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## MENTAL HEALTH LITERACY AND COMMUNITY SOCIAL SERVICE PRACTICE

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## Mental health literacy and community social service practice

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# *Mental health literacy and community social service practice*

I began working in the social service sector almost 3 decades ago as part of a group of summer students hired by a drop-in centre for street-involved and homeless youth. Drawn in by images of so-called 'risky' young people sporting spiked hair, shaved heads, combat boots and dog collars splashed on the pages of the newspaper, I, in all my privilege and whiteness, believed I could help. As a parting gift from my job at the bank, a supervisor provided me with a whistle. She was concerned for my safety. But I, naively, believed I was ready.

My new employers at the drop-in centre tried to prepare their summer recruits by providing a week-long orientation including

an experiential exercise of staying outside all night with a mere \$3 in our pockets. Following this, we were launched into direct service roles. Passion, a whistle, and the 5 days of training did not prepare me for the trauma, painful stories, and observations of violence, exploitation, and mental illness.

It was like opening the front door to temperatures of -30 in the dead of winter—a smack of cold air hitting your lungs rendering you gasping for your next breath. I was ill-prepared for social service practice. Wiping away futile tears<sup>1</sup> at the end of summer, I returned to university believing that a book-lined pathway mental health literacy was the way to become an effective practitioner.

1. *Tears of futility* is a concept identified by Neufeld (2012) to describe emotional experiences when we encounter circumstances that we cannot change, which in turn leads to transformation.

## MENTAL HEALTH LITERACY

The preparation for social service practice provided within higher education settings can vary widely and opportunities to learn about mental health and suicide can be significantly limited (Ranahan, 2013a). As a result, standardized programs, such as Mental Health First Aid (MHFA) or Applied Suicide Intervention Skills Training (ASIST) have emerged in order to fill this gap and further develop practitioners' *mental health literacy*.

Mental health literacy (MHL) is a concept developed by Australian psychiatrist, Anthony Jorm (1997) and his colleagues and includes the following: “understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one’s mental health care and self-management capabilities)” (Kutcher, Wei, & Coniglio, 2016, p. 155).

Given that 1 in 5 Canadians are impacted by mental illness each year (Smetanin et al., 2011), it is worth exploring how MHL may be enhanced and better applied to social service practice. And given the limited mental health and suicide prevention content that exists in pre-service education, and the reality that community social service professionals often work in direct contact with populations impacted by, or vulnerable to, mental health challenges, MHL is becoming increasingly relevant to frontline practice.

In this article, I draw upon several studies that I conducted with child and youth care professionals over the past several years to unpack how MHL can show up in practice. I outline some of the possible mental health literacy among direct service staff and propose some current and potential approaches for better developing MHL. I also explore how we must appreciate, contextually, the process of applying such literacies to social service practice that go beyond relying on rote learning or memorization and the book-lined journey I embarked on several decades ago.

## KNOWLEDGE VS LITERACY

To date, efforts directed towards research and promoting MHL often focus on measuring and enhancing individuals' knowledge of mental disorders. Knowledge of the symptoms and criteria of particular disorders, as outlined in the Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM-V) are front and centre—especially among informal mental health care providers and community social service practitioners.

For example, a key method used to assess MHL in research studies is to use case scenarios depicting the expressed symptoms of a particular mental disorder. Following a review of the scenario, participants are asked what is wrong with the character, along with whom or what can help them. Participants are deemed 'literate' or 'illiterate' based on their ability to identify the mental disorder as described in the DSM-V and its recommended evidence-based treatment.

Arguably, social service practitioners' knowledge of DSM-V criteria and familiarity with effective treatments can be useful when communicating with other professionals. Yet what seems to be more important in practice are the varied characteristics of the formal mental health provider as perceived by practitioners—being helpful, approachable, and encouraging interprofessional collaboration (Ranahan & Thomas, 2016).

## A HIERARCHY OF KNOWLEDGE

Complicating our understanding of mental health literacy is the fact that a “knowledge hierarchy” can often show up in areas of practice where mental health concerns are present. Formal mental health providers, such as psychiatrists or psychologists, are often thought of as mental health “knowledge-keepers” with greater expertise on mental disorders and treatments available (Ranahan, 2013b).

It is a common practice and policy within some community service organizations to refer persons in mental distress to outside formal resources. However, this dynamic can result in community social service practitioners finding themselves on the periphery of mental health care, where they are forced into the role of either detective (focusing solely on identifying indicators or ‘warning signs’ that someone may be suffering from a mental disorder) or observer (watching for recurrence of symptoms and treatment compliance among those under their care) (Ranahan, 2014).

Procedurally, referrals that are simply ‘hand-offs’ to a formal mental health provider both serve to reinforce this hierarchy and disrupt the relationship between social service practitioners and the people they serve (a disruption that is even more pronounced when the client does not desire the referral and/or the original practitioner becomes excluded). People are often best served by referrals if there is continuity of care, collaborative decision-making, and an opportunity for the client to identify and include support persons as they see fit. Improving service delivery requires enhanced mental health literacy on both levels of this hierarchy and more careful consideration of how, when, and why such referrals take place.

