Zdravstvena pismenost u području mentalnog zdravlja

/ *Mental Health Literacy*

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Zdravstvena pismenost u području mentalnog zdravlja (engl. *Mental Health Literacy*) pokazala se jednom od značajnih odrednica mentalnog zdravlja koja ima potencijal za poboljšanje kako zdravlja pojedinca tako i populacije. Navedeni istraživački konstrukt prvi je puta opisan 1997. godine te podrazumijeva znanja i vjerovanja pojedinca o mentalnom zdravlju odnosno mentalnim poremećajima koja pomažu u njihovom prepoznavanju, upravljanju ili prevenciji (Jorm i sur. 1997). Istraživanja u različitim zemljama, provedena različitim metodološkim pristupima, ukazuju na nedostatno znanje na razini opće populacije i specifičnih dobnih skupina o tome kako prevenirati poteškoće mentalnog zdravlja i mentalne poremećaje, kako ih prepoznati, koji su oblici pomoći dostupni i korisni te kako pružiti prvu podršku osobama koje manifestiraju poteškoće. Cilj ovog rada je prikaz razvoja i razumijevanja konstrukta zdravstvene pismenosti u području mentalnog zdravlja te povećanje istraživačkog interesa u području mentalnozdravstvene pismenosti. U radu se daje kratak prikaz razvoja navedenog područja istraživanja, istraživačke metodologije i dobivenih spoznaja kao i njihovih implikacija kada je u pitanju očuvanje mentalnog zdravlja pojedinaca i populacije kao i prevencije mentalnih poremećaja.

/ *Mental health literacy has been recognized as one of the most important mental health determinants with a potential to improve the mental health of both individuals and the population. This concept was first described in 1997, mostly defined as the knowledge and beliefs about mental health and mental disorders which help the recognition, management, and prevention of mental health problems or disorders (Jorm et al. 1997). Studies from different countries conducted with different methodologies have suggested a lack of knowledge at both public and specific age-group levels about how to prevent and recognize mental health problems and mental disorders, how to provide first support to people manifesting mental health problems, and about the available and useful forms of help. By giving an overview of the development of mental health literacy as a research construct, this paper aims to contribute to the knowledge, understanding, and expansion of research interest in this field, its methodology and results, as well as their implications for the prevention of mental disorders and preservation of mental health.*

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UVOD

Prema shvaćanju zdravlja u definiciji Svjetske zdravstvene organizacije, mentalno zdravlje je neizostavan i neizmjerno važan dio sveukupnog zdravlja jer "Zdravlje je stanje potpunog fizičkog, psihičkog i socijalnog blagostanja, a ne samo odsustvo bolesti i nemoći" (1). Svjetska zdravstvena organizacija definira mentalno zdravlje kao stanje blagostanja u kojem svaki pojedinac ostvaruje svoj puni potencijal, može se nositi s normalnim stresnim životnim situacijama, može produktivno raditi i doprinosi svojoj zajednici (2).

Mentalno zdravlje i mentalna bolest često se opisuju kao dvije točke jednog kontinuuma. Međutim, suvremeni dvojni ili dualni model kontinuuma mentalnog zdravlja i mentalne bolesti pokazuje da je sveukupno mentalno zdravlje više od samog odsustva mentalnih bolesti i poremećaja. Prema ovom modelu mentalno zdravlje i mentalna bolest su dva nezavisna kontinuuma, koji se međusobno isprepliću. Jedan obuhvaća postojanje odnosno nepostojanje bolesti, a drugi slabu odnosno izraženu osobnu dobrobit (emocionalnu, psihičku, društvenu, tjelesnu i duhovnu). Tako osoba koja pati od mentalne bolesti (s izraženim psihopatološkim simptomima) može istodobno imati visoku osobnu dobrobit (dobro mentalno zdravlje), što znači da osoba koja ima mentalnu bolest može biti produktivna za sebe, svoju obitelj, društvo i zajednicu kao i osoba s niskom razinom ili bez psihopatoloških simptoma (mentalnom bolesti) (3). Dvojni ili dualni model također zagovara važnost prevencije i ulaganja u osobnu dobrobit, odnosno dobro mentalno zdravlje. To je u skladu s mišljenjem da u mentalno zdravlje, kao i zdravlje općenito, moramo neprestano i aktivno ulagati i paziti na njegovo očuvanje kako bismo spriječili razvoj mentalne bolesti. Ovaj pristup pruža najbolji uvid u sveukupno mentalno zdravlje pojedinca uključujući i funkcionalnost i procjenu težine stanja (4-6). Kada je kod osobe prisutno odstupanje od uobičajenog doživljava-

INTRODUCTION

According to the definition of the World Health Organization, mental health is the indispensable and immensely important part of overall health, as "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (1). The World Health Organization defines mental health as a state of well-being in which every individual realizes their full potential, can cope with normal life stress situations, can be productive, and contributes to their community (2).

Mental health and mental illness are often described as two ends of the same continuum. However, the contemporary dual model of the continuum of mental health and illness indicate that the overall mental health is more than just the absence of mental illnesses and disorders. According to this model, mental health and illness are two independent continuums that intertwine. One continuum is the presence or absence of mental illness and the other is weak or strong personal wellbeing (emotional, psychic, social, physical, and spiritual). Therefore, a person with mental illness (or high psychopathology symptoms) can have high personal wellbeing (good mental health) at the same time, which means that the person with mental illness can be as productive with regard to themselves, their family, society and the community as a person with low or no psychopathology symptoms (mental illness) (3). This dual model also supports to the importance of prevention and investment in personal wellbeing and mental health. This is in line with the view that we must continually and actively invest and take care of our mental health, as well as health in general, to maintain it and to prevent the development of mental illness. This approach gives us the best insight into overall mental health of an individual and thus into their functionality and the assessment of the seriousness of the condition (4-6). Deviation from ordinary perception or behavior in a per-

nja ili ponašanja to se može kategorizirati kao psihički simptom, poremećaj ili bolest (7), ali ne nužno kao loše mentalno zdravlje. Mentalne bolesti odnosno poremećaji mogu biti prepreka ostvarivanju punih potencijala pojedinca i onemogućiti njegovo optimalno funkcioniranje. Mentalni poremećaj podrazumijeva odstupanje u jednoj ili u manjem broju psihičkih funkcija te manje oštećuje ukupno funkcioniranje osobe, a povezan je isključivo s funkcionalnim promjenama. Za razliku od bolesti većinom traje kraće, ne ostavlja (dugo)trajne posljedice te je povoljnije prognoze. Mentalna bolest je dulje i jače odstupanje u više psihičkih funkcija i cjelokupnom funkcioniranju osobe, a može biti povezana i sa strukturnim promjenama mozga (7). Ipak, često se pojmovi mentalne bolesti i poremećaja ne razgraničavaju u stručnoj literaturi, odnosno upotrebljavaju se kao istoznačnice.

Iako i loše mentalno zdravlje može uključivati teškoće u svakodnevnom funkcioniranju osobe, mentalne bolesti i poremećaji su okarakterizirani sveobuhvatnom psihološkom i biološkom disfunkcijom, odnosno disfunkcijom u ponašanju pojedinca. One uključuju čitav niz smetnji od poremećaja afekta, opažanja, mišljenja, inteligencije, pažnje, nagona i volje do poremećaja svijesti kao i njihove kombinacije koje čine određenu kliničku sliku (8). Mentalne bolesti i poremećaji često su kroničnog tijeka, s početkom u adolescenciji i mlađoj odrasloj dobi, te je njihova prevalencija relativno visoka i u stalnom porastu. Poznato je da se oko 75 % mentalnih poremećaja može dijagnosticirati prije 25. godine života (9).

