MENTAL HEALTH LITERACY in Canada: Phase One Draft Report Mental Health Literacy Project

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CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH

ALLIANCE CANADIENNE POUR LA MALADIE MENTALE ET LA SANTÉ MENTALE

Acknowledgements

The paper was prepared by:

Beverley Bourget
Richard Chenier

for the Canadian Alliance on Mental Illness and Mental Health (CAMIMH),
under the direction of the CAMIMH Mental Health Literacy Project Steering Committee:

Phil Upshall
Annette Osted
Francine Knoops
Joan Montgomery
Darene Toal-Sullivan
Chris Summerville
Mona Forest

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EXECUTIVE SUMMARY

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

CAMIMH was established in 1998 and serves as the only national coalition representing the mental health sector across the continuum of non-governmental stakeholders. The core purpose of CAMIMH is to put mental illness and mental health on the national health and social policy agendas. CAMIMH has been highly effective in forging collaborative national leadership on mental illness and mental health policy through four pillars of public education, research, data collection and reporting, and policy frameworks.

Mental Health Literacy Project

Mental health literacy has been defined as the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy appears to confer a range of benefits: prevention, early recognition and intervention, and reduction of stigma associated with mental illness. The Mental Health Literacy (MHL) project is the first of its kind in Canada, funded by Health Canada under the Population Health Fund (PHFN) as a response to the Chronic Disease - Integrated Approaches to Chronic Disease funding priority. It is a three-year project, which commenced in the fall of 2005. The report represents the conclusion of the first phase of the MHL project, which included a review of existing data, a national survey on MHL and follow-up focus group discussions. The next steps in the project involve sharing project findings and engaging with prospective partners across sectors and developing an *Integrated National Strategy for Canada on Mental Health Literacy.*

Data Sources and Areas of Investigation

Data sources for the MHL project included an extensive review of the research literature pertaining to mental health literacy, preliminary focus group discussions with Canadian seniors and youth, a national survey of Canadians and an Aboriginal survey, and follow-up focus group discussions across Canada. The sample sizes were not large and the focus groups may not have been representative of all Canadians however, in the opinion of the authors, triangulation of results lends credibility to the project findings. For the most part, the results from the surveys and focus groups are mutually confirming and consistent with research findings from the literature review.

Section two of the report includes summaries of the results of each of these investigations and implications for enhancing mental health literacy. The knowledge domains reviewed include prevalence, recognition, perceived causes, attitudes about interventions and recovery, conceptions of mental illness, stigmatizing attitudes and perceptions of dangerousness, beliefs about protecting and promoting mental health, and perceived linkages between mental and physical health.

Section three of the report provides an overview of an integrated model for enhancing mental health literacy, possible strategies and next steps.

KEY FINDINGS

Perceived Prevalence and Recognition of Mental Disorders

Canadians appear to have reasonably good MHL regarding prevalence, awareness of warning signs, and ability to identify a mental disorder as such. These capacities would likely enhance the ability to identify a mental health problem and to intervene early. There is room for some improvement of general knowledge of mental health problems: many people underestimate the prevalence of mental disorders and many, especially youth, confuse other types of disorders with mental disorders.

Perceived Causes

Like people in other countries, Canadians are inclined to prefer psychosocial explanations for mental health problems, although they are more apt to identify biomedical causes for serious mental illness. It is debatable to what extent these tendencies represent an area for intervention. There is strong evidence for psychosocial causal influences especially prolonged stress, for common mental disorders. In addition, biomedical, particularly genetic, explanations can increase stigma and reduce optimism about recovery.

Attitudes about Treatment and Recovery

Compared to those studied in other research, Canadians are more inclined to recommend medical help for symptoms of mental disorders. However, they are still somewhat ambivalent about medical care, especially for common mental health problems and with regard to psychiatric medications, as found in other studies. Focus group results show that many people would like access to a range of treatment options, but many have a poor understanding of the different options available.

Canadians are generally optimistic about the prospect of recovery from mental disorders, but more so for common mental health problems compared to serious disorders.

Conceptions of Mental Illness, Stigma and Perceptions of Dangerousness

Stigma and discrimination toward persons with mental disorders remain somewhat problematic in Canada, although more so for serious mental illness. Canadians know that stigma and discrimination towards mental disorders exist, and they exhibit some reluctance about disclosing mental health problems especially in the workplace, for fear of stigma and discrimination.

Public education about mental disorders may help to reduce stigma. Because Canadians prefer to maintain a distinction between common mental health problems and serious disorders, targeted anti-stigma campaigns may be most effective. For less serious mental disorders, initiatives that emphasize the commonness of mental health problems appear to be helpful. As fear of stigma can deter treatment seeking, access to self-help interventions represents a promising practice. Workplace initiatives are needed to manage people's concerns about disclosing mental health problems at work. Community development and self-help initiatives including training in communication and advocacy, would support mutual empowerment for social action to reduce stigma, end discriminatory practices, and improve services.

Beliefs about Protecting/Promoting Mental Health

Canadians appear to have good knowledge of prevention strategies and many of the strategies they recommended such as social support, physical exercise and stress reduction, are indeed protective factors. The focus group participants who attributed mental illness to genetic causes expressed more pessimism about prevention; this finding calls for careful construction of key messages for educational initiatives.

Perceived Linkages between Mental and Physical Health

Canadians show a good intuitive understanding of the mind/body connection. A significant body of research investigating how the relationship works has emerged in recent years, and people could benefit from this information, to protect their mental and physical health. Raising public awareness about the connections between stress, depression and chronic disease represents a good opportunity for intersectoral collaboration, which is itself integral to effective health promotion.

TOWARDS A NATIONAL STRATEGY FOR MENTAL HEALTH LITERACY

Assessing the degree of mental health literacy in a population depends on how mental health literacy is defined. The existing definition of mental health literacy, knowledge and beliefs about mental disorders that aid their recognition, management or prevention, does not specify which knowledge and beliefs represent good mental health literacy. There is a tendency among professionals to assume the mental health literacy of the public will increase as it comes into alignment with professional thinking and an expectation that this will result in stigma reduction, improvements in help seeking and better treatment outcomes. However, there are limitations and risks to this approach.

Mental health literacy could be more broadly defined as the range of cognitive and social skills and capacities that support mental heath promotion. This includes the capacity to act on social as well as individual determinants of mental health and mental illness. An expanded definition could serve as the basis for a comprehensive, population health model for enhancing mental health literacy, at all levels.

The next stage of this project will be to share project findings with prospective partners across sectors, including existing health prevention/promotion coalitions and alliances, the media, youth, seniors, health care providers, the private sector, other NGOs. Consultations will focus what the findings mean to prospective partners, the potential benefits of an integrated approach, identification of barriers, solutions and proposed contributions to a integrated plan to enhance mental health literacy in Canada.

1. Introduction and Background

Canadian Alliance on Mental Illness and Mental Health

CAMIMH was established in 1998 and serves as the only national coalition representing the mental health sector across the continuum of non-governmental stakeholders. The core purpose of CAMIMH is to put mental illness and mental health on the national health and social policy agendas. Most of the major mental illness and mental health organizations in Canada are now members of CAMIMH including: Autism Society of Canada, Canadian Association for Suicide Prevention, Canadian Coalition for Seniors Mental Health, Canadian Medical Association, Canadian Mental Health Association, Canadian Psychiatric Association, Canadian Psychiatric Research Foundation, Canadian Psychological Association, Registered Psychiatric Nurses of Canada, Native Mental Health Association of Canada, National Network for Mental Health, Mood Disorders Society of Canada, and the Schizophrenia Society of Canada.

CAMIMH has been highly effective in forging collaborative national leadership on mental illness and mental health policy through public education, research, data collection and reporting, and policy frameworks to address major national systemic issues.

Mental Health Literacy Project

In September 2004, CAMIMH submitted a successful proposal to the Population Health Fund (PHFN) to respond to PHFN funding priorities. The MHL proposal was a response to the Chronic Disease - Integrated Approaches to Chronic Disease funding priority. It is a three-year project, which commenced in the fall of 2005. Prior to approval of the project, two related initiatives were conducted, for which funding was provided to CAMIMH from Health Canada under a project amendment as part of financial assistance for National Voluntary Organizations. These are the mental health literacy literature review and the initial exploratory focus groups, which were used in designing the questions for the survey and the second series of focus groups.

The mental health literacy project is the first in Canada to investigate the knowledge, beliefs and understanding that Canadians have about mental illness and mental health. *Health literacy* is defined as the degree to which people can obtain, process and understand basic health information and services they need to make acceptable health decisions. *Mental health literacy* may be understood similarly as knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy is thought to confer a range of benefits: prevention, early recognition and intervention, and reduction of stigma associated with mental illness.

Developing strategies to improve mental health literacy is a relatively new approach to mental health promotion, particularly in Canada. Some countries, such as Australia, have been doing a great deal of work assessing the degree of mental health literacy in the population and applying social marketing approaches to enhance it. In Canada, we are lacking in the information we need to implement a national strategy for action, including critical benchmark data on the level of knowledge and awareness about mental health and mental illness among Canadians. The project has been designed to gather the information needed to implement a collaborative national strategy to improve mental health literacy in Canada.

This report represents the conclusion of the first phase of the project, which involved implementation of a project steering committee, identification of project manager and team, ratification of project purpose and activities, adoption of an evaluation plan, review of existing data, and research on MHL in Canada. The findings of the project are based on four areas of investigation:

- Preliminary exploratory focus groups with Canadian youth and seniors
- Literature review
- National survey
- Follow-up focus groups with a diversity of Canadians.

The next steps in the project involve:

- Sharing project findings and engaging with prospective partners across sectors, including existing health prevention/promotion coalitions and alliances, the media, youth, seniors, health care providers, the private sector, other NGOs, and representatives from provincial health ministries.
- A national inter-sectoral conference to identify priority items for action in the development of an integrated strategy for enhancing mental health literacy in Canada.
- Establishment of an Inter-sectoral Implementation Team to define roles and responsibilities for attaining goals and objectives, identify the resources required to implement the strategy and develop a plan for obtaining these resources.
- An *Integrated National Strategy for Canada on Mental Health Literacy,* which will be shared with project participants and tabled with Health Canada and the Health Council of Canada.

2. Results of Investigations

METHODOLOGY AND LIMITATIONS OF RESEARCH

The Mental Health Literacy project involved four phases of investigation:

- Preliminary exploratory focus groups with Canadian youth and seniors
- Literature review
- National survey of the Canadians
- Follow-up focus groups with a diversity of Canadians.

Literature Review

A review of the research literature pertaining to mental health literacy was conducted in November 2004, and the review was updated in May 2007 with recent research findings. Multiple databases were searched for the following terms and combinations of terms: health literacy, mental health literacy, 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, PsychoInfo, Sociological Abstracts and Social Services Abstracts (Social Work). Other relevant journal articles in the reference list are cited references in the journal articles obtained through database searches, or obtained through web searches.

