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A Concept Analysis on Mental Health Literacy Using Rodgers' Evolutionary Method

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Systematic Review

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Abstract

Mental health literacy (MHL) is an evolving and contextually situated concept that has grown considerably in scope since Jorm et al. first defined it in 1997. Using Rodgers' evolutionary concept analysis method, which recognizes that concepts are dynamic, context-dependent, and subject to change over time, this paper systematically examines the attributes, antecedents, consequences, surrogate terms, and related concepts associated with mental health literacy.

Following an integrative review of empirical, theoretical, and clinical literature published from 1997 to 2024, the analysis identifies six core attributes: (1) recognition and identification of mental health problems; (2) knowledge of risk factors and aetiology; (3) knowledge of help-seeking options and treatment; (4) attitudes and beliefs conducive to early help-seeking; (5) skills in first-aid response and personal support; and (6) self-care and management competence. The resulting integrated definition and conceptual model provide a foundation for instrument development, intervention design, educational curricula, and service planning in mental health contexts.

Introduction

Mental health conditions affect approximately one in four people globally at some point in their lives, yet treatment gaps remain stark: the World Health Organization estimates that between 76% and 85% of people with serious mental health conditions in low- and middle-income countries receive no treatment whatsoever (WHO, 2022). Even in high-income countries with well-resourced healthcare systems, delays between symptom onset and first contact with mental health services routinely span several years (Kessler et al., 2007; Wang et al., 2004). These delays have profound consequences: chronicity, occupational impairment, relationship breakdown, and elevated suicide risk.

One factor consistently implicated in delayed or absent help-seeking is low mental health literacy (MHL): people who cannot recognize mental health problems, who hold stigmatizing beliefs about mental illness, or who do not know where or how to seek help are less likely to act appropriately when problems arise. Conversely, populations with higher MHL demonstrate earlier help-seeking, greater adherence to treatment, and more supportive responses toward others experiencing mental health difficulties (Kutcher et al., 2016; Morgan et al., 2018).

Despite its growing salience in research, policy, and professional practice, mental health literacy suffers from significant conceptual inconsistency. Definitions vary across disciplines and cultures; the concept is used interchangeably with terms such as 'mental health awareness', 'mental health knowledge', and 'psychological literacy'; and its boundaries with adjacent constructs: stigma, general health literacy, emotional intelligence, and help-seeking intention remain poorly specified. This conceptual ambiguity undermines measurement, limits the comparability of research findings, and impedes the design of targeted interventions.

A thorough concept analysis is therefore warranted. The present paper applies Rodgers' (1989, 2000) evolutionary method of concept analysis to mental health literacy. This method is particularly well suited because it recognizes that concepts are not static entities but are historically embedded, dynamic, and shaped by their disciplinary and cultural contexts, precisely the characteristics that typify MHL as it has evolved since its introduction in 1997. The evolutionary method provides a systematic, inductive approach to concept clarification without the prescriptivism of approaches that seek a single 'correct' definition.

The aims of this analysis are to:

- Trace the historical development and contextual evolution of the MHL concept;
- Identify the core attributes that define mental health literacy across disciplines and time;
- Clarify antecedents and consequences;
- Differentiate MHL from alternate and related concepts;
- Offer an integrated, contemporary definition suitable for research, education, and practice;
- Identify implications for research, instrument development, and professional practice.

Rodgers' Evolutionary Method: Theoretical Foundations

Concept analysis has a long tradition in nursing science and health-related disciplines, where it serves to clarify the language of theory and practice, support instrument development, and expose disciplinary assumptions. Several competing methods exist, each resting on different philosophical assumptions about the nature of concepts.

Walker and Avant's (1983, 2019) method, arguably the most widely used, draws on ordinary language philosophy and assumes that careful examination of usage will reveal an underlying, essentially stable set of defining attributes. Critics argue, however, that this approach produces artificially fixed definitions that fail to capture how concepts shift over time, across disciplines, and between cultures (Penrod & Hupcey, 2005; Tofthagen & Fagerstrom, 2010).

Rodgers (1989) proposed an alternative grounded in evolutionary epistemology. Drawing on the work of Toulmin (1972), Rodgers argues that concepts are not fixed entities but tools: they are adopted, modified, and discarded as disciplinary communities engage with changing problems and evidence. Meaning is therefore inherently contextual and provisional, a concept means what it means in any given disciplinary and historical context, not what some transcendent analysis decrees it to mean.

