Mental Health Literacy among Young and Adult Population in the Caraga Region, Philippines

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ABSTRACT

Background. Mental health literacy (MHL) is an important mental health strategy since it contributes to early detection, enhances help-seeking behavior, and reduces stigma and discrimination against people with mental disorders.

Objective. The objectives of the present study were to assess the level of mental health literacy and its correlation, and to examine the predictive effect of demographic profiles on mental health literacy among young and adult populations in the five cities of Caraga, using a standardized mental health literacy scale in 2023.

Methods. This study applied a cross-sectional survey. It surveyed 729 individuals from five cities in Caraga using the Mental Health Literacy Scale from Dias et al. Descriptive analysis, such as frequency, percentage, mean, and standard deviation, and inferential statistics, such as Pearson correlation, independent t-test, and multi-linear regression, were used for data analysis.

Results. The mental health literacy of the young and adult populations can be classified as adequate or good. Zooming in on details, the respondents have a very good understanding of help-seeking behavior and self-strategies but only a good understanding of knowledge and beliefs/attitudes. Pearson's correlation analysis revealed a significant positive relationship between knowledge, erroneous beliefs, self-strategies, and help-seeking behavior ($p < 0.001$). In addition, Independent t-test and ANOVA revealed significant differences in sex, family income, employment, civil status, educational level, and age group ($p < 0.01$). A multiple linear regression indicated that demographic profile predictors were found to be statistically significant, and positively with mental health literacy, with education and family income as the strongest predictors.

Conclusion. The present study concluded that the young and adult populations in the five cities in Caraga have adequate literacy on mental health, encompassing knowledge, beliefs, self-strategies, and help-seeking behaviors. The increases in knowledge, belief, and self-strategies are associated with their higher level of help-seeking; in addition, the demographic profiles (e.g., sex, age, education, monthly income, and employment) have implications on young and adults' mental health literacy in the five cities in Caraga. The result may not be generalizable beyond the studied region or demographic. In addition, it recommended that mental health literacy programs prioritize individuals with lower levels of education and family income as these factors were found to have the most significant influence.

Keywords: mental health literacy, mental health, young and adult population

INTRODUCTION

Mental health currently has become everyone's concern since the prevalence of mental health problems is increasing globally. The World Health Organization (WHO) states less than a billion people around the world currently live with a diagnosable mental disorder. Unfortunately, most of them do not have access to effective care because services and supports are not available, cannot be accessed, or are unaffordable; or because widespread stigma stops people from seeking help.[1] Moreover, the COVID-19 pandemic has exacerbated this situation. In the Philippines, one-fourth of the study samples in Luzon, Philippines, were experiencing moderate to severe anxiety. At the same time, one-sixth of the respondents reported moderate to severe depression and psychological impacts in the early COVID-19 pandemic.[2]

Mental health literacy (MHL) is recognized as a key to improving knowledge and reducing erroneous beliefs about mental health. Studies have identified several impacts of MHL, such as increasing people's resilience and control over their mental health; enhancing help-seeking self-efficacy; helping the early detection of mental illness, and minimizing mental illness stigma; and it is cost-effective and appropriate for low and middle-income countries that encounter mental health problems but have limited mental health resources.[3-5]

Unfortunately, data on comprehensive global statistics on MHL are limited since this issue is frequently overlooked in the health literacy survey. However, Tay et al. argued that the global MHL level is low/insufficient.[6] It was corroborated by a Mental State of the World Report 2024 from Sapien Labs Global Mind Project that the worldwide average Mental Health Quotient is at a moderate level (62.84).[7] Eventually, there are global, 70-80% of young people and adults with mental health problems may not receive the mental health care and treatment they need as timely and early as possible.[8] Similarly to the Philippines, the MHL level is also considered low. An analysis from the first national survey reveals that 51.5% of Filipinos aged 15-70 years old had limited health literacy, including mental health.[9] Therefore, addressing mental health literacy could help to improve the early detection of mental health problems and access to professional mental health care and treatment.[8]

Jorm et al. were the pioneers who introduced MHL and defined it as *"knowledge and beliefs about mental disorders which aid in their recognition, management, and prevention, include the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and professional help available; and attitudes that promote recognition and appropriate help-seeking.*[10] The concept of MHL, therefore, generally covers four domains:
- Understanding how to obtain and maintain good mental health.
- Understanding mental disorders and their treatment.
- Decreasing stigma against mental illness.
- Enhancing help-seeking efficacy.

