

Why & how to use Health Literacy Development to improve health & equity in the mental health sector

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Equally Well Symposium

24-26 July 2023

Richard's dream

All public health interventions...

- Are co-created with community, health professionals & other stakeholders
- Are developed based on unbiased and well-characterised needs
- Have an implementation and scaling up strategy that was integral to the design
- Have implementation feasibility proven before expensive RCTs
- Are so fit for purpose they become “sucked” into practice
- Are evaluated for impact - people’s lives are better
- Can be implemented equally well by non-expert and expert groups

What is Health Literacy?

Health Literacy is a way to understand:

- what are people's health information needs
- why some people struggle to look after themselves
- why adhering to medications and lifestyle change can be so difficult for some people
- why many of our interventions are so ineffective
- what **we** need to do to improve service quality and effectiveness for all people

... and much more

But... most research is *not* reproducible

- What is reproducibility?
- Why might research not be reproducible?
- Is my research reproducible?
- Does this matter?

How are programs and interventions usually developed?

How can we improve the usefulness of the programs and policies?

COMMENT

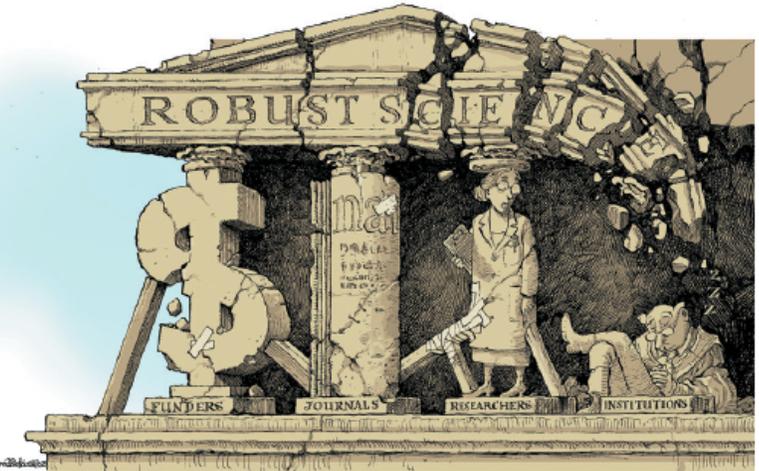
ENERGY Subsidize renewables to break fossil-fuel stronghold and spur carbon pricing **p.27**

HISTORY Richard Holmes on the scientific and cultural legacy of Ada Lovelace **p.30**



EQUALITY Memoir of a salmon run to nowhere **p.31**

CONSERVATION Offsets are often the only way to meet commitments **p.33**



Institutions must do their part for reproducibility

The funding to verified good institutional practice, and robust science will shoot up the agenda, say C. Glenn Begley, Alastair M. Buchan and Ulrich Dirnagl.

Irr reproducible research poses an enormous burden: it delays treatments, wastes patients' and scientists' time, and squanders billions of research dollars. It is also widespread. An unpublished 2015 survey by the American Society for Cell Biology found that more than two-thirds of respondents had on at least one occasion been unable to reproduce published results. Biomedical researchers from drug companies have reported that one-quarter or fewer of high-profile papers are reproducible^{1,2}.

Many parties are addressing the problem. Funding bodies such as the US National Institutes of Health (NIH) have announced

training initiatives³ and explicitly instructed grant reviewers to consider whether experimental plans ensure rigour. New methods of data analysis and peer review have been proposed to deflate bias.

Several journals, including *Nature* and *Science*, have updated their guidelines and introduced checklists. These ask scientists whether they followed practices such as randomizing, blinding and calculating appropriate sample size. *Science* has also added statisticians to its panel of reviewing editors. Philanthropic and non-profit organizations have sponsored projects to improve robustness.

Funders' policies, journal guidelines and

widespread soul-searching are necessary. But they are not sufficient.

Conspicuous by their absence from these efforts are the places in which science is done: universities, hospitals, government-supported labs and independent research institutes. This has to change. Institutions must support and reward researchers who do solid — not just flashy — science and hold to account those whose methods are questionable.

SPOT THE SHIRKERS

Although researchers want to produce work of long-term value, multiple pressures and prejudices discourage good scientific

ILLUSTRATION BY DW/DRINKS

Design of policy and programs (top-down and bottom-up)

Top down: Centralised policy decision making processes



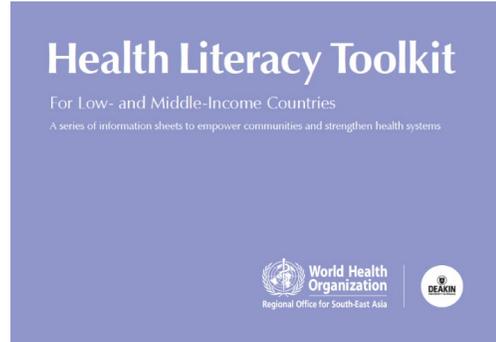
Bottom up: Input and deliberation from diverse community

Global interest in health literacy-informed interventions

HLQ Health Literacy Questionnaire

ophelia

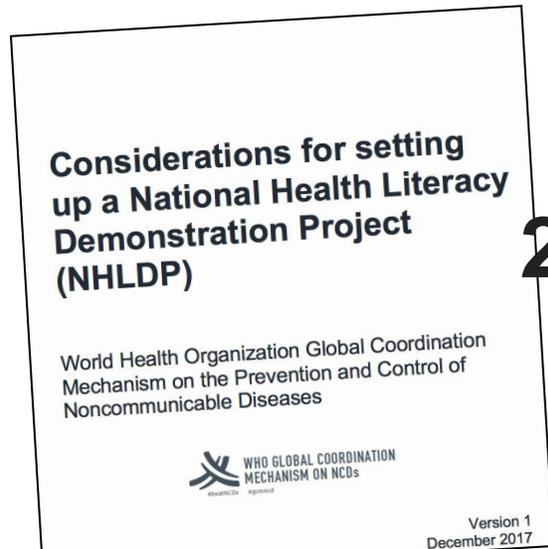
2008-2013



2014

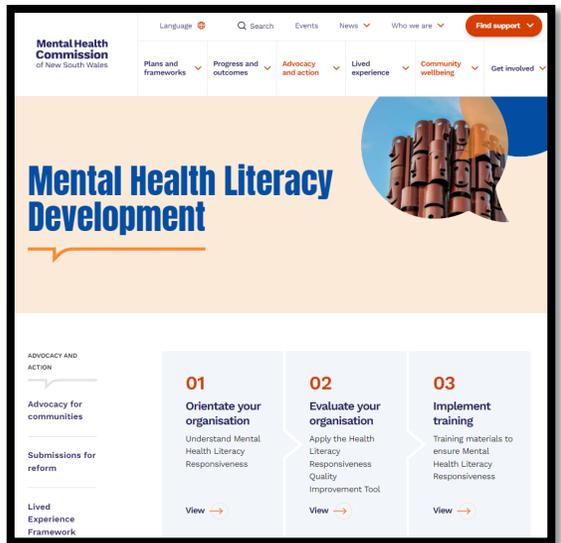


2022



2017

2021



2023





Health literacy development for the prevention and control of noncommunicable diseases: Volume 1. Overview

6 November 2022 | Report



Download (580 kB)

Overview

This report provides a pragmatic approach to health literacy development for the prevention and control of noncommunicable diseases (NCDs). It provides new insights into what people know about NCDs and their risk factors, and these new insights reveal the mechanisms behind how people, communities, and organizations learn and can be supported to take action against NCDs, including their risk factors and determinants.

Importantly, health literacy is understood as a social practice whereby decisions about health, and the available support to change to, or maintain, healthy behaviours, are determined by powerful and unique community norms and cultures, and organizational and political factors impacting communities.

This report has four volumes. Additional volumes can be accessed on WHO's publications repository via the following links:

- [Health literacy development for the prevention and control of noncommunicable diseases: Volume 2. A globally relevant perspective](#)

<https://www.who.int/publications/i/item/9789240055339>



Foreword by the WHO Director-General

The burden caused by the epidemic of noncommunicable diseases (NCDs) and mental health conditions and their modifiable risk factors on people, communities and economies is a major challenge to health, well-being and sustainable and equitable development. Governments need to address the urgency of investing in healthy populations and resilient health systems, with increased investments in prevention, screening, early diagnosis and appropriate treatment for NCDs. They must do so through inclusive, contextual and equity-driven strategies that are fit for local purposes and with a commitment to leaving no one behind.



A key enabler to accelerating progress towards the NCD targets in the Sustainable Development Goals is health literacy, to support people, communities and organizations to understand, recognize and take effective actions to protect and promote their own health.

This report provides practical recommendations for developing health literacy interventions to support countries to systematize the co-design of health literacy actions to enhance the impact of policies, programmes and services for the prevention and control of NCDs and mental health conditions, and their modifiable risk factors and determinants.

These recommendations draw from the findings of 16 case studies from low- to high-income countries, which have generated data supporting the development of locally owned and fit-for-purpose NCD strategies that are more likely to be embraced, implemented and sustained, especially among disadvantaged and poor communities.

The imperative is for rapid development and systematic implementation of country-relevant, context-specific solutions. The wide-scale implementation of the guidance contained in this report by World Health Organization (WHO) Member States will generate implementable and sustainable NCD health literacy development actions that respond to local contexts and demand. This will help to drive progress towards the WHO Triple Billion targets and improve health and well-being for current and future generations.