The Six Steps of Rodgers' Method

Rodgers (1989, 2000) operationalized evolutionary concept analysis as a six-step inductive process:

Step	Phase	Activity
1	Identify the concept and associated terms	Specify the concept of interest and survey surrogate terms, related concepts, and variant usages across disciplines and time periods.
2	Identify the relevant literature	Systematic or integrative review of databases; purposive sampling across disciplines, time periods, and geographical contexts.
3	Collect data regarding attributes, antecedents, consequences, and context	Inductive extraction of conceptual data from included literature; iterative comparison and categorization.
4	Analyze data regarding the concept's use	Identify patterns in attributes, contextual factors, and temporal evolution; note areas of consensus and divergence.
5	Identify an exemplary case	Identify a case from the literature that exemplifies the concept in its fully realized form.
6	Identify implications and hypotheses for future research	Specify the integrated definition, propose a conceptual model, and identify gaps and directions for theory and research.

A key feature of the evolutionary method is its acknowledgement of the 'cycle of inquiry': findings from one iteration of the analysis generate hypotheses that can be tested empirically, feeding back into further refinement of the concept. This cyclical character distinguishes it from single-pass definitional approaches and makes it particularly appropriate for concepts, like MHL, that are actively under development.

Search Strategy and Literature Identification

Databases and Search Terms

The literature search was conducted across five electronic databases: MEDLINE (PubMed), PsycINFO, CINAHL, Scopus, and Web of Science. The search encompassed publications from January 1997, the year in which Jorm and colleagues introduced the term 'mental health literacy' to December 2024. No language restrictions were applied, but only English-language abstracts were reviewed for non-English sources.

Search terms were developed iteratively and applied using Boolean operators. The primary search string combined:

- "Mental health literacy" OR "MHL"
- "Mental illness" AND ("knowledge" OR "awareness" OR "literacy" OR "recognition")
- "Help-seeking" AND "mental health" AND ("knowledge" OR "literacy")
- "Stigma" AND "mental health literacy"

- “Concept analysis” AND “mental health”

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Empirical studies, theoretical papers, reviews, and concept analyses addressing MHL	Purely clinical case reports without conceptual content
Studies addressing recognition, knowledge, help-seeking, stigma, or skills related to mental health	Studies addressing only physical health literacy without attention to mental health
Studies across all age groups, settings, and geographic contexts	Conference abstracts without full paper availability
Publications from 1997 to 2024	Duplicate publications (most recent or comprehensive version retained)
All mental health populations and public samples	Grey literature without peer review

Following removal of duplicates and title/abstract screening, a final corpus of 147 papers was included in the concept analysis. These were subjected to inductive content analysis guided by Rodgers’ framework, with iterative coding and constant comparison across documents until conceptual saturation was achieved.

Historical Context and Evolution of the Concept

Origins: Jorm et al. (1997)

The term ‘mental health literacy’ was coined by Jorm, Korten, Jacomb, Christensen, Rodgers, and Pollitt in a landmark 1997 paper in Acta Psychiatrica Scandinavica. Drawing on the analogy of ‘health literacy’ in general medicine, Jorm et al. (1997, p.182) defined MHL as “knowledge and beliefs about mental disorders which aid their recognition, management, or prevention.” Their initial framework identified five components:

- Ability to recognize specific disorders
- Knowledge and beliefs about risk factors and causes
- Knowledge and beliefs about self-help interventions
- Knowledge and beliefs about professional help available
- Attitudes that facilitate recognition and appropriate help-seeking

This foundational definition was groundbreaking in that it linked knowledge specifically to functional outcomes: recognition and help-seeking. Unlike prior work on public knowledge of mental health (which

tended to treat knowledge as an end in itself), Jorm et al. (1997) situated MHL within an action-oriented framework, literacy was defined by what it enabled people to do.

Expansion Phase (2000–2010)

The period from 2000 to 2010 saw considerable expansion of the original construct. Several developments are notable:

1. First-aid and early intervention focus: The Mental Health First Aid (MHFA) movement, originating in Australia (Kitchener & Jorm, 2002), extended MHL to include skills for providing support to others experiencing mental health crises. This added an interpersonal, action-oriented dimension that was absent from the original definition.
2. Youth-focused literacy: Researchers in Canada (Kutcher & Chehil, 2007), Australia (Burns & Rapee, 2006), and the UK identified distinctive features of adolescent MHL, including age-appropriate recognition, peer-oriented help-seeking, and school-based intervention pathways.
3. Cultural contextualization:re Cross-cultural studies revealed significant variation in MHL profiles across countries and ethnocultural groups, complicating universalistic definitions and pointing to the culturally embedded nature of explanatory models for mental illness.

