ความรอบรู้ด้านสุขภาพจิต: ปิดช่องว่างความเข้าใจ เพื่อผลลัพธ์ที่ดีกว่า

วิวัฒนาการ บทพิสูจน์ และ 4 เสาหลักสู่การลงมือทำ
(Evolution, Evidence, and the 4 Pillars of Action)

อ้างอิงจากบทบรรยายโดย Anthony Jorm
ลำดับความสำคัญเชิงกลยุทธ์สำหรับ APEC

1997: ความรู้เพื่อการตระหนัก (Passive Recognition)

ความรู้และความเชื่อเกี่ยวกับความผิดปกติทางจิต ที่ช่วยในการจดจำ จัดการ หรือป้องกัน

เน้นที่การมีข้อมูลพื้นฐานและการรับรู้ว่าปัญหาคืออะไร (Knowledge as a baseline).

2025: ความรู้สู่การลงมือทำ (Active Intervention)

ความรู้เกี่ยวกับปัญหาสุขภาพจิตที่เป็นรากฐานของการลงมือทำ ซึ่งสร้างประโยชน์ต่อสุขภาพจิต

ความรู้จะไม่มีประโยชน์หากไม่นำไปสู่การปฏิบัติ (Knowledge linked to action).

เกณฑ์ 3 ประการของความรู้ที่ประชาชนต้องการ:

1. **ตรงกับบริบท**
(Relevant to life stage/culture)

2. **นำไปสู่การปฏิบัติ**
(Underpins action)

3. **เป็นประโยชน์ต่อสุขภาพจิต**
(Benefits mental health)

กลไกการขับเคลื่อน: ความรอบรู้สร้างสุขภาพที่ดีได้อย่างไร?
(The Program Logic)

การแทรกแซง
(Intervention)

การให้ความรู้ การรณรงค์
และการฝึกอบรมในระดับ
ชุมชนหรือองค์กร

ความรอบรู้ด้านสุขภาพจิต
(Mental Health Literacy)

ความเข้าใจที่ถูกต้อง
เกี่ยวกับอาการ
การปฐมพยาบาล
และแหล่งช่วยเหลือ

การลงมือทำ
(Mental Health Action)

การตัดสินใจ
ช่วยเหลือตนเอง
การเข้าสู่ระบบการรักษา
หรือการสนับสนุนผู้อื่น

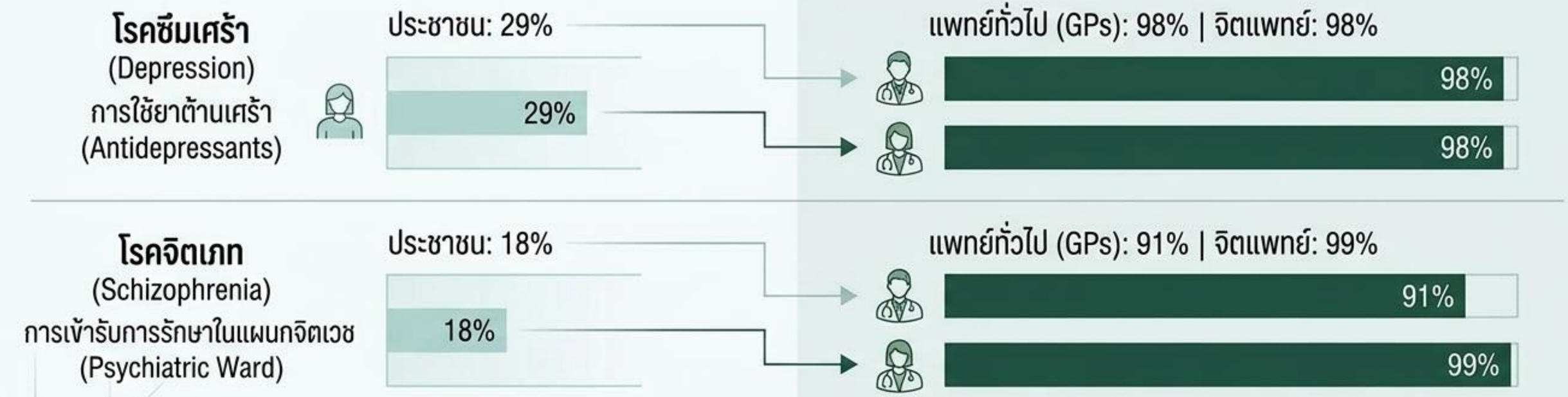
สุขภาพจิตที่ดีขึ้น
(Improved Mental Health)

ผลลัพธ์สุดท้าย:
อัตราการฟื้นตัวสูงขึ้น
และลดความสูญเสียจาก
วิกฤตสุขภาพจิต

วิกฤตความเข้าใจ: ช่องว่างระหว่างประชาชนและแพทย์ผู้เชี่ยวชาญ

ความเชื่อของประชาชนทั่วไปเกี่ยวกับวิธีการรักษาที่ได้ผล สวนทางกับข้อเท็จจริงทางการแพทย์อย่างสิ้นเชิง

Comparison Matrix: Public Belief vs. Professional Consensus



⚠ **วิกฤตความเสี่ยง:** ความคลาดเคลื่อนนี้ส่งผลให้ผู้ป่วยปฏิเสธการรักษาที่ได้ผลจริง และนำไปสู่ผลลัพธ์ที่เลวร้ายลง

3 ปัจจัยหลัก: ประชาชนมองรูปแบบการรักษาอย่างไร? (General Factors of Literacy)

ความเข้าใจของประชาชนมักถูกแบ่งออกเป็น 3 กลุ่มแนวทาง

ปัจจัยทางการแพทย์ (Medical Factor)

ยารักษาโรคทั้งหมด (ยกเว้นวิตามิน)
การรักษาในแผนกจิตเวช
การทำภาพบำบัดด้วยไฟฟ้า (ECT)

กลุ่มที่ประชาชนมักมีทัศนคติเชิงลบหรือหวาดกลัวมากที่สุด

ปัจจัยทางจิตวิทยา (Psychological Factor)

นักให้คำปรึกษา
นักสังคมสงเคราะห์
จิตแพทย์
นักจิตวิทยา
จิตบำบัด
สายด่วนให้คำปรึกษา

กลุ่มที่ได้รับการยอมรับและเข้าถึงได้ง่ายกว่าในความรู้สึกของประชาชน

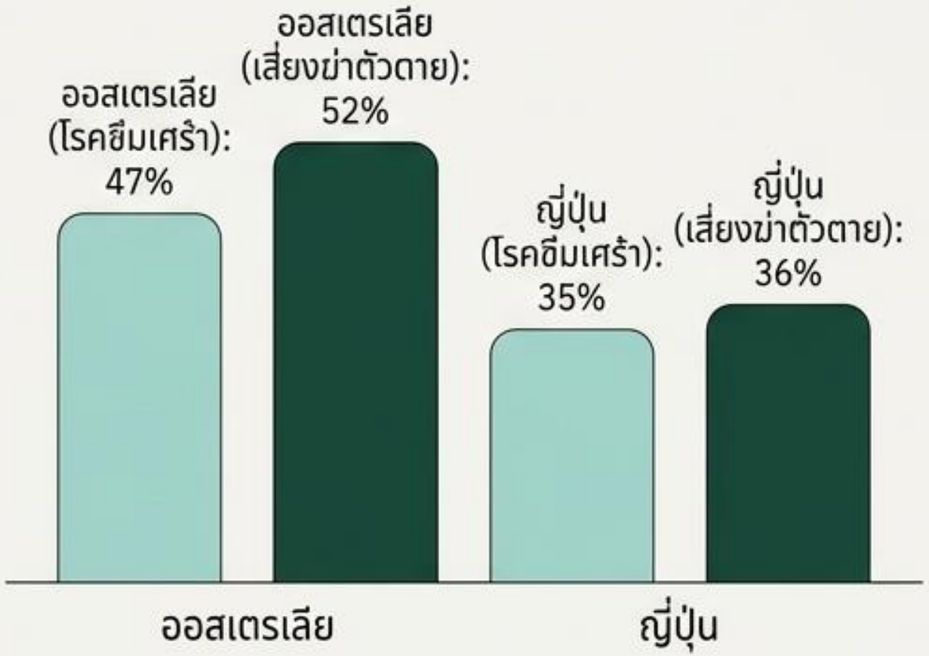
ปัจจัยด้านวิถีชีวิต (Lifestyle Factor)

ครอบครัว
เพื่อนสนิท
วิตามิน
ธรรมชาติบำบัด
การออกกำลังกาย

กลุ่มที่ประชาชนให้คะแนนความเชื่อมั่นสูงที่สุด แม้ในภาวะเจ็บป่วยรุนแรง

บริบทระดับสากล และมายาคติเรื่องวิตามิน

ความเชื่อมั่นในยาต้านเศร้า



แม้ในกลุ่มประเทศพัฒนาแล้ว ความเชื่อมั่นใน วิธีรักษามาตรฐานทางการแพทย์ก็ยังอยู่ในระดับต่ำ

มายาคติเรื่องวิตามิน (The Vitamin Myth)

ประชาชนออสเตรเลียมักมองว่าการพึ่งพา:

- **นักให้คำปรึกษา** (74%)
- และ **วิตามิน** (57%)

มีประโยชน์ในการรักษา โรคซึมเศร้า มากกว่าการพบ:

- **นักจิตวิทยา** (49%)
- หรือ **การใช้ยาต้านเศร้า** (29%)

ประชาชนมีแนวโน้มประเมินค่าวิธีทางเลือกสูงเกินจริง และประเมินค่าการแพทย์มาตรฐานต่ำเกินจริง

4 เสาหลักของความรอบรู้ด้านสุขภาพจิต (The 4 Pillars of Knowledge)

โครงสร้างข้อมูลพื้นฐานที่ประชาชนจำเป็นต้องรู้เพื่อปิดช่องว่างความเข้าใจ

1. ความช่วยเหลือจากผู้เชี่ยวชาญ (Professional Help)

เข้าใจบทบาทของแพทย์และเข้าถึงการรักษาที่ผ่านการพิสูจน์แล้ว

2. กลยุทธ์การดูแลตนเอง (Self-Help)

รู้วิธีการดูแลตนเองที่มีประสิทธิภาพและอิงหลักฐานทางวิทยาศาสตร์

3. การปฐมพยาบาลด้านสุขภาพจิต (First Aid)