Tedros Adhanom Ghebreyesus

Volume 4



WHO Health Literacy Development projects (and other Ophelia projects)

-  Initial
-  New
-  Upcoming



A simple key concept... listen



Key concepts

The NCD health literacy dilemma: Disconnect between people's experiences of, and beliefs and attitudes about disease risk factors and the determinants of disease

Daily habits and beliefs (NCD risk factors)

Fast food is a treat for my family
We always have smog in my area
I worry if I can put enough food on the table
I smoke like my 90-year-old father
I don't have time to exercise
All my friends drink



Some people are aware of links between daily habits and the development of NCDs, and they take preventative action

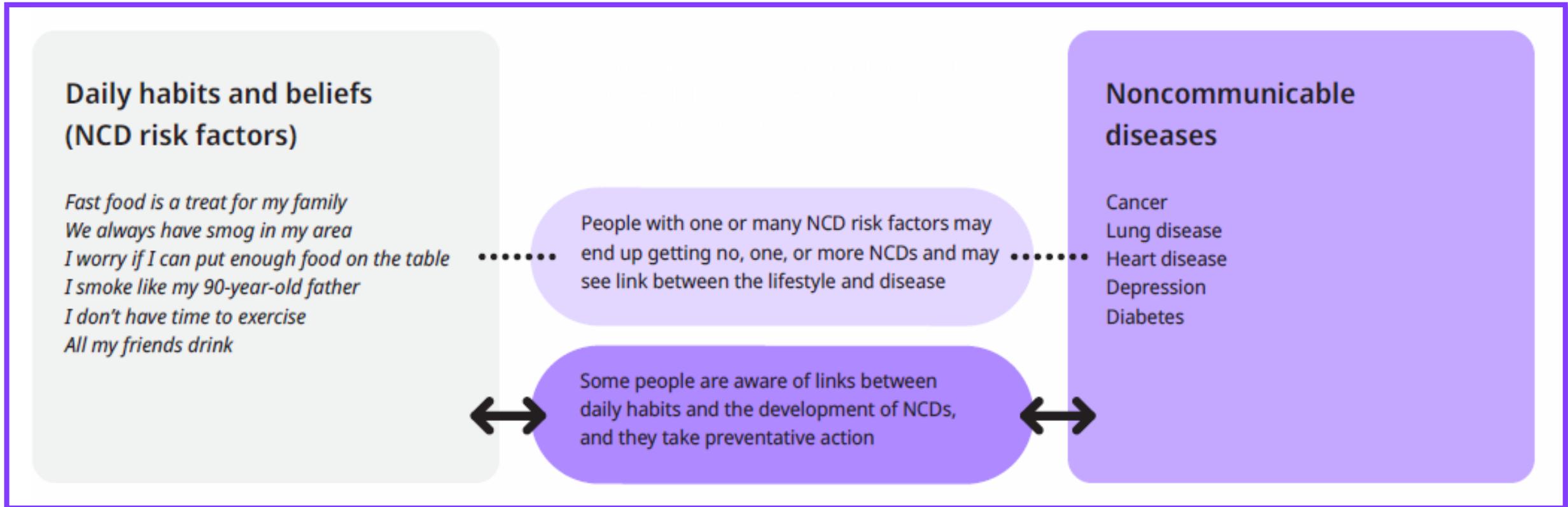


Noncommunicable diseases

Cancer
Lung disease
Heart disease
Depression
Diabetes

Key concepts

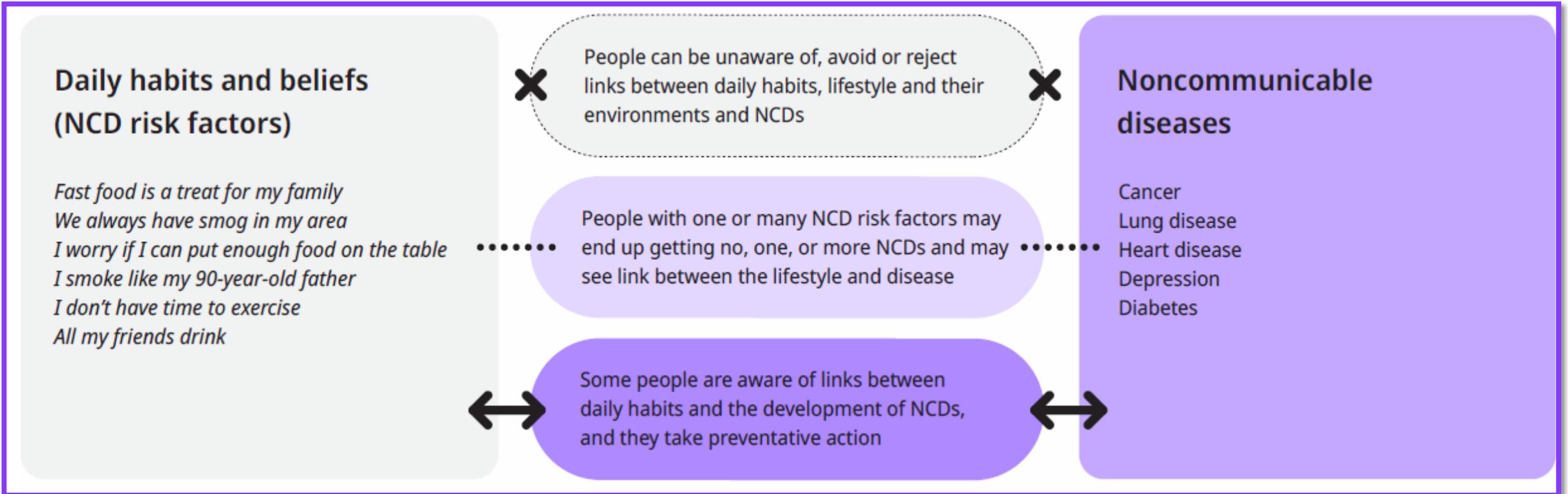
The NCD health literacy dilemma: Disconnect between people's experiences of, and beliefs and attitudes about disease risk factors and the determinants of disease





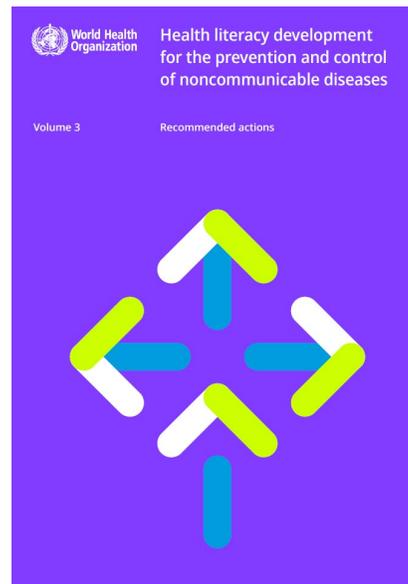
Key concepts

The NCD health literacy dilemma: Disconnect between people's experiences of, and beliefs and attitudes about disease risk factors and the determinants of disease



Health literacy of an individual (WHO 2022)

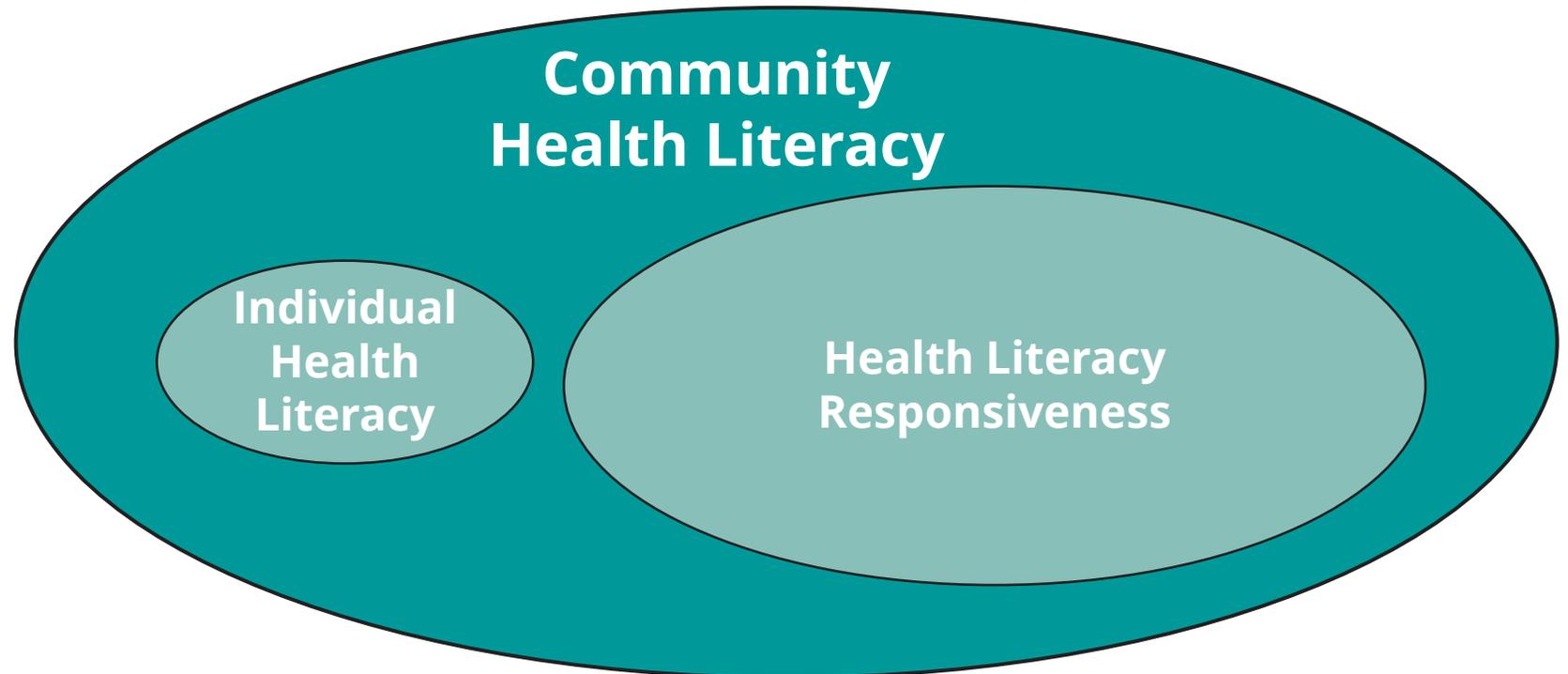
As viewed from a globally relevant perspective, this is people's **knowledge, confidence and comfort** – which accumulate through daily activities and social interactions and across generations – to **access, understand, appraise, remember** and **use** information about health and health care, for the health and well-being of themselves and those around them.