Reconceptualization (2012–2018)

A pivotal reconceptualization came from Jorm (2012), who published a revised and extended definition in the International Journal of Epidemiology. The 2012 update acknowledged limitations of the 1997 definition including its neglect of skills, self-management, and the interpersonal domain and proposed a broader formulation encompassing:

- Knowledge of how to prevent mental disorders
- Recognition of when a disorder is developing
- Knowledge of help-seeking options and treatments available
- Knowledge of effective self-help strategies for milder problems
- First-aid skills for assisting others

Kutcher et al. (2016) further argued for a health-of-the-nation framing, positioning MHL not merely as individual knowledge but as a social determinant of good mental health, one that operates at population level through education systems, media, and community norms.

Contemporary Consolidation (2018–Present)

Recent literature has increasingly treated MHL as a public health infrastructure concept. Key developments include:

- Integration with health literacy frameworks (Nutbeam, 2008; Sørensen et al., 2012), positioning MHL as a specific domain within broader health literacy models;
- Digital and social media dimensions, recognizing that MHL is increasingly shaped by online information environments (Morgan et al., 2018);
- Provider MHL, extending the concept to healthcare professionals and lay helpers who may lack specialized mental health training;
- Intersectional analyses examining how race, gender, age, and socioeconomic position shape MHL profiles and their functional consequences.

Alternate Terms and Related Concepts

Alternate Terms

Alternate terms are labels used in some contexts to refer to the same, or substantially the same phenomenon as MHL. Identifying them is essential for comprehensive literature searches and for understanding how the concept travels across disciplinary boundaries.

Alternate Term	Notes on Usage
Mental health knowledge	Used primarily in surveys and epidemiological studies; typically, narrower than MHL as it omits skills and attitudes.
Psychiatric literacy	Used in some European and Australasian contexts; broadly synonymous with MHL; emphasizes psychiatric diagnostic categories.
Mental illness literacy	Common in Australian literature; emphasizes disorder-specific knowledge over wellbeing spectrum.
Psychological literacy	Used in psychology education contexts; sometimes broader, encompassing scientific reasoning about behavior.
Mental health awareness	Widely used in public health campaigns; typically, less rigorous, denoting general familiarity rather than functional knowledge.
Mental health competence	Emphasizes the skills dimension; overlaps with the action-oriented components of MHL.

Related Concepts

Related concepts occupy adjacent conceptual territory: they overlap with MHL but are not synonymous. Distinguishing MHL from these concepts is essential for conceptual precision.

Related Concept	Overlap with MHL	Distinction from MHL
General health literacy	System navigation; information appraisal; health decision-making	General health literacy does not specifically address mental health recognition, stigma, or the emotional barriers specific to mental health help-seeking
Mental health stigma	Negative beliefs and attitudes toward mental illness are one component of MHL	Stigma is a single attitudinal dimension; MHL encompasses recognition, knowledge, skills, and multiple attitudinal domains
Help-seeking intention	Willingness to seek support is a behavioral consequence partly shaped by MHL	Help-seeking intention is a downstream outcome of MHL; MHL provides the knowledge and attitudinal platform that enables or inhibits intention
Emotional intelligence	Self-awareness of emotional states can contribute to recognizing personal mental health changes	EI focuses on emotion regulation and interpersonal perception rather than on knowledge of disorders, treatments, and service pathways
Resilience	Effective coping strategies overlap with the self-management component of MHL	Resilience is a broader resource for adversity adaptation and does not specifically address disorder recognition or professional help-seeking
Mental health awareness	Awareness that mental health is important and that problems can occur	Awareness is general and non-functional; MHL is specific, functional, and action-enabling

Core Attributes of Mental Health Literacy

Following inductive analysis of the included literature, six core attributes were identified. These attributes represent the defining characteristics whose presence is necessary for the concept of mental health literacy to be appropriately applied. They are presented in approximate developmental sequence, from foundational recognition through to action-oriented skills though this ordering does not imply strict temporal precedence.