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One alternative approach to treatment is offered by Carson (2011) who suggests that “[w]hen knowledge and skills are shared within the ‘circle of care,’ professionals are likely to feel better about the jobs they do” (p. 130). In other words, challenging this hierarchy of knowledge and shifting where mental health expertise is located has the potential to transform social service practice.

When mental health knowledge is no longer viewed as being owned by particular professional groups but shared within a circle of care, collaboration between professionals is

enhanced, specific expertise recognized, and hierarchical power relations dismantled.<sup>234</sup> Most importantly, children, youth, families and community members can receive more effective and comprehensive care.

## **STIGMA, HELP-SEEKING, AND SERVICE DELIVERY**

“Stereotype, prejudice, and discrimination can rob people labelled mentally ill of important life opportunities that are essential for achieving life goals” (Corrigan, 2004, p. 616). This same stigma and the resulting fear or anxiety about being viewed as “crazy” (Draucker, 2005, p. 158) or having an inherent weakness may also prevent people from seeking help and thus prevent practitioners from connecting people in need to formal mental health care providers.

Community social service practitioners are not exempt from this problem. At times they may attribute symptoms to controllable behaviour problems, recent stressors, or adverse experiences in childhood (Stolzenburg, Freitag, Schmidt, & Schomerus, 2018). They may view suicidal behaviours as manipulative or attention-seeking (Awenat, Peters, Shaw-Nunez, Gooding, Pratt, & Haddock, 2017). But a

key part of mental health literacy is understanding that the ways in which we view the causes or triggers of mental disorders and suicidal behaviours influences how we respond both as individual practitioners and as communities.

When practitioners or clients interpret symptoms of a mental health issue as a behaviour problem, they may be less likely to offer or accept help that would alleviate these symptoms and may employ punitive responses that exacerbate suffering. For example, a young adult who displays emotionally disregulated behaviour in a community outreach drop-in program may be barred from accessing services regardless of whether or not their behaviour is a symptom of mental illness. A key component of mental health literacy is thus the ability to recognize when mental health problems are present so practitioners can follow up with responsive and appropriate help.

As with providing help, stigma and seeking help for mental health issues are also intertwined. Our understanding of the stigma around help-seeking is also integral to improving MHL. Rickwood et al. (2005) define help-seeking as “communicating with other people to obtain help in terms of

2. See Kutcher, S., Davidson, S., & Manion, I. (2009). Child and youth mental health: Integrated health care using contemporary competency-based teams. *Paediatrics & child health*, 14(5), 315-318.

3. See Nadeau, L., Rousseau, C., & Measham, T. (2012). Integrated networks in child and youth mental health: A challenging role transformation for child psychiatrists and allied mental health professionals? *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 21(2), 83-84.

4. See Rousseau, C., Pontbriand, A., Nadeau, L., & Johnson-Lafleur, J. (2017). Perception of interprofessional collaboration and co-location of specialists and primary care teams in youth mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 26(3), 198-204.

understanding, advice, information, treatment, and general support in response to a problem or distressing experience” (p. 4).

In practice, we often hear individuals being labelled as ‘resistant’ or ‘noncompliant’ when they do not show up to appointments or refuse to take medication, rather than unable or unwilling to seek help. Given the stigma that surrounds mental health issues, people may avoid seeking help from mental health services out of fear of public identification of being “mentally ill” (Corrigan, 2004, p. 616). Thus, avoiding treatment may be a strategy to escape from stigma as much as anything else.

Instead of framing avoidance as resistance or noncompliance, social service practitioners can recognize disengagement more as a program or organizational challenge to be understood and addressed. Improving mental health literacy requires understanding help-seeking differently and realizing that overcoming these barriers are not the individual’s sole responsibility.

## **STANDARDIZED MENTAL HEALTH LITERACY**

Standardized professional development programs designed to promote MHL among the general population and within specific professional groups are already

available. For example, MHFA is a two-day workshop designed to enhance features of mental health literacy including knowledge of mental disorders and assessing the risk of suicide or harm (Jorm et al., 2005). Interpersonal communication skills (i.e., active listening, empathy) and strategies to promote help-seeking and referral are also included in these programs.

In studies, MHFA program participants’ self-reported improved confidence and intentions to provide help and decreased stigmatizing attitudes.<sup>5</sup> However, a key challenge in implementing standardized programs, such as MHFA, is the dynamic uniqueness

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of each context (i.e., region, community, organization, professional group) in which it is delivered. Efforts to enhance MHL must also consider the complexities and variability of context, including the relational and systemic elements that influence how MHL may be understood and applied.

## **COMMUNITY CONTEXTS**

Mental health resources in one community can vary greatly from the next community. Moreover, every community and every organization has its own unique history of

5. See Bond, K. S., Jorm, A. F., Kitchener, B. A., & Reavley, N. J. (2015). Mental health first aid training for Australian medical and nursing students: an evaluation study. *BMC psychology*, 3(1), 11.

mental health services and relationship to mental health. This history includes what community members are more likely to be impacted by mental health or suicide events, who is delegated as a person or professional to offer help, and how services are organized and funded.