Since its introduction in 1997, the measurement of MHL has seen significant development. Numerous psychologists and scholars have contributed to this progress by developing MHL scales and questionnaires. It is reported that more than 200 measurement tools have been created for MHL.[8] A comprehensive MHL measurement should minimally contain three components: knowledge, attitude/belief, and help-seeking behavior. This evolution in measurement tools is also a testament to MHL's growing interest and understanding in public health.

Based on a literature review from the previous studies, many existing MHL studies have adolescents and young adults, particularly college students, as the respondents. The rationale may be that 70-75% of adult mental health problems and mental disorders start to manifest during adolescence or early adulthood (12-25 years old).[3] In the Philippines, studies also mainly focus on young people and assessing the extent of MHL in education settings by using students as respondents; or conducted mostly in the northern part of the Philippines.[11-15] Thus, it creates a gap in the information and data about MHL on other demographic groups or outside education settings. In addition, MHL study in the general public is considered important for several reasons, such as mental illness being commonly poorly understood by the general public, and strong myths and disbelief about mental health and illness, which most likely appear in every community/group.[5]

Although mental health literacy is acknowledged as a crucial determinant of help-seeking behavior, most studies in the Philippines have narrowly focused on school-based youth in northern regions. Thus, it creates gap where there is limited empirical evidence on how MHL manifests in the young people and adult across underserved regions such as Caraga. Many studies, furthermore, have identified that some demographic profile characteristics correlate with or affect the individual's MHL level. For instance, family income and occupational status are predictors of community attitude toward mental health problems in Ethiopia; sex, age, education, and employment status correlate with knowledge of subtle symptoms of mental health problems in Hong Kong; ethnicity, religion, educational level, and location correlate with MHL knowledge and attitude among residents in Malaysia.[16-18] Additionally, this present study addresses these gaps by examining both the level and predictors of MHL in young people and adults in five urban cities in the Caraga Region.

METHODS

Research Design

The present study employed a descriptive cross-sectional design to measure MHL levels in the Caraga Region. This design did not infer causality but allowed for comparisons across the research variables.

Participants

A total of 729 respondents completely answered the questionnaire during September-October 2023. The study population consisted of Filipinos 18-65 years old. Individuals who resided in the Caraga Region for less than one month, were unable to read or write, and were not in good health (both mental and physical) when the study was conducted were excluded from the survey. The respondents were selected proportionally based on the population from five cities in the Caraga Region (e.g., Butuan, Cabadbaran, Bayugan, Surigao, and Bislig). The reasons for selecting these cities in the present study were due to the cities represent more than 50% of total population in the Caraga Region, and where also mental health care are only available.

Each city represents provinces in the Caraga Region, except for Butuan City. Within each city, cluster sampling was used to select barangays and puroks. To ensure proportionally respondent representation, a purposive sampling was used, where the characteristics of variables were gender (female/male), age (15-24, 35-49, 55-65 years old), and sectors (education-health-public). The rationale for using purposive sampling was that it allowed the researchers to target participants across different demographic profiles who were relevant to the present study. The distribution of the variables was based on the population proportion. One household is only represented by one respondent to minimize the effect of intra-cluster homogeneity.[9]

Table 1 presents the socio-demographic profile of respondents. Table 1 shows there are more females (58.8%), young and early adults with an age range between 25-49 years old (54.2%); no school – K12 undergraduate degree (38.6%); married (47.5%), work as a government employee (45.1%); have family income <10,957 pesos per month (68.9%), and live in an urban area (64.6%)