The literature relating directly to mental health literacy mostly emanates from Australia and Europe, where researchers have studied public knowledge and beliefs about mental illness and mental health. Most of the other literature reviewed related to stigma, public attitudes and perceptions, and public education about mental illness and mental health. Most of the research was focused on depression and schizophrenia, with a smaller number of research articles relating to other mental disorders such as substance abuse or anxiety disorders. The complete literature review may be found in *Appendix A*

National Surveys

CAMIMH solicited bids from three qualified firms for the national MHL survey of Canadians and selected COMPAS Research Inc. to conduct the survey. COMPAS designed the survey questionnaire with input from the CAMIMH Steering Committee and Project Team. The national survey was conducted in March 2006 with 1000 Canadians. The Aboriginal survey was conducted following the national survey and involved 355 First Nations/Métis/Inuit (FNMI) respondents. Due to cost constraints, the FNMI survey had fewer questions than the national survey.

The sample sizes were relatively small. However, the results of the national survey may be considered accurate to within approximately three percentage points 19 times out of 20, and the results of the Aboriginal survey to within approximately five percentage points 19 times out of 20. The results of the Canadian survey are located in *Appendix C* and the Aboriginal survey findings in *Appendix D*.

Focus Groups

The project team conducted two series of focus group discussions across Canada. The first round involved six discussions in five communities with seniors and youth in late winter 2005. The objective was to get a preliminary sense of the mental health literacy of Canadian seniors and youth and to see how closely it corresponded with the literature review findings, in preparation for the development of a national survey. The second round of focus group discussions followed the national survey to obtain a deeper understanding of survey results and other pertinent research findings about mental health literacy in Canada. It involved ten discussions in seven cities across the country.

The facilitators engaged participants in discussions about their knowledge and perception of mental illness, perceived causes, stigma and social distance, how language shapes their thinking, how best to promote and protect mental health and the mind/body connection. Facilitators presented some groups with vignettes used in other research to assess recognition and perceived causes of mental illness, social distance and stigma, and attitudes towards interventions and recovery. They also asked participants about their perceptions of mental illness and mental health.

In total, 126 people participated in the discussions including male, female, senior, youth, Francophone, Aboriginal and Multi-cultural participants. The full reports may be found in *Appendix B and Appendix E.*

Limitations

Sample sizes for the surveys were not large, the literature reviewed did not include an analysis of research methodologies, and the focus groups may not be representative of the population as a whole, or of the respective constituency groups. However, triangulation of results with similar patterns emerging from the literature review, survey and focus group findings, lends credibility to the project report.

Executive Summary of Literature Review

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.[1] 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.[2] It is clear that social determinants of physical health such as poverty, education and social support, also influence mental health.[3] 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.[4]

[1] *WHO, 2001; WHO, 2004a*
[2] *Arben, 1996; Harris, 2001; WHO, 2001*
[3] *Stephens, 2001; WHO, 2004b*
[4] *WHO, 2001*

Mental Health Literacy

The term *mental health literacy* was first introduced in Australia by Anthony Jorm. [5] 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.[6] In recent years the definition has expanded to include a range of increasingly complex cognitive and social skills, which are related to personal and collective empowerment for health promotion. By extending the concept of health literacy to include skills and abilities that humans use to create meaning from and exert control over the environment, the revised definition situates health literacy within a population health model.[7]

Mental health literacy has been defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention".[8] It represents a relatively new area of investigation and, compared with health literacy, researchers and policymakers have not articulated a comprehensive model for mental health literacy as a gradient of evolving skills and capacities that build empowerment for mental health promotion. 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.[9] 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. [10]

In the West, most people believe that psychosocial factors such as environmental stressors or childhood events, are the primary causes of mental disorders.[11] Attitudes towards mental disorders often involve negative stereotypes and prejudice, or stigma.[12] People with mental health problems often fear stigma and this may influence help-seeking behaviour or cause failure to adhere to treatment.[13] Stigma and discrimination in the workplace is common.[14] Stigma and discrimination are associated with fears of

[5] *Jorm, 1997a.*
[6] *Black, 2002; Hixon, 2004*
[7] *Gazmararian et al, 2000; Nutbeam, 2000; Kickbush, 2001; Ratzan, 2001; Rootman, 2002; Rootman, 2004.*
[8] *Jorm, 1997a*
[9] *Priest et al, 1996; Jorm et al, 1997a; Link et al, 1999; Angermeyer and Matschinger, 1999; Jorm, 2000; Highet et al, 2002; Lauber et al, 2003a; Jorm et al, 2005a; Jorm, 2007*
[10] *Goldney et al, 2005; Jorm et al, 2005b; Jorm et al, 2006a; Jorm et al, 2006b*
[11] *Priest et al, 1996; Jorm, 1997b; Link et al, 1999; Jorm, 2000; Walker and Read; 2002*
[12] *Sims, 1993; Priest et al, 1996; Link et al, 1999; Walker and Read, 2002; Corrigan and Penn, 1999; Phelan et al, 2000; Martin et al, 2000; Stuart, 2005*
[13] *Priest et al, 1996; Watson & Corrigan, 2001; McNair et al, 2002*
[14] *Stuart, 2005*

unpredictability and dangerousness.[15] 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 see persons with serious mental illness as potentially violent and dangerous.[16]

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.[17] 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.[18] Having a medical understanding of mental disorders appears to increase stigma and social distance, perhaps because the illness is perceived as fixed and chronic.[19]

Some research shows that the number of people seeking professional help has increased over the years [20] although they still represent a minority of those with mental health problems.[21] 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. [22] Help seeking appears to be influenced by how people define the problem, what they perceive to be the cause, and the anticipated prognosis.[23] In general, people prefer self-help, lay support and lifestyle interventions for mental disorders, and they are uncomfortable with medical and especially pharmacological, interventions.[24] Some studies show that public attitudes about treatment have become more akin to those of mental health professionals over the past few years, perhaps because of public education initiatives.[25]

The range of attitudes among mental health professionals in relation to stigma is similar to that of the general public, and discriminatory behaviour from professionals towards persons with mental illness does occur.[26] Compared to the public, mental health professionals are generally more negative about prognosis and long-term outcomes of mental disorders, and the likelihood of discrimination.[27] Mental health professionals vary considerably in their attitudes toward interventions and this variability relates to professional orientation.[28]

The Role of the Media

[15] *Link et al, 1999; Walker and Read, 2002; Read and Law, 1999; Phelan et al, 2000; Corrigan et al, 2003*
[16] *Pescosolido et al, 1999; Crisp et al, 2000; Phelan et al, 2000; Walker and Read, 2002*
[17] *Martin et al, 2000; Phelan et al, 2000; Angermeyer and Matschinger, 2001; Jorm et al, 2000b; Prior et al, 2003; Mann and Himelein, 2004*
[18] *Pescosolido et al, 1999; Phelan et al, 2000; Prior et al, 2003; Mann and Himelein, 2004; Phelan et al, 2005*
[19] *Read and Law, 1999; Martin et al, 2000; Walker and Read, 2002; Lauber et al 2004*
[20] *Phelan et al, 2000*
[21] *Angermeyer and Matschinger, 1999; Jorm, 2000; Simonds and Thorpe, 2003*
[22] *Jorm et al, 2005b; Jorm et al, 2007*
[23] *Angermeyer and Matschinger, 1999; Lauber et al, 2003a; Prior et al 2003*
[24] *Angermeyer and Matschinger, 1996; Priest et al, 1996; Jorm, 2000; Angermeyer and Matschinger, 2001; Lauber et al, 2001; Hegerl et al, 2002; Hoencamp et al, 2002; Highet et al, 2002; Lauber et al, 2003b*
[25] *Goldney et al, 2005; Jorm et al, 2006a; Jorm et al, 2006b*
[26] *Gray, 2002; McNair et al, 2002; Mazeh et al, 2003; Patel, 2004*
[27] *Jorm et al, 1999; Hugo, 2001*
[28] *Caldwell and Jorm, 2000; Tiemeier et al, 2002*

The media may bear some responsibility for the reported increase in public perceptions of fear and dangerousness related to mental disorders. Although the relationship between the media and personal attitudes and beliefs is complex, the media does appear to exert some effect, particularly regarding perceptions of dangerousness related to serious mental illnesses like schizophrenia.[29] 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.[30]

Cultural and Social Considerations

There are significant cultural variations in how people recognize, explain, experience and relate to mental disorders and treatment.[31] These variations are closely connected to social and environmental conditions.[32] 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.[33]

There are multiple socioeconomic and environmental determinants of mental health and mental illness, just as there are for physical health and physical illness.[34] Social determinants of physical health including poverty, education and social support also influence mental health.[35] 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.[36]

Research on Change Strategies

There is some evidence that people who have information about mental illness are less stigmatizing and more supportive of others who have mental health problems,[37] 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. [38] Because of the public's reluctance to associate common mental health problems with illness, educational and awareness campaigns appear to benefit from reducing the use of language linking common mental health problems with illness, and emphasizing prevalence and shared responsibility.[39] Educational initiatives that provide evidence-based information about which interventions work, how to help oneself, and how to help others, represent promising practices.[40]

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[29] *Granello et al, 1999; Olstead, 2002; Anderson, 2003; Stuart, 2003; Clarke, 2004*
[30] *Stuart, 2003; Clarke, 2004; Stuart, 2005*
[31] *Littlewood, 1998; Kirmayer et al, 2000; Sheikh and Furnham, 2000; Weiss et al, 2000; Jadhav et al, 2001; Moldavsky, 2004; Jorm et al, 2005a*
[32] *Kirmayer et al, 2000, Moldavsky, 2004*
[33] *Littlewood, 1998; Jadhav et al, 2001*
[34] *WHO, 2004b*
[35] *Stephens et al, 2001; WHO, 2004*
[36] *Chandler and Lalonde, 1998; Kirmayer et al, 2000*
[37] *Penn and Couture, 2002; Jorm et al, 2007*
[38] *Paykel et al, 1997; Paykel et al, 1998; Rix et al, 1999; Moncrieff, 1999; Thompson et al, 2000; Hegerl et al, 2003;*
[39] *Walker and Read, 2002; Hegerl et al, 2003; Hickie, 2004*
[40] *Kitchener and Jorm, 2002; Jorm et al, 2003 Christensen et al, 2004;Kitchener and Jorm, 2004; Jorm et al, 2007*

The most comprehensive national campaign to date is *beyondblue: the national depression initiative* in Australia, which involves multiple targeted initiatives:

- 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).