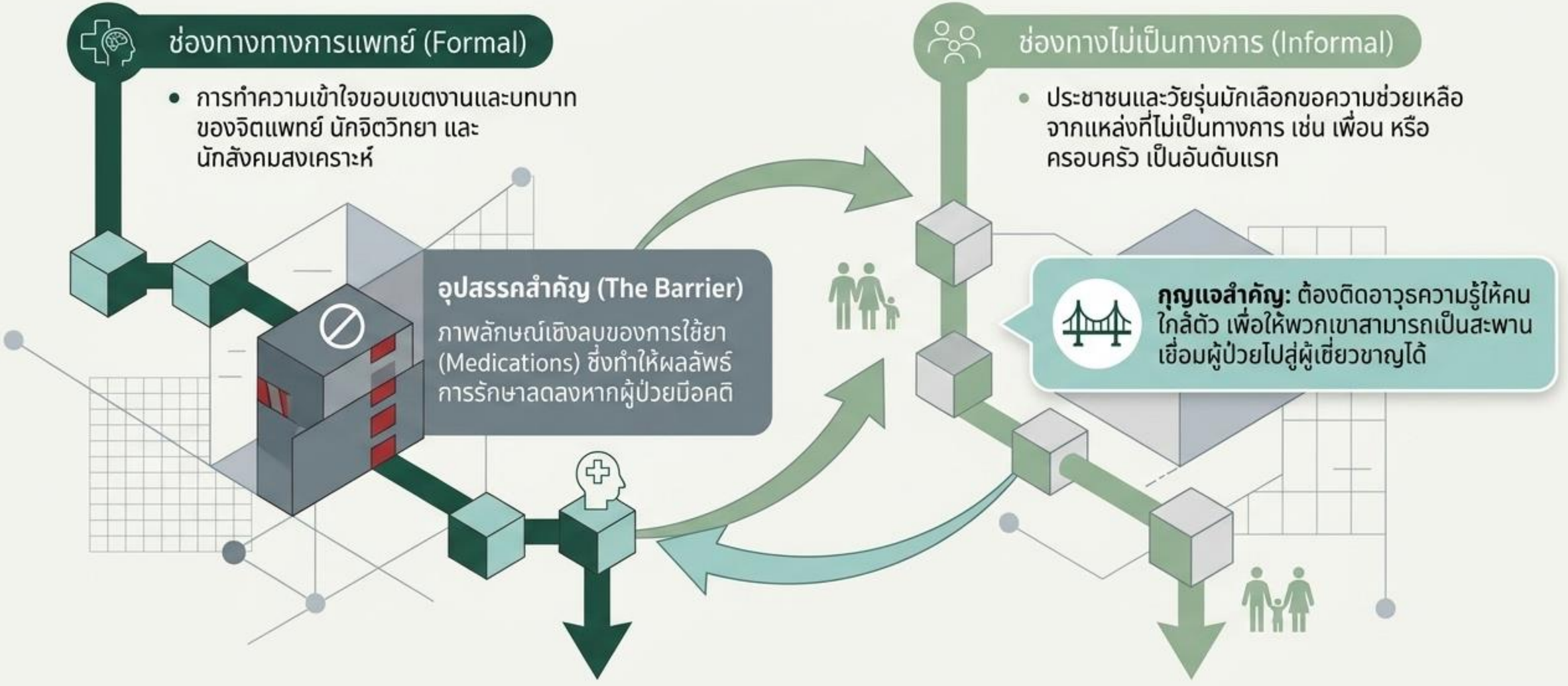
ทักษะในการสังเกต สนับสนุน และช่วยเหลือผู้อื่นในยามวิกฤต

4. การป้องกัน (Prevention)

การลดปัจจัยเสี่ยงและสร้างสภาพแวดล้อมที่ปกป้องสุขภาพจิต

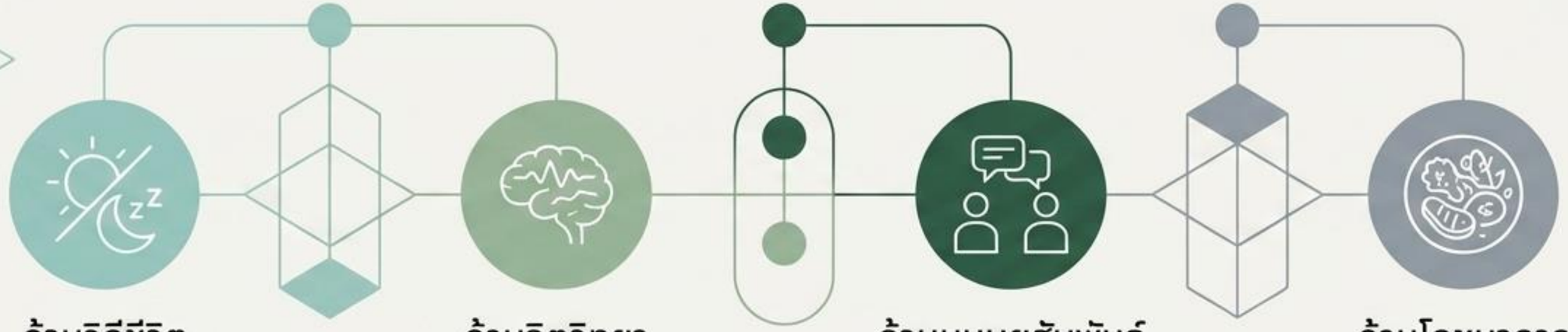
เสาหลักที่ 1: การเข้าถึงความช่วยเหลือจากผู้เชี่ยวชาญ

ทลายกำแพงความกลัวและสร้างความเข้าใจที่ถูกต้องเกี่ยวกับผู้ทำการรักษา



เสาหลักที่ 2: กลยุทธ์การดูแลตนเองที่มีประสิทธิภาพ (Effective Self-Help)

ประชาชนนิยมการดูแลตนเอง แต่ต้องรู้ว่าสิ่งใดได้ผลจริง และไม่ใช้ทดแทนการรักษาหลัก



ด้านวิถีชีวิต (Lifestyle)

- การออกกำลังกายสม่ำเสมอ
- การรักษาสุขอนามัยและตารางการนอนหลับ
- ออกจากบ้านและมีส่วนร่วมในกิจกรรมที่มีเป้าหมายทุกวัน

ด้านจิตวิทยา (Psychological)

- เรียนรู้วิธีการผ่อนคลายความเครียด (Relaxation methods)
- ให้รางวัลตนเองเมื่อทำสำเร็จในเป้าหมายเล็กๆ

ด้านมนุษยสัมพันธ์ (Interpersonal)

- พูดคุยระบายความรู้สึกกับคนที่ไว้ใจและพร้อมสนับสนุน
- แจ้งให้ครอบครัวหรือเพื่อนทราบถึงสภาวะอารมณ์เพื่อสร้างความเข้าใจ

ด้านโภชนาการ (Dietary)

- การรับประทานอาหารที่สมดุลและดีต่อสุขภาพ

เสาหลักที่ 3: การปฐมพยาบาลด้านสุขภาพจิต (MHFA)

เปลี่ยนคนรอบข้างให้เป็นผู้ช่วยหลือคนแรกในยามวิกฤต

การปฐมพยาบาลด้านสุขภาพจิต (Mental Health First Aid)
คือการเข้าช่วยเหลือผู้ที่กำลังเริ่มมีปัญหา หรือผู้ที่อยู่ในภาวะวิกฤตทางจิตใจ

Level 1: ผู้ใหญ่ สู่ ผู้ใหญ่ (Standard MHFA)
สร้างเครือข่ายความปลอดภัยในที่ทำงานและชุมชน

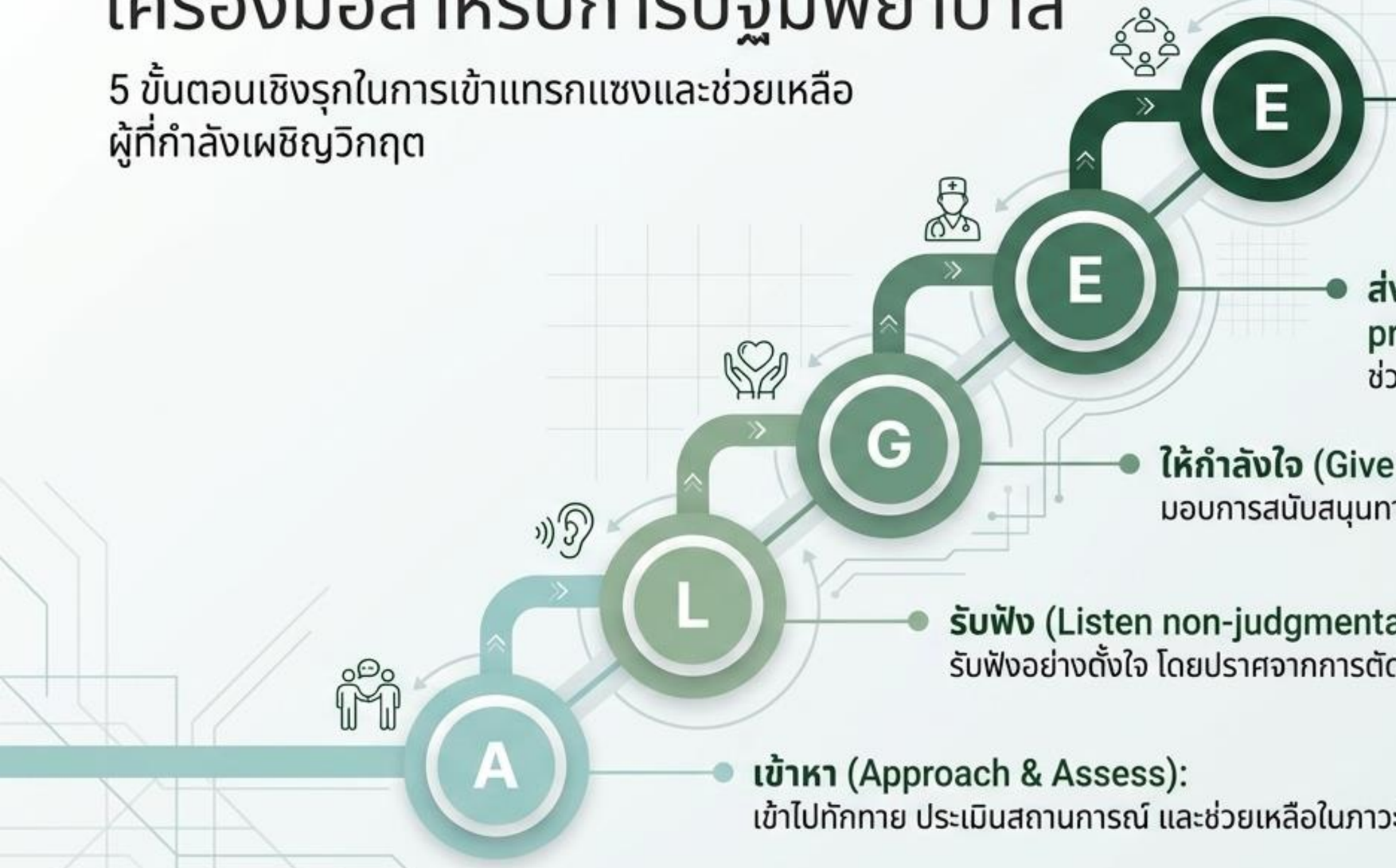
Level 2: ผู้ใหญ่ สู่ เยาวชน (Youth MHFA)
พ่อแม่และครูที่สามารถตรวจจับสัญญาณเตือนภัยล่วงหน้า

Level 3: วัยรุ่น สู่ วัยรุ่น (Teen MHFA)
สำคัญที่สุด เพราะวัยรุ่นมักหันหน้าพึ่งพาเพื่อน
ในวัยเดียวกันเป็นอันดับแรก

การศึกษายืนยัน: การฝึกอบรม MHFA ช่วยเพิ่มความรอบรู้ ลดตราบาป (Stigma) และเพิ่มพฤติกรรมการช่วยเหลือผู้อื่นได้อย่างมีนัยสำคัญ