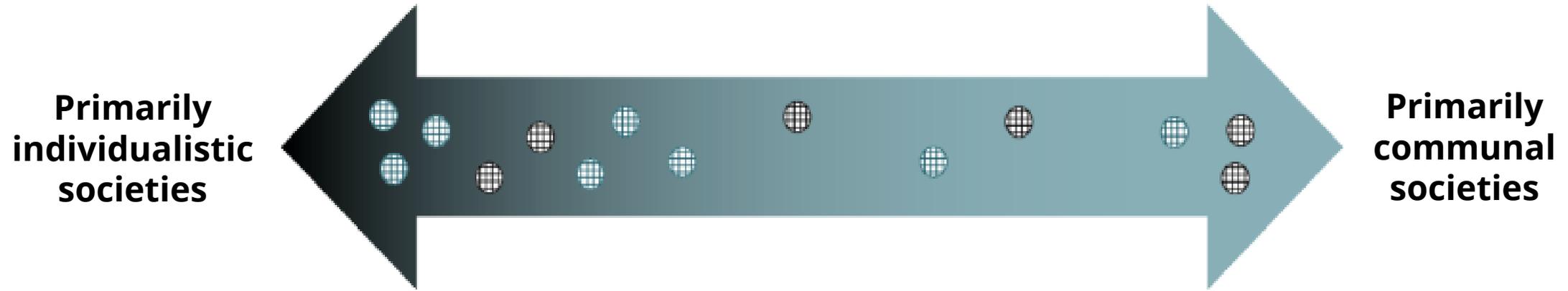
Health literacy unpacked

1. Health literacy of an individual
2. Community health literacy
3. **Health literacy responsiveness**

Which is the
most
important?



Health literacy is a **social practice**: most people live in communal societies (or settings) and make decisions with other people



Health literacy is a **social practice**: most people live in communal societies (or settings) and make decisions with other people



- Communal groups (e.g., migrant groups, people with disabilities, infants and elderly, and people with other dependencies) that often function within individualistic societies and even, sometimes, within communal societies

Five components of health literacy and the role each has in allowing people to effectively engage in healthy behavior

1. Accessing	2. Understanding	3. Appraising	4. Retrieving / remembering	5. Applying
People have different preferred learning styles and need to access different sorts of information at different times	There are many levels of understanding health information including no understanding to problem solving.	This is more than just believing or judging something to be scientific or if the source is trustworthy, but deciding if it is relevant or even possible to do.	There is a lot of knowledge that we want people to have for use in the future. We need to help them know where it is and get it at the right time.	Whether to apply something is rarely a one-time decision, but a decision that people need to make repeatedly

A framework to understand the utility of current tools and to plan implementation of health literacy and education programs.

1. Printed materials (pamphlets, posters, written resources)
2. Talk with health staff
3. Media, TV, radio
4. Community conversations (friends, family neighbours, religious / community)
5. ICT, Internet, social media, Apps
6. Arts (songs, plays, paintings, drawings)

A well-considered mix of interventions is needed for effective disease prevention and control...

But how do people actually learn (or absorb our complex messages)?

Health Literacy Learning Matrix - Observations on the roles of modalities for the tasks in health knowledge work to impact on disease prevention and control

	1. Accessing	2. Understanding	3. Appraising	4. Retrieving / remembering	5. Applying
1. Printed materials (pamphlets, posters, written resources)	Limited value as the primary source for many people. More important for remembering.	Often applied but not helpful for low literate people.	Often applied but not helpful for low literate people.	High impact if materials kept in place that is accessible in the future when the need for the information arises.	High value for practical knowledge on how-to-do self-care tasks (e.g. recipes, exercise sheets).
2. Talk with health staff	Useful if person is able to get to see knowledgeable and communicative professional.	Often best way, especially if combined with other modes and with Teach-back.	Helpful if staff take time to explain.	Can assist with reminders. Health service recall/reminder systems.	Important to assist with problem-solving and to build confidence.
3. Media, TV, radio	Can be the only source of information. Main source in some rural/remote settings. Relevant to illiterate people and sometimes to minority language groups.	Strong method for many people. Effective if affected people discuss in narrative/interview formats. Declining youth engagement in these media.	Can be very valuable if it allows real people to share and discuss experiences (life stories, talk-back radio).	Most programs/media is one-off, but can provide repeated exposure to key messages to aid memory and to prompt action.	Can assist people to know how to use health services. Practical advice and examples.
4. Community conversations (friends, family, neighbours, religious and community leaders)	Word of mouth among peers and intergenerational transfer of information. Only method for some groups.	Particularly important in working out what it would mean to translate advice into action. Can also leading to misunderstanding (e.g., myths about vaccines causing MS).	Highly and consistently important. The work of deciding what to believe and what is relevant and feasible occurs through discussion with family and friends.	Family and group processes can assist in making actions routine. Family, friends, colleagues often remind and prompt each other.	Friends influence how health actions are applied and sustained. A sources of practical ideas and problem solving from within local contexts
5. ICT, Internet, social media, Apps	Useful if person or family have devices. People who are socially isolated or remote can be informed about access options.	Useful if devices accessible. Can be primary source of understanding. Can introduce erroneous information.	Social media can be a substitute community but this can also be a source of misinformation and confusion. Some Apps are good personal planning tools.	Highly useful. Wide use of recall and reminders for NCD management. Can support regular monitoring.	Useful if have access to devices. Can facilitate remote healthcare, accurate use of strategies, monitoring and motivation.
6. Arts (songs, plays, paintings, drawings)	Can overcome language, literacy and other learning barriers.	Some people are visual or narrative etc learners, thus helps catch attention and easier to remember.	Can help make ideas and strategies relevant and feasible.	Embedded community art and music can provide reminders and prompts with positive associations.	Can provide examples of simple practical action undertaken in familiar local contexts.

Health Literacy Learning Matrix - Observations on the roles of modalities for the tasks in health knowledge work to impact on disease prevention and control

	1. Accessing	2. Understanding	3. Appraising	4. Retrieving / remembering	5. Applying
1. Printed materials (pamphlets, posters, written resources)	Limited value as the primary source for many people. More important for remembering.	Often applied but not helpful for low literate people.	Often applied but not helpful for low literate	High impact if materials kept in place that is accessible in the home for the	High value for practical knowledge on how-to-do self-care tasks (e.g. recipes, exercise sheets).
2. Talk with health staff	Useful if person has to see knowledge communicated				Important to assist with problem-solving and to build confidence.
3. Media, TV, radio	Can be the only source of information. Relevant to ill and sometimes language groups				Can assist people to know how to use health services. Practical advice and examples.
4. Community conversations (friends, family, neighbours, religious and community leaders)	Word of mouth and intergenerational transfer of information. Only method for some groups.				Friends influence how health actions are applied and sustained. A sources of practical ideas and problem solving from within local contexts
5. ICT, Internet, social media, Apps	Useful if person has access to devices. People who are socially isolated can be informed about options.		Some Apps are good personal planning tools.		Useful if have access to devices. Can facilitate remote healthcare, accurate use of strategies, monitoring and motivation.
6. Arts (songs, plays, paintings, drawings)	Can overcome language, literacy and other learning barriers.	Some people are visual or narrative etc learners, thus helps catch attention and easier to remember.	Can help make ideas and strategies relevant and feasible.	Embedded community art and music can provide reminders and prompts with positive associations.	Can provide examples of simple practical action undertaken in familiar local contexts.