Program evaluations show several positive outcomes.[41]

Most of the research on stigma reduction pertains to serious mental illness and not to common mental health problems.[42] Direct experience with a person with a mental disorder has been shown to improve attitudes and reduce stigma, but is most effective if prolonged, under friendly conditions, and the parties are equal status.[43] Because contact is so powerful, it is important that consumers participate in de-stigmatization campaigns.[44]

Collective empowerment is a key factor in health promotion.[45] Mental health consumer groups who come together for social action experience direct benefits of social support and mutual empowerment. [46] 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.[47] Specific targets for advocacy include improving the quality and quantity mental health services,[48] and eliminating discrimination in the workplace, insurance industry, and housing.[49]

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.[50] 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.[51] This approach does appear to have resulted in some improvements to mental health literacy; 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

[41] *Hickie, 2004; Pirkis, 2004*
[42] *Corrigan and Penn, 1999; Read and Law, 1999; Watson and Corrigan 2001; Wallach, 2004; Stuart, 2005; Corrigan et al, 2005*
[43] *Corrigan and Penn, 1999*
[44] *Read and Law, 1999*
[45] *WHO, 1998; Nutbeam, 2000; Ratzan, 2001*
[46] *Corrigan and Penn, 1999 Waring et al, 2000*
[47] *Kirmayer et al, 2000; Moldavsky, 2004*
[48] *Hickie, 2004; Gow and McGiven, 2004*
[49] *Corrigan et al, 2003; Stuart, 2005*
[50] *Jorm et al, 2006a; Jorm et al, 2006b*
[51] *Jorm et al, 2006a*

as medical illnesses.[52] 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.[53]

For the most part, laypeople resist medical explanations and treatments for common mental health problems and prefer psychosocial, lifestyle and self-help interventions.[54] Some of these beliefs and preferences are supported by research evidence and do not necessarily connote poorer mental health literacy [55] In addition, mental health professionals often differ among themselves with regard to opinions about interventions, [56] and some of the interventions preferred by laypeople are evidence-based. [57] Lay concerns about disclosing mental health problems for fear of stigma and discrimination also have validity.[58]

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.[59]

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. 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.[60] Critical mental health literacy involves the development of skills to critically analyze and use information to mobilize for social and political action, as well as individual action. [61]

[52] *Phelan et al, 2000; Prior et al, 2003*
[53] *Read and Law, 1999; Martin et al, 2000; Walker and Read, 2002; Lauber et al 2004; Phelan et al, 2006*
[54] *Jorm, 1997b; Link et al, 1999; Pescosolido et al, 1999; Phelan et al, 2000; Jorm, 2000; Prior et al, 2003; Mann and Himelein, 2004; Phelan et al, 2006*
[55] *Read and Law, 1999; Stephens et al, 2000; Harris, 2001; Beatson and Taryan, 2003*
[56] *Tiemeier et al, 2002*
[57] *Jorm, 2000; Jorm et al, 2002; Jorm et al, 2004*
[58] *Jorm et al, 1999; Hugo, 2001; McNair et al, 2002 Gray, 2002; Mazeh et al, 2003*
[59] *Herman, 2000; WHO, 2001; Kickbush, 2002*
[60] *Nutbeam, 2000*
[61] *Nutbeam, 2000*

National Survey and Focus Group Findings

INTRODUCTION

The CAMIMH MHL Project Steering Committee selected COMPAS Research Inc. to conduct two surveys on mental health literacy in Canada. COMPAS designed the survey questionnaire with input from the CAMIMH Steering Committee and Project Team. The national survey on mental health literacy was completed in March 2006 with 1000 Canadians. The Aboriginal survey was conducted following the national survey and involved 355 First Nations/Métis/Inuit (FNMI) respondents. The survey report may be found in *Appendix C.*

The project team conducted two series of focus group discussions across Canada. The first round involved six groups with seniors and youth in five communities, in February 2005. The objective was to get a preliminary sense of the mental health literacy of Canadian seniors and youth and how closely it corresponded with the literature review findings, in preparation for the development of a national survey of the mental health literacy of Canadians. The second round of focus group discussions followed the national survey to obtain a deeper understanding of survey results and other pertinent research findings about mental health literacy. It involved ten discussions in seven cities across the country. In total, 126 people participated in the discussions including male, female, senior, youth, Francophone, Aboriginal and Multi-cultural participants. The full reports may be found in *Appendix B and Appendix E.*

SUMMARY OF FINDINGS

Prevalence Rates and Recognition

The actual prevalence rate for mental disorders in Canada is approximately 20%–one in five Canadians will experience a mental illness in their lifetime.[62] The COMPAS poll revealed that almost two-thirds of respondents estimate the prevalence of mental disorders as between one in 10 and one in five Canadians. However, about a third believes that one in 50 Canadians or fewer will experience a mental health disorder. First Nation/Métis/Inuit (FNMI) responses were similar to those of other Canadians. Health care workers were only slightly more accurate in their assessments of the frequency of mental illness compared to other Canadians. Youth were slightly more accurate than older people are.

A large majority of survey respondents agreed that anyone could suffer from mental health problems (90%), that mental health problems are widespread and should get proper attention but people are sometimes too embarrassed to talk about them (82%), and that untreated mental health problems can result in suicide (82%).

Most of the focus group participants asked to assess their own knowledge about mental health problems rated it as low, and many said they would like to learn more. However, they showed a reasonable knowledge of prevalence rates: Few were sure of the exact figures but most agreed that mental health problems are very common. A majority agreed that anyone could suffer from a mental health problem, although several thought the level of personal risk would depend on the type of mental health problem. For example, everyone may be vulnerable to common disorders such as mild depression or

[62] *Government of Canada, 2006*

anxiety but not everyone is at risk for serious disorders. The idea that almost everyone would experience some kind of mental health problem at some point, either personally or through a family member or friend, emerged in almost every group.

> *"Everyone will experience a mental health problem in their lifetime."*
> Winnipeg Focus Group Participant

In the survey, most Canadians correctly identified depression as the most pervasive mental illness. Fifty-eight per cent selected depression, 10% stress or anxiety disorders, and 6% schizophrenia.

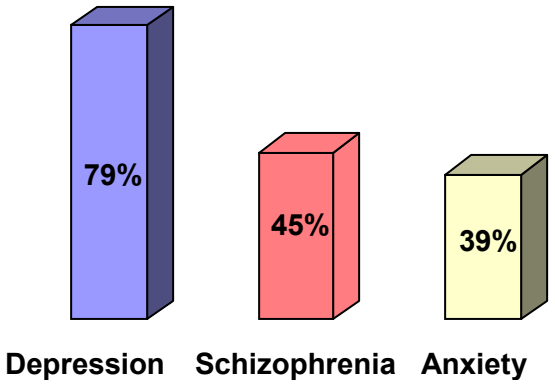
Similarly, when asked to identify the most common mental health problems, the most frequent response in both series of focus groups was depression, followed by anxiety/stress. Almost every group also had participants who identified schizophrenia as a common mental illness. These results are similar to research findings from Australia.[63] Focus group findings also suggest that, like Australians, Canadians do not think of mental health problems as health problems: In the first series of discussions, youth and seniors were asked to identify the major health problems facing their age group, and no one mentioned mental disorders, although depression represents a significant health problem in Canada.[64] Many participants in both series of focus group discussions were unsure of what exactly constitutes a mental illness, and they identified a range of disorders as mental illnesses including developmental disabilities and neurological disorders.

The literature review indicates that people are often unable to identify a mental illness in a vignette using the correct diagnostic label, although recognition of depression has improved over the years in countries that have mounted public education campaigns.[65] Canadians showed a higher degree of recognition of mental disorders, especially depression, than might be expected.

Figure 1 shows the survey results for recognition, with combined responses for the male and female vignettes. Recognition was high for depression, with almost four out of five Canadian respondents able to label depression correctly in a vignette. Accuracy was much lower in the case of vignettes with individuals showing symptoms of schizophrenia and anxiety, and respondents often identified depression incorrectly instead. Women were more accurate than were men. Healthcare workers were only slightly more accurate compared to non-health care workers.

[63] *Highet et al, 2002*
[64] *Government of Canada, 2006*
[65] *Jorm et al, 1997a; Jorm et al, 2005a; Goldney et al, 2001; Lauber et al, 2003; Jorm et al, 2006b*

Figure 1: Recognition of Mental Disorders in a Vignette
(National Survey Results)



FNMI respondents were less likely to label a vignette correctly compared to the general population; they were more likely to give a vague or general evaluation, saying that the character in the scenario has a "mental problem" or a "mental disorder" rather than cite a specific illness. Compared to the general public, FNMI respondents were also more likely to say that they "don't" know" or are "not sure" what is wrong. The reasons for these findings are unclear.

When presented with vignettes of persons exhibiting symptoms of depression or schizophrenia, the Canadian focus groups showed a reasonably high degree of recognition. All of the senior groups and one youth group correctly identified depression. The other youth groups attributed the symptoms to stress/anxiety. Compared to survey findings, recognition for schizophrenia was high, and all of the youth and senior groups correctly identified schizophrenia.

Focus group participants asked about warning signs of a mental health problem showed good recognition. Most participants cited significant changes to normal behaviour such as changes to eating and sleeping patterns, and changes in mood, as warning signs.

Implications for Enhancing Mental Health Literacy

Canadians appear to have reasonably good MHL regarding prevalence, awareness of warning signs, and ability to identify a mental disorder as such. These capacities would likely enhance the ability to identify a mental health problem and to intervene early.[66] While recognition for mental disorders is quite high, Canadians do not always know the correct diagnostic labels. It is not clear how important it is that people know specific diagnostic labels. Diagnostic labeling can increase stigma [67] although unusual or disturbing behaviour is stigmatized more than psychiatric labels per se.[68] However, the capacity to label a mental health problem correctly could improve communications with mental health professionals and increase the likelihood of timely diagnosis and treatment. [69] In any event, there is room for some improvement of general knowledge of

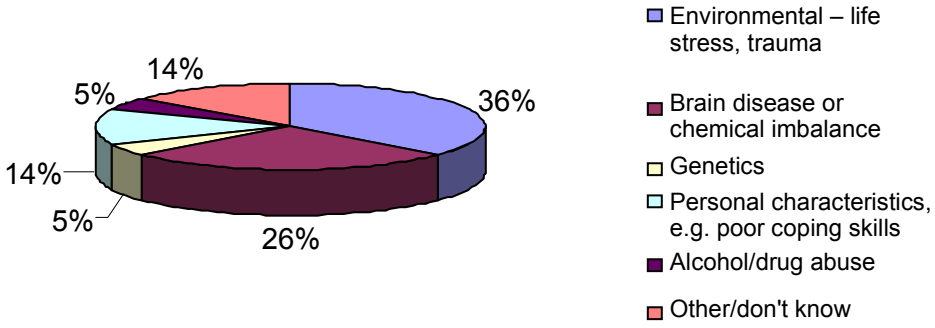
[66] *Jorm, 2000; Jorm et al, 2006a*
[67] *Sartorius, 2002; Patel, 2004*
[68] *Mann and Himelein, 2004*
[69] *Jorm et al, 2000*

mental health problems: many people underestimate the prevalence of mental disorders and many, especially youth, confuse other disorders with mental disorders.