Mentalne bolesti i poremećaji donose veliku subjektivnu patnju za oboljelog, narušavajući kvalitetu njegova života te, osim opterećenja samog pojedinca, donose i veliko opterećenje za njegovu okolinu i širu zajednicu (10). Prema Studiji globalnog opterećenja bolešću iz 2017, uzimajući kao pokazatelj opterećenja samo godine života u punom zdravlju izgubljene zbog onesposobljenosti, odnosno zbog oštećenja

son can be categorized as a mental symptom, disorder, or illness (7) but not necessarily as poor mental health or lack thereof.

Mental illnesses and disorders can be an obstacle to achieving the full potential of an individual and prevent their optimal functioning. Mental disorder is deviation in one or several mental functions, and a person with a mental disorder has less severely damaged overall health. Unlike mental illness, a disorder has a shorter duration, does not leave (long) lasting consequence, and has better prognosis. Mental illness is a longer and stronger deviation in more mental functions and in overall health and can also be related to structural brain changes, while a disorder is exclusively related to functional changes (7). However, the terms mental illness and mental disorder are not differentiated in many literature references, but are instead used as synonym.

Although poor mental health can include difficulties in functioning and daily activities, mental illnesses and disorders are characterized by psychological and biological dysfunction, i.e. dysfunction in the behavior of an individual. They include a variety of disturbances, from affective, perception, thought, intelligence, attention, instinct, and volition disorders to consciousness disorders as well as their combinations, all of which form a specific clinical picture (8). Mental illnesses and disorders often have chronic progression after starting in adolescence and at a young adult age, and their prevalence is relatively high and constantly increasing. It is well-known that 70% of mental disorders can be recognized before the age of 25 (9).

Mental illnesses and disorders are a significant source of subjective pain for a patient, decreasing the quality of their life, and, apart from being a burden to the patient itself, they bring a large burden for their environment and wider community as well (10). According to the 2017 Global Burden of Disease Study, only considering lost years because of disability, i.e. lost

(zdravlja) koje je uzrokovano bolešću (engl. *years lived with disability*, YLDs), među 10 najčešćih uzroka u svijetu dva su iz skupine mentalnih bolesti i poremećaja (veliki depresivni poremećaj na trećem mjestu i anksiozni poremećaji na osmom mjestu) (11). Navedena studija donosi podatke i za svaku zemlju pojedinačno, pa se tako u 10 najčešćih uzroka onesposobljenosti prema YLD-u u Republici Hrvatskoj depresivni poremećaji nalaze na šestom mjestu (12).

Posebno važan bihevioralni čimbenik, kada je u pitanju očuvanje mentalnog zdravlja, prevencija, rano prepoznavanje, liječenje kao i oporavak od mentalnih bolesti i poremećaja, je traženje pomoći stručnjaka u području mentalnog zdravlja i bolesti (13). Istraživanje Svjetske zdravstvene organizacije o mentalnom zdravlju provedeno 2007. godine u petnaest zemalja svijeta pokazalo je da je razdoblje od prve pojave simptoma do početka liječenja prilično dugo. Medijan odgode među onima koji su dobili pomoć u nekom trenutku je u rasponu od 1 do 14 godina za poremećaje raspoloženja, od 3 do 30 godina za anksiozne poremećaje i od 6 do 18 godina za poremećaje uzrokovane upotrebom psihoaktivnih tvari (14). U nekim istraživanjima se procjenjuje da samo jedna četvrtina odraslih osoba s visokom razinom psihičkih tegoba i jedna trećina odraslih s mentalnim poremećajem potraži stručnu pomoć. Europsko istraživanje o dostupnosti usluga zaštite mentalnog zdravlja provedenom u šest zemalja od 2001. do 2003. godine pokazalo je kako je najmanje vjerojatno da će mladi u dobi od 18 do 24 godine dobiti potrebnu skrb vezanu za probleme mentalnog zdravlja (15).

Stigmatizacija, koja uključuje negativne stavove, predrasude i diskriminaciju osoba s problemima mentalnog zdravlja te mentalnim bolestima i poremećajima, stvara probleme i čini prepreku kada je u pitanju traženje pomoći. Prema podatcima istraživanja provedenog u Ujedinjenom Kraljevstvu u sklopu jedne antidiskriminirajuće kampanje gotovo 9 od 10 osoba koje pate od mentalnih poremećaja

years because of (health) damage caused by illness (years lived with disability, YLDs) as the indicator of a burden, two entries in the group of mental illnesses and disorders are among 10 most common causes of disease burden in the world: major depressive disorder in third place and anxiety disorders in eighth place (11). The same study provides data for each country individually, and depressive disorders in Croatia are at the sixth place among the 10 most common causes of disability based on YLD (12).

Appropriate help-seeking behavior from an expert in the field of mental health and illness has been shown to be a particularly important behavioral determinant when it comes to maintaining mental health, prevention, early recognition, treatment, as well as recovery and rehabilitation from mental illnesses and disorders (13). The World Health Organization Mental Health Survey conducted in 2007 in fifteen countries showed that the period from the time when the first symptom appeared to the time when person started a treatment is quite long. Among those who received treatment at some point of time, the median postponement ranged from 1 to 14 years for mood disorders, 3 to 30 years for anxiety disorders, and 6 to 18 years for disorders caused by usage of psychoactive substances (14). Some studies estimate that only one quarter of adult people with a high level of mental difficulties and one third of adults with mental disorder seek professional help. The European Study of the Epidemiology of Mental Disorders conducted in six countries from 2001 to 2003 showed that young people between the age of 18 and 24 are least likely to receive necessary care related to mental health problems (15).

Stigmatization, which includes negative attitudes, prejudices, and discrimination of people with mental health problems, disorders, or illnesses, creates problems and presents an obstacle for help-seeking. According to the results of a survey conducted in the United Kingdom as part of an anti-discrimination campaign, al-

izjavilo je da su bili stigmatizirani i diskriminirani. Zbog stigmatizacije osobe često odgađaju traženje pomoći, a što kasnije potraže pomoć i podršku teži je i dulji njihov oporavak (8). Muškarci, mlade i starije osobe te pripadnici određenih nacionalnih skupina kao i pojedinci nižeg obrazovnog statusa s velikom epizodom depresije (engl. *major depression*) posebno su rizični kad je u pitanju netraženje pomoći (16). Pri pojavi blažih poteškoća u području mentalnoga zdravlja osobe su sklonije potražiti pomoć nestručnih izvora i laika, a mnogi pojedinci, posebno muškarci, uopće ju ne traže (17-19).

Među čimbenicima koji doprinose netraženju pomoći ističu se negativan stav prema stručnoj pomoći (uvjerenje da stručna pomoć nije korisna), vjerovanje da se sami trebaju nositi s problemima, manjak emocionalne kompetencije, nedostatno znanje o znakovima koji upućuju na mentalnu bolest ili poremećaj te strah od stigme (20). S druge strane, među čimbenicima koji potiču traženje pomoći su povećana osjetljivost na probleme vezane za mentalno zdravlje, pojačana percepcija težine mentalnog poremećaja, što uključuje i negativne posljedice te lakši pristup sustavu zaštite mentalnog zdravlja (21). Također, istraživanja ukazuju na to da čimbenici koji povećavaju vjerojatnost izbjegavanja liječenja, zakašnjelog dolaska na liječenje ili prekid liječenja uključuju: nedostatak znanja potrebnih za prepoznavanje obilježja moguće mentalne bolesti (znanja o obilježjima i tretmanu mentalnih poteškoća i poremećaja); neznanje o tome kako doći do stručne pomoći, procjene i liječenja; predrasude prema osobama koje imaju mentalnu bolest ili poremećaj te očekivanje da će i sami biti izloženi stigmi i diskriminaciji (13,21-25).