A simple message:
When developing services or engaging with people about their wellbeing and their illnesses, for both management and prevention... use health literacy thinking

Health literacy tasks

	1. Accessing	2. Understanding	3. Appraising	4. Retrieving / remembering	5. Applying
1. Printed materials (pamphlets, posters, written notices)	Limited value as the primary source for many people. More important for remembering.	Often applied but not helpful for low literate people.	Often applied but not helpful for low literate people.	High impact if materials kept in place that is accessible in the future when the need for the information arises.	High value for practical knowledge on how-to-do self-care tasks (e.g. recipes, exercise sheets).
2. Talk with health staff	Useful if person is able to see knowledgeable communicative professional.			Can assist with reminders. Health service recall/reminder	Important to assist with problem-solving and to build confidence.
3. Medical radio	Can be the only information. More relevant to ill and sometimes language groups.			Radio/TV programs/media is one-way. Can provide repeated key messages to prompt	Can assist people to know how to use health services. Practical advice and examples.
4. Community conversations (friends, family, religious community leaders)	Word of mouth and intergenerational transfer of knowledge. Only method for some groups.			Group processes for making actions. Friends, family, friends, religious leaders often remind and prompt.	Friends influence how health actions are applied and sustained. A sources of practical ideas and problem solving from within local contexts
5. ICT, mobile phones, social media	Useful if person or family has access to devices. People who are socially isolated or remote can be informed about access options.			Useful. Wide use of recall and reminders for NCD management. Can support regular monitoring.	Useful if have access to devices. Can facilitate remote healthcare, accurate use of strategies, monitoring and motivation.
6. Arts (plays, paintings, drawings)	Can overcome language, literacy and other learning barriers.	Some people find narrative etc learners, can catch attention and easier to remember.	Some people find visual aids and strategies relevant and feasible.	Embedded community art and music can provide reminders and prompts with positive associations.	Can provide examples of simple practical action undertaken in familiar local contexts.

How people learn

Daily health literacy skills and ability

HLQ
Health Literacy Questionnaire

ophelia



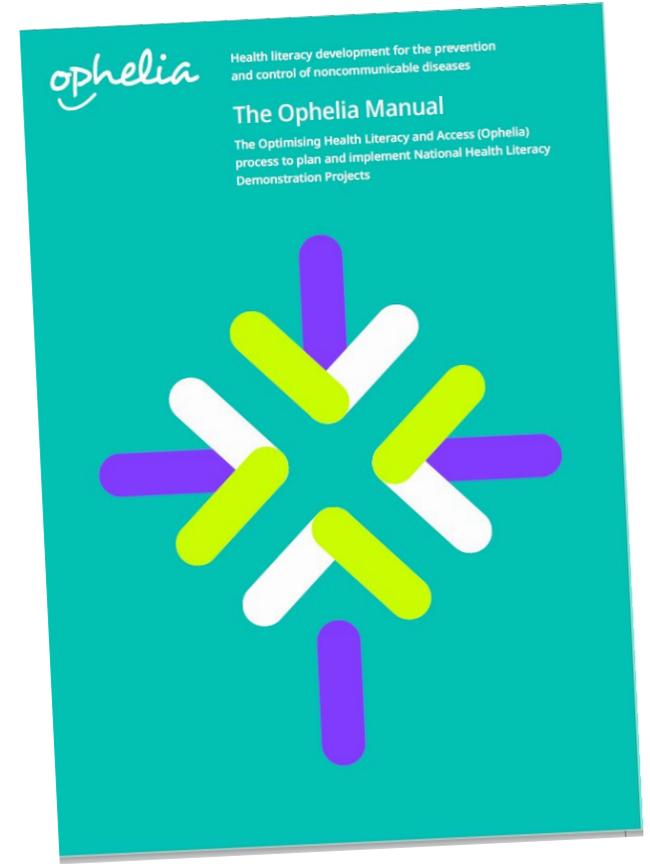
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MONASH University
Medicine, Nursing and Health Sciences



The Ophelia (OPTimising HEalth Literacy and Access) process

- uses *health literacy thinking* to connect people at all levels in a community in co-design, prioritisation and the implementation of locally designed, fit-for-purpose solutions



The three phases and eight steps of the Ophelia process

Phase 1
Identify strengths, needs and action ideas

Step 1 Project set-up (c0-design with stakeholders)

Step 2 Data collection using multidimensional Health Literacy Questionnaire

Step 3 Stakeholder and community engagement to generate action ideas. Use vignettes (patient stories) derived from real data

Phase 2
Select, plan and test health literacy actions

Step 4 Select health literacy actions (program logic models)

Step 5 Plan actions (develop implementation and evaluation plans)

Step 6 Test and refine health literacy actions (quality improvement cycles to test processes and materials)

Phase 3
Implement, evaluate and improve health literacy actions

Step 7 Implement and evaluate health literacy actions

Step 8 Develop an ongoing quality improvement strategy

See Page 6
of Ophelia
Manual

The Health Literacy Questionnaire (HLQ): 9 separate dimensions

Phase 1
Identify
strength, needs
and action
ideas

Step 1 Project set-up

Step 2 Data collection using Health Literacy Questionnaire (HLQ)

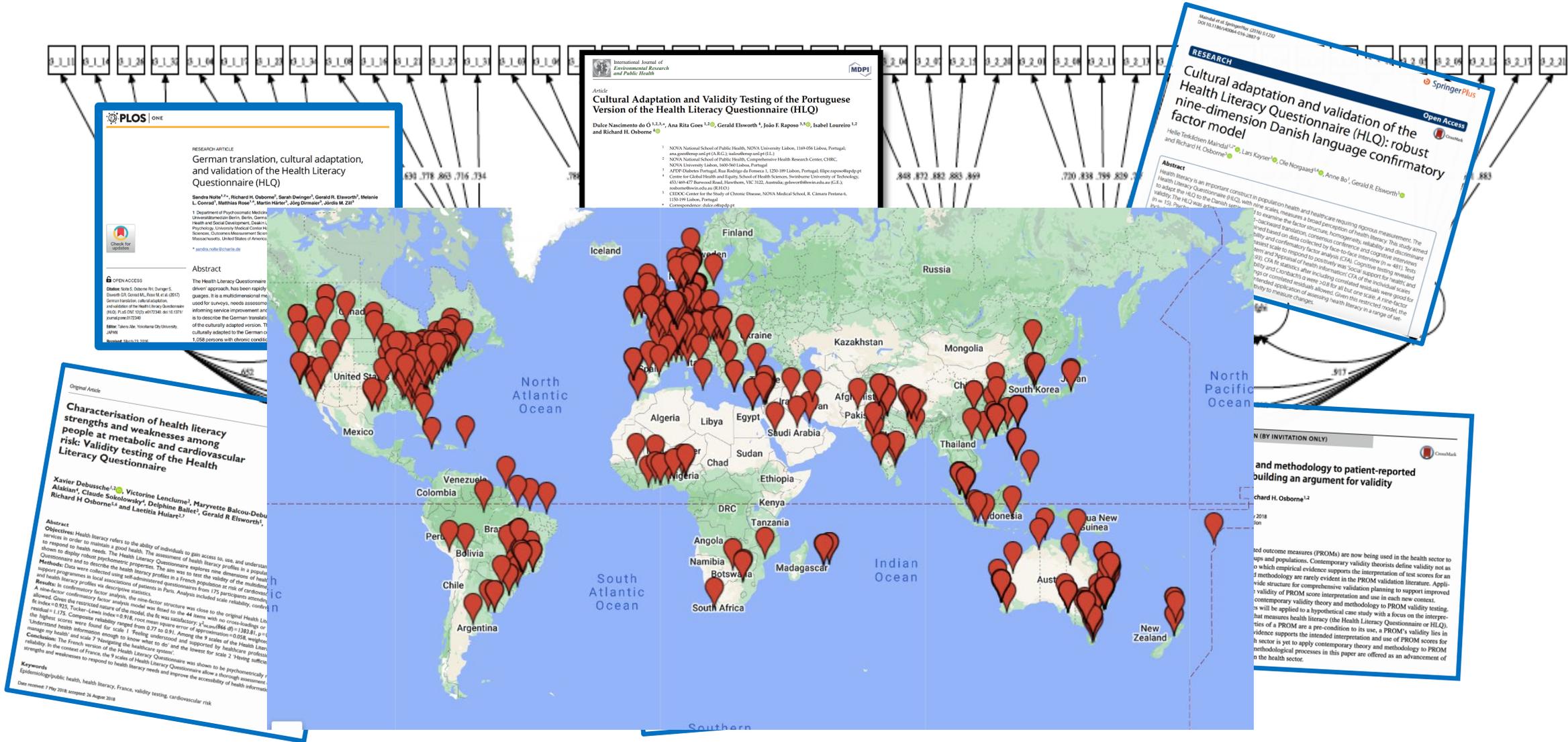
Step 3 Apply vignettes (community stories) from real data.
Stakeholder and community engagement to generate action
ideas. Develop overall health literacy strategy

HLQ scales

1. Feeling understood and supported by providers
2. Having sufficient information to manage my health
3. Actively managing my health
4. Social support for health
5. Appraisal of health information
6. Ability to actively engage with healthcare providers
7. Navigating the healthcare system
8. Ability to find good health information
9. Understand health information well enough

**People do have highly
diverse range of skills
across the 9 dimensions**

Psychometric properties of HLQ in English, French, Danish, German, Dutch, Norwegian, Urdu, Arabic, Slovakian, Portuguese... very strong



ophelia



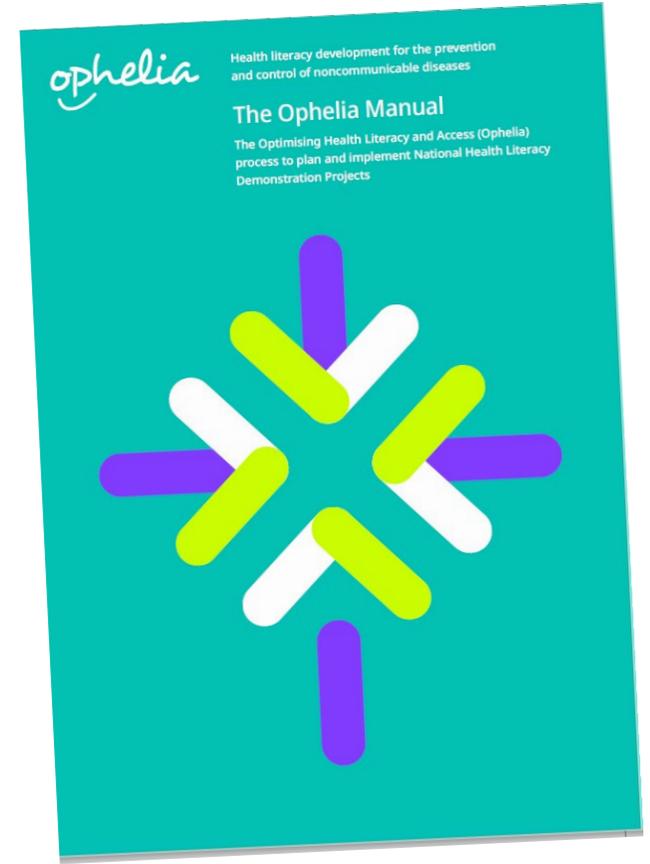
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Mental Health Literacy Development