แผนปฏิบัติการ ALGEE: เครื่องมือสำหรับการปฐมพยาบาล

5 ขั้นตอนเชิงรุกในการเข้าแทรกแซงและช่วยเหลือผู้ที่กำลังเผชิญวิกฤต



เข้าหา (Approach & Assess):
เข้าไปทักทาย ประเมินสถานการณ์ และช่วยเหลือในภาวะวิกฤตเบื้องต้น

รับฟัง (Listen non-judgmentally):
รับฟังอย่างตั้งใจ โดยปราศจากการตัดสินหรืออคติ

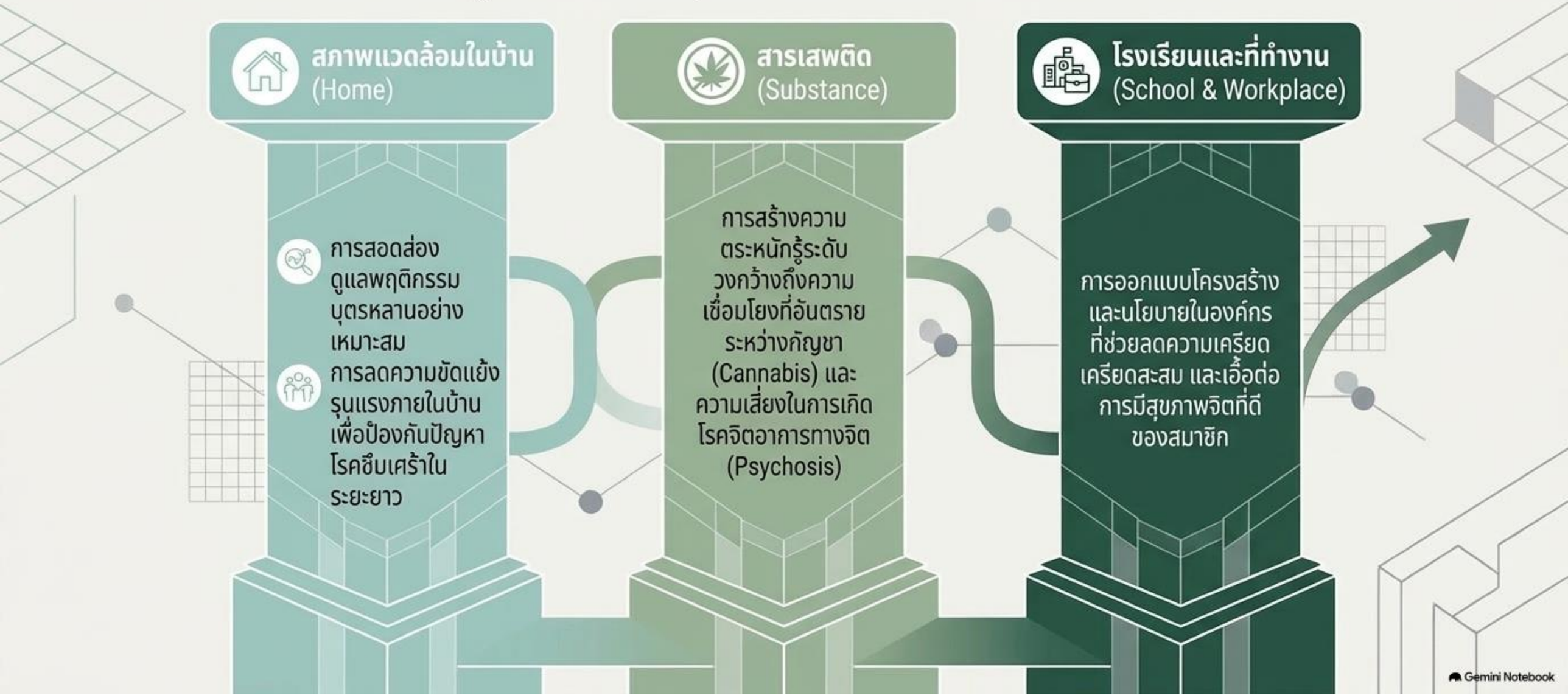
ให้กำลังใจ (Give support & info):
มอบการสนับสนุนทางจิตใจและให้ข้อมูลเบื้องต้นที่ถูกต้อง

ส่งเสริมการรักษา (Encourage professional help): สนับสนุนให้เข้าถึงความช่วยเหลือจากแพทย์หรือผู้เชี่ยวชาญ

ส่งเสริมเครือข่าย (Encourage other supports):
แนะนำให้ใช้กลยุทธ์ช่วยเหลือตนเอง หรือหาแรงสนับสนุนจากคนใกล้ตัว

เสาหลักที่ 4: การป้องกันเชิงรุก (Proactive Prevention)

พื้นที่ที่ถูกละเลยมากที่สุด: การลดปัจจัยเสี่ยงตั้งแต่ต้นทาง



อนาคตของนิยาม: ความรอบรู้ควรครอบคลุมกว้างขึ้นหรือไม่? (The Broadening Debate)

แนวคิดสนับสนุนการขยายขอบเขต (Proposals for Broadening)

ข้อเสนอจากกลุ่ม Kutcher, Kusan, Bjørnsen

- ควรรวมแนวคิดด้านจิตวิทยาเชิงบวก (Positive Psychology)
- เพิ่มเรื่องความยืดหยุ่นทางจิตใจ (Resilience) และการเจริญสติ (Mindfulness)
- การลดตราบาป (Stigma) และประสิทธิภาพในการแสวงหาความช่วยเหลือ

ข้อโต้แย้ง (Objections to Broadening)

ข้อเสนอจากกลุ่ม Spiker & Hammer

- การรวมทัศนคติเชิงบวกและการลดตราบาปเข้ามา เป็นเพียงการนำโครงสร้างเก่ามาเปลี่ยนชื่อใหม่

ความเสี่ยง: อาจสร้างความสับสนในการวิจัย และทำให้เป้าหมายหลักในการกระตุ้นการลงมือทำเจือจางลง

ลำดับความสำคัญเชิงกลยุทธ์สำหรับ APEC (Strategic Priorities)

นโยบายสาธารณะควรเริ่มต้นจากสิ่งเล็กๆ ที่สามารถทำสำเร็จได้จริง (Start small and achievable)

Strategy Cards

“การเลี้ยงดูที่ดี คือน้ำสะอาดของสุขภาพจิต”

(Good parenting is the clean water of mental health)

นโยบายระดับชาติที่เน้นพัฒนาทักษะการเลี้ยงดูบุตร (Parenting Skills) ถือเป็นการลงทุนโครงสร้างพื้นฐานด้านสุขภาพจิตที่คุ้มค่าที่สุด ป้องกันปัญหาล่วงหน้าก่อนเกิดวิกฤต

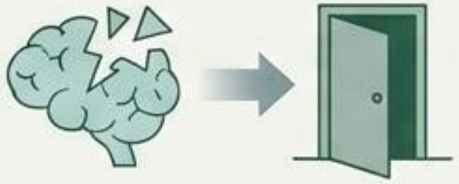
Strategy Cards

“การพูดคุยเรื่องความคิดฆ่าตัวตาย เป็นเรื่องที่ทำได้”

(Talking about suicidal thoughts is okay)

ทำลายความเชื่อผิดๆ ที่ว่าการถามเรื่องการฆ่าตัวตายจะเป็นการชี้โพรงให้กระรอก ต้องสร้างแคมเปญระดับชาติเพื่อสอนให้ประชาชนกล้าตั้งคำถามและรับฟังโดยไม่ตัดสิน

บทสรุป: สู่สังคมแห่งความเข้าใจและการลงมือทำ



1 **ปัญหา:** ช่องว่างความเข้าใจทำให้ประชาชนปฏิเสธการรักษาที่ได้ผล

2 **กรอบแนวคิด:** 4 เสาหลัก (ผู้เชี่ยวชาญ, ดูแลตนเอง, ปฐมพยาบาล, ป้องกัน) คือแผนที่นำทาง

3 **ผลลัพธ์:** ความรอบรู้ด้านสุขภาพจิต (MHL) ไม่ใช่แค่เรื่องของการท่องจำ แต่คือการสร้างพฤติกรรมที่ถูกต้องเพื่อช่วยเหลือตนเองและคนรอบข้าง

เป้าหมายสูงสุดไม่ใช่เพียงการให้ความรู้ แต่คือการสร้างพลเมืองที่มีความพร้อมในการปกป้อง ดูแล และฟื้นฟูสุขภาพจิตของตนเองและสังคมโดยรวม

Mental Health Literacy and Priorities for APEC

Anthony (Tony) Jorm
University of Melbourne

Overview of Talk

- Definitions of mental health literacy
- Key things the public need to know
- Examples of interventions to improve mental health literacy
- Can a nation's mental health literacy be improved?
- Some (very tentative) suggestions on APEC priorities

Public Knowledge of Actions They Can Take on Physical Illnesses

Prevention

Examples: safe sex to prevent HIV, link between smoking and disease, what constitutes a healthy diet

Early intervention

Examples: early warning signs of cancer, how to recognize a heart attack or stroke, how to give first aid

Treatment

Examples: sources of professional help, types of treatments available and their benefits

Concept of Mental Health Literacy

“Knowledge and beliefs about mental disorders which aid their recognition, management or prevention”.

Note: mental health literacy is not simply knowledge, but knowledge linked to action to benefit one’s own mental health or that of others.

"Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment

Anthony F Jorm, Ailsa E Korten, Patricia A Jacomb, Helen Christensen, Bryan Rodgers and Penelope Pollitt

Abstract

Objectives: To assess the public's recognition of mental disorders and their beliefs about the effectiveness of various treatments ("mental health literacy").

Design: A cross-sectional survey, in 1995, with structured interviews using vignettes of a person with either depression or schizophrenia.

Participants: A representative national sample of 2031 individuals aged 18–74 years; 1010 participants were questioned about the depression vignette and 1021 about the schizophrenia vignette.

Results: Most of the participants recognised the presence of some sort of mental disorder: 72% for the depression vignette (correctly labelled as depression by 39%) and 84% for the schizophrenia vignette (correctly labelled by 27%). When various people were rated as likely to be helpful or harmful for the person described in the vignette for depression, general practitioners (83%) and counsellors (74%) were most often rated as helpful, with psychiatrists (51%) and psychologists (49%) less so. Corresponding data for the schizophrenia vignette were: counsellors (81%), GPs (74%), psychiatrists (71%) and psychologists (62%). Many standard psychiatric treatments (antidepressants, antipsychotics, electroconvulsive therapy, admission to a psychiatric ward) were more often rated as harmful than helpful, and some non-standard treatments were rated highly (increased physical or social activity, relaxation and stress management, reading about people with similar problems). Vitamins and special diets were more often rated as helpful than were antidepressants and antipsychotics.

Conclusion: If mental disorders are to be recognised early in the community and appropriate intervention sought, the level of mental health literacy needs to be raised. Further, public understanding of psychiatric treatments can be considerably improved.

MJA 1997; 166: 182-186

"Health literacy" has been defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health.[1] By extension, we have coined the term "mental health literacy" to refer to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking.