Measures

The structured questionnaire was used to collect information from the respondents. The questionnaire has two parts, namely 1) demographic profile which contains information on the socio-demographics of respondents like age, sex, education level, family income, civil status, employment status, and their role in the household, and 2) a mental health literacy questionnaire (MHLq) from Dias et al.[19] The MHLq consisted of 29 items and was designed to measure four dimensions/components such as knowledge of mental health problems (cause and symptoms), erroneous belief/attitude, help-seeking and first aid skills, and self-help strategies. The MHLq instrument has a good reliability value of Cronbach's Alpha equal to 0.84 for the total score (29 items), 0.74 for knowledge of mental health problems (11 items), 0.72 for erroneous belief/stereotypes (8 items), 0.71 for first aid skills and help-seeking behavior (6 items), and 0.60 for self-help strategies (4 items). The total score for 29 items of the MHLq ranged between 29 and 145, and the mean score of the initial MHLq was 105.27.

Table 1. Socio-demographic Profiles of Respondents

Profiles	Category	n	%
Age group (years)	18-24	182	25.0
	25-49	395	54.2
	50-65	152	20.9
Monthly income (in pesos)	<10,957	502	68.9
	10,957-21,914	107	14.7
	>21,915	119	16.9
Sex	Male	300	41.2
	Female	429	58.8
Decision-maker	Yes	281	38.5
	No	448	61.5
Location	Urban	471	64.6
	Rural	258	35.4
Civil status	Single	250	34.3
	Married	346	47.5
	Widow/Widower	29	4.0
	Live-in partner	86	11.8
	Separated	18	2.5
Employment	Unemployed	196	26.9
	Student	71	9.7
	Government employee	329	45.1
	Private employee	78	10.7
	Self-employed	55	7.5
Educational level	No school – K12 undergraduate	282	38.6
	K-12 graduate – college undergraduate	199	27.3
	College graduate – post doctorate	248	34.1

n – number of participants, % – percentage

The MHLq was made in dual language, and the English version of MHLq was translated into the local language (Bisaya) to accommodate respondents who do not understand English. A bilingual expert (English-Visaya) translated the Bisaya version back into the English version to confirm the accuracy of the original translation. A face validity study was conducted on the dual-language version of MHLq. A professional psychologist and health officers from DOH Caraga were asked for their input and comments, and then a pre-test with 29 participants was conducted in the two barangays. The instrument's reliability score in the present study was 0.757.

Procedure

Ahead of the data being collected, the research proponent secured approval from the Ethics Research Committee of the University Mindanao Philippines. Before filling out the survey, the respondents were asked to read the informed consent form containing study objectives, participants' rights, (possible) risks, research methods, study benefits, and how the data and information would be treated. The enumerators were residents of the selected barangays and had experience conducting surveys. They have undergone training from the research proponent and been assigned information such as

the name of selected puroks, the proportion of male and female respondents, the proportion of age groups, and the proportion of sectors.

The trained enumerator visited the household where the survey was conducted through face-to-face interaction and respondents were given an option either to fill up by themselves or the trained enumerators read through the questions. Respondents had opted out of the survey, and only participants who had signed the informed consent form were included in the study. Suppose one member of the household had completed the survey. In that case, the enumerator must move to another household for other respondents. The enumerators have also been asked to take a picture with the respondents as proof of the data collection. The research proponent also conducted a random check by calling respondents and asking if they participated in the survey.

All collected data was kept in a secure storage and only the principal researcher has access to the data. The data will be stored for five years from the date the study was conducted.

Data Analysis Treatment

The data were analyzed statistically using Jeffreys's Amazing Statistics Program (JASP) version 0.17.1 software, which the University of Amsterdam supports.

For descriptive analysis, statistical data was presented on frequency and percentage for categorical data (e.g., nominal or ordinal), and mean and standard deviation for continuous data. For correlational analysis, Pearson product-moment was used to investigate the correlation among variables (e.g., knowledge, attitude/belief, self-strategies, and help-seeking behavior); Independent t-test and One-way ANOVA were used to investigate the comparison between groups in the demographic profile in terms of MHL. Lastly, multiple linear regression analysis was used to examine the value of MHL based on the demographic profiles. Before conducting statistical analyses such as correlation, ANOVA, and multi-regression, relevant statistical assumptions such as normality, outliers, homogeneity of variance, and variance inflation factor (VIF) were tested.