Korisni okvir za razumijevanje čimbenika koji mogu utjecati na ishode povezane s traženjem pomoći i zaštitu mentalnog zdravlja pojedinca pruža koncept zdravstvene pismenosti u području mentalnoga zdravlja ili mentalnozdravstvena pismenost (engl. *Mental Health Literacy*): višeznačan pojam, prvi je put opisan 1997. godine,

most 9 out of 10 people who suffer from mental disorders said they had been stigmatized and discriminated. People often postpone help-seeking due to stigmatization, and the later they look for help and support, the harder and longer their recovery is (8). Some surveys suggest that men, young and older people, and certain national group members as well as individuals with lower educational status and major depression are at risk when it comes to seeking help (16). If people have milder psychological (mental) distress or depressive symptoms, they are more prone to seek the help of non-professionals and lay persons, and many individuals, especially men, do not even seek help (17-19).

Negative attitudes toward professional help (e.g. beliefs such as that professional help is not useful or that it is better to cope with problems yourself), lack of emotional competence, and limited knowledge about signs which could indicate development of mental disorder or illness as well as fear of stigma are main obstacles when it comes professional help-seeking (20). On the other hand, factors that encourage help-seeking are increased sensitivity to mental health problems, increased perception of the severity of mental disorders, including negative consequences, and easier access to the mental health care system (21). Surveys also suggest that factors that increase the likelihood of avoiding treatment, seeking treatment too late, or terminating the treatment process include the lack of knowledge on recognizing characteristics of possible mental illness (knowledge about characteristics and treatments of mental health problems and mental disorders), ignorance about how to get a professional help, assessment and treatment, prejudice toward people with mental health problems or mental disorders, and the expectation that they themselves will be exposed to stigma and discrimination (13, 21-25).

A useful framework for understanding the factors that can affect outcomes regarding

podrazumijeva znanja i vjerovanja pojedinca o mentalnom zdravlju odnosno mentalnim poremećajima koja pomažu u prepoznavanju, upravljanju ili prevenciji (26). Mentalnozdravstvena pismenost je usmjerena na znanje i strategije za očuvanje ili postizanje i održavanje dobrog mentalnog zdravlja, osnovna znanja o mentalnim bolestima i poremećajima te njihovim tretmanima, strategijama za smanjenje stigme i poboljšanje učinkovitosti u traženju pomoći (27-29).

Cilj je ovog rada prikazati razvoj i opis pojma mentalnozdravstvene pismenosti, pregled istraživačke metodologije te primjene dosadašnjih znanstveno-istraživačkih spoznaja kada je u pitanju očuvanje mentalnog zdravlja pojedinca kao i traženje pomoći radi problema s mentalnim zdravljem.

RAZVOJ I OPIS KONCEPTA ZDRAVSTVENE PISMENOSTI U PODRUČJU MENTALNOG ZDRAVLJA

Pismenost se kao pojam u užem smislu definira kao sposobnost čitanja i pisanja. U novije doba s razvojem društva i tehnologija dolazi do širenja značenja ovog pojma i njegove interpretacije te se počinju prepoznavati različite vrste funkcionalne pismenosti (30).

Pojam zdravstvene pismenosti u znanstvenoj je literaturi poznat najmanje 30 godina. U Sjedinjenim Američkim Državama se ovaj pojam koristio za opisivanje i objašnjavanje odnosa između razine pismenosti pacijenata i njihove sposobnosti pridržavanja propisane terapije. Iz navedenog pristupa proizlazi shvaćanje da “adekvatna“ funkcionalna zdravstvena pismenost znači da je osoba u stanju primijeniti vještine pismenosti na materijale vezane za zdravlje kao što su recepti, uputnice, upute o lijeku i savjete za kućnu zdravstvenu zaštitu (31). Međutim, zdravstvena pismenost obuhvaća i više od same sposobnosti pojedinca za

help-seeking and protecting an individual’s mental health is provided by the concept of mental health literacy: a multidimensional construct, first time described in 1997, which implies having knowledge and beliefs about mental health problems or mental disorders that help to recognize, manage, or prevent them (26). Mental health literacy is focused on knowledge and strategies for maintaining or achieving and preserving good mental health, basic knowledge of mental disorders and illnesses and their treatments, and strategies for reducing stigma and improving effectiveness in help-seeking (27-29).

The aim of this paper was to present the development and describe the concept of mental health literacy and present an overview of the research methodology and application of current scientific findings for maintaining the mental health of an individual as well as seeking help for mental health problems.

DEVELOPMENT AND DESCRIPTION OF THE CONCEPT OF MENTAL HEALTH LITERACY

Literacy is defined in the narrow sense as the ability to read and write. In recent times, with the development of society and technology, the meaning of this term and its interpretation has expanded, and concepts of different functional literacies have been recognized (30).

The concept of health literacy has been present for at least 30 years in the clinical and scientific literature. In the United States of America, this concept was used to describe and explain the relationship between the patient’s degree of literacy and their ability to comply with prescribed therapy. This approach concludes that “adequate” functional health literacy means actually being able to apply literacy skills to health-related materials such as prescriptions, referrals, instructions for medications, and

čitanje letaka i razumijevanje informacija. On obuhvaća skup kognitivnih i socijalnih vještina koje određuju motivaciju i sposobnost pojedinca da dođe do informacija, razumije ih i koristi radi unaprjeđenja i održavanja dobrog zdravlja. Omogućujući bolji pristup zdravstvenim informacijama i unaprjeđujući sposobnost pojedinca da ih učinkovito koristi, zdravstvena pismenost je ključna u osnaživanju pojedinaca da preuzmu kontrolu nad očuvanjem vlastitog zdravlja (32).

Analogno konceptu zdravstvene pismenosti, Anthony Jorm sa suradnicima sredinom 1990-tih u Australiji, istražujući znanja i vjerovanja o mentalnim poremećajima među općom populacijom i drugim specifičnim skupinama (primjerice djeca i mladi te njihovi roditelji), definira istraživački koncept mentalnozdravstvene pismenosti (26,27). Autori pritom naglašavaju da navedeni pojam ne podrazumijeva znanja koja uče zdravstveni radnici da bi bolje dijagnosticirali i liječili mentalne poremećaje/bolesti, nego se radi o znanju povezanom s ponašanjima koja doprinose vlastitom mentalnom zdravlju pojedinca, ali i mentalnom zdravlju drugih osoba. Prvotno ga autori opisuju kao koncept koji se sastoji od sedam dimenzija: 1) sposobnost prepoznavanja specifičnih poremećaja; 2) znanja o tome kako tražiti informacije o mentalnom zdravlju; 3) poznavanje rizičnih faktora i uzroka; 4) znanja o samoliječenju i o 5) dostupnosti stručne pomoći, te 6) stavovi koji promoviraju prepoznavanje i 7) traženje odgovarajuće pomoći (26).

