundly influence mental health (WHO, 2004b). Social determinants of physical health including poverty, education and social support, also influence mental health (Stephens et al, 2000; WHO 2004b). Feelings of powerlessness and low self-esteem are linked to depression and minorities, women, and immigrant and refugee populations suffer from higher rates of depression in all countries (Stephens et al, 2000; Moldavsky, 2004). Around the world, despite their diverse cultures, Indigenous people have similar mental health problems, suggesting there are “common processes at work” (Kirmayer et al, 2000). These include the ongoing stresses of colonization, economic marginalization, and bureaucratic surveillance, which have resulted in high rates of mental health problems including common psychiatric disorders, substance abuse and suicide. As community autonomy increases and Aboriginal people regain control of their local governments, services and cultural activities, suicide rates drop (Chandler and Lalonde, 1998; Kirmayer et al, 2000).

**RESEARCH ON CHANGE STRATEGIES**

Various change strategies have been applied to enhance the mental health literacy of health professionals and of the public with differing degrees of success. Most of them have focused on raising awareness and changing attitudes, with the assumption that behaviour change will follow. It is important to note that changing attitudes does not ensure changes in behaviours; attitude change is most closely associated with behaviour change when attitudes are stable, formed as a result of direct experience and personally relevant (Corrigan and Penn, 1999; Stuart, 2005). However, there is some evidence to show that people who have information about mental illness may be less stigmatizing and more supportive of others who have mental health problems (Penn and Couture, 2002; Jorm et al, 2005b; Jorm et al, 2007).

**Stigma Reduction**

Most of the research on stigma reduction pertains to serious mental illness and not to common mental health problems (Corrigan and Penn, 1999; Read and Law, 1999; Watson and Corrigan 2001; Wallach, 2004; Stuart, 2005; Corrigan et al, 2005). For stigma reduction, disclosure (of mental health problems) and exposure (of the public to people with mental disorders) may be effective in modifying attitudes. For example, it is thought that celebrities who speak out may help to reduce stigma, because of their success and access to public forums (Hudson Jones, 1998), although there is no direct evidence to support this conclusion and disclosure may also place the person at risk of more stigma (Watson and Corrigan, 2001).
Providing specific information through public education campaigns and programs can be an effective method for reducing stigma and improving attitudes towards those with mental illnesses (Corrigan and Penn, 1999; Watson and Corrigan, 2001; Pirkis, 2004). However, broad, generic campaigns show limited effectiveness (Byrne, 2001). Campaigns targeted to the anxieties of specific sub-groups appear to be more useful (Byrne, 2001; Stuart, 2005).

Campaigns need to be carefully constructed. Research in social psychology suggests that stereotypes are persistent, as people tend to seek out information that confirms them (Corrigan and Penn, 1999). To disconfirm stereotypes it may be most helpful to share specific facts with the public, such as providing information about the risk of danger from persons with mental illnesses being no higher than from other groups such as young males (Read and Law, 1999; Corrigan and Penn, 1999). Beliefs about specific behaviours also appear to be more plastic than beliefs about traits (Corrigan and Penn, 1999). To improve housing opportunities for persons with serious mental illness, for example, it would be most useful to target landlords’ beliefs about the potential for violence among those with mental illness (behaviours) than to convince them that the persons are not irritable or unpredictable (traits).

Adult education programs involving the presentation of factual information about mental illness have shown some promise in reducing stigma, and are especially potent if the presenter is a person with mental illness, thus combining education with contact (Watson and Corrigan, 2001). Employment programs to re-integrate persons with mental illnesses into the workplace benefit the individuals themselves by increasing their self-esteem and self-worth, and may also increase social acceptance (Conway-Grieg and Bell, 2000).

Personal experience with a person with a mental disorder can modify attitudes and reduce stigma, and it may be helpful in certain structured environments, such as undergraduate training (Corrigan and Penn, 1999; Read and Law, 1999; Wallach, 2004). However, certain caveats apply: exposure has maximum benefits if it is prolonged, under friendly and intimate conditions, and especially if the parties are equal status. To be effective, contact must be with people who challenge the stereotypes of mental illness, not confirm them (Corrigan et al., 2005). Contact is not effective and may even be harmful under other circumstances such as brief undergraduate visits to mental institutions (Corrigan and Penn, 1999; Read and Law, 1999; Wallach, 2004). These findings imply that consumers need to play a lead role in de-stigmatization campaigns, with academics and professionals in a supporting capacity (Read and Law, 1999).