RESULTS

A descriptive statistic, such as mean, standard deviation (SD), and percentage, was used to provide summary and description of the main features of the dateset.

Table 2 revealed the result of the overall MHL and its sub-components; the overall MHL level of the general population in the five cities in the Caraga Region had a mean score of 113.31, SD=12.13, which was higher than the overall MHL in the study by Dias et al.[19] It indicates that the level of MHL in the five cities can be classified as sufficient. Zooming into the sub-components of MHL in the present study, the mean score for knowledge was 40.78, SD=7.57 (classified as sufficient) wherein the mean score for the cause of the mental illness was 14.79, SD=3.21 and for mental illness symptoms was 25.95, SD=5.19; the mean score for erroneous belief/attitude was 30.39, SD=4.28 (classified as sufficient) wherein mean score for positive belief was 17.78, SD=3.51 and for positive attitude was 12.56, SD=1.83; the mean score for self-help strategies was 17.00, SD=2.25 (classified as excellent); and the mean score for help-seeking behavior was 25.10, SD=3.07 (classified as excellent) wherein mean score for looking professional help was 17.31, SD=2.5 and for non-professional help (e.g., friends or family) was 7.64, SD=1.66. In summary, the findings inform that respondents demonstrate some understanding of mental health but still have gaps in their knowledge and beliefs.

Statistical analysis, namely Pearson r correlation, was used to determine the correlation between each sub-component of MHL.

The results in Table 3 revealed a significant correlation among sub-components of MHL. Knowledge had a significant positive relationship with belief/attitude, $r_{(727)}$=0.220, p=<0.001, which was classified as low correlation;

Table 2. Overall MHL and its Component Mean Scores of the Participants

Variables	Mean	SD	Max score	Percentage** (Mean/Max) × 100	Original MHLq
Overall Mental Health Literacy (29*)	113.31	12.13	145	78%	105.27
MHL components:					
Knowledge on mental health (11)	40.78	7.57	55	74%	44.50
Cause of mental health (4)	14.79	3.21	20	73%	
Symptoms of mental health (7)	25.95	5.19	35	74%	
Erroneous belief/attitude (8)	30.39	4.28	40	75%	19.75
Belief (5)	17.78	3.51	25	71%	
Attitude (3)	12.56	1.83	15	83%	
Self-help strategies (4)	17.00	2.25	20	85%	16.90
Help-seeking behavior (6)	25.10	3.07	30	83%	24.13
Professional help (4)	17.31	2.50	20	86%	
Non-professional help (e.g., friends, family) (2)	7.64	1.66	10	76%	

* *Number of statements*
** *Classification: 0-20% – worst, 21-40% – low, 41-60% – moderate, 61-80% – sufficient, 81-100% – best*

Table 3. Pearson's Correlations on Sub-components of MHL

Variable		Knowledge	Belief	Help-seeking Behavior
1. Belief/attitude	Pearson's *r*	0.220 ***		
	p-value	<0.001		
2. Help-seeking behavior	Pearson's *r*	0.335 ***	0.164 ***	
	p-value	<0.001	<0.001	
3. Self-help strategies	Pearson's *r*	0.417 ***	0.239 ***	0.486 ***
	p-value	<0.001	<0.001	<0.001

*** significant at 0.001*

Table 4. Independent t-Test for Sex, Location, and Decision-maker

Variable	Demographic profiles	Group	Mean	t value	P-value
MHL	Sex	Male	111.8	-2.817	0.005**
		Female	114.3		
	Location	Urban	113.6	1.117	0.264
		Rural	112.6		
	Decision-maker	Yes	112.5	-1.388	0.16
		No	113.8		

*** significant at 0.01*

with help-seeking behavior, $r_{(727)}$=0.335, *p*=<0.001, which was classified as moderate correlation; and with self-help strategies $r_{(727)}$=0.417, *p*=<0.001, which was classified as a moderate correlation. Belief/attitude had a significant positive relationship with help-seeking behavior $r_{(727)}$= 0.164, *p*=<0.001, which was classified as low correlation; with self-help strategies $r_{(727)}$= 0.239, *p*=<0.001, which was classified as low correlation; and help-seeking behavior had significant positive relationship with self-help strategies $r_{(727)}$= 0.486, *p*=<0.001, which was classified as a moderate correlation. Young people's and adults' knowledge and beliefs positively correlate with their self-strategies and help-seeking behavior.