ADVOCACY AND ACTION

Advocacy for
communities

Submissions for
reform

01

Orientate your organisation

Understand Mental Health
Literacy Responsiveness

02

Evaluate your organisation

Apply the Health Literacy
Responsiveness Quality
Improvement Tool

03

Implement training

Training materials to ensure
Mental Health Literacy
Responsiveness

SUNNY Consortium

Swinburne University of Technology (SUT)

University of New South Wales (UNSW)

University of Newcastle (UoN) / North Coast PHN

Different people have different things that they are good at, different things that they like and different problems in getting and using information to care for their health

HLQ scales

1. Feeling understood and supported by providers
2. Having sufficient information to manage my health
3. Actively managing my health
4. Social support for health
5. Appraisal of health information
6. Ability to actively engage with healthcare providers
7. Navigating the healthcare system
8. Ability to find good health information
9. Understand health information well enough

Groupings (clusters) of people with same scores (number in clusters)

	A	B	C	D	E	F	G	H	I	J	K
	84	84	48	195	104	179	76	70	36	104	38
1. Feeling understood and supported by providers	3.90	3.55	3.70	3.11	3.45	3.13	2.91	3.14	2.70	2.94	2.45
2. Having sufficient information to manage my health	3.79	3.53	3.70	3.07	3.28	3.04	3.00	2.98	3.14	2.82	2.43
3. Actively managing my health	3.69	3.88	3.88	3.04	3.88	3.88	3.04	3.04	3.98	2.61	2.81
4. Social support for health	3.79	3.88	3.88	3.04	3.88	3.88	3.04	3.04	3.98	2.85	2.48
5. Appraisal of health information	3.55	3.15	3.40	2.84	3.05	2.95	2.84	2.95	3.00	2.55	2.41
6. Ability to actively engage with healthcare providers	4.84	4.61	4.16	4.78	4.05	4.12	3.88	4.04	3.16	3.75	2.61
7. Navigating the healthcare system	4.68	4.39	4.02	4.62	3.79	3.95	3.81	3.75	3.42	3.51	2.49
8. Ability to find good health information	4.72	4.46	4.15	4.62	3.90	3.91	4.08	3.64	3.91	3.59	2.71
9. Understand health information well enough	4.82	4.65	4.30	4.79	4.16	3.93	4.48	4.05	3.92	3.73	3.25

Each cluster matched to specific lifestyle, social and health issues.

Matt – getting back on track

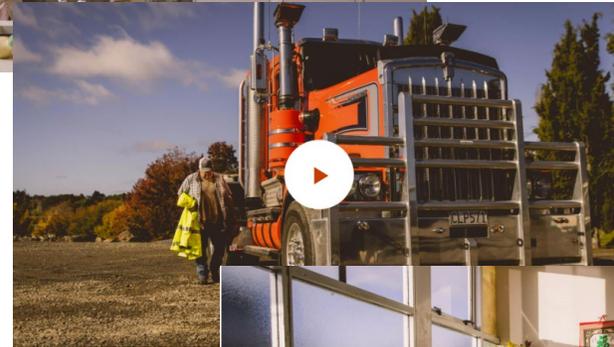
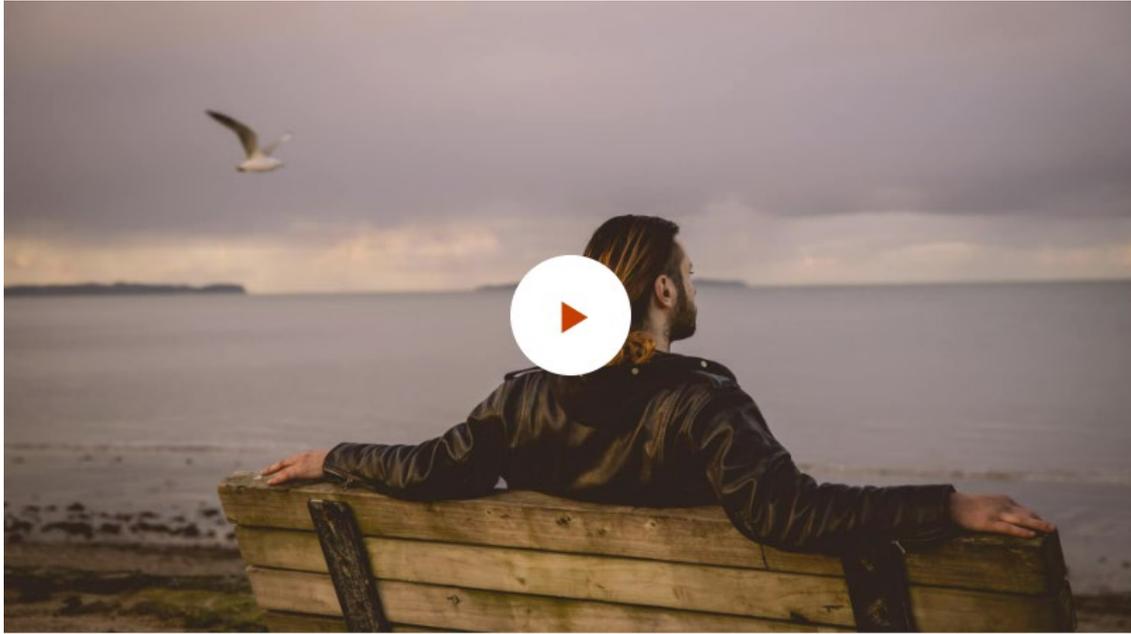
Matt is a 29 year old man, who in his late teens experienced several hospitalizations due to episodes involving extreme changes in the way he saw people around him, and occasionally hearing voices. This sometimes led him into danger and self-harm.

His problems also led to serious problems in his family and Matt spent time living on the streets or in various temporary forms of shelter. He also became a frequent user of alcohol and marijuana. As a teenager Matt always felt that the medications and treatments that he was forced to take were imposed on him and frequently resisted because of the side effects including shaking, weight gain and impotence. He developed a strong distrust of doctors and if he needed medical help he found himself at a hospital accident and emergency department.

Two people helped Matt turn things around a bit. The first was a youth worker who was very non-judgmental and was happy just to talk about whatever Matt wanted. He helped Matt to do little day-to-day things to make life better as well as to recover from setbacks. The second person was a peer support worker who had been through many of the things that Matt had. Talking to this guy changed the way Matt thought about treatment and about his family and helped Matt feel a bit more in control.

However Matt is still struggling to cope with life now and doesn't think about the future or about looking after his health. He has very poor oral health, has lost several teeth and has had some serious infections that originated from his teeth. His diet is erratic and unplanned and he doesn't have many established routines to care for his health.

Matt – getting back on track



1. Do you recognise this person in your community?
What is their main issues?

2. What strategies could be used to help this individual?

3. "If there were lots of people like this...
What could services/ community organisations etc do to improve outcomes for these people?"