Perceived Causes

The literature suggests that the public believes most mental disorders are caused by psychosocial factors such as environmental stressors or traumatic childhood events.[70] People are more inclined to attribute severe mental illness to biomedical causes like genetics.[71] Canadians consider a wide range of biomedical, social, psychological, and other potential factors as causes of mental illness. However, like people in other countries, they show a preference for psychosocial explanations (Figure 2).

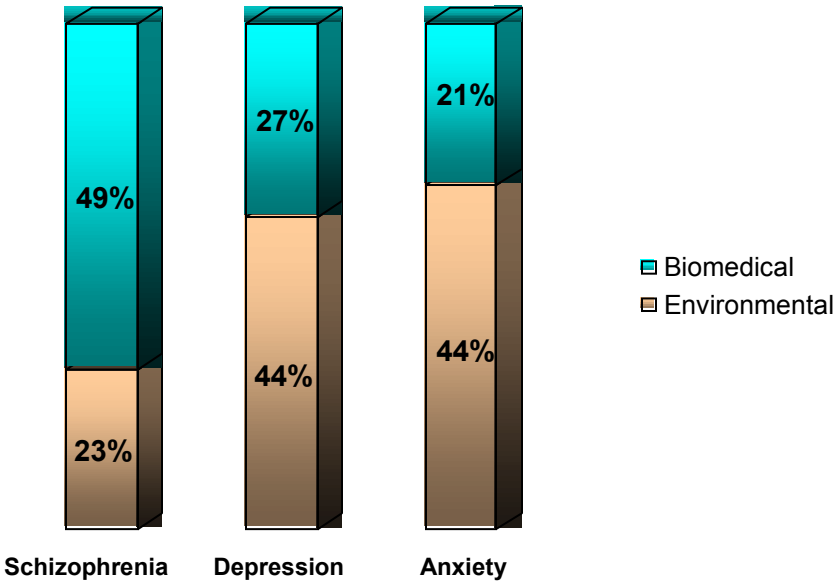
Figure 2: Perceived Causes of Mental Disorders
Summary of National Survey Responses



Canadians are more likely to attribute common mental disorders (anxiety and depression) to psychosocial influences such as life stresses, and more apt to link schizophrenia to biomedical causes, as shown in Figure 3. The most frequently cited environmental causal factor in the survey was stressful life events (divorce, death in the family, relationship or work problems). Less than one-quarter of Canadians linked depression or anxiety to biomedical factors. Chemical imbalance and genetics were cited more often as causes for schizophrenia but even for schizophrenia, less than half of respondents cited biomedical factors as the cause. Bio-medical explanations emerged more often among female respondents (31% vs. 23% among males), the young rather than the elderly (almost a third vs. 21%), and non-Quebecers (27% vs 21% in Quebec).

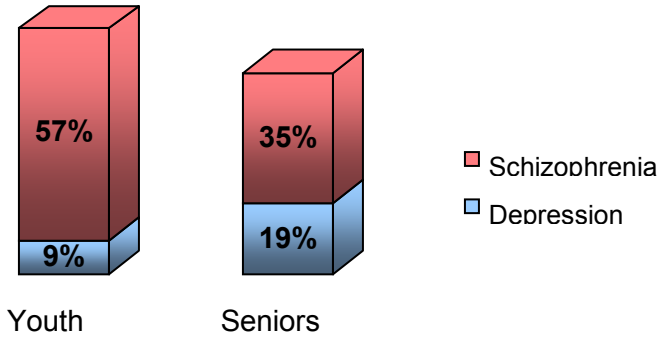
[70] *Priest et al, 1996; Jorm, 1997b; Link et al, 1999: Jorm, 2000; Walker and Read, 2002.*
[71] *Jorm, 1997b; Link et al, 1999,*

Figure 3: Perceived Causes by Disorder
Summary of National Survey Responses



When asked about probable causes for schizophrenia and depression in a vignette, focus group participants primarily cited psychosocial causes, but were more apt to link schizophrenia with biomedical causes, as seen in Figure 4. Bio-medical explanations for depression (genetics, brain disease, chemical imbalance) emerged more often among seniors but youth were more likely to cite biomedical causal factors for schizophrenia.

Figure 4: Proportion of Youth and Seniors Citing Biomedical Explanations for Mental Disorders
Focus Group Results



In the second series of focus groups, participants identified a variety of potential causes for mental health problems, including environmental causes (early childhood experience, life stress, trauma) and genetics. None of the groups excluded genetics as a causal factor, although initial responses leaned toward psychosocial causes: seven of the ten groups initiated the discussion by listing a range of psychosocial causes and two groups did not mention genetic causes until prompted by the facilitator.

The multi-cultural group identified life stress as a primary cause of mental health problems; for example, the challenges involved in adapting to a different culture. The senior group talked about the impact of life change and loss (aging, moving, losing your home, loss of traditional identity, etc), and of social isolation. Youth were more inclined than other groups to cite social pressure as a causal factor – from family, peers, and the media. They also talked about the pressure they are under to succeed in a competitive environment. Youth were the only participants to cite television news coverage of war and violence as a potential cause of mental health problems.

In the survey, FNMI respondents were less likely than were other Canadians to identify biomedical causes (brain disease, chemical imbalance) for mental illness. Their perceptions of which type of psychosocial causal factors are most influential also differed from perceptions of the general public. In the case of depression, FNMI respondents placed less emphasis on stressful life events and more emphasis on traumatic events (such as being victimized by violence), on substance abuse, and on a hard childhood. In the case of schizophrenia, FNMI respondents placed more emphasis on stressful life events, on a hard childhood and possibly on substance abuse. Focus group results showed similar findings: the Aboriginal group, while acknowledging the influence of genetics, placed more weight on environmental causes such as racism and historical trauma.

> *"[Mental health problems are] very common in the Aboriginal community with our history. Residential schools, for example, have had an impact. The trauma shows in mental health problems and there is a lot of trauma in our community."*
> Aboriginal Focus Group Participant

Across the groups, people debated the relative impact of underlying causes (genetics, chemical or hormonal imbalances, childhood abuse) compared to triggering mechanisms. Some argued that stress or traumatic experiences could serve as a trigger. As the discussions progressed, a number of participants concluded that both genetics and environment probably play a role in the onset of a mental illness.

Implications for Enhancing Mental Health Literacy

Like people in other countries, Canadians are inclined to prefer psychosocial explanations for mental health problems, [72] although they are more apt to identify biomedical causes for serious mental illness.[73] The psychosocial explanations provided by focus group participants vary somewhat by age and culture but for the most part, relate to life stress. It is debatable to what extent these tendencies represent an area for intervention. There is strong evidence for psychosocial causal influences, particularly prolonged stress, for common mental disorders. [74] Adopting biomedical and especially genetic explanations, can increase stigma and reduce optimism about recovery.[75] In addition, focus group discussions revealed that people have a general understanding that there are often multiple causal factors at work in the onset of mental disorders.

[72] *Priest et al, 1996; Jorm, 1997b; Link et al, 1999; Jorm, 2000; Walker and Read, 2002*
[73] *Jorm, 1997b; Link et al, 1999; Jorm, 2000*
[74] *Read and Law, 1999; Stephens et al, 2000; Harris, 2001; Beatson and Taryan, 2003; Adelson, 2005*
[75] *Pescosolido et al, 1999; Phelan et al, 2000; Prior et al, 2003; Mann and Himelein, 2004; Phelan et al, 2005*

Knowledge and Attitudes about Interventions

Recommendations for Help Seeking

In the survey**,** the most frequently selected place to turn for help regardless of the type of mental illness was family physicians. Combining family physician and psychiatrist responses, a majority recommended seeking medical help for symptoms of schizophrenia (66%) and depression (61%). Fewer recommended medical help for symptoms of anxiety (46%). About one-third of respondents recommended non-medical interventions (counseling, social support, self-help), even for symptoms of schizophrenia. Sixty-two per cent agreed that psychotherapy could be helpful for people with mental health problems, although only a minority recommended seeking such help when experiencing symptoms of mental illness. Young people were more inclined than others to suggest turning to family and friends. Men were less apt than women to recommend turning to a family physician. Quebecers were less likely to recommend turning to a family physician compared to other Canadians.

FNMI survey respondents were less likely than were other Canadians to recommend seeking medical help (family doctor or psychiatrist) and more likely to recommend seeking help from a counselor, social worker or psychologist or from family and friends. Less than one-half of FNMI respondents recommended seeking medical help, except in the case of a male with symptoms of schizophrenia, where slightly more than one-half (54%) recommended seeking help from a doctor or psychiatrist.

A majority of youth and seniors in the first series of focus groups recommended medical help (GP, psychiatrist or medication) for symptoms of schizophrenia. For depression, seniors were more likely than youth to recommend a medical doctor (but not psychiatry or medication), while the youth favoured informal support from friends, family or school counselors.

The second series of focus groups revealed that many participants have a poor understanding of the roles and responsibilities of different mental health professionals; for example, few know the difference between psychiatrists and psychologists. While recognizing that most persons with a mental health problem seeking help would go to the family doctor, some participants questioned whether family physicians are sufficiently knowledgeable to treat mental disorders.

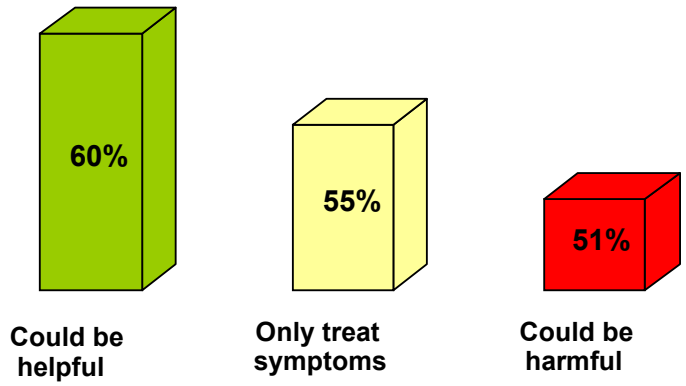
> *"A lot of people go only to the person they know, family doctor. They [the doctors] might not have the skills they need. It should be easier to get help."*
>
> *"Right, it should not be up to the family doctor – it might be out of his context."*
>
> Montreal Focus Group Participants

Despite a tendency to recommend medical help for mental health problems, Canadians show ambivalence about psychiatric medications, as seen in Figure 5, and this corresponds with literature review findings.[76] While a majority of those surveyed agreed

[76] *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*

that medications like anti-depressants could be helpful for people with mental health problems, a majority also agreed that medications treat only the symptoms and not the underlying cause of mental health problems, and that medications could be harmful.