The research proponent also assessed the demographic profile differences in overall MHL in the general population of the five cities in the Caraga Region. An independent sample t-test was carried out to examine if there was any difference in MHL between two groups in sex (male-female), location (urban-rural), and decision maker (Yes-No). The results shown in Table 4 indicated there was a significant difference for *sex (male-female)* in MHL ($t_{(727)}$=-2.81, *p=0.005*). Females have higher mental health literacy (*M*=114.28, *SD*=12.34) than males (*M*=111.80, *SD*=11.97). At the same time, location (urban-rural) ($t_{(727)}$=1.11, *p*=.264) and decision-maker ($t_{(727)}$=-1.38, *p*=.166) are not significantly different in MHL. These findings indicated that males, both urban and rural, and decision-makers or not, were the vulnerable group regarding MHL compared to females.

A one-way ANOVA was carried out to examine if there was any significant difference in MHL among groups (more than two groups) for age, education level, employment, civil status, sector, and family income. The result of one-way ANOVA in Table 5 indicated there was a significant difference in MHL for *age* ($F_{(2,726)}$=7.34, *p<0.001*); for

educational level ($F_{(2,726)}$=31.54, *p*<0.001); for *employment* ($F_{(4,724)}$=11.93, *p*<0.001); for *family income* ($F_{(2,726)}$=31.22, *p*<0.001); for *civil status* ($F_{(2,726)}$=2.81, *p*=.24). These findings indicate that young people, those with lower family income education, and those unemployed are the vulnerable groups regarding MHL. Their level of MHL in knowledge, attitude, help-seeking behavior, and self-strategies are lower than other groups.

Among the socio-demographics, only age, sex, education, employment, and family income have significant group difference.

Building on the findings of many previous studies, our research also investigated the effect of socio-demographic factors (e.g., age, sex, employment, civil status, education, location, decision-maker, and family income) on MHL. We took a rigorous approach, checking for a linear relationship between dependent and independent variables before applying multi-linear regression. The results showed that only sex, education, family income, and employment had a significant linear relationship with MHL at a *p–value* <0.05. These variables were then entered into a multiple linear regression model, allowing us to determine their combined effect on the respondents' MHL.

A multi-linear regression analysis was applied to examine the influence of demographic profiles like sex, educational level, family income, and employment on mental health literacy scores among the young and adult population in the five cities in Caraga. The result in the model summary indicated the regression model was significant [F(4,729)=24.75, p <0.001], and explained approximately 12% of the variance in mental health literacy scores (r^2=0.120, adjusted r^2=.115). The significant F-value in the ANOVA table indicates that the model explains a significant proportion of the total

Table 5. One-way ANOVA for Age, Education, Employment, Civil Status, and Family Income

Variable	Demographic profile	Group	Mean	F value	P-value
MHL	Age group (years)	18-24	111.6	7.34	<0.001***
		25-49	114.8		
		50-65	111.2		
	Educational level	No school – K12 undergraduate	109.7	31.54	<0.001***
		K-12 graduate – college undergraduate	112.8		
		College graduate – post doctorate	117.7		
	Employment	Unemployed	109.0	11.93	<0.001***
		Student	113.2		
		Government employee	116.1		
		Private employee	113.6		
		Self-employed	110.8		
	Civil status	Single	113.2	2.81	0.024
		Married	114.1		
		Widow/Widower	110.1		
		Live-in partner	110.3		
		Separated	117.9		
	Family income (in pesos/month)	<10,957	111.1	31.22	<0.001***
		10,957-21,914	115.6		
		>21,915	120.1		