Literacy is shaped by our participation in social interactions and activities and it is established in personal, historical, cultural and social contexts (Cervetti, Damico, & Pearson, 2006; Scribner, 1984). We need to

**Every community and every organization has its own unique history of mental health services and relationship to mental health.**

appreciate that enhancing MHL requires moving beyond thinking about literacy as an individual skill-set or having knowledge of the symptoms of mental disorders and consider the “degree of fit” between social service providers and members of the community (Rootman, 2009).

This requires a deep understanding of the community. Each person brings expectations, preferences, and skills to an interaction, and this interaction is located within a particular social-ecological context. The young person living in a group home may prefer discussing his concerns about anxiety or depression with his key youth worker assigned to his case and with whom he has a relationship. Whereas, in a rural or remote

community “where strangers are few and personal information seems to belong to everyone,” confidentiality concerns may inhibit a person from accessing a mental health service provider known to them (Wilson-Forsberg & Easley, 2012, p. 281). While both individuals may have knowledge about mental disorders, and of treatments available, each brings a preference that underpins access to mental health care.

With this in mind, learning and enhancing MHL must extend beyond a focus on rote mental health knowledge and observed skills in simulations, and be a process of engagement, connected to learners’ lived experiences, provide opportunities to provoke new awareness of the experiences of others and

self, alongside an ethical duty to promote change within communities and contexts they are located within (Ranahan, 2015).

**PROFESSIONAL DEVELOPMENT**

There are several ways to enhance existing professional development efforts in promoting MHL. First, mobilizing the existing knowledge of practitioners is needed. Given the prevalence of mental health and suicide concerns, community social service practitioners are likely to have personal lived experience through familial or social relationships that have contributed to their understanding of, and responses to, mental disorders. Creating learning activities that draw upon this knowledge as valid and



vital to learning can contribute to shifting the hierarchy of expertise often found in mental health care provision.

For example, a lived experience conversation series at Concordia University brings together mental health researchers with persons who have a mental health diagnosis together in conversations that are open to the university community. Such social-contact-based interventions, where service providers connect with people who have lived experience of mental illness, are also found to be effective in reducing stigma and enhancing knowledge in the short-term (Thornicroft et al., 2016).

Second, interdisciplinary learning opportunities integrated into college and university programs and in professional development training can offer the external structure needed to cultivate interprofessional relationships (Ranahan & Thomas, 2016). These learning opportunities would allow professionals to articulate their own and others' roles and perspectives, which can contribute to increased confidence and engagement in mental health care teams (Ranahan, 2018).

Lastly, enhancing MHL must move beyond a sole focus on vignettes or case scenarios that are read and analyzed. It must include experiential learning activities that require learners to actively apply knowledge to practical situations. Role-playing and mindfulness training may be integrated into professional development workshops in order to support learners to work through emotional or physiological responses that may arise during practice when faced with situations

involving mental health or suicide (Ranahan & White, 2016).

## CONCLUSION

My experience of being launched into direct social service practice with little experience and knowledge was similar to child and youth care practitioners who participated in a recent study exploring their initial encounters with young people who were suicidal. Practitioners identified themselves as “green” or “novice”, which left them unable to respond (Ranahan & Pellissier, 2015). One participant described feeling “struck” by this first experience, identifying this experience as serving to break a “barrier” between not knowing and knowing (i.e., fully experiencing) in an embodied way.

Practitioners often embark on a career in social service because of a passion for helping others or a calling to the field itself (Stuart, 2013). When feeling inadequately prepared, social service practitioners may end up questioning, or even exiting, their chosen career. Reliance only on memorization of the symptoms of mental disorders and the criteria for diagnosis—and the absence of learning experiences that can simulate practice in authentic and transformative ways—may well leave practitioners believing that they are unable to meet the needs of the children, youth, families and communities they serve.

MHL is an essential component of community social service practice, yet how this concept is defined and understood shapes our ability and efforts to enhance and apply

MHL in practice. Knowledge of mental disorders, treatments and resources within communities are critical to recognizing and responding to mental health issues. Sharing and improving this information also works to promote interprofessional collaboration. But applying this knowledge in practice requires concentrated efforts to remain attuned both to the individual client we are serving and the community and organizational context.

Ideally, social service practitioners will develop MHL through ongoing personal, professional and educational opportunities that allow them to adapt and adjust to dynamic and emerging practice contexts. At times, interactions between those seeking help and those providing help run smoothly—times when there is a good ‘fit’ between practitioner and consumer.

But this is not always the case; at times, organizational policies or decision-making models that focus strictly on referrals to formal mental health service providers may be inconsistent with the client’s expressed desire for who can help or what kind of help is being sought out.

That’s why we need to move beyond understanding MHL as the sole property of certain individuals (i.e., measuring practitioner’s MHL) or particular professional groups (i.e., formal mental health care providers such as psychologists, psychiatrists) to a new approach where community social service practitioners and their organizations examine ways in which they can create communities that invite collective action against stigma and remove barriers to participation in efforts that maintain and enhancing mental health and wellness.

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