Figure 5: Attitudes about Use of Medications for Mental Health Problems
(National Survey Results)



Focus group results were similar, with people expressing mixed views about psychiatric medication. Several suggested that medication is often prescribed inappropriately, or treats only the symptoms and not the underlying problems. Across the groups, a number of participants suggested that treatment has to address the underlying problem or it will not be helpful.

> *"…If they go for treatment and whatever is causing the problem has not been solved – like family problems, stress – then treatment will not help."*
> Multicultural Focus Group Participant

Most participants acknowledged that medication could be useful as a component of a comprehensive approach, and that it may be necessary for the more serious mental illnesses. However, most did not think that medication is sufficient on its own. In general, people agreed that a variety of treatments and supports could be helpful, depending on the problem. These include professional and non-professional resources (community, peer and family support).

> *"I don't think medications alone are effective. In combination with therapy, community programs, social support, yes. Treatment needs to be more holistic."*
> *Toronto Focus Group Participant*

The Aboriginal group emphasized the importance of culturally appropriate interventions, including a holistic approach, traditional medicine and Elders.

Attitudes about Recovery

Most Canadians surveyed show optimism about the prospect for recovery, with 59% agreeing with the statement that people can recover completely from mental health

problems. Fifty per cent of FNMI respondents agreed with the statement. The survey did not assess attitudes about recovery by type of mental disorder. In the focus groups, participants were generally more optimistic about the prospect of recovery from depression than from schizophrenia, and less likely to say that schizophrenia could improve without treatment compared to depression. This is consistent with research findings that show serious mental illness is more apt to be viewed as a medical illness requiring of treatment, but also as chronic and often not amenable to treatment interventions.[77]

Implications for Enhancing Mental Health Literacy

Canadians show mixed preferences with regard to treatment interventions. While they are more inclined to recommend medical help for symptoms of mental disorders than would be expected from the research, they remain ambivalent about medical care. The ambivalence is more pronounced toward medical treatment for common mental health problems and toward the use of psychiatric medications, as found in other studies.[78] These results are consistent with the expressed beliefs of Canadians about causal factors-–if the principal cause of mental disorders is situational stressors, then as suggested by focus group participants, medication would not address the underlying problem.

The findings may also reflect Canadian health care system realities. Because most people receive their primary health care from physicians and the only publicly funded treatment options are medical, people are more familiar with and are more likely to recommend medical care. This may explain why a majority of survey respondents thought psychotherapy would be helpful but few recommended it, and why in the focus groups, people indicated a preference for a variety of supports but often lacked knowledge about the options available.

There are several implications of these findings for enhancing mental health literacy. As family physicians will continue to serve as primary care providers for most Canadians with mental health problems, enhancing the capacity of physicians to identify and manage mental disorders is essential.[79] Focus group results revealed a preference for a comprehensive approach to mental health care, and collaborative mental health care shows benefits for practitioners and consumers. However, implementation requires advocacy to remove policy and funding barriers. [80]

Empowerment, wherein people gain more control over the decisions and actions that influence their health, is a key concept in health promotion. [81] Focus group participants expressed an interest in accessing a variety of interventions. There is a wide range of psychosocial and self-help interventions known to be helpful for common mental health problems,[82] and Canadians could benefit from education about what works and how to access it. Technology could be a useful tool in this regard, by providing access to web-based information and self-help interventions. [83] We did not investigate self-perceived

[77] *Angermeyer and Matschinger, 1999; Lauber et al 2004; Mann and Himelein, 2004; Phelan et al, 2006*
[78] *Angermeyer and Matschinger, 1996; Priest et al, 1996; Jorm, 2000; Angermeyer and Matschinger, 2001; Lauber et al, 2001; Hegerl et al, 2002; Hoencamp et al, 2002; Highet et al, 2002; Lauber et al, 2003b*
[79] *Rix et al, 1999; Thompson et al, 2000*
[80] *Gow and McNiven, 2004*
[81] *WHO, 1998*
[82] *Gazmararian et al, 2000; Jorm, 2000; Jorm et al, 2002; Jorm et al, 2004*
[83] *Ratzan, 2001; Christensen et al, 2004*

capacity to help others with mental health problems, but there is no reason to think that Canadians would differ significantly from people in other countries in this regard. Educational initiatives could be implemented in Canada to improve individual capacity to provide support to others with mental health problems, as has been done elsewhere. [84]

Conceptions of Mental Illness, Stigma and Perceptions of Dangerousness

The research literature shows that the public tends to characterize severe mental disorders but not common mental disorders, as "mental illness", and has negative perceptions of mental illness including fears of unpredictability and violence. [85] People also resist medical explanations for common mental disorders, and are more inclined to recommend medical interventions for serious mental illness.[86]

Focus group results indicate that Canadians share these tendencies. Both rounds of focus group discussions included a question about what thoughts and images come to mind when people hear the term "mental illness". Most groups mentioned schizophrenia. In every group, stereotypical responses emerged, including terms such as "crazy", "out of control", "unpredictable" and the like. Many suggested this is how other people think or used to think, not how they think, and many said that these perspectives are not representative of most persons with mental disorders. However, some people were very open about their own negative conceptions of mental illness including images of out of control, violent or heavily medicated individuals and institutions. For other participants, mental illness evokes fear, of danger or loss of identity.

> *"I think about – I hope I don't offend anyone – crazy. Someone who cannot control themselves, someone who needs help, who might hurt themselves or somebody else, could be a threat to the general public."*
> Toronto Focus Group Participant

In both series of focus group discussions, people made a clear distinction between common mental disorders (such depression and anxiety) and serious disorders (such as schizophrenia and bipolar disorder). The former are seen as "mental health problems", which are situational, transitory, and not requiring of medical treatment. The participants reserved the term "mental illness" for serious mental disorders, which are chronic, impair capacity to function in life, and call for medical intervention. Most agreed that anyone could suffer from mental health problems but fewer people would be at risk for a mental illness.

> *"Mental health problems are less severe...The more common things, like anxiety and depression, are not mental illnesses. Schizophrenia and bipolar are more mental illnesses."*
> Calgary Focus Group Participant

[84] *Kitchener and Jorm, 2002; Kitchener and Jorm, 2004; Jorm et al, 2005b; Jorm et al, 2007*
[85] *Pescosolido et al, 1999; Walker and Read, 1999; Phelan et al, 2000; Martin et al 2000; Gray, 2002; Prior et al, 2003; Lauber et al 2004.*
[86] *Jorm, 1997b; Angermeyer and Matschinger, 1999; Link et al, 1999; Walker and Read 2002; Prior et al, 2003; Lauber et al, 2003a; Phelan et al, 2006.*

> *"We all have mental health problems, but we are not all mentally ill."*
> Senior Focus Group Participants

Reasons People Might Not Seek Help

Survey respondents were asked to explain why a person with a mental illness might **not** seek assistance. The most frequent response was denial or an inability to recognize having a mental health problem. Being too ashamed or uncomfortable asking for help was in second place. That response was slightly higher for the male character in the vignette, suggesting that men are perceived as having a harder time asking for help. Concerns over the stigma associated with mental illness came third and were roughly equal for all three types of illness discussed. Not knowing where to go for help ranked fourth. If shame and stigma are combined, they become the main reason for not seeking help, edging out denial or a refusal to recognize the problem. FNMI responses were similar to those of other Canadians.

In the focus groups, participants thought that people might be reluctant to seek help because of denial, or fear of being branded or judged. Some reported having had negative experiences themselves from care providers. They also noted that people may not know how to access appropriate help and resources, and that more education is needed to increase awareness about treatment options. They suggested that people will often "tough it out" until they have no choice but to seek help, because of stigma and fear. Canadian beliefs about shame and fear of stigma operating as a deterrent to help seeking correspond with literature review findings. [87]

> *"Most people will probably not seek help until they have to. That's not the way it should be, just the way it is."*
> Calgary Focus Group Participant

[87] *Prior et al, 1996; McNair et al, 2002; Mann and Himelein, 2004*

Attitudes about Media Portrayals

As noted in the literature review, fear and perceptions of dangerousness related to persons with mental illness, particularly those with serious mental illness, may have increased over the past few decades.[88] Some researchers have speculated that media images of persons with serious mental illness, e.g. in popular films, could be playing a role in this.[89] Most people appear to be aware that media portrayals are often inaccurate: a majority of Canadians surveyed (66%) agreed completely or almost completely with the statement that *people with mental health problems are often inaccurately portrayed in the media.* Similarly, focus group participants said the media does not portray mental health problems accurately, primarily because sensationalism sells. It is the most extreme and graphic stories, often involving violence, that are most likely to make news, and these stories often dehumanize the person with mental illness, turning him or her into a label.

Social Distance and Perceived Dangerousness

Stigma is often assessed by asking people about their level of comfort with various situations of increasing social proximity (social distance measures). Preferences about social distance are related to social rejection and stigma,[90] which are also associated with perceptions of dangerousness and fear. [91]

In the survey, Canadians reported some openness to social interaction with the mentally ill but less comfort putting them in positions of responsibility. Asked if they would be comfortable being neighbours or friends with the person in the vignette, most said they would be very or somewhat comfortable, although less so with the person in the schizophrenia vignette, especially a male. When asked how they would feel working on a project with them, the means dropped. Scores were lowest when asked about having the person in the vignette take care of a friend's children. Respondents said they were very or somewhat uncomfortable with a mentally ill person looking after children. They were less comfortable with males with mental illness in this role than with females and least comfortable with the idea of persons with schizophrenia watching children, particularly males.

Similarly, focus group participants were less comfortable with the people in both scenarios (schizophrenia and depression) as social distance decreased, but much less comfortable with the person with schizophrenia. The comment below reveals that, as suggested by research, [92] the symptoms of depression are considered part of normal human experience but the symptoms of schizophrenia are not.