The lifetime risk of developing a mental disorder is so high (nearly 50%)[2] that almost the whole population will at some time have direct experience of such a disorder, either in themselves or in someone close. A high public level of mental health literacy would make early recognition of and appropriate intervention in these disorders more likely.

Previous information on this topic is limited and is derived from national surveys on depression alone,[3-5] or on depression and schizophrenia.[6] Although these surveys found that most people believed depression to be treatable,[3-5] most respondents had negative views about the effectiveness of medication for mental disorders. In contrast, counselling and psychotherapy were generally viewed more favourably.[3,4,6]

To assess the mental health literacy of the Australian population, we surveyed a representative national sample of adults on their knowledge of and beliefs about schizophrenia and depression. We report our findings on the ability of this population to recognise these disorders and their beliefs about the effectiveness of various treatments.

Methods

Sample

The survey was carried out by the Australian Bureau of Statistics in August 1995 as part of its Population Survey Monitor.[7] This is a household survey covering all private dwellings in urban and rural areas (excluding the sparsely settled areas) across all States and Territories. Selected households were initially sent a letter explaining that their dwelling had been selected for the survey. The letters gave advance notice that an interviewer would call to make an appointment. Interviewers made at least three call-backs in rural areas and at least five in urban areas before a dwelling was classified as "non-contact". Contact was made with a sample of 2531 households, with one person randomly sampled per household for a personal interview; 2164 persons agreed to participate (85%). Because a pilot study showed that people aged more than 75 years often had trouble understanding

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Anthony F Jorm, PhD, DSc, Deputy Director; **Ailsa E Korten,** BSc, Research Officer; **Patricia A Jacomb,** MSc, Research Assistant; **Helen Christensen,** PhD, Fellow; **Bryan Rodgers,** PhD, Fellow; **Penelope Pollitt,** PhD, Research Fellow.
No reprints will be available. Correspondence: Dr A F Jorm, NHMRC Social Psychiatry Research Unit, The Australian National University, Canberra, ACT 0200.
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Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public

ANTHONY F. JORM, AILSA E. KORTEN, PATRICIA A. JACOMB, BRYAN RODGERS, PENELOPE POLLITT, HELEN CHRISTENSEN and SCOTT HENDERSON

Background The study aimed to compare the beliefs of health professionals about the potential helpfulness of various mental health interventions with those of the general public.

Method Surveys were carried out in Australia of 872 general practitioners, 1128 psychiatrists, 454 clinical psychologists and 2031 members of the public. Respondents were presented with a case vignette describing either a person with depression or one with schizophrenia. Respondents were asked to rate the likely helpfulness of various types of professional and non-professional help and of pharmacological and non-pharmacological interventions.

Results The professionals gave much higher ratings than the public to the helpfulness of antidepressants for depression, and of antipsychotics and admission to a psychiatric ward for schizophrenia. Conversely, the public tended to give much more favourable ratings to vitamins and minerals and special diets for both depression and schizophrenia, and to reading self-help books for schizophrenia.

Conclusion The beliefs that health practitioners hold about mental disorders differ greatly from those of the general public. There is a need for mental health education campaigns to help close the gap between professional and public beliefs.

We have recently reported a national survey of the Australian public's beliefs and attitudes about mental disorders (Jorm *et al*, 1997). This survey was based around a vignette describing a person with either major depression or schizophrenia. The respondents were asked to rate a range of possible interventions as likely to be helpful, harmful or neither for the person described. The interventions presented in the survey involved various professional groups, pharmacological and non-pharmacological treatments, and included a number of non-standard interventions. It was found that general practitioners (GPs) and counsellors were rated very highly, but psychiatrists and psychologists less so. Some standard psychiatric treatments were more often rated as harmful than helpful, including antidepressants for depression, and antipsychotics and admission to a psychiatric ward for schizophrenia. By contrast, some non-standard interventions were rated highly for both depression and schizophrenia, including increased physical and social activity, relaxation and stress management, and reading about people with similar problems. Even vitamins and special diets were rated much more highly than standard psychiatric treatments.

These results suggest that there may be some major discrepancies between public and professional beliefs about the helpfulness of interventions for mental disorders. If such discrepancies exist, they could lead to a lack of willingness to accept help from mental health professionals or poor adherence to advice given. In light of these results, we decided to extend our survey of the public with national surveys of three professional groups which treat mental disorders, in order to pinpoint any major discrepancies in beliefs.

METHOD

As reported previously, a household survey was carried out with a nationally representative sample of 2031 Australian adults aged 18–74 in August 1995 (Jorm *et al*, 1997). Because it was not feasible to do personal interviews with the health professionals, the interview was modified to make a questionnaire for self-completion which was mailed out during May–June 1996. The survey was posted to all 1580 psychiatrists and a sample of 1495 GPs listed on the national register of medical practitioners (the Medicare Provider File), and to all 702 members of the College of Clinical Psychologists. Those who did not respond within 3–4 weeks received a reminder.

The questionnaire was based on a vignette of a person suffering from a mental disorder. Half of each professional group were given a vignette describing a person who met ICD–10 (World Health Organization, 1993) and DSM–IV (American Psychiatric Association, 1994) diagnostic criteria for major depression, and the other half were given a vignette of a person who met criteria for schizophrenia. The gender of the person described was randomly assigned to be either male ('John') or female ('Mary').

The depression vignette was as follows:

> John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity.

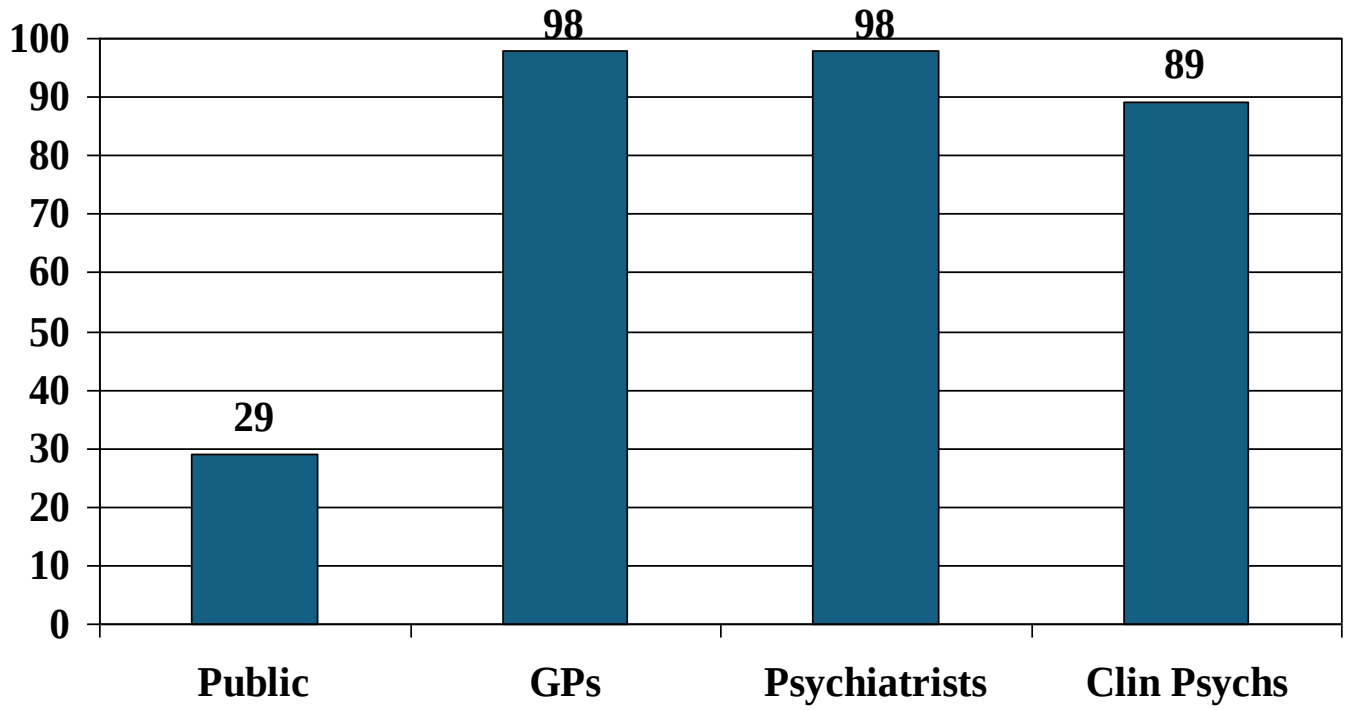
The schizophrenia vignette was:

> John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realise he is not taking drugs because he never sees anyone or goes anywhere.

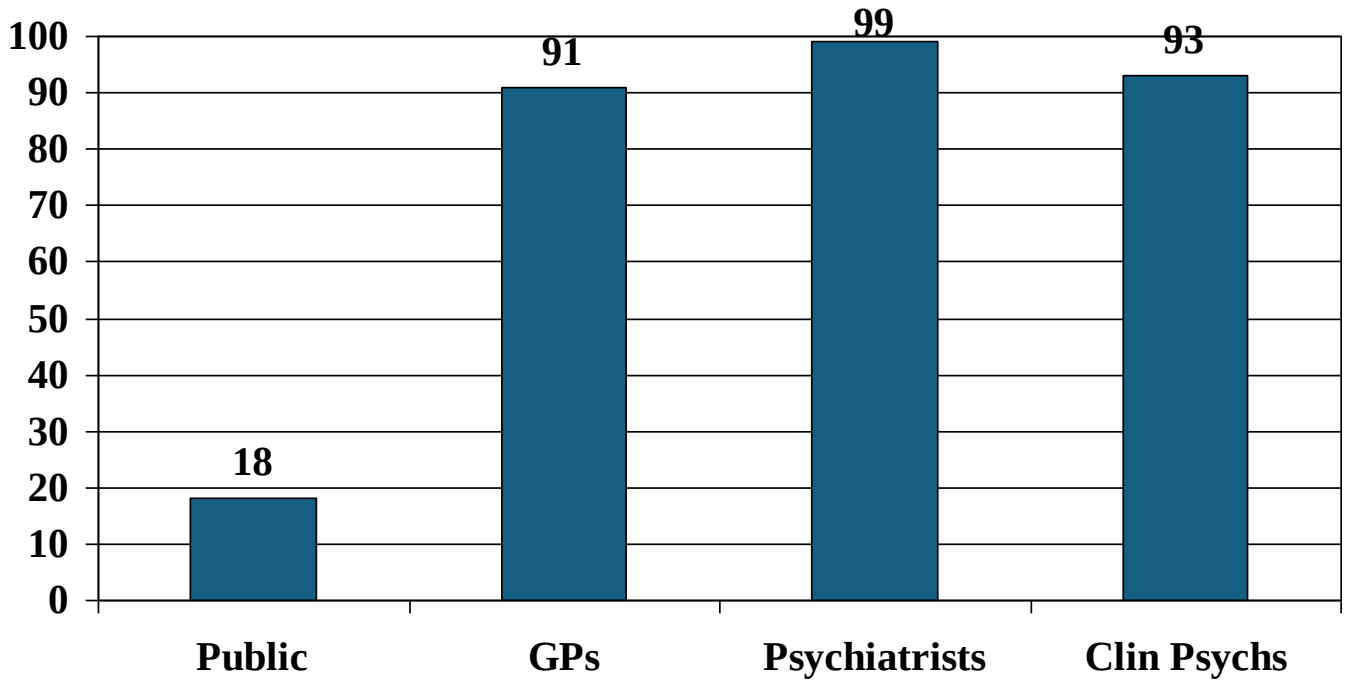
Respondents were first asked an open-ended question: 'From the information given, what, if anything, is wrong with John?' Up to three responses were coded into diagnostic categories for each respondent.