Note on Attribute Analysis

In Rodgers' evolutionary framework, attributes are the defining features of a concept as it is used in each disciplinary and temporal context. They are derived inductively from literature and may evolve with further inquiry. The six attributes below represent the most consistent cross-disciplinary consensus identified in the included literature.

Attribute 1: Recognition and Identification

The foundational and most consistently cited attribute of MHL is the ability to accurately recognize the signs and symptoms of mental health problems, both in oneself and in others. Recognition encompasses:

- Identification of common mental disorders (e.g., depression, anxiety disorders, psychosis, eating disorders, substance use disorders) from behavioral, cognitive, and somatic symptoms;
- Discrimination between normal distress responses and clinically significant presentations;
- Recognition of mental health on a continuum from positive wellbeing through subthreshold difficulties to diagnosable disorder;
- Recognition of early warning signs and prodromal presentations;
- Self-recognition: applying the same recognition capacities to one's own mental states.

Recognition is typically operationalized in research through vignette-based measures in which participants read a standardized case description and are asked to identify what is 'wrong' with the person described (Jorm et al., 1997; Reavley & Jorm, 2011). Recognition accuracy varies substantially by disorder type, depression and anxiety are more consistently recognized than schizophrenia, bipolar disorders, and eating disorders and by age, education, and cultural background of respondents.

Attribute 2: Knowledge of Risk Factors and Aetiology

Mental health literacy requires more than recognition of symptoms: it also encompasses knowledge of the factors that increase vulnerability to mental health problems and understanding of how those problems develop. This attribute includes:

- Knowledge of biological risk factors (e.g., genetic predisposition, neurobiological processes);
- Knowledge of psychological risk factors (e.g., trauma history, attachment patterns, cognitive vulnerabilities);
- Knowledge of social and environmental risk factors (e.g., adverse childhood experiences, poverty, discrimination, social isolation);
- Understanding of causal models: recognition that mental health problems typically arise from multiple interacting factors rather than a single cause;
- Awareness of protective factors and resilience-building processes.

Knowledge of aetiology is particularly important because causal attributions shape attitudes: people who attribute mental illness exclusively to personal weakness or moral failing are more likely to stigmatize affected individuals and less likely to recommend professional help (Corrigan et al., 2003; Angermeyer & Dietrich, 2006). Aetiology knowledge that is biologically reductionist (e.g., 'chemical imbalance' models) can reduce blame but may simultaneously reduce perceived treatability and recovery optimism (Kvaale et al., 2013), highlighting the nuanced relationship between this attribute and downstream outcomes.

Attribute 3: Knowledge of Help-Seeking Options and Professional Treatments

The third attribute reflects the action-enabling dimension of MHL: knowing where, how, and when to seek help. This includes:

- Knowledge of professional help sources: primary care (GP), community mental health services, psychiatry, psychology, counselling, social work, peer support services;
- Knowledge of treatment options: pharmacological interventions, psychological therapies (CBT, DBT, psychodynamic approaches), combined treatments;
- Understanding of evidence hierarchies: distinguishing evidence-based from non-evidence-based interventions;
- Knowledge of how to access services: referral pathways, waiting lists, self-referral options, crisis services;
- Knowledge of rights: service user rights, informed consent, confidentiality, advocacy;
- Help-navigation skills: the practical capacity to identify appropriate next steps given a specific presentation and context.

This attribute is frequently found to be the weakest component of MHL in population surveys: while recognition of common disorders has improved considerably since the 1990s in many Western countries, knowledge of treatment effectiveness and help-seeking pathways remains limited, particularly for less well-known disorders (Reavley & Jorm, 2011; Gulliver et al., 2010).

Attribute 4: Attitudes and Beliefs Conducive to Help-Seeking

Functional knowledge is insufficient if it is undermined by negative attitudes. This attribute encompasses the evaluative and affective dimension of MHL:

- Recognition of mental health problems as legitimate health conditions (as opposed to personal weakness, spiritual failure, or character flaws);
- Belief that effective treatments exist and that recovery is possible;
- Reduced personal stigma: willingness to seek help for oneself without shame or fear of judgement;
- Reduced social stigma: absence of discriminatory or distancing attitudes toward individuals with mental health problems;
- Openness to professional help-seeking as appropriate and effective;
- Confidence in one's ability to support others who are experiencing mental health problems.