> *"We all go through a mild [depression] period from time to time, but there is no [schizophrenia] period in everyone's life."*
> Sudbury Youth Focus Group Participant

Canadian survey respondents perceive persons with schizophrenia, especially males, as potentially more dangerous compared to persons with other forms of mental illness,

[88] *Phelan et al, 2000; Walker and Read, 2002*
[89] *Granello et al, 1999; Olstead, 2002; Anderson, 2003; Stuart, 2003; Clarke, 2004*
[90] *Corrigan and Penn,, 1999; Corrigan et al, 2003; Phelan et al, 2000; Mann and Himelein, 2004; Lauber et al, 2004*
[91] *Link et al, 1999; Walker and Read, 1999; Phelan et al, 2000; Read and Law, 1999; Corrigan et al, 2001; Corrigan et al, 2003*
[92] *Prior et al, 2003; Gray, 2002; Simonds and Thorpe, 2002; Prior et al, 2003*

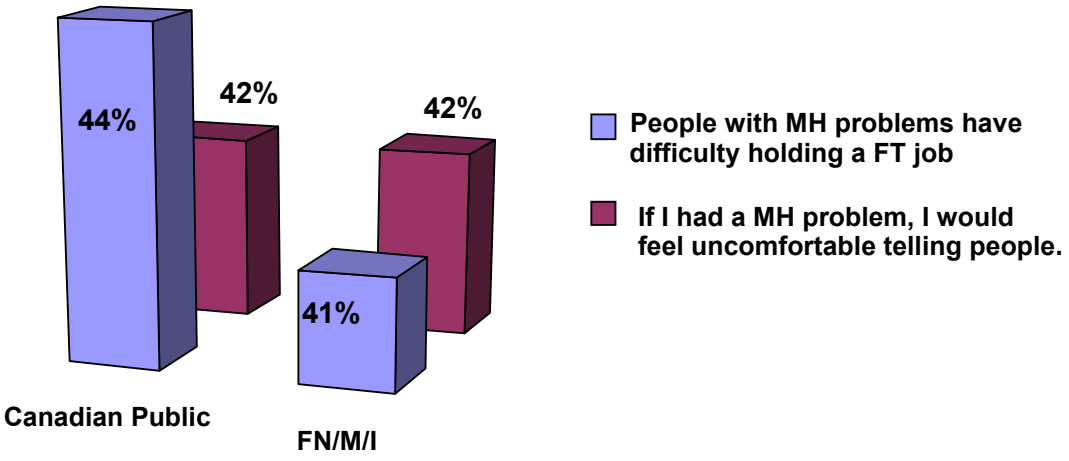
which corresponds with literature review findings.[93] FNMI survey respondents were less likely than were other Canadians to perceive persons with schizophrenia as dangerous, which accords with research findings that show less stigmatization of severe mental illness in non-Western cultures, including some Aboriginal and Inuit communities in Canada. [94]

In focus group discussions, more nuanced responses emerged to the question of dangerousness, and participants said that the chances of a person with mental illness being unpredictable or dangerous would vary, depending on the type of illness, the severity of the illness, the effectiveness of treatment (especially use of medication) and the individual personality. Several said that persons with a mental illness might be more likely to pose a danger to themselves than to others. However, participants did view people with serious mental illnesses, particularly schizophrenia, as potentially more dangerous than people with other mental health problems.

Stigmatizing Attitudes and Fear of Stigma

Responses to other survey questions and comments made in focus group discussions suggest that a significant minority of Canadians continue to hold stigmatizing attitudes towards mental disorders, and that many believe that others subscribe to these views. Survey results (Figure 6) show that many would be uncomfortable revealing a mental disorder and many believe that people with mental health problems would have difficulty working full-time.

Figure 6: Stigmatizing Attitudes about Mental Health Problems
(*National Survey Results)*



The focus participants agreed strongly that stigma and discrimination against people with mental illness still exist in Canadian society, and some suggested that people would suffer until they have no choice but to seek help, due to fear of stigma. Some said that

[93] *Pescosolido et al, 1999; Crisp et al, 2000; Phelan et al, 2000; Mann and Himelein, 2004*
[94] *Littlewood, 1998; Kirmayer et al, 2000*

there is still a stigma from medical professionals toward people with a mental illness, and some reported having had bad experiences with mental health professionals, or knowing someone who has. This is not uncommon–-care providers do sometimes stigmatize persons with mental health problems, and stigmatizing behaviour from professionals can influence treatment continuation. [95]

While some participants thought that stigma towards common mental health problems such as depression has diminished over the years, several expressed concern about disclosing common mental health problems in the workplace, for fear of negative consequences, even in workplaces that provide access to mental health interventions.

> *"I have heard people say they would lose a promotion, not be as credible to their employer, if they opened up in the workplace. I think people might be afraid even if it [mental health services] is confidential."*
> Toronto Focus Group Participant

Most focus group participants agreed that there is no simple answer to the question of whether someone with mental health problems could hold a full-time job. It would depend on a number of factors including the type and severity of disorder, whether the person is receiving effective treatment, and the type of job. Most agreed that workplaces could do more to reduce stigma and to support persons at risk for or suffering from a mental illness, and that they should do more.

Implications for Enhancing Mental Health Literacy

Stigma and discrimination toward persons with mental disorders remain somewhat problematic in Canada, although more so for severe disorders and particularly for males with serious mental illness. Canadians are reluctant to apply the term "mental illness" to common mental disorders, perhaps because of the stigma associated with serious mental illness, perceptions that it is fixed and chronic, and associations with dangerousness. Canadians are aware that stigma and discrimination towards mental disorders exist although there is a perception that stigma has diminished toward common mental health problems, which corresponds with literature review findings.[96] However, they continue to exhibit some reluctance about disclosing mental health problems, especially in the workplace, for fear of stigma and discrimination.

Most of the research on stigma reduction pertains to serious mental illness rather than to common mental health problems. [97] Stigma is much worse toward serious mental illness and is strongly associated with fears of unpredictability and dangerousness. [98] Attitudes towards common mental health problems are relatively benign [99] and the public may overestimate the degree of stigma toward common mental disorders, which can itself undermine help seeking. [100]

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[95] *Sirey et al, 2001; Watson and Corrigan, 2001; Gray, 2002*
[96] *Phelan et al 2000, Angermeyer and Matschinger, 2001; Jorm, 2000b; Mann and Himelein, 2004*
[97] *Link et al, 1999; Read and Law 1999; Phelan et al, 2000; Walker and Read 2000; Corrigan et al, 2003*
[98] *Corrigan and Penn, 1999; Read and Law, 1999; Watson and Corrigan 2001; Wallach, 2004; Stuart, 2005; Corrigan et al, 2005*
[99] *Phelan et al 2000; Jorm et al, 2000b; Angermeyer and Matschinger, 2001; Mann and Himelein, 2004*
[100] *Mann and Himelein, 2004*

There is some evidence to suggest that people who have more knowledge about mental illness are less stigmatizing [101] so education about mental disorders could help to reduce stigma. However, educational campaigns need to be carefully constructed to avoid confirming or increasing stigma, [102] and broad, public campaigns have generally shown limited effectiveness. [103]

Because Canadians prefer to maintain a distinction between common mental health problems and serious disorders, and the research shows this tendency is quite persistent [104] targeted anti-stigma campaigns may be most effective. For serious mental illness, the most effective strategies are contact-based and aimed at the needs of specific sub-groups. [105] This calls for consumer involvement in anti-stigma initiatives.[106] More research is needed on what works to enhance mental health literacy and to reduce stigma regarding serious mental illness. [107]

For less serious mental disorders, initiatives that emphasize the commonness of mental health problems appear to be helpful; this involves soft messaging that places less emphasis on common mental disorders as illnesses and more on prevalence and shared social responsibility. [108]

Because fear of stigma can deter treatment seeking, self-help interventions such as consumer guides, Mental Health First Aid training, and self-directed web-based interventions represent promising practices. [109]

Workplace initiatives are needed to manage people's concerns about disclosing mental health problems at work. Mental Health First Aid Training in workplaces represents a promising practice. [110] 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.[111] Workplace interventions teaching people stress management skills and providing management training also show promise, but more research is needed in this area.[112]

Engaging with the media to improve coverage of mental health issues may be an effective strategy for improving mental health literacy and reducing stigma. However, such efforts are likely to exert the greatest influence if they involve public/private partnerships and alliances (including consumer and caregiver voices) to negotiate collective solutions with the media. [113]

Community empowerment is a critical element of health literacy and a key factor in health promotion [114] Community development and self-help initiatives, including training

[101] *Gray, 2002; Penn and Couture, 2002; Jorm et al, 2007*
[102] *Corrigan and Penn, 1999*
[103] *Byrne, 2001*
[104] *Gray, 2002; Prior et al, 2003*
[105] *Watson and Corrigan 2001; Byrne, 2001; Stuart, 2005*
[106] *Read and Law, 1999*
[107] *Stuart, 2005*
[108] *Hickie, 2004; Pirkis, 2004; Walker and Read; Hegerl et al, 2003*
[109] *Kitchener and Jorm, 2002; Jorm et al, 2003; Kitchener and Jorm, 2004; Christensen et al, 2004; Jorm et al, 2005b; Jorm et al, 2007*
[110] *Kitchener and Jorm, 2002*
[111] *Conway-Grieg and Bell, 2000*
[112] *BOHRF, 2005*
[113] *Ratzan, 2001; Stuart, 2003*
[114] *WHO,1998; Nutbeam, 2000*

in communication and advocacy, support mutual empowerment for social action.[115] For mental health practitioners, enabling users to influence service development is another strong anti-stigma move: collaboration with stigmatized people on projects has had major impacts on attitudes in other arenas of discrimination.[116] Advocacy is needed for health reform for better quality and quantity mental health services,[117] such as collaborative care [118] and improved hospital policies and procedures for treating persons with mental illness.[119] Advocacy is also required for legislative change, to end discrimination against those with mental disorders in the workplace, the insurance industry, and housing.[120]

Beliefs about Protecting/Promoting Mental Health

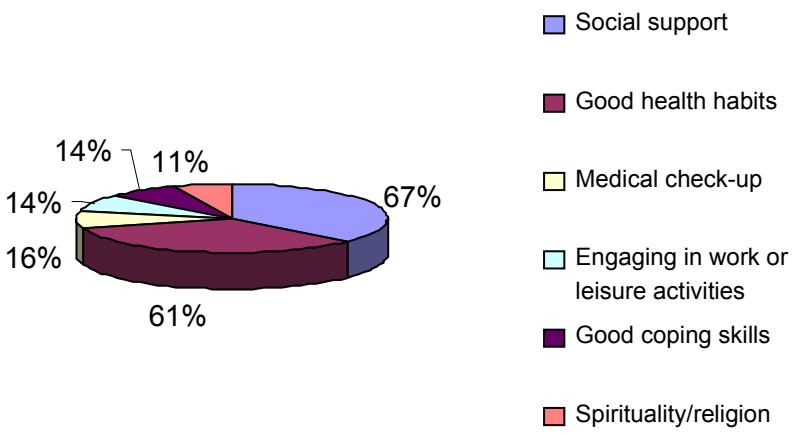
When asked how people could protect mental health and prevent mental illness, most focus group participants identified a number of strategies. Some participants argued that mental illness is not preventable because it is genetic and its appearance at some point is therefore inevitable. Some also made the point that there is no way to prevent traumatic events that could trigger mental illness.