Prvo istraživanje koje su Jorm i suradnici proveli kako bi procijenili razinu prepoznavanja mentalnih poremećaja i uvjerenja o učinkovitosti raznih tretmana odnosno zdravstvenu pismenost stanovništva u području mentalnog zdravlja provedeno je 1995. godine na reprezentativnom nacionalnom uzorku opće populacije kao dio redovite Ankete za praćenje populacije (engl. *Population Survey Monitor*) (26). Otada su u nekoliko navrata provedena slična istraživanja kako u općoj populaciji odraslih tako i u djece i mladih: 2003. – 2004. godine u sklopu kros-kul-

home health care advice (31). However, health literacy is more than being able to read a flyer and understand the information. It includes a group of cognitive and social skills that determine the individual's motivation and ability to acquire information, understand it, and use it to improve and maintain good health. By providing better access to health information and enhancing the individual's ability to use it effectively, health literacy is the key factor in empowering individuals to take control of maintaining their own health (32).

By analogy with the concept of health literacy, Anthony Jorm and his associates in the mid-1990s in Australia studied knowledge and beliefs about mental disorders among the general population and other specific groups (e.g. children and young people and their parents) and first defined the mental health literacy (MHL) research concept (26, 27). The authors of the concept emphasize that MHL does not imply knowledge that health practitioners learn to better diagnose and treat mental disorders, but refers to knowledge related to behavior that contribute to both an individual's own mental health and to mental health of others. It was originally described by the authors as a concept consisting of seven dimensions: 1) the ability to recognize specific disorder; 2) knowledge of how to seek mental health information; 3) basic knowledge of risk factors and causes; 4) basic knowledge of self-help and of 5) availability of professional help, and 6) attitudes that promote recognition and 7) seeking appropriate help (26).

The first assessment of the level of recognition of mental disorders and beliefs about effectiveness of various treatments, i.e. mental health literacy, was conducted by Jorm et al. in 1995 in a cross-sectional survey performed on a representative sample of the general population as a part of regular a Population Survey Monitor study (26). Since then, more surveys have been conducted, both in the general adult

turalnog istraživanja (engl. *Australia Japan Partnership Mental Health Survey*), 2006. godine ciljano istraživanje zdravstvene pismenosti u području mentalnog zdravlja na reprezentativnom uzorku djece i mladih u dobi od 12 do 15 godina starosti te jednog roditelja s kojim dijete koje je sudjelovalo živi (engl. *National Survey of Youth Mental Health Literacy*), dva istraživanja 2011. godine na općoj populaciji starijoj od 15 godina (engl. *Mental Health Literacy in Adults*) i na populaciji mladih od 15 do 25 godina (engl. *Mental Health Literacy in Young People*) (33). Rezultati navedenih istraživanja upućivali su na potrebu podizanja svjesnosti i znanja o standardnim tretmanima, budući da se pokazalo da su mišljenja o njima prilično negativna ili se utvrdilo njihovo nepoznavanje (26). Općenito, pokazalo se kako poboljšanje mentalnozdravstvene pismenosti doprinosi pravovremenom prepoznavanju i poboljšanju ishoda liječenja (34).

Posljednjih nekoliko godina koncept mentalnozdravstvene pismenosti širi svoj fokus i na očuvanje dobrog mentalnog zdravlja i zaštitne čimbenike, odnosno znanja i sposobnosti koje doprinose očuvanju mentalnog zdravlja, što uključuje komponentu razumijevanja kako postići i očuvati (održati) dobro mentalno zdravlje (27,28).

METODOLOGIJA ISTRAŽIVANJA ZDRAVSTVENE PISMENOSTI U PODRUČJU MENTALNOG ZDRAVLJA

U sklopu istraživanja zdravstvene pismenosti u području mentalnoga zdravlja u Australiji je razvijen jedan od najprimjenjivanijih mjernih instrumenata ovog područja: Upitnik zdravstvene pismenosti u području mentalnoga zdravlja (engl. *Mental Health Literacy Questionnaire*, MHLQ) (26). Primjena navedenog upitnika i prikupljanje podataka strukturiranim intervjuom omogućili su isprva mješoviti istraživački pristup u kojem su korišteni i kratki opisi doživljavanja i ponašanja osobe s određenim mentalnim pore-

population as well as in children and youth in Australia: 2003-2004 as part of cross-cultural survey (Australia Japan Partnership Mental Health Survey), a 2006 targeted mental health literacy survey on a representative sample of children and youth between the age of 12 and 15 and one parent with whom they lived (National Survey of Youth Mental Health Literacy), two 2011 surveys – a general population survey with participants over 15 years of age (Mental Health Literacy in Adults) and a youth population survey with participants aged 15 to 25 (Mental Health Literacy in Young people) (33). The results of these studies indicated the need to raise awareness and knowledge about standard treatments, since opinions about them were found to be quite negative or they were perceived as unfamiliar (26). In general, improving mental health literacy has been shown to increase early detection of mental disorders and contribute to better treatment outcomes (34).

In recent years, the concept of mental health literacy has been expanding its focus to maintaining good health and protective factors, i.e. knowledge and abilities that contribute to mental health, which include the component of understanding how to achieve and maintain good mental health (27, 28).

MENTAL HEALTH LITERACY RESEARCH METHODOLOGY

As part of the mental health literacy surveys in Australia, one of the widely used instruments for measuring mental health literacy was developed: the Mental Health Literacy Questionnaire (MHLQ) (26). The application of this questionnaire and the data collected through a structured interview initially enabled mixed research approaches which used short descriptions of experiences and behaviors of a person with certain mental disorders (so-called vignettes), while pure quantitative measures

mećajem (tzv. vinjete), dok su čiste kvantitativne mjere (ljestvice) razvijene kasnije. Također, prvotno prikupljanje podataka je provedeno individualnim intervjuiranjem u kućanstvu (26), a kasnije individualnim telefonskim intervjuiranjem uz pomoć računala metodom CATI (engl. *Computer Assisted Telephone Interviews*) (35). Svaka osoba intervjuirana upitnikom MHLQ dobiva kratku priču (vinjetu) s prikazom osobe koja boluje od mentalnog poremećaja (spol i poremećaj osobe prikazane u vinjeti nasumično se dodjeljuju). Nakon što pročitaju vinjetu, ispitanici odgovaraju na niz pitanja otvorenog i/ili zatvorenog tipa (ponuđeni odgovori), primjerice "*Što biste rekli, ako išta, da nije u redu s.....?*", „*Što mislite kako bi se najbolje moglo pomoći ....?*", odnosno "*Koji je oblik stručne pomoći najprimjereniji?*" (26,36). MHLQ je prvotno uključivao pitanja vezana za prepoznavanje poremećaja u vinjeti, vjerovanja o osobama koje mogu pomoći, vjerovanja i osnovna znanja o tretmanima i njihovim ishodima (prognozi), poznavanje rizičnih čimbenika i uzroka pojedinih poremećaja, vjerovanja povezana sa stigmom i diskriminacijom, osobna iskustva s mentalnim poremećajima. Dodatno su u MHLQ uključena pitanja o vjerovanjima povezanima sa stigmom i diskriminacijom - procjena osobne i percipirane stigme, socijalna distanca, zatim vjerovanja o izvorima informacija o mentalnom zdravlju / mentalnim poremećajima, izloženost kampanjama i informacijama o mentalnom zdravlju iz medija (svijest o njihovom postojanju, dosjećanje), namjere i vjerovanja o pružanju prve pomoći u području mentalnog zdravlja te vjerovanja o prevenciji i traženju pomoći. Istraživanja mentalnozdravstvene pismenosti korištenjem vinjetne metodologije i MHL upitnika provedena su osim u Australiji i u nizu drugih zemalja (primjerice Japan, Portugal, Švedska, Irska, Sjedinjene Američke Države, Švicarska, Tajvan ...) te na različitim populacijama (srednjoškolci, adolescenti, roditelji, opća populacija) (36-42). Treba naglasiti da ova metodologija ne dopušta donošenje zaključaka na individualnoj razini, ali se pokazala korisnom u određivanju razine mental-