The relationship between stigma and MHL is complex and has been extensively debated. Corrigan and colleagues (2014) distinguish between public stigma, self-stigma, and structural stigma, each with distinct antecedents and consequences. Within MHL frameworks, stigma reduction is conceptualized as a necessary condition for the translation of knowledge into appropriate action: a person may know that

professional help is available yet still not seek it due to anticipated stigma. This attribute therefore serves as a mediating variable between knowledge (Attributes 1–3) and action (Attributes 5–6).

Attribute 5: First-Aid and Interpersonal Support Skills

Arising from the MHFA movement (Kitchener & Jorm, 2002) and extensively developed in the subsequent two decades, this attribute extends MHL beyond individual self-management to encompass the capacity to provide effective support to others. It includes:

- Ability to approach and communicate with someone who may be experiencing mental health difficulties;
- Active listening skills and non-judgmental communication;
- Knowledge of appropriate and inappropriate responses in crisis situations (e.g., suicidal ideation, acute psychosis, panic attacks);
- Knowledge of when and how to escalate to emergency services or professional support;
- Capacity to provide practical and emotional support while maintaining appropriate boundaries;
- Awareness of the limits of lay support and the importance of professional involvement.

Research has consistently demonstrated that MHFA training, which directly targets this attribute improves attitudes toward mental illness, increases supportive behaviors, and increases confidence in approaching people with mental health concerns (Kitchener & Jorm, 2006; Morgan et al., 2018). The interpersonal dimension represented by this attribute has become increasingly central to contemporary conceptualizations of MHL, reflecting recognition that mental health literacy has social as well as individual consequences.

Attribute 6: Self-Care and Self-Management Competence

The sixth attribute, introduced explicitly in Jorm's (2012) revised definition, addresses knowledge and skills for managing one's own mental health. This includes:

- Knowledge of evidence-based self-help strategies for common difficulties (e.g., behavioral activation for low mood, progressive muscle relaxation for anxiety, sleep hygiene for insomnia);
- Knowledge of lifestyle factors with established mental health relevance (exercise, nutrition, social connection, substance use);
- Ability to monitor one's own mental health status over time and recognize deterioration;
- Knowledge of when self-help is appropriate versus when professional input is required;
- Capacity to use digital mental health tools, apps, and online resources critically and effectively;
- Adherence to recommended treatment and self-management plans.

Self-management competence is increasingly prominent in contemporary MHL discourse as mental health systems shift toward stepped care and self-management support models. It aligns with broader

trends in chronic illness management and patient activation, and reflects the recognition that individuals spend most of their lives outside formal healthcare settings.

Antecedents

Antecedents are conditions or events that typically precede and contribute to the development of the concept. They are not part of the definition of MHL but provide essential context for understanding how it arises and how it can be cultivated. The following antecedents were consistently identified in the literature:

1. *Education and Formal Learning*

Formal education, particularly school-based mental health education and professional training is the most consistently identified antecedent of MHL. Higher levels of general educational attainment are associated with higher MHL across populations (Jorm et al., 1997; Coles & Coleman, 2010). Structured mental health education programmes, when implemented with fidelity and appropriate content, produce measurable improvements in recognition accuracy, attitudes, and help-seeking intentions (Wei et al., 2011; Kutcher et al., 2016). Healthcare and social care professional training constitutes a particular form of educational exposure that can significantly enhance MHL in workforce populations.

2. *Contact Experience*

Direct personal experience of mental health problems, whether through personal diagnosis, informal caregiving, or close relationships with affected individuals is a significant antecedent of higher MHL. Contact theory (Allport, 1954), extended to mental health contexts by Corrigan and colleagues (2007), posits that positive intergroup contact reduces prejudice and improves understanding. Applied to MHL, personal contact with individuals with lived experience of mental health problems, particularly in contexts where challenge stigma is associated with improved attitudes and more diverse knowledge. Disclosure campaigns and educational programmes that incorporate personal testimony leverage this antecedent.

3. *Information Access and Media Environment*

The quantity and quality of mental health information available in an individual's environment shapes MHL development. Access to credible, evidence-based information through educational curricula, public health campaigns, primary care encounters, and digital platforms is associated with higher MHL (Gould et al., 2005). Conversely, exposure to misinformation including sensationalist media portrayals of mental illness, stigmatizing framing, and inaccurate digital content can impair MHL development or reinforce unhelpful misconceptions. The rise of social media as a primary information source, particularly for young people, presents both opportunities (peer normalization and accessible psychoeducation) and risks (misinformation and contagion effects) for population MHL.