In terms of specific prevention strategies, many participants talked about the importance of stress reduction and coping skills. Most of the groups emphasized the importance of a healthy lifestyle—eating well, exercising regularly, and not taking drugs or drinking to excess. One group agreed that it is important to have life goals. Many participants said that social support, from people you can talk to and who care about you, helps to maintain mental health. In two of the groups, participants talked about the need to live a balanced life, with equal emphasis on the mental, physical and spiritual elements. Some thought that connecting with spirit in the sense of something larger than the individual self, is healing.

The Canadians surveyed showed a similar range of responses, as shown in Figure 7. The most common responses about how to protect or promote mental health related to social support and good health habits, followed by having a medical check-up, engaging in activities for work or pleasure, having good coping skills, and being spiritual or religious.

[115] *Corrigan and Penn, 1999;Waring et al, 2000*
[116] *Gray, 2002; Stuart, 2005*
[117] *Hickie, 2004*
[118] *Gow and McNiven, 2004*
[119] *Stuart, 2005*
[120] *Watson and Corrigan, 2001; Corrigan et al, 2003*

Figure 7: Best Ways to Protect Mental Health
National Survey Results



Social support responses were about having supportive and good relationships with friends and family (42%) and asking for help or talking to family and friends in times of stress or trouble (25%). The good health habits identified as important included physical exercise (25%), getting enough sleep and taking time for relaxation (19%), good eating habits (13%) and getting enough sunshine (4%).

Women were more apt to suggest a medical checkup—20% versus 12% among men. More Quebecers suggested positive thinking (16%) and good eating habits (18%) than did Canadians as a whole (10% and 13%, respectively). Outside Quebec, there was more emphasis on a medical check-up (16% in Canada versus 13% in Quebec) and having good relationships with friends and family (42% in Canada versus 37% in Quebec). Young people were more likely to say that getting enough sleep is important. A quarter of those under 25 chose this option, compared with only 13% of those 65 and older. The elderly recommended medical care more often, with 22% saying that seeking regular medical attention is important, compared with 14% of those under 25.

FNMI survey respondents' views on how to look after their mental health were much the same as those of other Canadians. FNMI respondents were slightly more likely to recommend being spiritual or religious than Canadians as whole (16% versus 11%) and were slightly less likely to recommend good relationships with friends and family (36% versus 42%). In the focus group discussion, the Aboriginal participants emphasized the importance of balance and taking care of the self holistically.

> *"Your soul, your spirit, your emotions, your mind – if you do not take care of all four, you throw yourself out of balance. Just understanding that is so important."*
> Aboriginal Focus Group Participant

In the Francophone and multi-cultural focus groups, participants talked about the need for social change to promote mental health and prevent mental illness, such as addressing social and economic inequities, reducing social pressure to succeed, and strengthening the role of the family.

Some focus group participants said they have enough knowledge and personal empowerment to protect their own mental health. However, some argued that it is not possible to control the onset of a mental illness regardless of the level of knowledge or personal empowerment. Several thought that the ability to monitor and protect mental health requires a high level of insight and self-awareness, which may increase with age and life experience. Many agreed that people would be unlikely to seek information unless directly affected by the issue, and therefore knowledge and capacity to self-monitor would be higher in those who have experience with mental health problems.

Implications for Enhancing Mental Health Literacy

Canadians appear to have good knowledge of prevention strategies and many of the strategies they recommended, such as social support, physical exercise and stress reduction, are indeed protective factors. [121] The focus group participants who attributed mental illness to genetic causes exhibited more pessimism about prevention. This is similar to other research findings showing that biomedical perspectives are associated with increased pessimism about treatment outcomes. [122] Such perspectives may also reduce the sense of personal empowerment for health promotion, if people feel that preventing mental health problems is futile. [123] This calls for careful construction of key messages for educational initiatives about mental health problems and prevention strategies.

Mind and Body:
Perceived Linkages between Physical and Mental Health

Mental health and physical health are closely associated and each influences the other. [124] Many chronic diseases are associated with a higher prevalence of depression including diabetes, cardiovascular disease and arthritis [125] Depression is a risk factor in itself for physical health problems, such as heart disease [126] and it is associated with poorer prognosis and higher risk of all-cause mortality from chronic disease. [127] Research suggests it may also be an independent risk factor for all-cause mortality in older persons. [128] Prolonged stress can lead to depression [129] as well as to physical health problems, such as suppressed immune function, autoimmune disorders, heart disease, diabetes and obesity.[130] These effects occur along a social gradient, as persons of higher social status normally have more control over life events including work, and therefore experience less chronic stress. [131] The mechanisms by which stress and depression lead to physical illness appear to be related to damage to the body from prolonged exposure to stress hormones. [132]

Almost all of the focus group participants agreed that there is a link between mental and physical illness. Many perceive the relationship as bilateral: that mental health could

[121] *Stephens et al, 2000; WHO, 2004b*
[122] *Read and Law, 1999; Martin et al, 2000; Walker and Read, 2002; Lauber et al 2004; Phelan et al, 2006*
[123] *Read and Law, 1999; Harris, 2001*
[124] *WHO, 2004b*
[125] *Kivimaki et al, 2003*
[126] *Abas, 2002*
[127] *Kivimaki et al, 2003*
[128] *Schulz et al, 2000*
[129] *Adelson, 2005*
[130] *Johnston-Brooks et al, 1998; Egede, 2005; NIH, 2002; Boscarino, 2004; Chandola et al, 2006*
[131] *Evans et al, 1994; Chandola et al, 2006*
[132] *Johnston-Brooks et al, 1998; NIH, 2002; Abas, 2002; Boscarino, 2004;Chandola et al, 2006*

affect physical health and vice versa. Most said that mental health problems could lead to poor physical health through wear and tear on the body from stress or poor health habits. Many also thought that people with chronic, debilitating health problems, such as cancer, HIVAIDS, or chronic pain, could have an increased vulnerability to mental health problems. No one connected physical health problems to disorders such as schizophrenia. No one in any group made a specific linkage between heart disease and stress or depression.

Implications for Enhancing Mental Health Literacy

Canadians show a good intuitive understanding of the mind/body connection. A body of research investigating how this relationship works has emerged in recent years, and people could benefit from this information to protect their mental and physical health.[133] Raising public awareness about the connections between stress, depression and chronic disease represents a good opportunity for intersectoral collaboration, which is itself integral to effective health promotion. [134]

SPECIFIC ISSUES

First Nation, Métis and Inuit People

FNMI survey respondents and focus group participants differed in some respects from the broader Canadian population. They placed less emphasis on biomedical causes of mental disorders and more emphasis on traumatic events and substance abuse. They were less inclined to recommend medical treatment and more in favour of seeking help from counselors, social workers or friends and family. They placed a high priority on access to culturally appropriate interventions, including a holistic approach, traditional medicine and Elders.

The experiences of colonization, oppression and abuse, and loss of cultural continuity have left a legacy of historical trauma for Indigenous people in Canada, and this continues to influence mental health.[135] Suicide rates are much higher in many Aboriginal communities compared to suicide rates of the general population.[136] Many Indigenous cultures around the world have been subjected to similar processes, the effects of which are akin to the disruptions and collective trauma experienced by victims of war and natural disasters. [137]

Strategies to enhance mental health literacy of Aboriginal people must involve community development and community empowerment, and must focus on the social determinants of mental health. Cultural renewal and enhancement are critical strategies for mental health promotion in Aboriginal communities[138] and these must be led by Aboriginal people and be consistent with the Aboriginal worldview. [139] This involves conceptions of whole person and whole community health.[140] Strategies to enhance

[133] *WHO, 2004b*
[134] *WHO, 1998; WHO, 2004b*
[135] *RCAP, 1995; Chrisjohn et al, 1997; Kirmayer et al, 2000; Wesley-Esquimaux and Smolewski, 2004*
[136] *Leenaars, 2000; Statistics Canada, 2006*
[137] *RCAP, 1995*
[138] *RCAP, 2005; White and Jodoin, 2004*
[139] *RACP, 1995; Kirmayer, 1999; Smye and Mussell, 2001; Health Canada, 2003; Mussell et al, 2004; White and Jodoin, 2004; Brant-Castellano, 2005.*
[140] *Health Canada, 2003*

mental health literacy must also attend to socioeconomic factors and basic needs such as food security, housing, and employment. [141]

Children and Youth

A number of the Canadian focus group participants spoke about the effects of early experience and parenting on mental health and emphasized the need for parent education. There is strong evidence of the effect of early experience, particularly traumatic experience, on mental health throughout life [142] and improving the mental health literacy of parents with regard to the importance of good early nurturing, would appear to be a priority. Effective parenting interventions show good long-term results in terms of child mental health and wellbeing. [143]

Contrary to what previous research has shown, a recent Canadian study indicates that youth mental health is poor compared to persons in other age groups, and that mental health generally improves across the lifespan. [144] This could be attributed to the improvement in socioeconomic conditions for seniors relative to those of youth over the past few decades. Responses of youth participants suggest that they experience significant social pressure to fit in with peers and to succeed in a competitive environment. Focus group participants stressed the need for education about and support for mental health problems in school, starting early, and school-based interventions for mental health promotion have shown positive results. Engaging youth in sharing information about mental disorders represents a promising approach to reducing stigma and building empowerment.[145]

[141] *Smye and Mussell, 2001; Mussell et al, 2004*
[142] *Mustard and Cynader, 1997; Perry, 1997; Stephens et al, 2000*
[143] *Jané-Llopis, 2006*
[144] *Stephens et al, 2000*
[145] *Waring et al, 2000; Jané-Llopis, 2006*

3. Toward a National Strategy for Mental Health Literacy

MODEL FOR ENHANCING MENTAL HEALTH LITERACY

Assessing the degree of mental health literacy in a population depends on how mental health literacy is defined. The existing definition of mental health literacy as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" [146] does not specify which knowledge and beliefs represent good mental health literacy. There is a tendency among professionals to assume the mental health literacy of the public increases as it aligns with professional thinking [147] and an expectation that this will result in stigma reduction, and improvements in help seeking and treatment outcomes.[148] However, there are many reasons for caution about adopting this approach, including its inability to encompass the complex and evolutionary character of health literacy[149], its limited explanatory power for the broader social and situational determinants of mental health[150] and its emphasis on medical perspectives, which may be associated with disempowerment, pessimism, and increased stigma. [151]

Mental health literacy could be more broadly defined as the range of cognitive and social skills and capacities that support mental heath promotion. This includes the capacity to act on social as well as individual determinants of mental health and mental illness. [152] An expanded definition for mental health literacy could be the basis for a comprehensive model for enhancing mental health literacy. Such a model could accommodate a diversity of attitudes and beliefs about mental health and mental disorders, insofar as these 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, and critical analysis and collective empowerment for action on the social and environmental determinants of mental health. It would support social as well as individual benefits, building social capital, and promoting social and economic development.[153] Ultimately, it is expected to result in improved individual and population mental health outcomes. [154]