Respondents were also asked whether it would be likely to be helpful, harmful or neither if John were to seek various kinds of help. Responses of 'helpful' were coded 1, 'neither' as 0, and 'harmful' as −1, while more complex responses were coded as

Percent Saying Antidepressants Helpful for Person with Depression



Percent Saying Admission to Ward Helpful for Person with Schizophrenia



Is There a General Factor of 'Mental Health Literacy'?

Soc Psychiatry Psychiatr Epidemiol (1997) 32: 468–473

ORIGINAL PAPER

A.F. Jorm · A.E. Korten · B. Rodgers · P. Pollitt
P.A. Jacomb · H. Christensen · Z. Jiao

Belief systems of the general public concerning the appropriate treatments for mental disorders

Medical Factor: all drug treatments (except Vitamins), Psychiatric ward and ECT

Psychological Factor: Counsellor, Social Worker, Phone counselling, Psychiatrist, Psychologist, Psychotherapy and Hypnosis

Lifestyle Factor: Close family, Close friends, Naturopath, Vitamins, Physical activity and Get out more.

Should the Concept of Mental Health Literacy be Broadened?

Proposals for broadening

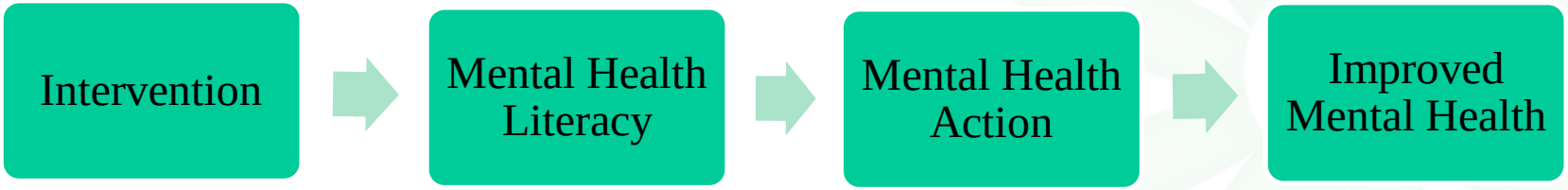
- Kutcher et al. (2015)– understanding of positive mental health, help-seeking efficacy, reduction in stigma
- Kusan (2013)– concepts from positive psychology, including resilience, salutogenesis, mindfulness
- Bjørnsen et al. (2017)– what contributes to positive mental health

Objections to broadening

Spiker & Hammer (2018)– "the inclusion of attitudes, stigma, positive mental health and help-seeking efficacy in [mental health literacy's] content domain simply repackages these well-established constructs into a broader construct with a new name…which can create confusion among researchers"

Mental Health Literacy Program Logic

Mental Health Literacy Program Logic (Extended)



Jorm (2025) Definition

“Knowledge about mental health problems that underpins action that can benefit mental health”.

Proposed Criteria for What Public Needs to Know

1. The knowledge is relevant (e.g. to stage of life, roles and culture)
2. The knowledge underpins action
3. The action benefits mental health

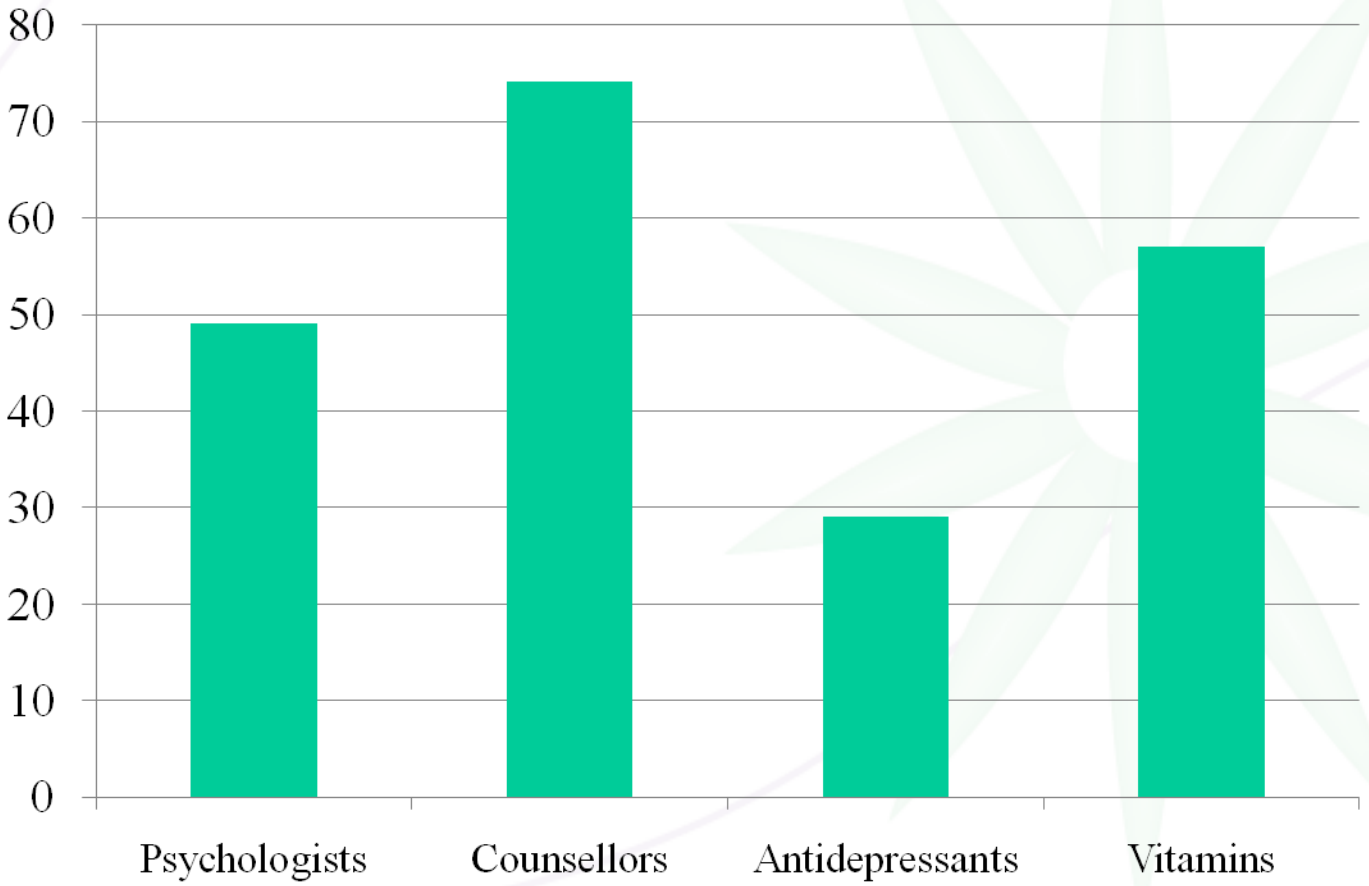
Some Things That the Public Can Benefit from Knowing

1. Knowledge of **professional help and treatments** available
2. Knowledge of effective **self-help** strategies
3. Knowledge and skills to give **first aid** and support to others
4. Knowledge of how to **prevent** mental disorders

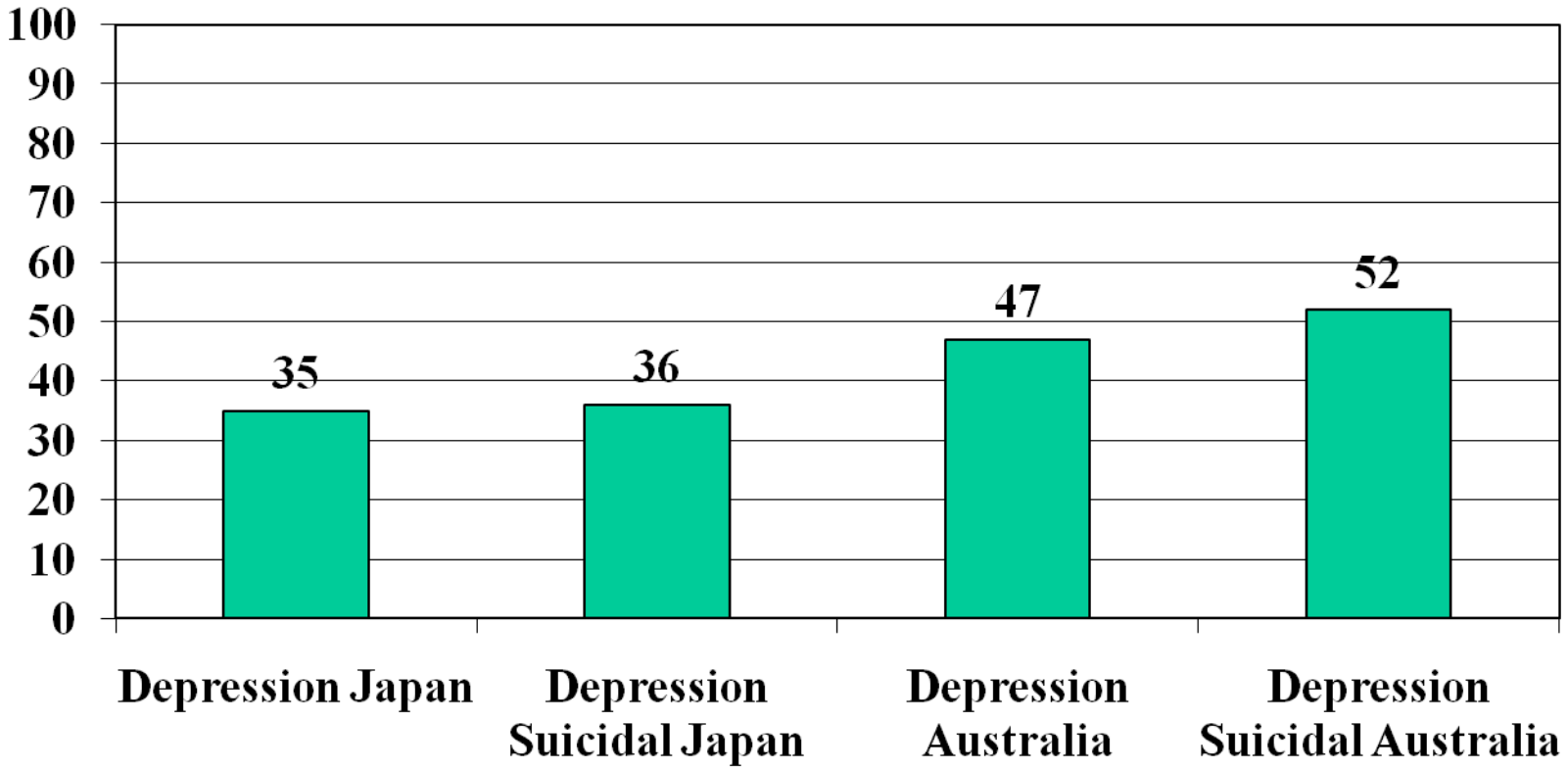
1. Knowledge of Professional Help and Treatments Available

- People need to know about the role of mental health professionals, the range of evidence-based treatments, and how to access these.
- Many people prefer informal sources of help to professionals, e.g. adolescents may seek help from peers.
- Professions with specialized training are not necessarily preferred, e.g. psychologists versus counsellors.
- Some treatments have a negative image, especially medications. Results in less benefit when used.