4. *Cultural and Community Norms*

Cultural context is a pervasive antecedent that shapes every dimension of MHL. Cultural explanatory models of mental distress, whether spiritual, psychosocial, or biomedical determine what kinds of knowledge are considered relevant, which help-seeking pathways are regarded as legitimate, and what attitudes toward affected individuals are normatively acceptable. In collectivist cultures, family-mediated help-seeking may be the normative pathway, with individual help-seeking carrying stigma. Religious and spiritual frameworks may provide protective or risk-conferring influences on attitudes and recognition. These cultural variations do not render MHL culture-specific but require that assessments and interventions are culturally adapted and contextually sensitive.

5. *Socioeconomic and Structural Factors*

Socioeconomic position is associated with MHL, though the direction and magnitude of association vary across components. Higher income and occupational status are generally associated with higher recognition accuracy and more positive attitudes, likely through educational attainment pathways. However, lived experience of structural adversity such as poverty, discrimination, housing instability, also shapes MHL in complex ways, sometimes generating pragmatic help-seeking knowledge derived from necessity rather than formal education. Structural factors also mediate the translation of MHL into action: access to services is shaped by socioeconomic position, so high MHL does not guarantee appropriate help-seeking in contexts of structural inequality.

Consequences

Consequences are outcomes that typically follow the occurrence of the concept. In Rodgers' method they are distinguished from the concept itself and from its antecedents, though the relationships are not always unidirectional in practice.

Earlier and More Appropriate Help-Seeking

The most consistently documented consequence of higher MHL is improved help-seeking behavior: greater willingness to seek professional support, earlier engagement with services, and more appropriate selection of help sources. Gulliver et al.'s (2010) systematic review identified MHL as one of the primary facilitators of mental health service use. The effect is mediated partly through attitudinal change (reduced stigma, increased perceived treatability) and partly through increased knowledge of service availability and referral pathways. Critically, the help-seeking consequence is not uniform across disorder types or populations: higher MHL appears to have stronger effects on help-seeking for depression and anxiety than for psychosis or eating disorders, and effects are moderated by gender, age, and cultural background.

Reduced Stigma and Improved Interpersonal Responses

Higher MHL is consistently associated with reduced stigmatizing attitudes toward people with mental health problems (Corrigan et al., 2003; Kitchener & Jorm, 2006). This encompasses reduced social

distance, greater recovery optimism, and more supportive interpersonal responses. At a population level, widespread improvements in MHL could shift social norms around mental illness, creating environments more conducive to disclosure and help-seeking. The relationship between MHL and stigma is, however, bidirectional: stigma reduction can facilitate MHL development (by reducing barriers to information-seeking), and MHL can reduce stigma (by displacing attributions of personal blame with aetiological understanding).

Improved Self-Management and Coping

Higher MHL enables more effective self-management through the selection of evidence-based coping strategies, more effective monitoring of mental health status, and more informed engagement with professional treatment. Studies have documented associations between MHL and use of adaptive coping strategies, adherence to treatment recommendations, and reduced use of harmful self-management approaches (e.g., substance use as coping). The self-management consequence is particularly important in the context of mental health conditions that follow a chronic or recurrent course, where informed self-management between episodes can reduce relapse rates and functional impairment.

Broader Public Health Outcomes

At population level, improvements in MHL are hypothesized to contribute to earlier detection and intervention, which in turn may improve long-term outcomes and reduce the economic costs of mental ill-health. The causal pathways through which population-level MHL improvements translate into epidemiological outcomes remain under-researched, but modelling studies (Burns et al., 2010) suggest that even modest improvements in recognition and help-seeking rates could produce meaningful reductions in the prevalence of untreated mental illness. MHL also has potential workforce implications: healthcare and social care professionals with higher MHL may provide more effective, stigma-free care and make more appropriate referral decisions.

Case Exemplars

Rodgers' method recommends identifying model, borderline, and contrary cases to test conceptual boundaries and clarify the role of each attribute in defining the concept.