Professional Education

There has been a professional consensus that direct education for physicians in primary care settings is needed to improve outcomes for consumers with depression, as depression often undiagnosed and under-managed (Rix et al., 1999; Thompson et al., 2000). Several such campaigns have been initiated, with mixed success. For example, an educational campaign for general practitioners (GPs) in Sweden showed some improvements, but these reverted to baseline three years later (Rix et al., 1999). An evaluation of the Defeat Depression Campaign in Britain national educational activities to enhance the ability of GPs to recognize and manage depression showed some positive effects: most physicians were aware of the campaign and some of the educational materials—a consensus statement on the recognition and management of
depression, and physician guidelines for treatment—appeared to have a positive impact. However, patient outcomes were not assessed (Rix et al, 1999). A study of an education program for GPs that did assess clinical outcomes did not show any improvements (Thompson et al, 2000). Improving primary care for depression is one of the key objectives of beyondblue: the national depression initiative in Australia, and guidelines have been developed for treating depression in primary care (Ellis and Smith, 2002). The program evaluation shows some reduction in systemic and service-related barriers along with an increase in the number of primary care physicians who feel equipped to treat depression (Pirkis, 2004).

Public Education

Researchers acknowledge that primary care initiatives need to be paired with campaigns are needed to raise public awareness and change attitudes (Bird and Parslow, 2002). Several public campaigns to raise awareness and modify attitudes about the treatment of mental health problems have been evaluated. In Britain, the Defeat Depression Campaign (1991-1996) aimed to reduce stigma and educate the public about depression and its treatment and to encourage earlier help seeking. Various media activities were used to disseminate key messages. It was expected that the campaign would be effective in enhancing public awareness, and modest changes in public attitudes toward depression and the use of anti-depressants were reported (Paykel et al, 1997; Paykel et al, 1998). However, the use of sick benefits and disability insurance related to depression showed no reduction (Moncrieff, 1999). In Germany, the Nuremberg Alliance Against Depression Campaign sought to inform the public about the causes and treatment of depression using educational materials, the media and contests. Post-campaign evaluations showed that public awareness of the campaign was fairly high and there were some changes in attitudes, but the effect was small and attitudes towards anti-depressant medications remained very negative (Hegerl et al, 2003). In the U.K., the Royal College of Psychiatrists launched the Changing Minds campaign (1998-2003) to educate the public and reduce stigma about mental disorders. A pre-campaign survey of the public has been published (Crisp et al, 2000), but no other published literature relating to the campaign could be found.

Because of the public’s resistance to associate common mental health problems with illness, it has been suggested that educational and awareness campaigns limit the use of language linking common mental health problems with illness, sickness and disease (Walker and Read, 2002). Public campaigns using key messages such as “depression is a severe illness” and “anti-depressants are not addictive and do not change one’s personality” have been completely ineffective in modifying attitudes toward psychiatric medications (Hegerl et al, 2003). The national depression initiative in Australia, beyondblue, uses softer key messages that emphasize the commonness of depression, the need for help (without specifying what type of help) and shared social responsibility. Key messages include “depression is common and likely to affect every family”, “people with depression need assistance to get care” and depression is a community problem and demands a community response”. Evaluations show that public and professional awareness is increasing (Hickie, 2004; Pirkis, 2004).