(scales) were developed later. Additionally, the initial data collection was conducted through individual household interviews (26) and later by individual telephone interviews using the Computer Assisted Telephone Interviews (CATI) method (35). Each person interviewed with the MHLQ receives a short story (vignette) describing a person suffering from a mental disorder (the gender and disorder of the person presented in the vignette are randomly assigned). After reading the vignette, respondents answer a series of open-ended and / or closed-ended questions (answers offered), such as "What would you say, if anything, that was wrong with...?", "What do you think could best be helped ....?", Or "What is the most appropriate form of professional assistance?" (26, 36). MHLQ initially included questions related to recognition of mental disorders in the presented vignette, beliefs about people who can help, beliefs and basic knowledge of treatments and their outcomes (prognosis), knowledge of risk factors and causes of mental disorders, beliefs related to stigma and discrimination, and personal experiences with mental disorders. More questions about beliefs related to stigma and discrimination were also included in the MHLQ – assessment of personal and perceived stigma and social distance. Additional questions were also added related to beliefs about sources of mental health information / mental disorders, exposure to campaigns and mental health information from the media (awareness of their existence, recall), intentions and beliefs about mental health first aid, and beliefs about prevention and seeking help. Mental health literacy studies using the vignette methodology and the MHLQ have been conducted in other countries as well (e.g. Japan, Portugal, Sweden, Ireland, United States, Switzerland, Taiwan, etc.) and adjusted for different survey populations (high school students, adolescents, parents, general population) (36-42). It should be emphasized that this methodology

nozdravstvene pismenosti populacije (44). Također, upitnici utemeljeni na vinjetnom pristupu, kojima se procjenjuje znanje pružajući detaljnije opise u odnosu na samo postavljanje pitanja o znanju o problemima mentalnoga zdravlja, predstavljaju hipotetičke slučajeve i stoga se dobiveni odgovori još uvijek mogu razlikovati od stvarnih situacija (42,45,46). Autori sustavnih pregleda napominju da postoje dodatna metodološka ograničenja u upotrebi upitnika MHLQ i interpretaciji rezultata. Nije uvijek moguće precizno i jasno procijeniti razinu znanja odvojeno od uvjerenja, stavova ili mišljenja, a kako bi se razumio jedinstveni doprinos svakog od tih čimbenika kao i njihov potencijalni međusobni učinak (47). Drugo ograničenje koje se spominje vezano je za razumijevanje problema mentalnog zdravlja odnosno mentalnih poremećaja koja su opisana u vinjetama, a koja čine polazište u odnosu na koje sudionici odgovaraju na preostala pitanja. Na primjer, sudionik na navedena pitanja može odgovarati pretpostavljajući da osoba opisana u vinjeti ima blagi stres umjesto depresije te će posljedično davati i različite odgovore (npr. kada je u pitanju potreba za kontaktom s psihijatrom) (44). Također, zbog obilježja pitanja otvorenog tipa koja su prisutna u MHLQ upitniku, posebice njihovih slabosti kada je u pitanju procjenjivanje, npr. stupnja izraženosti (učestalosti ili intenziteta) niza čimbenika, kasnije su razvijeni i alternativni anketni pristupi u korištenju vinjeta kojima je dodatno omogućeno bodovanje (44).

Većina mjera koje se zasnivaju na kvantitativnom pristupu razvijena je za procjenu samo pojedinih aspekata zdravstvene pismenosti u području mentalnog zdravlja (25,44). Primjeri nekih takvih mjernih instrumenata su Ljestvica pismenosti o depresiji (engl. *Depression Literacy Scale,* DLS) (47), upitnici znanja o shizofreniji (engl. *Knowledge about Schizophrenia Questionnaire* i *Schizophrenia Knowledge Questionnaire,* KASQ i SKQ) (48,49), instrumenti za mjerenje stigme kao što su Ljestvica socijalne distance (engl. *Social Distance Scale;* SD) (50) i Stavovi za-

does not allow conclusions to be drawn at the individual level, but has been shown to be useful in determining the level of mental health literacy of the population (44). Furthermore, the vignette-based questionnaire, which assess knowledge by providing more detailed descriptions compared with just asking knowledge questions, represents hypothetical cases, and answers obtained might therefore still differ from real-life situations (42, 45, 46). The authors of the systematic reviews note that there are additional methodological limitations in the use of the MHLQ questionnaire and in the interpretation of the results. It is not always possible to accurately and clearly assess the level of knowledge separately from beliefs, attitudes, or opinions in order to understand the unique contribution of each of these factors as well as their potential interaction (47). Another limitation is related to understanding the mental health problems and mental disorders described in the vignettes, which create a baseline in relation to which participants answer the remaining questions. For example, the participant can answer these questions under the assumption that the person described in the vignette has mild stress instead of depression, which will consequently result in different answers (e.g. when it comes to the need to contact a psychiatrist) (44). Furthermore, due to the characteristics of the open-ended questions that are present in the MHLQ questionnaire, especially their weaknesses when it comes to assessing e.g. the degree (frequency or intensity) of a number of determinants, alternative survey approaches were later developed in the use of vignettes that further enabled scoring (44).

Most measures that are based on a quantitative approach have been developed to assess only particular aspects of mental health literacy (25, 44). Some examples of these instruments are the Depression Literacy Scale (DLS) (47), the Knowledge about Schizophrenia

jednice prema mentalnim bolestima (engl. *Community Attitudes towards Mental Illness;* CAMI, modificirana verzija OMI-a) (51). Nadalje, slične se jednodimenzionalne ljestvice koriste u procjeni ponašanja povezanih s traženjem pomoći, primjerice Ljestvica stavova prema traženju pomoći (engl. *Attitudes towards Help-Seeking Scale*), kasnije modificirana kao Ljestvica stavova prema traženju profesionalne psihološke pomoći (engl. *Attitudes toward Seeking Professional Psychological Help Scale; ATSPPH*) (52,53).

Zbog prepoznatog nedostatka instrumenata koji omogućuju sveobuhvatnije istraživanje mentalnozdravstvene pismenosti i pružaju metodološki jak i vremenski učinkovit pristup, nedavno su razvijene ljestvice za procjenu pismenosti u području mentalnog zdravlja, poput Ljestvica zdravstvene pismenosti u području mentalnoga zdravlja (MHLS) (54) ili Upitnik za mentalnozdravstvenu pismenost (MHLq) (55) i ljestvice razvijene za određene skupine, kao što su Ljestvica pismenosti za mentalno zdravlje za studente zdravstvene zaštite (MHLs_HS) (56). Ljestvice se sastoje od 32 do 35 čestica kojima se procjenjuju različiti aspekti mentalnozdravstvene pismenosti, većinom zasnovane na originalnom konceptu zdravstvene pismenosti u području mentalnog zdravlja, kao što je predložio Jorm (znanja i uvjerenja o mentalnom zdravlju općenito, a ne nekom određenom problemu mentalnog zdravlja, stavovi ili stigma prema ljudima s problemima mentalnog zdravlja ili mentalnim poremećajima, traženje pomoći i ponašanje/vještine pružanja prve pomoći te strategije samopomoći), ali neki od njih dodatno procjenjuju i znanja o održavanju pozitivnog mentalnog zdravlja. MHL ljestvice također su razvijene za upotrebu u evaluaciji obrazovnih programa i intervencija usmjerenih na poboljšanje pismenosti mentalnog zdravlja.