Model Case

Model Case: Sarah, 34-year-old secondary school teacher

Samantha notices that a colleague has been arriving late, appearing disheveled, and withdrawing from staff interactions over several weeks. She recognizes these as potential signs of depression or another mood disorder. Drawing on her knowledge of risk factors, she considers that her colleague has recently experienced a bereavement. Samantha knows that GP referral and psychological therapies are effective first-line options and is aware of her school's employee assistance programme. She approaches her colleague privately with nonjudgemental concern, listens actively, and gently shares what she has noticed. When her colleague discloses that she has been struggling, Samantha helps her identify the GP as a first point of contact, offers to accompany her, and does not share information with other colleagues. She monitors her own stress in the days that follow and uses breathing exercises she learned in a wellbeing programme. This case exemplifies all six attributes: recognition (she identifies signs), aetiology knowledge (she considers risk factors), help-seeking knowledge (she knows appropriate pathways), positive attitudes (she acts without stigma or judgement), first-aid skills (she approaches and supports effectively), and self-management (she monitors and manages her own wellbeing).

Borderline Case

Borderline Case: James, 45-year-old manager

John has attended a half-day mental health awareness session at work and can identify that one of his team members is 'not himself'. He is sympathetic and avoids making stigmatizing comments. However, he does not know the difference between clinical depression and normal low mood, is uncertain whether his team member would benefit from professional support or just 'time off' and does not know how to initiate a supportive conversation. He therefore does nothing. This borderline case is partially consistent with MHL: Attribute 4 (positive attitudes) is present. However, Attributes 1 (recognition specificity), 3 (help-seeking knowledge), and 5 (first-aid skills) are absent or incomplete. The case illustrates that awareness without functional knowledge and skills does not constitute full mental health literacy.

Contrary Case

Contrary Case: Derek, 58-year-old senior manager

Donny believes that mental health problems are a sign of weakness and that people should 'pull themselves together.' He dismisses a distressed employee's disclosure as 'making excuses'. He has heard the term 'depression' but regards it as a medically contrived label for normal sadness. He actively discourages team members from accessing mental health services, believing they create dependency. He has no knowledge of effective treatments and has not sought help for his own high levels of occupational stress. This case is contrary to MHL across all six attributes: recognition is absent or distorted (dismissal of symptoms), aetiology knowledge is absent (moral attribution), help-seeking knowledge is absent, attitudes are stigmatizing, first-aid skills are absent, and self-management is absent.

Synthesized Definition and Conceptual Mode

Proposed Definition

Proposed Definition: Mental Health Literacy

Mental health literacy is a dynamic, learnable, and culturally situated set of knowledge, beliefs, and skills that enables individuals to recognize mental health problems in themselves and others, understand their aetiology and treatment options, hold stigma-reducing attitudes conducive to help-seeking, provide effective first-aid support to others, and engage in informed self-care and self-management.

Mental health literacy is functional, it is defined by what it enables people to do and evolves in response to changing evidence, social norms, and service configurations.

Conceptual Model

The following model represents the relationships between antecedents, attributes, and consequences of MHL as identified in this analysis:

ANTECEDENTS	▶	ATTRIBUTES	▶	CONSEQUENCES
• Education & formal training		1. Recognition & identification		• Earlier & appropriate help-seeking
• Contact experience		2. Aetiology knowledge		• Reduced stigma
• Information access & quality		3. Help-seeking knowledge		• Improved self-management
• Cultural & community norms		4. Stigma-reducing attitudes		• Effective support of others
• Socioeconomic & structural factors		5. First-aid & support skills		• Improved population mental health
		6. Self-care competence		

Empirical Referents

Empirical referents are observable phenomena that indicate the presence of the concept in each individual or population. They translate abstract attributes into measurable indicators suitable for research and clinical assessment.

Attribute	Empirical Referent	Example Measure
Recognition & identification	Correct identification of disorder labels from standardised vignettes	MHL Questionnaire (MHLq; O'Connor & Casey, 2015); Jorm vignette paradigm
Aetiology knowledge	Endorsement of evidence-consistent causal explanations; rejection of blame-based attributions	Attribution Questionnaire (AQ; Corrigan et al., 2003); Knowledge of Mental Disorders scale
Help-seeking knowledge	Correct selection of appropriate help sources from scenario-based items; knowledge of referral pathways	General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005); MHLS (O'Connor et al., 2014)
Stigma-reducing attitudes	Low scores on social distance, personal stigma, and treatment-related stigma scales	Social Distance Scale; RIBS; MICA-4; Personal Stigma Scale
First-aid & support skills	Confidence in approaching and supporting a person with mental health problems; knowledge of appropriate responses	MHFA Self-Efficacy Scale; Knowledge of First Aid for Mental Disorders (KFAMD)
Self-management competence	Self-efficacy for self-care; knowledge of evidence-based self-help strategies; monitoring behaviour	MHLq self-management subscale; MHLS self-care items; Patient Activation Measure (mental health version)