Laypeople show a marked preference for self-help interventions, and there is research evidence to support some of the self-help and complementary interventions that people consider helpful for anxiety and depression (Gazmararian et al, 2000; Jorm et al, 2000b; Jorm et al, 2002; Jorm et al, 2004). These include social support, physical exercise, light
therapy for seasonal affective disorder, and self-directed cognitive-behavioural therapy. Providing people with information about which interventions are evidence-based, to promote informed choice, has been done in Australia with some preliminary positive results (Jorm et al, 2003). People were provided with access to information about a range of treatment options in the form of a consumer guide; they rated the guide as more helpful than a control brochure and reported that they were more likely to take action (primarily self-help related) and to give advice to others. There were no significant differences between the two groups with regard to symptoms or disability, but there were trends towards more improvement in the consumer guide group. *Beyondblue* has a similar guide available on its bluepages: [www.bluepages.anu.edu.au](http://www.bluepages.anu.edu.au)

The Internet can be a useful source of health information and interactive self-help interventions as it reduces geographical, social and attitudinal barriers to help. It has the potential to play a significant role in improving health literacy (Ratzan, 2001), including mental health literacy. Websites related to mental health are very popular with the public. The *Beyondblue* initiative is promoting national standards for depression websites and has supported the development of an on-line cognitive-behavioural program called MoodGYM. While the quality of information can be inconsistent on websites, research-based web interventions are effective in the treatment of depression (Christensen and Griffiths, 2000; Christensen et al, 2004).

Targeted educational initiatives have defined goals, and are generally aimed at subgroups or implemented in specific environments such as the workplace. Some of these represent promising practices. Educational campaigns to encourage persons with early symptoms of schizophrenia to seek help report some success in reducing the length of time between onset of symptoms and access to adequate treatment (Larsen et al, 2001). An innovative approach to assisting people to provide help to others in the form of a *Mental Health First Aid Course* has been developed and implemented in Australia (Kitchener and Jorm, 2002; Kitchener and Jorm, 2004; Jorm et al, 2007). The course has been provided to the public and in workplaces with positive results: an improved ability to recognize mental disorders, changed beliefs about treatment, and decreased social distance from those with mental disorders (Kitchener and Jorm, 2002; Kitchener and Jorm, 2004; Jorm et al, 2007). In the workplace application, the course was also found to improve the mental health of the participants (Kitchener and Jorm, 2002). Creating supportive work environments through management training and teaching workers about strategies for stress reduction could also help to reduce fears of disclosure and enable people to better manage mental health problems; however more research is needed in this area (BOHRF, 2005).

Comprehensive strategies involving multiple targeted initiatives represent a promising approach. One of the most comprehensive national campaigns to date is *Beyondblue: the national depression initiative* in Australia. It is working across multiple domains simultaneously including raising consumer awareness, supporting national consumer and caregiver advocacy, promoting prevention and early intervention, promoting primary care training and partnerships for service reform, and funding strategic and applied research (Hickie, 2004; Pirkis, 2004). In its first five years of operations, the campaign has shown demonstrable improvements in community awareness, the number and range of early intervention and prevention programs, engagement of consumers and caregivers, and depression-related research. There is also some indirect evidence for stigma reduction (Pirkis, 2004).
Community Empowerment

Community empowerment, within consumer communities and communities at large, is a key factor in health promotion (WHO, 1998). Within consumer communities, those with mental health disorders benefit from the social support and mutual empowerment related to coming together for collective action (Corrigan and Penn, 1999). Often consumers are motivated to work with the broader community to effect change, and initiatives can be developed to support these objectives through training in communication and advocacy (Waring et al, 2000). Schools have been the focus of innovative approaches to engage youth in sharing information about mental disorders, and have shown positive results with regard to reducing stigma and building empowerment (Waring et al, 2000).

Advocacy

Media images and stories about people with mental illness are often negative and mostly inaccurate, and the media represents a natural focus for advocacy work (Granello et al, 1999; Olstead, 2002; Anderson, 2003; Stuart, 2003; Clarke, 2004). Change attempts reported in the literature include local media interventions and consumer group advocacy. Local media interventions appear to have minimal impact (Stuart, 2003). Consumer groups have emerged in some areas to promote a sustained media response, such as the Mental Health Media Group in Britain and the national consumer/caregiver alliance sponsored by beyondblue in Australia (Clarke, 2004; Hickie, 2004). At this point, however, it is not clear how much successful these efforts are. Stuart (2003) has noted that national and international alliances are likely to exert the greatest influence. These will likely be most effective if they involve public/private partnerships and alliances (including consumer and caregiver voices) to negotiate collective solutions with the media (Ratzan, 2001).