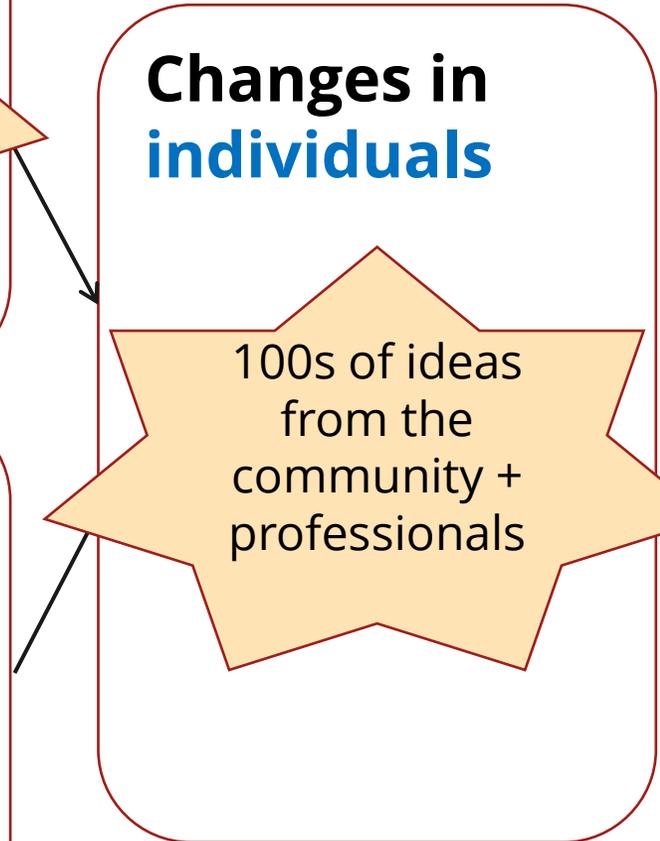
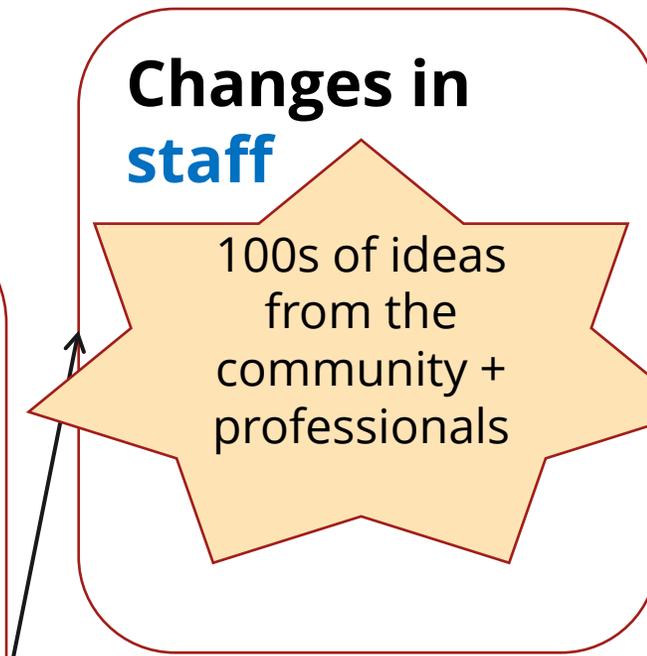
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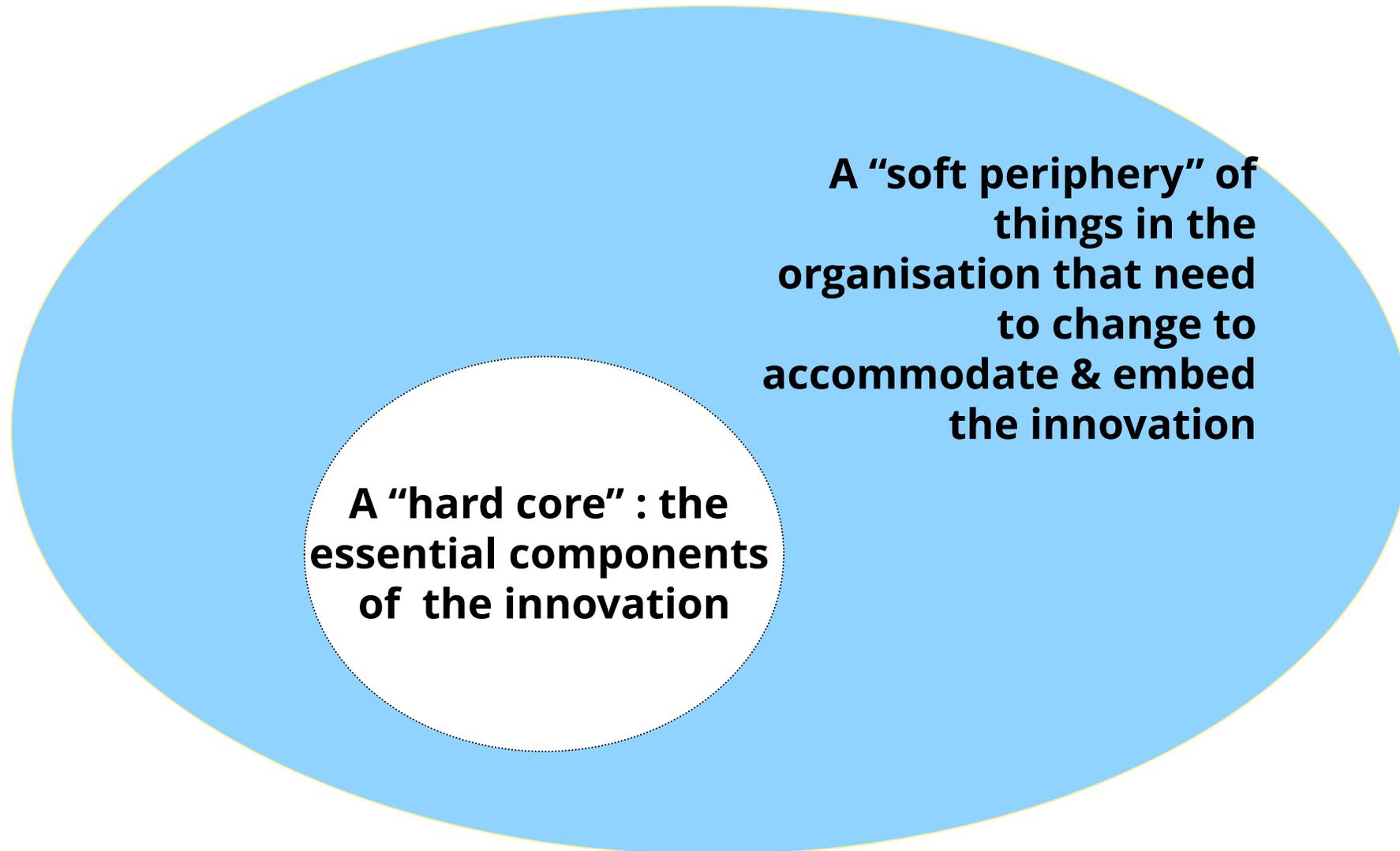
100s & 100s of ideas from the community + professionals

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Integrated Ophelia framework for Health Literacy interventions



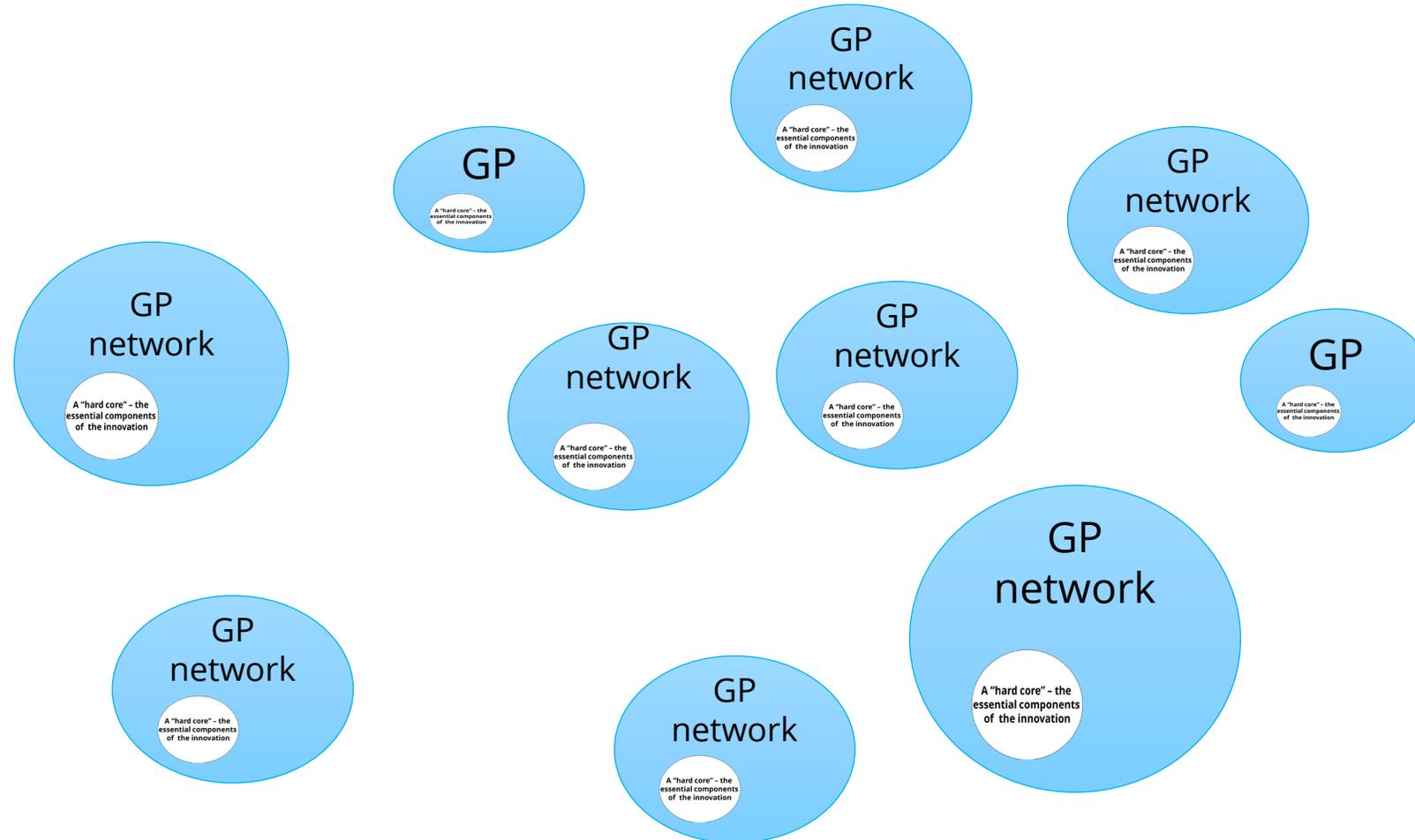
All complex service-level innovations have...