Percentage of Australian Adults Rating as Helpful for Depression 1995



Percent Saying Antidepressants Helpful (2003)



2. Knowledge of Effective Self-Help Strategies

- The public are very positive about self-help and commonly use these strategies for anxiety and depression.
- Some popular self-help strategies are likely to be helpful (e.g. exercise), but others not (e.g. alcohol).
- We need to encourage knowledge of which ones are likely to work, while at the same time not seeing them as a substitute for professional help.

Useful Self-Help Strategies for Mild Depression

Lifestyle strategies

- Engage in exercise or physical activity
- Practice good sleep hygiene
- Maintain a regular sleep schedule
- Do something they enjoy
- Try to remain involved in purposeful activities for at least a small part of every day
- Make a list of strategies that have worked in the past for depression and use them
- Engage in an activity that gives a feeling of achievement
- Enlist a trusted friend or relative to help them get out and about or do activities
- Make sure they get out of the house for at least a short time each day

Useful Self-Help Strategies (Continued)

Psychological strategies

- Reward themselves for reaching a small goal
- Learn relaxation methods

Interpersonal strategies

- Talk over problems or feelings with someone who is supportive and caring
- Let family and friends know how they are feeling so that they are aware of what they are going through

Dietary strategies

- Eat a healthy, balanced diet

3. Knowledge and Skills to Give First Aid and Support Others

- Mental health first aid is the help offered to a person developing a mental health problem, experiencing the worsening of an existing mental health problem or in a mental health crisis
- Other people can encourage professional help-seeking. This is particularly important in adolescence.
- Good social support promotes recovery and reduces the impact of traumatic events.

Knowledge and Skills to Give First Aid and Support to Others (Continued)

- Surveys of the public show limitations in knowledge of how to give first aid.
- There is a particular reluctance to discuss suicidal thoughts.
- Some people use harmful strategies (e.g. talk to the person firmly).

4. Knowledge of How to Prevent Mental Disorders

- This is the most neglected area, perhaps because mental disorders lack strong risk factors that can be used to communicate simple messages.
- Cannabis as a risk factor for psychosis needs to be more widely known.
- Parents can take action to reduce substance use (e.g. parental monitoring) and prevent depression (e.g. reduce conflict in home).
- Schools and workplaces can also take preventive action (e.g. to reduce bullying).

Interventions to Improve Mental Health Literacy

There is reasonable evidence that the following can improve mental health literacy and (probably) mental health:

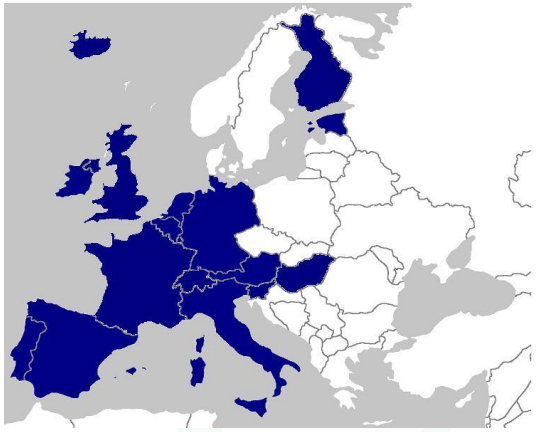
1. Community campaigns
2. Training courses
3. Web-based information

1. Community Campaigns

“Beyond Blue: the national depression initiative”

- An Australian national non-profit organization to address depression and anxiety
- Uses many methods to get its message across (media advertising, sponsorship of events, community education forums, training of managers, prominent people as champions, web and print information)
- Has led to better recognition and beliefs about treatments

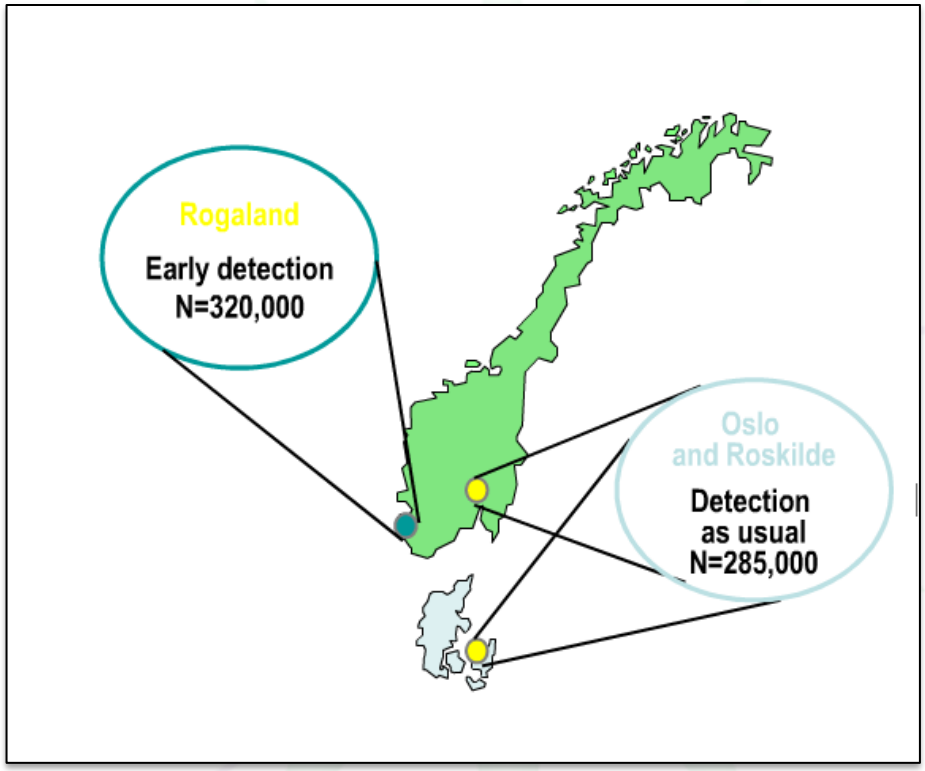
EUROPEAN ALLIANCE AGAINST
DEPRESSION



- Began in Germany as *Nuremberg Alliance Against Depression*, but has spread to many other countries
- A complex campaign with many elements targeting the general public, GPs, community facilitators (e.g. police, teachers), consumers, relatives
- A comparison of Nuremberg with a control city found a number of benefits, including lower suicide rate

TIPS Treatment and Intervention in Psychosis

- Aims to get earlier treatment of psychosis
- Involves an information campaign and an early detection team
- Successfully reduced duration of untreated psychosis in intervention area compared to control areas



2. Training Courses

Examples of Training Courses

- **Gatekeeper training** for suicide prevention. Changes knowledge, skills and attitudes, and may reduce suicide.
- **Mental Health First Aid training** has a broader aim to getting better support and earlier professional help for people developing mental health problems or in mental health crises.

Mental Health First Aid has an Action Plan: ALGEE

Hello, my name is Algee. I am the MHFA mascot.

A pproach the person, assess and assist with any crisis

L isten and communicate non-judgmentally

G ive support and information

E ncourage person to get appropriate professional help

E ncourage other supports

The Mental Health First Course

- Training courses have been developed for adults to help adults (Standard MHFA), adults to assist youth (Youth MHFA) and adolescents to assist peers (teen MHFA).
- Numerous studies have found that MHFA training increases mental health literacy, support to others, and reduces stigma.
- More than 8 million people trained worldwide.

Behavior Therapy
Available online 9 June 2026
In Press, Journal Pre-proof What's this?

State of the Science: Mental Health First Aid Training of the Public

Anthony F. Jorm [a], Betty A. Kitchener [b], Amy J. Morgan [a], Laura M. Hart [a]

Jorm et al. BMC Psychiatry (2018) 18:132
https://doi.org/10.1186/s12888-018-1722-y

BMC Psychiatry

RESEARCH ARTICLE Open Access

Associations of training to assist a suicidal person with subsequent quality of support: results from a national survey of the Australian public

Anthony F. Jorm*, Angela Nicholas, Jane Pirkis, Alyssia Rossetto and Nicola J. Reavley

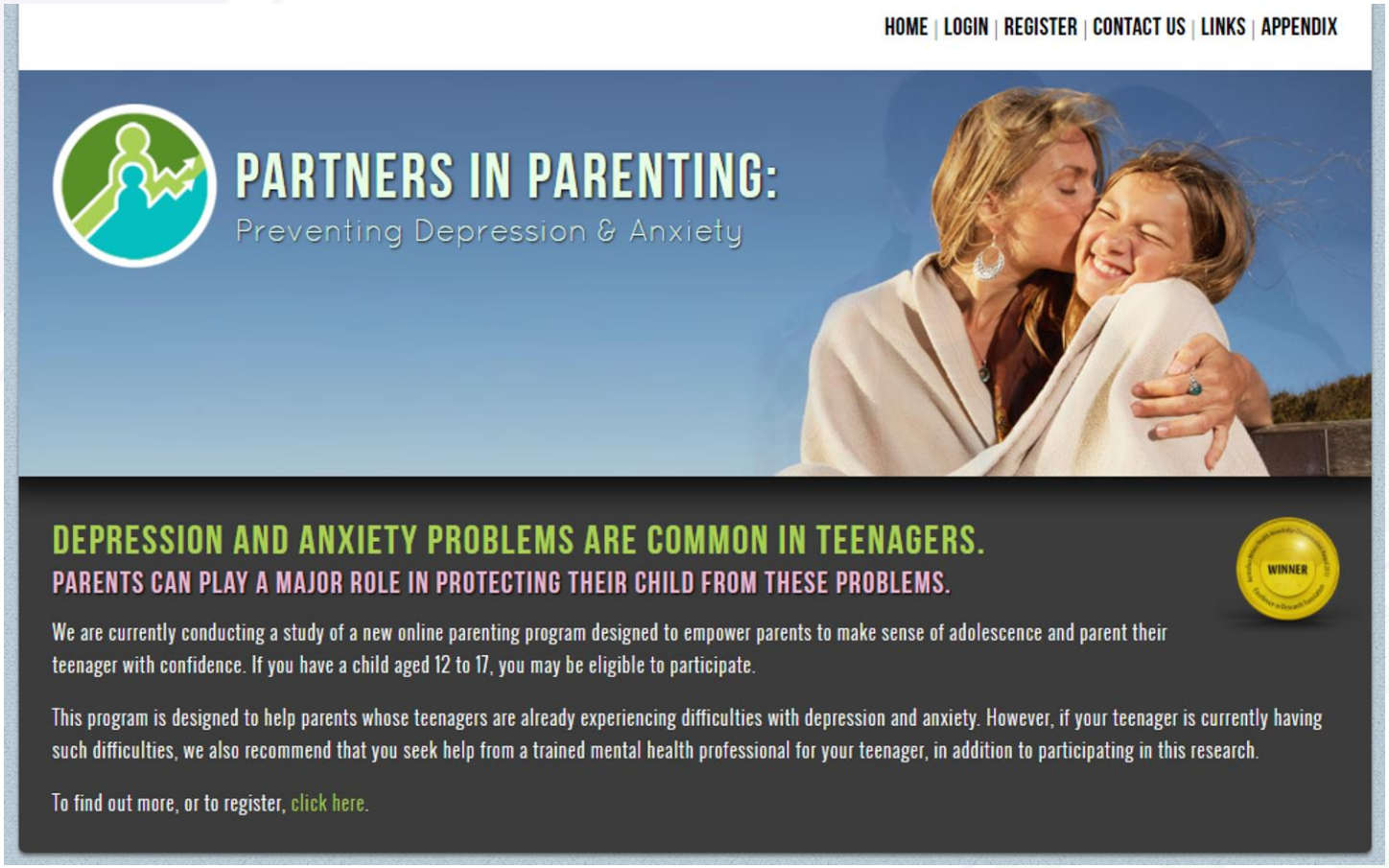
3. Web-Based Information

Evolution of Web Information

- The Web is now a major source of information on mental health problems
- Early research found that the quality of the information is often poor. Wikipedia is good quality but requires high reading level
- AI is growing in importance, but usefulness is unclear
- More research is needed on effects on action and mental health.