Social and political action for legislative and policy reform are important areas for advocacy work. For race and gender, history shows that social and political activism calling for more social justice ultimately succeeded in reducing stigma and realigning attitudes in more positive directions (Corrigan et al, 2003). It is reasonable to assume that social and political action will result in similar improvements for persons with mental health problems. Health reform is needed for better quality and quantity mental health services (Hickie, 2004) such as collaborative mental health care, which is associated with benefits for practitioners and consumers (Gow and McNiven, 2004). Political action is needed to eliminate discrimination against those with mental disorders in the workplace, the insurance industry, and housing (Watson and Corrigan, 2001; Corrigan et al, 2003). For example, employers could be required by law to accommodate people with mental disorders. In Australia, the beyondblue initiative includes an agenda for broad social change that includes the removal of key social barriers, such as discrimination in employment and insurance (Hickie, 2004; Pirkis, 2004).
KEY CONSIDERATIONS IN MENTAL HEALTH LITERACY

The Need for a Comprehensive Model

The review of the literature suggests a need for a more clearly defined and comprehensive model of mental health literacy that corresponds to recent thinking in the field of health literacy. The mental health literacy of the public is often assessed in terms of how closely public knowledge and beliefs mirror professional knowledge and beliefs (Link et al, 1999; Jorm et al, 2006a; 2006b). Medical professionals sometimes assume that people are reluctant to seek treatment for mental disorders and hold negative perceptions of mental illness because they have not acknowledged that mental disorders are medical illnesses (Heginbotham, 1998; Read and Law, 1999; Prior et al, 2003). From this perspective, changing public thinking to correspond with professional thinking about mental disorders may reduce stigma and lead to improvements in help seeking and treatment outcomes (Jorm et al, 2006a). This approach does appear to have resulted in some improvements to mental health literacy—people have become more socially accepting of mild to moderate mental disorders and in some cases public attitudes have become more consistent with the medical model, possibly because of public education campaigns (Link et al, 1999; Phelan et al, 2000; Hightet et al, 2002; Fisher and Goldney, 2003; Goldney et al, 2005; Jorm et al, 2006a; Jorm et al, 2006b). However, it is not without limitations and risks.

First, having a medical understanding of mental health disorders, regardless of the disorder, increases stigma and social distance, and reduces optimism about treatment outcomes, perhaps because the disorder is viewed as fixed and chronic (Read and Law, 1999; Martin et al, 2000; Walker and Read, 2002; Lauber et al 2004; Phelan et al, 2006). Indeed, public attitudes towards serious mental disorders, which are much more likely to be labeled as medical illnesses and attributed to genetic causes, remain intractably negative (Pescosolido et al, 1999; Phelan et al, 2000; Prior et al, 2003; Mann and Himelein, 2004; Phelan et al, 2006). Fear, perceptions of dangerousness, stigma and social rejection persist, and may have worsened (Phelan et al, 2000; Martin et al 2000; Lauber et al, 2004). An emphasis on genes and brain chemicals can create images of people with faulty brain functioning who are unpredictable and dangerous, and unlikely to recover (Walker and Read, 2002; Phelan et al, 2006). The reported increase in social acceptance of less serious disorders may therefore relate more to emerging perceptions of common mental health problems as normal social or emotional problems of living, than to an understanding of these as medical illnesses (Phelan et al, 2000; Prior et al, 2003).

Second, having a strictly medical understanding of mental health problems may be disempowering for persons with mental health disorders. It can cause people to feel that they have no control over their problems, and that they and their experiences are reduced to the workings of brain chemistry (Read and Law, 1999). In the light of research findings that associate feelings of powerlessness with the final pathway to depression, and optimism and hope with mental health and recovery, this is troublesome (Harris, 2001;WHO, 2004). Many consumers have in fact rejected the conventional paradigm that distinguishes between normal/abnormal, healthy/sick in favour of a worldview that honours differences and supports them in constructing their own identities (Scrambler, 1998).
Third, notwithstanding perceptions of dangerousness and social rejection of those with serious mental disorders, some lay attitudes and beliefs have validity. The public is much more receptive to psychosocial explanatory models, especially for common mental health problems (Jorm, 1997b; Link et al, 1999; Jorm, 2000) and there is evidence of social and environmental causal factors for many common mental disorders, including adverse life events and early experience (Read and Law, 1999; Stephens et al, 2000; Harris, 2001; Beatson and Taryan, 2003; Who, 2004b). Broad determinants of physical health including life stress, education and social support, influence mental health (Stephens et al, 2000; WHO, 2004b), and social and cultural factors affect the expression and course of mental disorders (Littlewood, 1998; Kirmayer et al, 2000; Sheikh and Furnham, 2000; Weiss et al, 2000; Jadhav et al, 2001; Moldavsky, 2004).