Wei i sur. u nizu preglednih radova analizirali su nedostatke i prednosti pojedinih instrumenata za mjerenje mentalnozdravstvene pismenosti, te su istaknuli pojedinačne preporuke za

Questionnaire (KASQ) and the Schizophrenia Knowledge Questionnaire (SKQ) (48, 49), instruments for measuring stigma such as Social Distance Scale (SD) (50), and the Community Attitudes Towards Mental Illness (CAMI, modified version of OMI) (51). Furthermore, similar one-dimensional scales are used in assessment of help-seeking behaviors such as the Attitudes toward Help-Seeking Scale, later modified into the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) (52, 53).

Due to the recognized lack of scales that would allow more comprehensive exploration of mental health literacy and provide a methodologically strong and time-efficient approach, some scales for assessing mental health literacy have been recently developed, such as the Mental Health Literacy Scale (MHLS) (54) or Mental Health Literacy Questionnaire (MHLQ) (55), and scales have been developed for specific groups, such as the Mental Health Literacy Scale for Healthcare Students (MHLS_HS) (56). These scales consist of 32 to 35 items assessing different aspects of mental health literacy, mostly based on the original concept of mental health literacy as proposed by Jorm (knowledge and beliefs about mental health in general, not some particular mental health problem, attitudes or stigma toward people experiencing mental health problems or mental disorders, help-seeking and first aid behavior/skills, and self-help strategies), but some of them also assess knowledge of maintaining positive mental health. MHL scales have also been developed for use in evaluation of educational programs and interventions aimed to improve mental health literacy.

In a series of review papers, Wei et al. analyzed the shortcomings and strengths of different mental health literacy instruments and highlighted individual recommendations for their use (25, 57-59). In doing so, they emphasized

njihovo korištenje (25,57-59). Pritom naglašavaju kulturološka ograničenja te zaključuju da ne postoje instrumenti koji bi bili općenito primjenjivi za sve populacije.

U konačnici MHLQ, premda prema navedenim sustavnim pregledima ne pripada instrumentima koji nude dobre metrijske karakteristike, zaslužuje istraživačku pozornost zbog svoje sveobuhvatnosti i pružanja podataka o višestrukim dimenzijama mentalnozdravstvene pismenosti, što potvrđuje i njegova široka primjena. Mješovita (kvalitativna i kvantitativna) priroda MHLQ upitnika pruža dublji uvid u obilježja i razinu mentanozdravstvene pismenosti, što nedostaje većini drugih instrumenata.

Zdravstvena pismenost nije čest predmet istraživanja u Hrvatskoj, a zdravstvena pismenost u području mentalnog zdravlja još i manje. U Hrvatskoj je 2017. provedeno istraživanje mentalnozdravstvene pismenosti odgojno-obrazovnih djelatnika iz osnovnih i srednjih škola. Cilj istraživanja je bio dobiti uvid u osnovna znanja i vjerovanja odgojno-obrazovnih djelatnika u području mentalnog zdravlja djece i mladih s naglaskom na depresivne smetnje te razinu prepoznavanja problema i spremnost pružanja prve pomoći i podrške. Istraživanje je provedeno prema australskom modelu mentalnozdravstvene pismenosti te je za potrebe istraživanja MHLQ upitnik prilagođen cilju istraživanja i metodi prikupljanja podataka putem interneta (60).

PRAKTIČNA PRIMJENA REZULTATA ISTRAŽIVANJA ZDRAVSTVENE PISMENOSTI U PODRUČJU MENTALNOG ZDRAVLJA – RAZVOJ PROGRAMA I INTERVENCIJA

Istraživanja pokazuju da unaprjeđivanje zdravstvene pismenosti u području mentalnog zdravlja može doprinijeti boljem prepoznavanju ranih znakova problema mentalnog

cultural constraints and concluded that there are no instruments that would be generally applicable to all populations.

Finally, even though systematic reviews highlight that MHLQ is not among the instruments that offer good metric characteristics, it deserves attention for its comprehensiveness and the provision of data on multiple dimensions of mental health literacy, as evidenced by its widespread use. The combined qualitative and quantitative nature of MHLQ provides a deeper insight into the characteristics as well as level of mental health literacy, which most other instruments lack.

Health literacy is not a frequent research interest in Croatia, and mental health literacy even less so. A study assessing mental health literacy of educational staff from primary and secondary schools in Croatia was conducted in 2017. The aim of the study was to gain insight into the basic knowledge and beliefs of educational staff in the field of mental health of children and young people with an emphasis on depressive symptoms and the level of problem recognition and willingness to provide mental health first aid and support. The study was conducted according to the Australian mental health literacy model and, for that purpose, the MHLQ was adapted to the objectives and method of data collection via the Internet (60).

PRACTICAL IMPLICATIONS OF THE MENTAL HEALTH LITERACY SURVEY FINDINGS – DEVELOPMENT OF MHL PROGRAMS AND INTERVENTIONS

Studies show that improving mental health literacy can contribute to better recognition of early signs of mental health problems among non-professionals and improve attitudes towards seeking help (11). Furthermore, the

zdravlja među nestručnjacima te poboljšanju stavova prema traženju pomoći (11). Također, provedena istraživanja ukazuju na potrebu razvoja i provedbe programa za unaprjeđenje opće zdravstvene pismenosti u cilju ranog prepoznavanja problema mentalnoga zdravlja i mentalnih poremećaja te pružanja primjerene pomoći i emocionalne podrške (26, 33).

Pri osmišljavanju intervencija za unaprjeđenje zdravstvene pismenosti u području mentalnog zdravlja treba uzeti u obzir razlike koje su pronađene između dobnih skupina i pojedinih mentalnih poremećaja/bolesti. Primjerice, rezultati istraživanja Farrer i sur. su pokazali da su stariji odrasli (iznad 70 godina) s manjom točnošću od mlađih odraslih (18-24 godine) prepoznavali depresiju i shizofreniju, ali su mlađi češće zamijenili shizofreniju za depresiju. Razlike su utvrđene i u vjerovanju o korisnosti pomoći stručnjaka, medicinskih tretmana i životnih navika u liječenju shizofrenije i depresije, a stariji su u većoj mjeri smatrali da shizofrenija može biti uzrokovana slabošću karaktera (61). Posebnu pozornost treba usmjeriti na destigmatizaciju osoba narušenog mentalnog zdravlja ili s dijagnosticiranim mentalnim poremećajima / bolestima (62, 63).