Some Examples of Good Quality Web Information

1. **Partners in Parenting** to prevent child anxiety and depression
2. **Mood Memos** for early intervention for mild depressive symptoms
3. **Blue Pages** and **"What Works"** booklets for depression interventions


HOME | LOGIN | REGISTER | CONTACT US | LINKS | APPENDIX
PARTNERS IN PARENTING:
Preventing Depression & Anxiety
DEPRESSION AND ANXIETY PROBLEMS ARE COMMON IN TEENAGERS.
PARENTS CAN PLAY A MAJOR ROLE IN PROTECTING THEIR CHILD FROM THESE PROBLEMS.
WINNER
We are currently conducting a study of a new online parenting program designed to empower parents to make sense of adolescence and parent their teenager with confidence. If you have a child aged 12 to 17, you may be eligible to participate.
This program is designed to help parents whose teenagers are already experiencing difficulties with depression and anxiety. However, if your teenager is currently having such difficulties, we also recommend that you seek help from a trained mental health professional for your teenager, in addition to participating in this research.
To find out more, or to register, click here.

Journal of Affective Disorders
Volume 156, 1 March 2014, Pages 8-23

Review

Parental factors associated with depression and anxiety in young people: A systematic review and meta-analysis

Marie Bee Hui Yap [a, b], Pamela Doreen Pilkington [a, b], Siobhan Mary Ryan [a, b], Anthony Francis Jorm [a, b]

Journal of Affective Disorders
Volume 156, 1 March 2014, Pages 67-75

Research report

Parenting strategies for reducing the risk of adolescent depression and anxiety disorders: A Delphi consensus study

Marie B.H. Yap [a, b], Pamela D. Pilkington [a, b], Siobhan M. Ryan [a, b], Claire M. Kelly [c, d], Anthony F. Jorm [a, b]

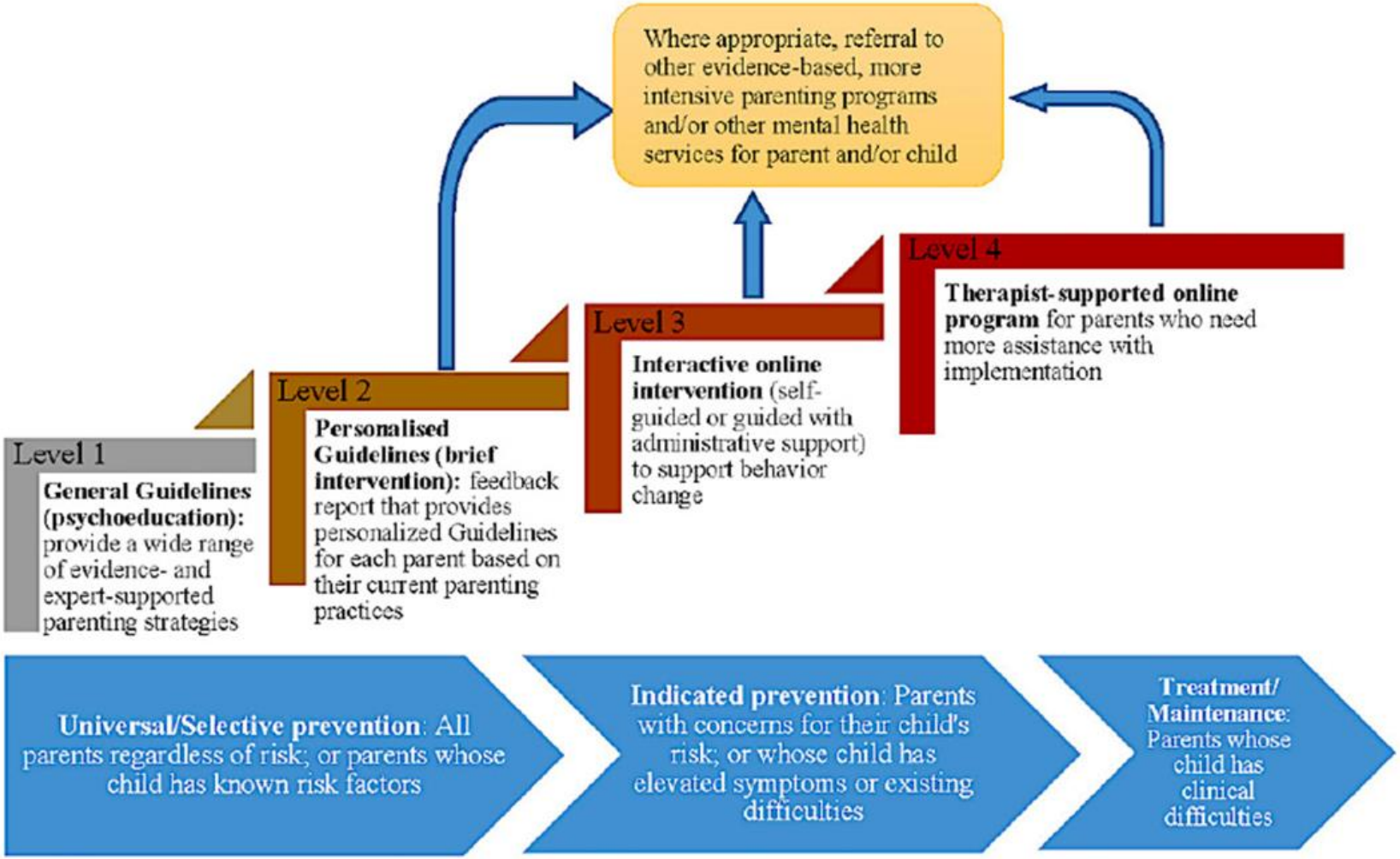
Parenting Factors Associated with Depression or Anxiety

Factors that decrease risk

- Warmth
- Autonomy granting
- Monitoring
- Encouraging sociability

Factors that increase risk

- Inter-parental conflict
- Over-involvement
- Aversiveness
- Withdrawal
- Inconsistent discipline


Where appropriate, referral to other evidence-based, more intensive parenting programs and/or other mental health services for parent and/or child
Level 1
General Guidelines (psychoeducation): provide a wide range of evidence- and expert-supported parenting strategies
Level 2
Personalised Guidelines (brief intervention): feedback report that provides personalized Guidelines for each parent based on their current parenting practices
Level 3
Interactive online intervention (self-guided or guided with administrative support) to support behavior change
Level 4
Therapist-supported online program for parents who need more assistance with implementation
Universal/Selective prevention: All parents regardless of risk; or parents whose child has known risk factors
Indicated prevention: Parents with concerns for their child's risk; or whose child has elevated symptoms or existing difficulties
Treatment/ Maintenance: Parents whose child has clinical difficulties

Original Paper

Medium-Term Effects of a Tailored Web-Based Parenting Intervention to Reduce Adolescent Risk of Depression and Anxiety: 12-Month Findings From a Randomized Controlled Trial

Marie Bee Hui Yap[1,2], MPsych, PhD; Mairead C Cardamone-Breen[1], DPsych; Ronald M Rapee[3], PhD; Katherine A Lawrence[1], DPsych; Andrew J Mackinnon[4], PhD; Shireen Mahtani[1], DPsych; Anthony F Jorm[2], PhD, DSc

Having trouble reading this email? View it in a web browser

mood memos

Dear Amy,

You can help yourself feel less depressed by **keeping up with your daily tasks.**

Why?

- Depression makes it hard to get up and do things. However, avoiding daily tasks can make you feel worse because you feel guilty about it.
- Keeping active will prevent you from being preoccupied with negative thoughts and will help fight feelings of lethargy.
- Keeping up with your daily tasks was recommended by more than 80% of therapists and people who have recovered from depression.

How?

- Try to do some things you have let slide lately.
- For example, are the dishes piling up? Have you stopped brushing your teeth because it is too hard? Are your clothes in need of a good wash? Do you have bills that need paying? Have you been avoiding returning emails or phone calls?
- Try to tackle these things each day, for at least some part of the day.
- To help motivate yourself, give yourself a compliment or a reward when you have completed a task.

But...

You may be thinking that it is pointless to keep up with activities because you don't have any energy. Don't listen to those thoughts – just try to do as much as you can. Remember also not to be hard on yourself if there are times when you fall back into the habit of doing nothing.

Commit

Make a commitment to fight the desire to do nothing. Right now, set aside a minute to plan a goal you would like to achieve this week.

Imagine **when** and **where** you are going to do it. Write your goal down, or remember to tell someone your goal. You can also print this email as a reminder.