Implications for Research, Practice, and Policy

Implications for Research

- Measurement consistency: Future research should operationalize MHL in line with the six-attribute framework proposed here, enabling cross-study comparisons and cumulative evidence synthesis. Single-component measures (e.g., recognition-only vignette studies) should acknowledge their limitations and situate findings within the broader construct.
- Longitudinal study: The evolutionary nature of MHL acknowledged within Rodgers' framework calls for longitudinal research tracking changes in the concept's meaning and measurement over time, particularly as digital information environments evolve.
- Cultural adaptation: The cultural contingency of MHL warrants systematic investigation of how attributes manifest across cultural contexts, and development of culturally adapted measures and interventions.
- Causal inference: The consequences identified in this analysis are largely based on cross-sectional and observational evidence. Randomized controlled trials and natural experiments are needed to establish the causal effects of MHL improvement on help-seeking, stigma, and mental health outcomes.

Implications for Practice

- Workforce development: Healthcare and social care professionals require structured MHL training that addresses all six attributes, not merely disorder recognition. Interdisciplinary curricula should incorporate first-aid skills, service navigation knowledge, and self-care competence.
- Stepped care alignment: MHL interventions can be integrated with stepped care frameworks, positioning self-management competence as the first step and professional help-seeking as a later step, with MHL providing the skills and knowledge to navigate the continuum appropriately.
- Peer-delivered approaches: Given the antecedent role of contact experience, peer-facilitated MHL interventions, drawing on lived experiences, should be incorporated into educational and community programmes alongside professionally delivered content.

Implications for Policy

- National curricula: Mental health education should be incorporated into compulsory school curricula from primary age, extending through secondary education with age-appropriate progression across the six attributes.
- Public health campaigns: Population-level MHL initiatives should extend beyond awareness-raising to address functional components: help-seeking pathways, service navigation, and stigma reduction. Campaigns should be evaluated against all six attribute domains.
- Service design: Mental health services should be designed with MHL improvement as an explicit objective, providing accessible psychoeducation, service navigation support, and peer support as integral components of care pathways.

Limitations

Several limitations of this analysis warrant acknowledgement. First, the literature reviewed was predominantly from high-income, English-speaking countries (Australia, Canada, UK, USA), which may have introduced a cultural bias into the attribute framework. The degree to which the identified attributes generalize to low- and middle-income country contexts, or to non-Western cultural frameworks, requires empirical investigation. Second, while the evolutionary method captures the historical development of the concept, the review was necessarily limited by the boundaries of accessible literature. Third, the inductive coding process, though guided by explicit methodological principles, cannot be entirely free of analyst interpretation; independent coding and member-checking are recommended for future replications. Fourth, the proposed definition, while grounded in a comprehensive literature review, should be regarded as a provisional working framework subject to further refinement as evidence accumulates.

Conclusion

This concept analysis has applied Rodgers' evolutionary method to provide a thorough, historically positioned account of mental health literacy as it has developed since its introduction in 1997. The analysis confirms that MHL is a genuinely multi-dimensional construct encompassing six core

attributes: recognition and identification; knowledge of risk factors and aetiology; knowledge of help-seeking options and professional treatments; attitudes and beliefs conducive to help-seeking; first-aid and interpersonal support skills; and self-care and self-management competence. These attributes are functionally interrelated: recognition enables knowledge application; knowledge enables informed attitudes; and attitudes and skills enable appropriate action.

The evolutionary framework has informed the dynamic nature of MHL: the concept has grown substantially in scope over three decades, responding to new evidence, emerging service models, and changing social contexts. The proposed combined definition, which emphasizes functionality, learnability, and cultural situatedness, offers a conceptual anchor for research, education, and practice that can accommodate this ongoing evolution without losing conceptual coherence.

The clinical and public health significance of this work lies in its implications for how we design, deliver, and evaluate mental health literacy interventions. A richer, more precise understanding of what MHL is, and what it enables, should produce more targeted and effective approaches to one of the most tractable antecedents of improved population mental health.

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