A "hard core" : the essential components of the innovation

A "soft periphery" of things in the organisation that need to change to accommodate & embed the innovation

Mental Health Commission of NSW Health Literacy Initiative: A very complex project!

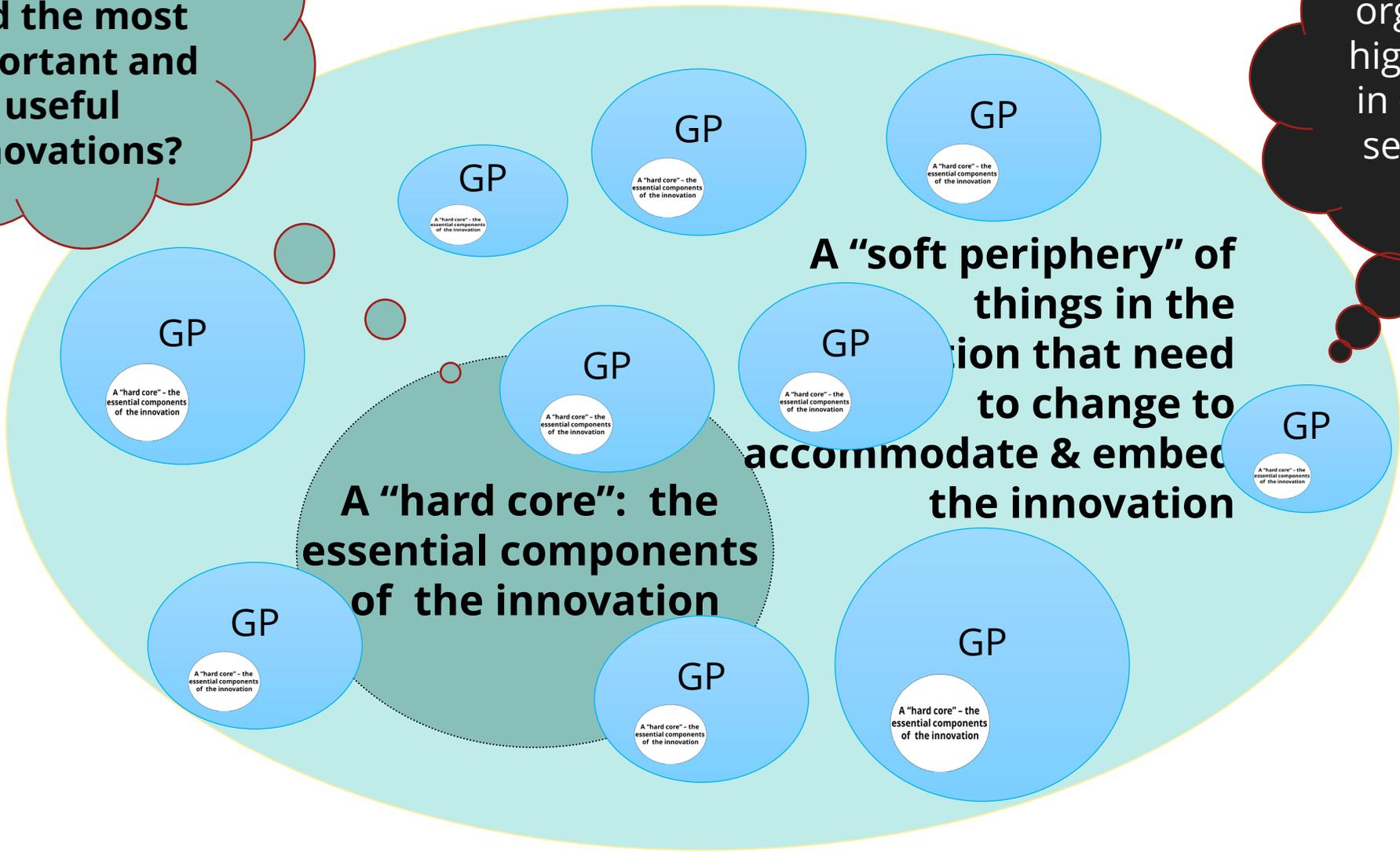


Mental Health Commission of NSW Health Literacy

Initiative is a very complex project!

How do we find the most important and useful innovations?

10 very different organisations with high to low interest in different issues, serving ~8 million people



Program logic model

People who have lived experience of mental health issues and caring, families and kinship groups

Receive services guided by the following principles, policies, regulations and guidelines...

Partnership of people and caring, families monitoring, joint activities (LEF)	Listening to and honouring lived experience including aboriginal people and people who have attempted suicide (KD 18-23)	Value all reform partners in the mental health services and social support sector.(KD 18-23)	Use evidence and data to drive change and	Allow for ongoing capacity building of all participants (awareness and skills to change culture) (LEF)	work to challenge the status quo regarding mindsets, values, culture and current practices)LEF)
---	--	--	---	--	--

Organisational level

Which include...

General primary care services delivered by general practice, community health and other agencies	Mental health primary care services	Community and civil social organizations including peer groups and cultural groups			
--	-------------------------------------	--	--	--	--

Organisational level

Which must achieve (service level outcomes that directly contribute to change lived experiences especially as people interact with health services)...

Health service provider capabilities and practices | Service organisation and capacity | Service integration

Responsiveness (Matching across this line)

Responsiveness (matching interventions to individual's needs)

								Overcoming institutionalised discrimination)	
--	--	--	--	--	--	--	--	--	--

Which it is expected will lead to... People with lived experience of mental health issues including their engagement with health services

Beliefs and affective state | Positive service delivery experiences | Avoid negative service delivery experiences

Feel that they have sufficient supportive people around them (isolation and loneliness)		Positive self image and sense of agency			Are supported to manage health over long periods including relapses, progressions and self-management fatigue		Experience minimally burdensome care provision – appointments, tests, repetition of communication	
---	--	---	--	--	---	--	---	--

Individual level

Which, in turn, it is expected will lead to the following beneficial outcomes for people with lived experience of mental health issues ...

Positive view of recovery potential	Ability and willingness to engage health services with confidence	Frame lived experience of mental health issues in cultural ways for themselves and caring family and kinship groups		
-------------------------------------	---	---	--	--

Individual level

Which ultimately lead to...

Improved access for people with lived experience of mental health issues to services including tailored options	Improved experience and satisfaction of people with lived experience using services	Improved health outcomes
---	---	--------------------------

That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life. (Key Directions 2018-2023)

11 Action Areas to Build System-wide Responsiveness

1. Action areas focused on connection between health services and the community

2. Action areas focused on accessing help at the right time in easy, friendly ways

1. Package of phone and internet-based services that are local, friendly and flexible

7. Engagement with schools and young people

5. Programs to help people to act early when they feel that 'somethings not quite right'

2. Multiple systems to help people connect with the community supports they need

3. Multiple well trained, supported and connected peer support options (formal and informal, one-to-one and group, face-to-face and online)

4. Guidelines, tool and training for helpful, user-friendly intake processes along with assistance where required

6. 'Whole health' strategy to address the needs of the 'whole person' including their physical and mental health needs

3. Action areas focused on training and capacity building in health and community services

8. Connected training for all health and community workers

9. Involve more workers from the community (e.g. youth workers, teachers, librarians)

10. Good and easily available information on community supports (formal and informal)

11. Ways to identify whose needs are not being met and to reward services for reaching out to the whole community (data and indicators)

Program logic model

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Individual level

Which ultimately lead to...

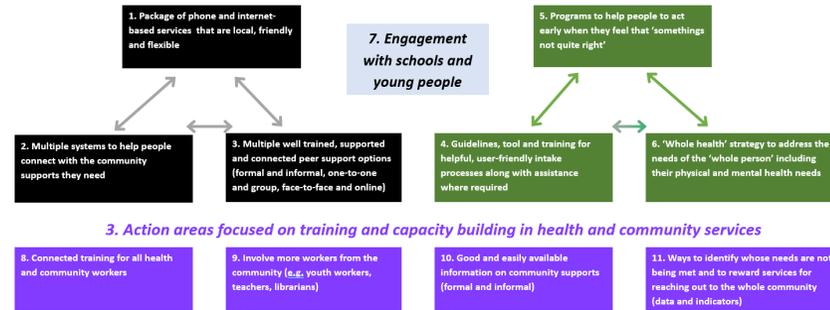
Improved access for people with lived experience of mental health issues to services including tailored options	Improved experience and satisfaction of people with lived experience using services	Improved health outcomes
---	---	--------------------------

That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life. (Key Directions 2018-2023)

ALL people who have lived experience of mental health issues and caring, families and kinship groups

What types of training, organizational development, services and programs will enable health and community workers and services to respond to the needs of people with lived experience, across all the differences that exist among people in the community?

11 Action Areas to Build System-wide Responsiveness



What is necessary for health and community workers and services to respond to the needs of people with lived experience, given all the differences in people in the community?

Appropriately skilled workers, user friendly and flexible services, good connections between health and the community

What do people with lived experience and those close to them need, especially those whose needs are not currently being met?

Need/want about themselves

Have sufficient supportive people around them
Encouraged to act quickly when they think that something is "not quite right"
Trust health providers and have some good relationships

Need/want in health and community services

Able to access support and assistance that are friendly and flexible
Providers listen and explain respectfully and admit when they don't know and refer on
Supported to connect with community supports, not just for problems but also for enjoyment of life
Engage and support family, kinship groups, friends in acceptable ways
Can access services in ways that are NOT bureaucratic, complex, unfriendly and judgemental
Services don't stop as soon as you get used to them and they start to help

That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life. (Key Directions 2018-2023)

01

Orientate your organisation

Understand Mental Health Literacy Responsiveness

View →

02

Evaluate your organisation

Apply the Health Literacy Responsiveness Quality Improvement Tool

View →

03

Implement training

Training materials to ensure Mental Health Literacy Responsiveness

View →

3 step program to improve your service

Why is a Mental Health Literacy Response needed?