Example

"*This week I will do the dishes and clean up the kitchen every evening.*"

Past commitments

In the last Mood Memo we sent you, we encouraged you to commit to **getting out of your home each day**. *How did you go?*

The British Journal of Psychiatry

Search

Article Metrics

Volume 200, Issue 5 May 2012 , pp. 412-418

Cited by 40

Access

Email-based promotion of self-help for subthreshold depression: Mood Memos randomised controlled trial

Amy J. Morgan [a1], Anthony F. Jorm [a1] and Andrew J. Mackinnon [a1]

DOI: https://doi.org/10.1192/bjp.bp.111.101394 Published online by Cambridge University Press: 02 January 2018

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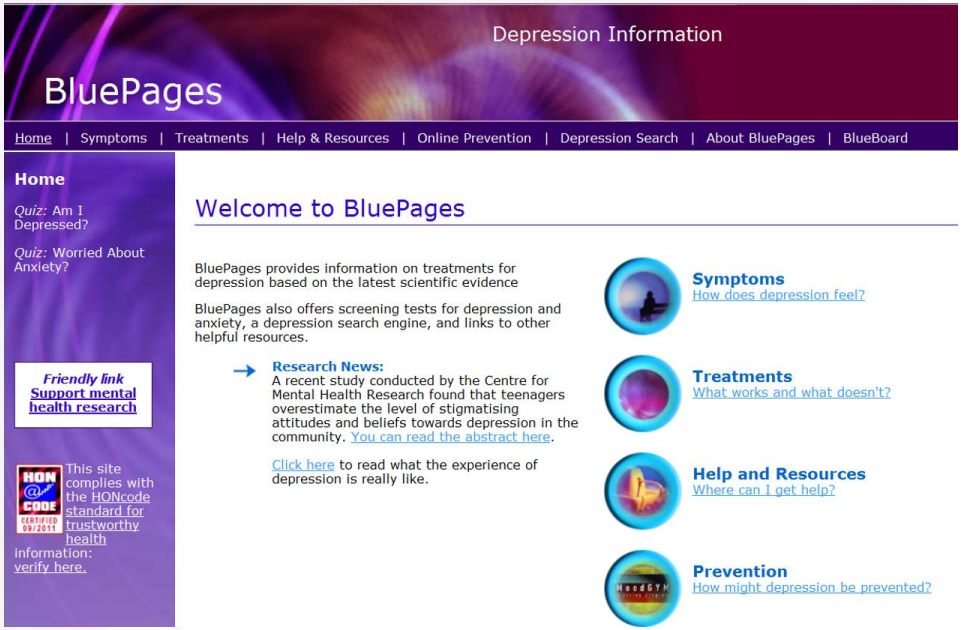
Shorter communication

Behavior change through automated e-mails: Mediation analysis of self-help strategy use for depressive symptoms

Amy J. Morgan, Andrew J. Mackinnon, Anthony F. Jorm Show more



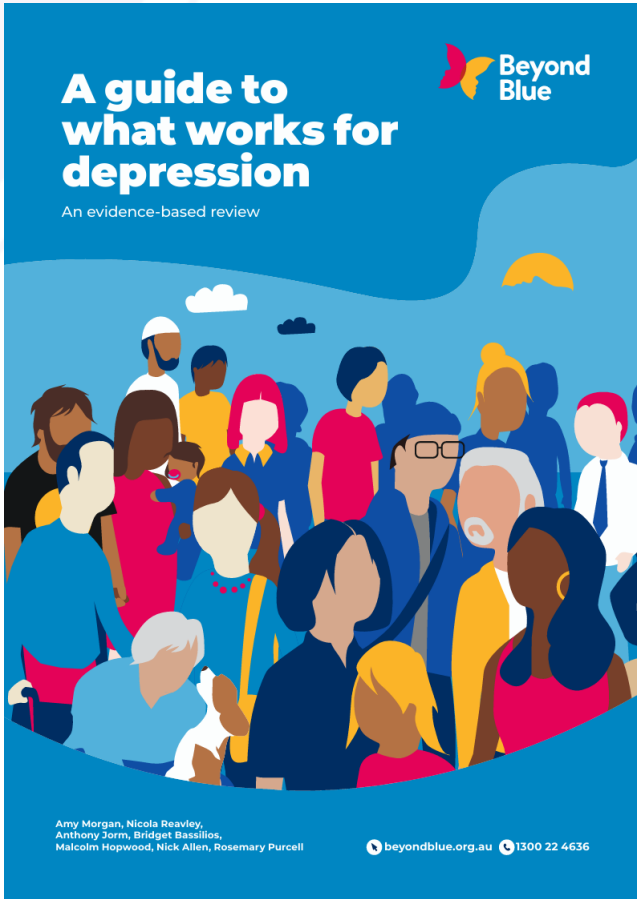
Cite this article as: BMJ, doi:10.1136/bmj.37945.566632.EE (published 23 January 2004)

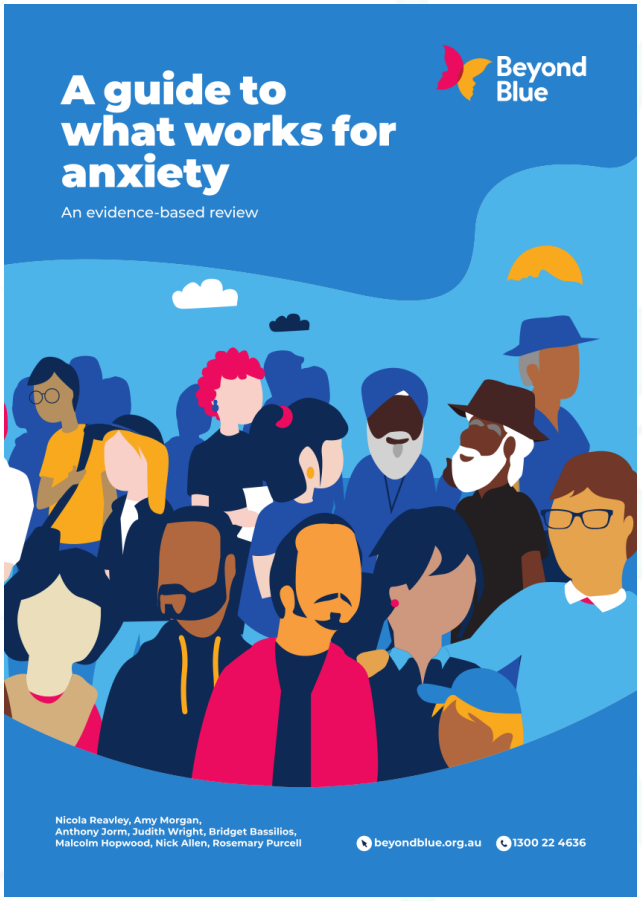
Primary care

Delivering interventions for depression by using the internet: randomised controlled trial

Helen Christensen, Kathleen M Griffiths, Anthony F Jorm

Guides to Treatments that Work





Exercise

Evidence rating

For adults

For adolescents

What is it?

The two main types of exercise are aerobic (exercises the heart and lungs, such as in jogging) or anaerobic (strengthens muscles, such as in weight training).

How is it meant to work?

This is unclear, however low levels of physical activity are often linked with depression. There are a few ideas on how exercise might work, such as by:

- improving sleep patterns
- changing levels of chemicals in the brain, such as serotonin, endorphins or stress hormones
- interrupting negative thoughts that make depression worse
- increasing perceived coping ability by learning a new skill
- socialising with others, if the exercise is done in a group.

Does it work?

A pooling of results from 35 studies looking at exercise for depression in adults found it moderately helpful. Exercise was compared with placebo (such as social activity) or no treatment in these studies. A smaller number of studies suggest it may be as helpful as psychological therapy and antidepressants. However, the benefits may fade if exercise is stopped. Five studies have looked at exercise for depression in adolescents. These studies also showed a benefit.

It is unclear what the best type of exercise is and how often and for how long it should be done. Current recommendations are that it should be aerobic (e.g. walking or cycling), done at low to moderate intensity, for at least 30 minutes, three to four times a week, for at least nine weeks, under the supervision of a professional trained in exercise.

Are there any risks?

People may injure themselves by exercising.

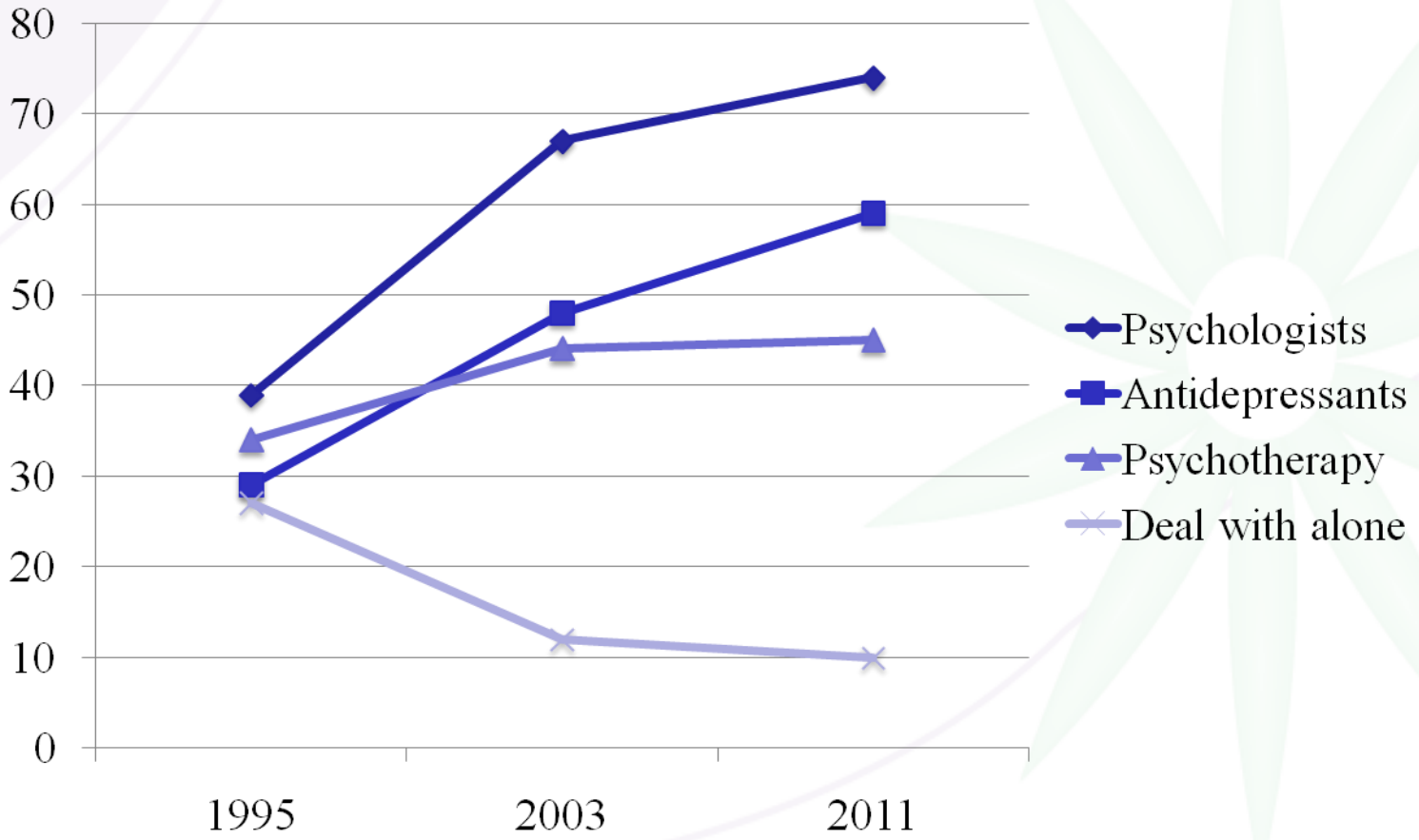
Recommendation

There is good evidence that exercise is helpful for depression in adults. It may also be helpful in adolescents. As it is not yet known which kind of exercise is best, people should choose a form they like, so that they will stick with it.

Can a Nation's Mental Health Literacy Be Improved?

- Australia and Germany have the best data on changes over time.
- There have been improvements in both countries.

Beliefs About the Helpfulness of Depression Interventions in Australia



Some Suggestions for APEC Priorities

- Start with something small and achievable.
- Possible theme: “Good parenting is the clean water of mental health”: What can we do to improve it?
- Another possible theme: Talking about suicidal thoughts is okay.