Jedan od primjera programa unaprjeđivanja zdravstvene pismenosti u području mentalnog zdravlja utemeljen na rezultatima istraživanja provedenih od 1995. godine u Australiji je program Prva pomoć u području mentalnoga zdravlja (engl. *Mental Health First Aid,* MHFA) (64). Zbog sve većeg broja ljudi s problemima mentalnog zdravlja koji ne uključuju nužno patološke simptome već i lakše poteškoće u svakodnevnom funkcioniranju prepoznata je potreba da se javnost senzibilizira i educira i o tom bitnom aspektu sveukupnog zdravlja osobe - mentalnom zdravlju. Radi se o standardiziranoj psihoedukativnoj intervenciji za unaprjeđivanje znanja te promjenu stavova i ponašanja vezano za probleme mentalnoga zdravlja i mentalne poremećaje/bolesti opće populacije ili specifičnih dobnih skupina i okruženja kao i stručnjacima raznih profila (65). Svjetska federacija za men-

results indicate that it is necessary to develop and implement programs for improving general mental health literacy in order to achieve early recognition of possible mental health problems or mental disorders and to provide appropriate assistance and emotional support (26, 33).

Differences in mental health literacy found between age groups and mental disorders should be taken into consideration when designing interventions to improve mental health literacy. For instance, Farrer et al. found that older adults (over 70 years of age) recognized depression and schizophrenia with less accuracy than younger adults (18-24 years), but younger participants confused schizophrenia and depression more often. Differences were also found in beliefs about the usefulness of professional help, medical treatments, and lifestyle habits in the treatment of schizophrenia and depression; older people also thought that schizophrenia could be caused by character weakness (61). Particular attention should be paid to the destigmatization of people with mental health problems or those diagnosed with a mental disorder or illness (62, 63).

The Mental Health First Aid (MHFA) program is an example of a mental health literacy program based on studies conducted since 1995 in Australia (64). Due to the increasing number of people with mental health problems that do not necessarily include pathological symptoms but rather also minor difficulties in their daily functioning, the need to sensitize and educate the public about this important aspect of a person's overall health and mental health has been recognized. It is a standardized psychoeducational intervention to advance knowledge and change attitudes and behaviors related to mental health problems and mental disorders / illnesses of the general population or specific age groups and environments as well as various professionals (65). The World Mental Health Federation, in collaboration with the World Health Organization, has highlighted

talno zdravlje je u suradnji sa Svjetskom zdravstvenom organizacijom 2016. istaknula program MHFA kao globalni primjer dobre prakse (66), a taj program je prepoznat i na europskoj razini kao učinkovita metoda javnozdravstvenog djelovanja u području prevencije depresije i samoubojstava (67). Program se ubrzo proširio na cijelo područje Australije (procjenjuje se da je program od 2001. odslušalo preko 2 % ukupne populacije odraslih u Australiji), a preko 25 država svijeta je licenciralo i prilagodilo navedeni program (68). U Europi se ovaj program provodi npr. u Danskoj, Engleskoj, Finskoj, Francuskoj, Irskoj, Malti, Nizozemskoj, Njemačkoj, Sjevernoj Irskoj, Škotskoj, Švedskoj, Švicarskoj i Walesu. Cilj je ovog programa osnaživanje javnosti da pruži pomoć osobama koje razvijaju probleme u području mentalnog zdravlja, doživljavaju pogoršavanje postojećih problema ili proživljavaju krizu. To je ono što zovemo još i psihološka prva pomoć. Ova se prva pomoć pruža dok se ne dobije odgovarajuća stručna pomoć ili dok se ne razriješi kriza. Navedena edukacija prve pomoći u području mentalnog zdravlja ne uči ljude kako se postavljaju dijagnoze ili radi tretman, što je područje profesionalnih edukacija, nego ih uči vještinama inicijalne podrške u zajednici.

Namjera programa MHFA je da svima u zajednici pruži vještine inicijalne podrške, a posebno je usmjeren na djelatnike koji se u svom svakodnevnom radu susreću s vulnerabilnim skupinama (djeca i mladi, starije osobe, kronično ili teže bolesne osobe i sl.). Tako su razvijeni i programi usmjereni na specifične skupine kao što su mladi (*Teen Mental Health First Aid*) ili odrasle osobe koje rade s djecom i mladima (*Youth Mental Health First Aid*) (69).

Dosadašnje evaluacije navedenog programa pokazuju pozitivne rezultate u više područja promjene javne svijesti o mentalnim poremećajima i bolestima. Nakon sudjelovanja u programu polaznici uspješnije prepoznaju znakove mentalnih poremećaja/bolesti u vinjetama koje opisuju osobe s primjerice simptomima depresije ili shizofrenije, izjavljuju o većem samopo-

the MHFA program as a global example of good practice in 2016 (66). It has also been recognized at European level as an effective method of public health practice for depression and suicide prevention (67). The program soon spread to the whole of Australia (it is estimated that over 2% of Australia's total adult population has finished the program since 2001) and over 25 countries have licensed and adopted the program globally (68). In Europe, this program is being implemented in Denmark, England, Finland, France, Ireland, Malta, the Netherlands, Germany, Northern Ireland, Scotland, Sweden, Switzerland, and Wales. The aim of this program is to empower the public to help people who develop mental health problems, experience exacerbation of existing problems, or experience a crisis. We can also call this psychological first aid. This first aid is provided until adequate professional assistance is obtained or until the crisis is resolved. Mental health first aid training does not teach people how to establish diagnoses or perform treatments, which is in the vocational training domain of professionals, but rather teaches them initial community support skills. The purpose of the MHFA program is to provide initial support skills to everyone in the community, and it is especially focused on employees who encounter vulnerable groups in their daily work (children and young people, the elderly, chronically or seriously ill people). Programs targeting specific groups such as children and youth, such as Teen Mental Health First Aid, or adults who work with children and youth, i.e. Youth and Youth Mental Health First Aid, have been developed (69).

Evaluations of MHFA have shown positive results in several areas of change in public awareness related to mental disorders and illnesses. After completing the training, participants are more successful in recognizing signs of mental disorders / illness in vignettes that describe people with, for instance, symptoms of depres-

uzdanju kad je u pitanju pružanje prve pomoći i podrške pokazuju manju socijalnu distancu i manje stigmatiziraju osobe koje boluju od depresije ili shizofrenije te uspješnije prepoznaju gdje potražiti pomoć kod problema mentalnoga zdravlja (61). Provedena je i meta-analiza 15 istraživanja s ciljem sistematizacije postojećih znanja o učinkovitosti provedbe programa MHFA (65). Utvrđene su najveće promjene u poboljšanju znanja sudionika, zatim u promjeni stava prema osobama s problemima mentalnog zdravlja odnosno mentalnim poremećajima/bolestima, a iako značajne, najmanje su promjene pronađene u ponašanju (65).

Posljednjih se godina naglašava potreba razvoja i evaluacije programa mentalnozdravstvene pismenosti kojima je glavni cilj stvaranje temelja za dobro mentalno zdravlje, blagostanje i produktivnu budućnost, posebice kada su u pitanju djeca i mladi (70).

ZAKLJUČAK

Istraživanja u području mentalnozdravstvene pismenosti posljednjih 20-ak godina doprinijela su razumijevanju navedenog istraživačkog konstrukta. Saznanja proizašla iz istraživanja dobar su putokaz u razvoju programa za poboljšanje zdravstvene pismenosti u području mentalnog zdravlja kako za opću populaciju tako i za specifične skupine i okruženja.