[146] *Jorm, 1997b*
[147] *Heginbotham, 1998; Link et al, 1999; Read and Law, 1999 Prior et al, 2003; Jorm et al, 2006a; 2006b*
[148] *Jorm, 2006a*
[149] *Nutbeam, 2000*
[150] *Summerfield, 2001*
[151] *Read and Law, 1999; Martin et al, 2000; Walker and Read, 2002;Mann and Himelein, 2004; Lauber et al 2004; Phelan et al, 2006*
[152] *WHO, 2001; Summerfield, 2001; Kickbush, 2002; WHO, 2004*
[153] *Kickbusch, 2002*
[154] *Nutbeam, 2000*

STRATEGIES TO ENHANCE MENTAL HEALTH LITERACY

Enhancing Functional Literacy

At the most basic level, mental health literacy is linked to general literacy. Problems with general literacy are prevalent in the developed world, where it has been estimated that 100 million people are functionally illiterate.[155] In Canada, four out of ten adults, representing nine million Canadians, struggle with low literacy, [156] and sixty per cent of immigrants have low literacy.[157]

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. [158]

Addressing issues of general literacy is critical to enhancing mental health literacy, and to increasing the overall health and quality of life for people in all societies.[159] All information, including reading materials, posters and signage, must be provided at literacy levels that will reach the broadest audience, i.e. in plain writing. [160] Mental health care providers must be aware of the issue and prepared to individualize care for and assist persons who have low literacy levels. [161] 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.[162]

Enhancing Interactive 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. [163] Effective health communication strategies, including public education and social marketing initiatives, support skill development and informed choice. These can engage people within the context of existing individual and cultural beliefs, as they provide information for people to think about, rather than telling them what to think.[164] They would involve education to advance understanding at all levels: how to prevent mental health problems, how to intervene early, and how to manage a mental disorder.[165] New technologies offer new opportunities for wide dissemination of information for individual use.[166]

Mental health care providers can facilitate the development of interactive mental health literacy by developing partnerships with clients and supporting informed choice. [167]

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[155] *Kickbusch, 2001*
[156] *ABC Canada, 2005a*
[157] *ABC Canada, 2005b*
[158] *Nutbeam, 2000*
[159] *Kickbusch, 2001*
[160] *Black, 2002; Hixon, 2004*
[161] *Hixon, 2004*
[162] *Mubbashar and Farooq, 2001*
[163] *Nutbeam 2000*
[164] *Ratzan, 2001*
[165] *Ratzan, 2001*
[166] *Ratzan, 2001*
[167] *Bauman et al, 2003*

Good communication promotes competence and personal control of clients over health, and improves the satisfaction of both parties. [168] The development of mental health communication strategies using an accessible format, such as translating research findings into plain language, would support the development of interactive mental health literacy.[169] Public education about mental health and mental disorders using terms with which people are comfortable, would fit here. This could include information about prevalence, prevention, interventions, self-help, and helping others. Self-help initiatives such as web-based self-directed therapy programs, would also promote empowerment and choice.

Enhancing Critical Literacy

Critical mental health literacy involves the capacity to critically analyze and use information to mobilize for social and political action, as well as individual action.[170] Social and political action can be directed toward changing public policy and the modifying social and economic determinants of health. [171] Enhancing critical mental health literacy supports collective empowerment and the development of social capital. [172] 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.[173] Such initiatives are 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.[174]

Community empowerment is a key factor in health promotion.[175] Community development programs and self-help/peer support initiatives develop critical mental health literacy because they build social capital and support collective empowerment for action. [176] 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.[177] Social capital is a characteristic of healthy communities, and healthy communities are able to make their own decisions about what is culturally appropriate for them, and to take community action to improve their own health and wellbeing. [178] Training in communication and advocacy can advance critical mental health literacy by giving people the skills they need to work for social justice. [179]

Developing alliances and partnerships for advocacy is a key factor in mental health promotion and exemplifies critical mental health literacy in action. [180] Advocacy is often both a result of enhanced mental health literacy and a driver of it. [181] Advocating for policy or legislative change, for example, occurs when people are aware of and mobilized to fight for policy change, and the policy change helps to promote mental health literacy. For example, advocating for collaborative care and a reduction of

[168] *Makoul et al, 1995; Bauman et al, 2003*
[169] *Ratzan, 2001*
[170] *Nutbeam, 2000*
[171] *Nutbeam, 2000*
[172] *Nutbeam, 2000; Ratzan, 2001*
[173] *Nutbeam, 2000*
[174] *Kirmayer et al, 2000; Moldavsky, 2004*
[175] *WHO, 1998*
[176] *Nutbeam, 2000*; *Corrigan and Penn, 1999*
[177] *Corrigan et al, 2003*
[178] *Ratzan, 2001*
[179] *Waring et al, 2000*
[180] *Ratzan, 2001*
[181] *Nutbeam, 2000*

funding barriers requires critical literacy. Successful implementation of a range of funded interventions would support the development of interactive literacy by empowering users. Negotiating with the media to influence mental health coverage would operate in a similar way.[182] 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.[183] These types of initiatives are critical in building a society with high mental health literacy and mental health

At the collective level, a critical benchmark of the mental heath literacy of Canadian society would be the development and implementation of a multi-faceted national strategy to improve knowledge, understanding and capacity to act to prevent and manage mental disorders. This would include partnership initiatives and programs that engage government and non-governmental organizations, consumers, family members, researchers and others working in the areas of health and mental health. A national strategy would operate across multiple domains simultaneously, with programs designed to:

- increase community awareness of mental disorders and implement prevention and early intervention strategies with families, schools and workplaces
- support active consumer participation, in research, public education and advocacy
- develop new models of primary care, including collaborative care and primary care physician training
- advocate for progressive policies and adequate funding for research and for prevention, treatment and supportive services.

NEXT STEPS

Partner Engagement

CAMIMH'S research relating to MHL reinforces the fact that the social, health and economic burden of mental illness is a major public health problem for Canadian consumers and our society as a whole. CAMIMH further recognizes that collaborative and sustained strategies and national courses of action are necessary to understand mental health literacy in this country and to formulate public policies and programs which challenge perceptions of mental illness, increase knowledge of mental health issues and provide support to Canadians in need. These investigations will serve as a model and foundation for cross-sector collaboration and relationship building in understanding and ultimately enhancing mental healthy literacy in Canada.

The next stage of this project will be to share project findings with prospective partners across sectors, including existing health prevention/promotion coalitions and alliances, the media, youth, seniors, health care providers, the private sector, other NGOs. This consultation process will focus on the following questions:

- What do the findings on mental health literacy mean to them and their sector?

[182] *Ratzan, 2001*
[183] *Hickie, 2004; Pirkis, 2004*

- What are the potential benefits of developing an integrated approach to enhancing mental health literacy in terms of chronic disease prevention and health promotion?

- What are the myths and barriers related to working collaboratively on the issue of mental health literacy?

- What are the solutions and what could each sector contribute in terms knowledge and/or resources to implement an integrated plan to enhance mental health literacy in Canada over the next three to five years?

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GLOSSARY

Advocacy for Health

In health promotion, advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program.

WHO Health Promotion Glossary, 1998

Collaborative Mental Health Care (CMHC)

CMHC is described as a collaboration between a broad range of mental health providers (psychiatrists, social workers, psychologists, psychiatric nurses, among others) and a full array of primary health care workers (physicians, nurses, social workers, among others). There are three main goals of collaborative care: increasing mental health access, optimizing mental health care and decreasing the burden of illness. These goals are met by increasing accessibility: "bringing services closer to home", using a number of different approaches.

Collaborative Care Approaches: Review of Selected International Initiatives (September, 2004) Draft Report. Prepared for: The Canadian Collaborative Mental Health Initiative. Trent Gow, TGA Policy Solutions; Maia MacNiven, MC MacNiven Consulting

Community Action for Health

Community action for health refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health.

WHO Health Promotion Glossary, 1998

Community Development

Community development is a range of activities dedicated to increasing the strength and effectiveness of communities, improving local conditions (especially for people in disadvantaged situations) and enabling people to participate in public decision-making and to achieve greater long-term control over their circumstances.

WHO Health Promotion Glossary, 1998

Empowerment

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

WHO Health Promotion Glossary, 1998

Determinants of Health

The range of personal, social, economic and environmental factors which determine the health status of individuals or populations.

WHO Health Promotion Glossary, 1998

Health Education

Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours and use of the health system.

WHO Health Promotion Glossary, 1998

Health Communication

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development**.**

WHO Health Promotion Glossary, 1998

Intersectoral Collaboration

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

WHO Health Promotion Glossary, 1998

Health Literacy

Health literacy was 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 higher order cognitive and social capacities that develop along a gradient of increasingly complex and interactive skills, and that relate to personal and collective empowerment.

By extending the concept of health literacy to include the skills and abilities that humans use to create meaning from and exert control over the environment, the revised definition brings health literacy into the domain of health promotion and situates it within a population health model.

Nutbeam, D. (September, 2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. Health Promotion International. 15(3): 259-266.

Kickbush, I.S. (September, 2001). Health literacy: Addressing the health and education divide. Health Promotion International. 16(3): 289-297.

Health Promotion

Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

WHO, Health Promotion Glossary, 1998

Mental Health

Mental health is a state of wellbeing in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

WHO (2001). *Strengthening Mental Health Promotion*. Geneva, World Health Organization, Fact Sheet 220.

Mental Health Literacy

Mental health literacy is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention", and is thought to consist of several components, including:

- 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 into public beliefs suggests that mental health literacy involves a number of factors, and that knowledge and beliefs about mental health disorders emerge from general pre-existing belief systems about health and health interventions.

Jorm, A.F., Korten, A.E. , Jacomb, P.A., Christensen, H., Rodgers, B. & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia. 166: 182-186.

Jorm, A. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. British Journal of Psychiatry. 177:396-401.

Social Capital

Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate coordination and cooperation for mutual benefit.

WHO Health Promotion Glossary, 1998

Social Support

Social support is that assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life.

WHO Health Promotion Glossary, 1998

Stigma

Stigma is a mark of disgrace or discredit that sets a person apart from others. It involves negative stereotypes and prejudice about others and is often measured in terms of social distance (the degree to which people are willing to interact socially with others). Stigma can be *enacted* through social rejection and discrimination or *felt* as the fear of social rejection and discrimination (Scrambler, 1998).

Byrne, P (2001). Psychiatric stigma. British Journal of Psychiatry. 178:281-284.
Corrigan, P.W. & Penn, D.L. (September, 1999). Lessons from social psychology on discrediting psychiatric stigma. American Psychologist. 54(9): 765-776.
Scambler, G. (1998) Stigma and disease: Changing paradigms. The Lancet. 352: 1054-1055.