Why mental health literacy is needed and how it can translate to practice.

Copy link

THE 11 ACTION AREAS PROVIDE SPECIFIC RECOMMENDATIONS FOR:

- Training and capacity building in health and community services

Pull up for precise seeking

ation between health and community services

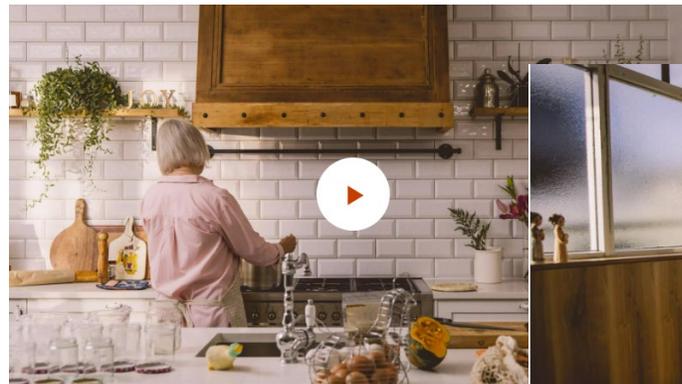
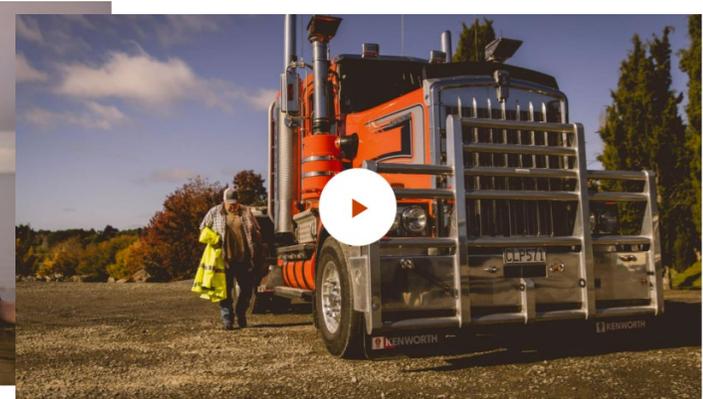
ng help at the right time

ment with schools and young people

MORE VIDEOS 0:04

4:32 / 7:26

CC YouTube



Powerful discussion starters for your organisation



What is mental health literacy?

A factsheet for service providers

This factsheet includes definitions of mental health literacy and mental health literacy responsiveness. These definitions were developed in consultation with people with lived experience of mental health issues and key service providers.

What is mental health literacy?

People's accumulated knowledge and their ability, confidence and comfort to access, understand, appraise, remember and use knowledge about health and healthcare for the mental and physical well-being of people with lived experience of mental illness and those around them:

- in everyday life
- throughout life, and
- across generations.

What is mental health literacy responsiveness?

Mental health literacy responsiveness is the provision of services, programs, support and information in ways that promote equitable access and engagement for all people in the community.

A mental health literacy responsive service should meet the diverse mental health literacy strengths, limitations and preferences of all people, and support individuals with lived experience of mental health issues and caring, their families, kinship groups and communities to make decisions regarding their health and wellbeing.

01

Orientate your organisation

Understanding mental health literacy responsiveness

View →

02

Evaluate your organisation

Evaluating your organisation's mental health literacy responsiveness

View →

03

Implement training

Implementing training to ensure mental health literacy responsiveness

View →

Evaluate your organisation

The second step is about evaluating your organisations towards Mental Health Literacy Responsiveness and applying the Health Literacy Responsiveness Quality tool in the 11 Action Areas.

11 Action Areas



Action Area 1 - Phone and web-based services

Establish phone or web-based services to provide information and support.

Read more →



Action Area 2 - Better connected systems

Build a connected system of referral and support across all levels of the health care system.

Read more →



Action Area 3 - Peer support options

Provide both formal and informal peer support options.

Read more →



Action Area 4 - Friendly intake processes

Meet health literacy standards for all documents, forms and processes related to assessment and intake processes.

Read more →



Action Area 5 - Early action programs

Help people to act early when they feel that 'something's not quite right'.

Read more →



Action Area 6 - Whole health strategy

Acknowledge and manage the interaction between physical and mental health.

Read more →



Action Area 7 - Youth engagement

Recognise the mental health needs of children and youth and support schools to identify signs of mental health issues.

Read more →



Action Area 8 - Professional development

Ensure consistent 'baseline' mental health training for all health and community workers.

Read more →



Action Area 9 - Community engagement

Involve more people from the community to support people with lived experience of mental health issues and caring.

Read more →



Action Area 10 - Community supports and services guide

Share information about all of the available community supports.

Read more →



Action Area 11 - Data and indicators

Use data to identify which groups in the community are receiving services and which are missing out.

Read more →



01

Orientate your organisation

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View →

02

Evaluate your organisation

Evaluating your organisation's mental health literacy responsiveness

View →

03

Implement training

Implementing training to ensure mental health literacy responsiveness

View →

03 Implement training

On this page:

- [A toolkit to support practitioner and organisational change](#) in primary care
- [Guides to facilitating training](#) in the 11 Action Areas in your organisation
- [Training and fact sheets explaining key concepts](#) such as sharing consumer information and adopting '[No Wrong Door](#)' approaches
- **Interviews** with experts and service providers
- Fact sheets, checklists and policy and [regulation guides](#)

You can use the resources on this page to:

- Address priorities identified in your Action Plan
- Implement targeted training and support materials to improve the mental health literacy responsiveness of your organisation

By the end of this step you will:

- Understand the evidence-informed options available to improve the mental health literacy responsiveness of your organisation
- Have begun improving how your organisation responds to the mental health literacy of people in the community

01

Orientate your organisation

Understanding mental health literacy responsiveness

View →

02

Evaluate your organisation

Evaluating organisational literacy responsiveness

View →

03

Implement training

03 Implement

Welcome to the Mental Health Literacy Responsiveness Quality Improvement Toolkit

This Mental Health Literacy Responsiveness Quality Improvement Toolkit supports the provision of services, programs and information in ways that promote equitable access and engagement for all people in the community.

As part of the Health Literacy Initiative, the Commission and its partners engaged and collaborated with communities across NSW to codesign resources to support the development of health literacy responsive services.

[What is Mental Health Literacy?](#)

[Overview of the Quality Improvement Toolkit](#)

Interested in using the Quality Improvement Toolkit?

The Quality Improvement Toolkit is currently restricted and available to a limited number of Primary Health Networks (PHNs). Get in touch and we can discuss your needs.

[Request Access](#)

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Mental Health Commission
of New South Wales

[Overview of the Quality Improvement Toolkit](#)

[What is mental Health Literacy](#)

[About us](#)

[Contact us](#)

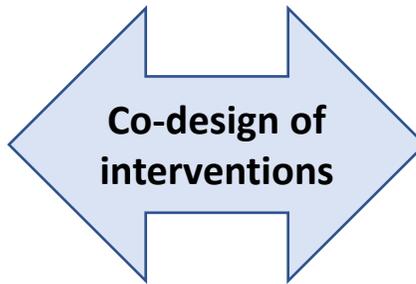
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Health Literacy Development program

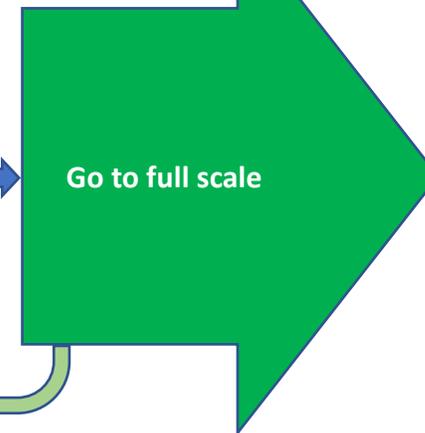


Novel practices co-designed with stakeholders
Existing practices: language use, understandings of distress/MH, stigma, preventive behaviours, early signs
Literature review of mental wellbeing

Prioritisation and set-up

Develop the scalable unit(s) suitable for state-wide implementation and/or across sociodemographic subgroup (young/older, geographic etc. Use PDSA (Plan, do, study, act) cycles

Test wider implementation and scale-up: Mix of state-wide and bespoke local/sociodemographic groups



Leadership, communication, social networks, local ownership, community of practice, support and promote local experts, customisation

Learning systems, flexible funding, bespoke and continuous training, dedicated personnel, data systems, flexible online continuous quality improvement system

Recommendations

Ophelia phases

Phases of scale up

Adoption mechanisms

System supports

Underpinned by
(tested/refined principles)

Richard's dream

All public health interventions...

- Are co-created with community, health professionals & other stakeholders
- Are developed based on unbiased and well-characterised needs
- Have an implementation and scaling up strategy that was integral to the design
- Have implementation feasibility proven before expensive RCTs
- Are so fit for purpose they become “sucked” into practice
- Are evaluated for impact - people’s lives are better
- Can be implemented equally well by non-expert and expert groups

Thank you

Richard Osborne rosborne@swin.edu.au

LinkedIn group:
Advancing health
and equity through
practical health
literacy development