Istraživanje Altweck i sur. 2015. potvrdilo je postojanje kulturoloških razlika u vezi zdravstvene pismenosti u području mentalnoga zdravlja u segmentima znanja kao i vjerovanja o uzrocima mentalnih poremećaja i traženja pomoći. Navedeno istraživanje naglašava važnost razumijevanja uvjerenja o mentalnim poremećajima i bolestima u različitim kulturama u cilju razvoja učinkovitijeg, pristupačnijeg i kulturološki osjetljivog sustava usmjerenog na zaštitu mentalnog zdravlja pa tako i prilagođenih programa mentalnozdravstvene pismenosti (71).

sion or schizophrenia, express more confidence when it comes to providing first help and support, show less social distance and less stigmatization toward people who suffer from depression or schizophrenia, and more successfully identify where to seek help for mental health problems (61). A meta-analysis was conducted to systematize existing knowledge on the effectiveness of the MHFA program that included 15 studies (65). The greatest changes were found in improving participants' knowledge, then in changing attitudes towards people with mental health problems or mental disorders / illnesses, and, although significant, the smalles changes were found in behavior (65).

The need for the development and evaluation of mental health literacy programs has been emphasized over the past few years, with the main objective being to create a foundation for good mental health, well-being, and a productive future, especially when it comes to children and young people (70).

CONCLUSION

Mental health literacy studies over the last 20 years have contributed to the understanding of this research construct. The research findings have provided important guidelines for the development of programs aimed at improving mental health literacy among the general population and specific groups and environments.

The study by Altweck et al. 2015 confirmed the existence of cultural differences in mental health literacy related to knowledge as well as beliefs about the causes of mental disorders and about seeking help. This research highlights the importance of understanding the beliefs about mental disorders and illness in different cultures in order to develop a more efficient, accessible, and culturally sensitive mental health system and thus tailored mental health literacy programs (71).

Nakon gotovo 20 godina istraživačkog i stručnog iskustva u području mentalnozdravstvene pismenosti stručnjaci naglašavaju da zdravstvena pismenost populacije u području mentalnog zdravlja i njeno praćenje mora biti interes nacionalnih politika mentalnoga zdravlja (27). U razvoju programa i intervencija je posebice važno prilagoditi ih ciljanoj populaciji, uzeti u obzir spolne, dobne i kulturološke razlike kao i specifičnosti okruženja. Navedene su razlike važne i pri organizaciji i razvoju sustava mentalnog zdravlja da bi oni postali učinkovitiji, pristupačniji i kulturološki osjetljivi. Stoga je pri razvoju programa važno temeljiti specifične ciljeve i odabir sadržaja na znanstveno utemeljenim spoznajama, a upotreba istraživačke metode i odabir mjernih instrumenata mora se temeljiti na dosadašnjim spoznajama u tom području povezano sa specifičnom ciljanom populacijom i kulturološkim okruženjem.

Međutim, navedeni programi nisu niti jedini niti dostatni kada je u pitanju poboljšanje zdravstvene pismenosti o mentalnom zdravlju. Istraživanje provedeno u Južnoj Australiji o promjenama razine zdravstvene pismenosti u području mentalnog zdravlja povezano s depresijom 1998. - 2004. pokazalo je da je došlo do povećanja pismenosti, ali je potvrdilo da je malo vjerojatno da bi do tog poboljšanja došlo da nije bilo utjecaja i brojnih inicijativa u cilju osvještavanja javnosti o mentalnim poremećajima (72).

Važnost unaprjeđivanja mentalnozdravstvene pismenosti u zajednici možemo prepoznati u akcijskom programu *Mental Health Gap Action Programme* (mhGAP) Svjetske zdravstvene organizacije iz 2019. godine (73). Navedeni dokument donosi nekoliko aktivnosti i intervencija koje se mogu provesti na razini zajednice, a koje uključuju:

- razgovor o mentalnom zdravlju kako bi se podigla razina znanja i osviještenosti te smanjili stigma i diskriminacija, potom aktivnosti promicanja mentalnog zdravlja i prevencije koje podizanjem osviještenosti o

After almost 20 years of research and professional experience in the field of mental health literacy, experts emphasize that mental health literacy and its monitoring must be the focus of interest for national mental health policies (27). In the development of the programs and interventions, it is especially important to adapt them to the target population and take into consideration gender, age, and cultural differences as well as specific characteristics of the environment. These differences are also important in the organization and development of the mental health system in order to make them more efficient, accessible, and culturally sensitive. Therefore, when developing a program, it is important to identify specific goals and select content while considering science-based knowledge, and the use of research methods and selection of instruments should therefore be guided by current knowledge in this area related to the specific target population and cultural environment.

Of course, these programs are not the only ones, nor are they sufficient when it comes to mental health literacy improvement. A study conducted in South Australia on changes in mental health literacy related to depression between 1998 and 2004 found that literacy had increased, but also confirmed that it was unlikely that improvement would happen if not for the effect of many initiatives aimed at raising the public's awareness of mental disorders (72).

Ihe importance of enhancing community mental health literacy is also emphasized in the 2019 WHO Mental Health Gap Action Program (mhGAP) (73). The document outlines several community-based activities and interventions that include:

- Talking about mental health to raise knowledge and awareness and reduce stigma and discrimination, followed by mental health promotion and prevention activities that contribute to early seeking and receiv-

mentalnom zdravlju u zajednici doprinose ranijem traženju i dobivanju pomoći onima s problemom mentalnoga zdravlja

- aktivnosti usmjerene na pružanje podrške osobama s problemima mentalnog zdravlja što uključuje i osnaživanje pomagača u zajednici s ciljem ranog prepoznavanja i pravovremenog dobivanja primjerene pomoći
- aktivnosti i intervencije koje podržavaju oporavak i rehabilitaciju u zajednici osoba s mentalnim bolestima i poremećajima kako bi ostvarili što veću kvalitetu života (73).

Upravo navedene aktivnosti preporučene unutar mhGAP-a sadržane su u programima koji se temelje na konceptu zdravstvene pismenosti u području mentalnog zdravlja. S obzirom na činjenicu da je mentalnozdravstvena pismenost važan čimbenik očuvanja mentalnog zdravlja potrebno je provoditi intervencije kojima će se podići razina mentalnozdravstvene pismenosti. Te intervencije pri tome moraju biti utemeljene na istraživanjima i znanstvenim dokazima te sastavni dio sveobuhvatnog pristupa promicanja i unaprjeđivanja mentalnog zdravlja te prevencije poremećaja. Stručnjaci iz vodećih svjetskih zemalja u istraživanjima i praksi usmjerenoj na poboljšanje mentalnozdravstvene pismenosti ističu da je potrebno bolje razumijevanje mentalnozdravstvene pismenosti i da su potrebne nacionalne inicijative razvoja kontekstualno i razvojno primjerenih te evaluiranih intervencija u ovom području da bi se u budućnosti unaprijedilo mentalno zdravlje na razini pojedinaca i opće populacije (28, 74).

ing help among those with mental health problems.

- Activities aimed at supporting people with mental health problems, including the empowerment of community-based helpers, in order to ensure that the problems will be recognized and appropriate assistance received as early as possible.
- Activities and interventions that support recovery and rehabilitation of people with mental illnesses and disorders in the community in order to achieve the highest possible quality of life (67).

These activities recommended in mhGAP are fully covered by programs based on the mental health literacy concept. Given the fact that mental health literacy is an important factor in maintaining mental health, it is necessary to implement interventions that will increase mental health literacy. In doing so, these interventions must be based on research and scientific evidence and must be an integral part of a comprehensive approach to promoting and improving mental health and the prevention of disorders. Experts from countries that are world leaders in research and practice of improving mental health literacy highlight that enhanced understanding of MHL and national initiatives in developing contextually and developmentally appropriate as well as validated interventions are needed in order to help achieve improvements in both individual and population mental health outcomes in the future (28, 74).

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