Finally, the public’s ambivalence about professional and especially medical treatment may not be completely misguided. There is no consensus among mental health professionals about appropriate interventions, but rather a range of opinions based on professional orientation and experience (Tiemeier et al, 2002). Research evidence supports some of the psychosocial, self-help and alternative interventions preferred by laypeople (Gazmararian et al, 2000; Jorm, 2000; Jorm et al, 2002; Jorm et al, 2004). Further, concerns about disclosing mental health problems for fear of stigma and discrimination may be valid. Mental health professionals, especially in the medical community, tend to have negative attitudes about the possibility of long-term recovery, and stigmatizing behaviour from mental health professionals does occur (Jorm et al, 1999; Hugo, 2001; Summerfield, 2001; Sartorius, 2002; McNair et al, 2002, Gray, 2002; Mazeh et al, 2003). Health professionals with a medical perspective are also less likely to support the involvement of consumers in planning and managing services (Read and Law, 1999).

Widening the lens through which people view mental health literacy to include diverse perspectives and multiple determinants of mental health and mental illness could be the basis for an expanded model, similar to the model for health literacy (Herman, 2000; WHO, 2001; Summerfield, 2001; Kickbush, 2002). Such a model could accommodate a diversity of attitudes and beliefs about mental health and mental disorders, insofar as these differences represent valid but divergent points of view. It could also accommodate the development of a broad range of strategies to enhance personal skills and capacities for informed choice, critical analysis and collective empowerment for action on the social determinants of mental health, including structural inequities. It would support social as well as individual benefits, building social capital and promoting social and economic development (Kickbush, 2002). Ultimately, it is expected to lead to improved individual and population mental health outcomes (Nutbeam 2000).

**Enhancing Basic/Functional Literacy**

At the most basic level, mental health literacy is linked to general literacy. For example, in some developing countries more than half the population is illiterate (Mubbashar and Farooq, 2001). Problems with general literacy are prevalent in the developed world also, where it has been estimated that 100 million people are functionally illiterate (Kickbusch, 2001). In Canada, four out of ten adults struggle with low literacy (ABC Canada, 2005a) and sixty per cent of immigrants have low literacy (ABC Canada, 2005b)
Improving functional mental health literacy is expected to result in improvements in the capacity to understand mental health risks and mental health services, and to comply with treatment, but it does not involve skill development, interactive communication or supportive interventions to build empowerment for informed choice (Nutbeam, 2000).

Addressing low literacy is critical to enhancing mental health literacy, and to increasing the overall health and quality of life for people in all societies (Kickbusch, 2001). All information, including reading materials, posters and signage, must be provided at literacy levels for the broadest audience, i.e. in plain writing (Black, 2002). Mental health care providers must be aware of the issue and be prepared to individualize care for and assist persons who have low literacy levels (Hixon, 2004). Where literacy levels are very low, innovative approaches are required, such as creating awareness among schoolchildren and their teachers, so they become the messenger force in their communities (Mubbashar and Farooq, 2001).

**Enhancing Interactive Literacy**

Enhancing interactive mental health literacy focuses on building personal skill and knowledge, and it is expected to result in an increased personal capacity to act on knowledge (Nutbeam, 2000). Effective health communication strategies, including public education and social marketing initiatives, support skill development and informed choice. This approach can engage people within the context of their individual and cultural beliefs, as it provides information for people to think about, rather than telling them what to think (Ratzan, 2001). It involves education to improve mental health literacy by advancing understanding at all levels: how to prevent mental health problems, how to intervene early, and how to manage a mental disorder (Ratzan, 2001). New technologies offer opportunities for wide dissemination of information for individual use (Ratzan, 2001).

Mental health care providers can facilitate the development of mental health literacy by developing partnerships with clients and supporting informed choice (Bauman et al, 2003). Good communication promotes competence and personal control of clients over health, and improves the satisfaction of both parties (Makoul et al, 1995; Bauman et al, 2003). The development of marketing communications about mental health in an accessible format, such as translating research findings into plain language, would support the development of interactive mental health literacy (Ratzan, 2001). Public education about mental health and mental disorders using terms with which people are comfortable, would fit here including information about prevalence, prevention, selecting effective interventions, and helping others with mental health problems. Self-help initiatives like web-based self-directed therapy would also promote empowerment and choice.

**Enhancing Critical Literacy**

Critical mental health literacy involves skill development to critically analyze and use information to mobilize for social and political action as well as individual action (Nutbeam, 2000). Social action can be directed toward changing public policy and modifying social and economic determinants of health (Nutbeam, 2000). Enhancing critical mental health literacy promotes collective empowerment and the development of social capital (Nutbeam, 2000; Ratzan, 2001). Because improving critical mental health literacy exerts influence on determinants of mental health, it can result in benefits to
mental health at a population level (Nutbeam, 2000). This is particularly important for marginalized groups suffering from a high incidence of mental health problems related to social and economic conditions, such as Aboriginal people and immigrant populations (Kirmayer et al., 2000; Moldavsky, 2004).

Community empowerment is a key factor in health promotion (WHO, 1998). Community development programs and self-help/peer support initiatives enhance critical mental health literacy because they build social capital and support collective empowerment for action (Corrigan and Penn, 1999). This is a key factor in stigma reduction, as it takes changes to political and economic relationships among social groups to create real improvements in labeling and stereotyping (Corrigan et al., 2003). Social capital is a characteristic of healthy communities that are able to make their own decisions about what is culturally appropriate for them, and thereby improve their own health and wellbeing (Ratzan, 2001). Training in communication and advocacy can advance critical mental health literacy and give people the skills they need to work for social justice (Waring et al., 2000).

Developing alliances and partnerships for advocacy is a key factor in mental health promotion and exemplifies critical mental health literacy in action (Nutbeam, 2000; Ratzan, 2001). Advocacy is often both a result of enhanced mental health literacy and a driver of it (Nutbeam, 2000). Advocating for policy or legislative change occurs when people are aware of and mobilized to fight for policy change, and the policy change then helps to promote mental health literacy. Advocating for collaborative care and a reduction of funding barriers to accessing a range of interventions requires critical literacy, for example, and would support the development of interactive literacy. Negotiating with the media to influence mental health coverage would operate in a similar way (Ratzan, 2001). In Australia, the beyondblue initiative has adopted an agenda for broad social change that includes the removal of key social barriers such as discrimination in employment and insurance (Hickie, 2004; Pirkis, 2004). These types of initiatives are critical in building a society with high mental health literacy and mental health.

REFERENCES


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APPENDIX

Sample Vignettes
Fisher and Goldney, 2003; Link et al, 1999

Depression

Mary (John) is _____ years old. She (he) has been feeling unusually sad and miserable for the last few weeks. Even though she (he) is tired all the time, she (he) has trouble sleeping nearly every night. Mary (John) doesn’t feel like eating and has lost weight. She (he) can’t keep her (his) mind on her (his) work and puts off making any decisions. Even day-to-day tasks seem too much for her (him). This has come to the attention of Mary’s (John’s) boss, who is concerned about her (his) lowered productivity.

Schizophrenia

John (Mary) is ______ years old. Up until a year ago, life was pretty okay for him (her). But then things started to change. He (she) thought that people around him (her) were making disapproving comments and talking behind his (her) back. He (she) was convinced that people were spying on him (here) and could hear what he (she) was thinking. John (Mary) lost his (her) drive to participate in work and family activities and retreated to his (her) room, eventually spending most of the day there. John (Mary) was hearing voices even though no one else was around. These voices told him (her) what to do and what to think. He (she) has been living this way for six months.