*** *significant at 0.001*

Table 6. Multiple Linear Regression Analysis to Explore Association between Mental Health Literacy (MHL) and Socio-demographic Factors

Model Summary - Overall Mental Health Literacy

Model	R	R^2	Adjusted R^2	RMSE	R^2 Change	F Change	df1	df2	p
H_0	0.000	0.000	0.000	12.134	0.000		0	728	
H_1	0.347	0.120	0.115	11.412	0.120	24.758	4	724	<0.001

ANOVA

	Model	Sum of Squares	df	Mean Square	F	p
H_1	Regression	12896.345	4	3224.086	24.758	<0.001
	Residual	94283.592	724	130.226		
	Total	107179.937	728			

Note: The intercept model is omitted, as no meaningful information can be shown.

Coefficients

	Model	Unstandardized	Standard Error	Standardized	t	p
H_0	(Intercept)	113.310	0.449		252.140	<0.001
H_1	(Intercept)	98.163	1.937		50.676	<0.001
	Sex	2.636	0.863	0.107	3.054	0.002
	Educational level	2.403	0.582	0.169	4.131	<0.001
	Employment	0.730	0.364	0.072	2.006	0.045
	Family income	2.949	0.645	0.185	4.569	<0.001

variability in the mental health literacy scores [$F(4, 724)=24.7$, $p < 0.001$]. It suggests that sex, education level, employment, and family income jointly predict mental health literacy scores better than chance. Lastly, the Coefficient table indicates that family income level was the strongest predictor for mental health literacy score (B=2.94 β=0.18, t=4.56, p <0.001). At the same time, employment was the weakest predictor (B=0.73 β=0.07, t=2.00, p=0.045). In summary, Table 6 shows respondents' demographic characteristics contribute as much as 11-12% to the overall MHL score. A significant association was found between MHL and factors such as sex, education, family income, and employment. This finding corroborates previous studies, which indicate that socio-demographics can affect mental health literacy.

DISCUSSION

This study assessed mental health literacy among young adults and adults in the five cities of the Caraga Region, Philippines.

The finding indicates that the mental health literacy level of young adults and adults in the five urban cities in Caraga could be classified as sufficient. It means that respondents have enough overall MHL, which covers the causes and symptoms of mental disorders, beliefs/attitudes about mental disorders, health-seeking behavior, and self-strategies.

This finding corroborates with previous studies in the Philippines, which found that Filipino mental health literacy ranges from moderate to high.[20-22]

In addition, the overall mean of MHL in the present study (M=113) was higher than the original MHLq study, which indicates that respondents in the present study have better literacy, especially in the component of belief/attitude toward mental health problem. However, the mean in the present study is still slightly below the minimum threshold (116) of healthy individuals/populations, which is suggested to be 80% of the maximum score.[23] It implies that although the young people and adult in the five cities is moderately good, MHL still has room for improvement, especially in knowledge and belief/attitude toward mental health problems.

Among MHL components, it indicates that literacy on knowledge of mental illness (causes and symptoms) and erroneous beliefs is lower than literacy on help-seeking behavior and self-help strategies. This finding corroborated with Furnham and Swami, who argued the general public has relatively poor recognition of the symptoms of mental health disorders.[24] This can be attributed to specific mental disorders like schizophrenia, which is not a common mental disorder compared to depression or anxiety in the Philippines. The Caraga Region is still one of the Philippines' underdeveloped regions (with a lower Human Development Index). Consequently, it has higher poverty incidence and many residents have lower educational attainment which may contribute to the findings of the present study.

The lower knowledge of mental disorders may pose a risk in early professional help-seeking practices. It is corroborated by the study by Fung et al. that concluded poorly identified subtle mental health symptoms are a major barrier to early professional help in highly educated working males in Hong Kong.[17]

There is also still persist quite strong disbelief about mental illness. This erroneous belief can be attributed to the persistence of stigma-related mental disorders in the community since it is correlated to belief, awareness, and knowledge toward mental illness and treatment intervention. Eventually, this erroneous belief could create stereotyping toward people with mental illness and hamper treatment for people with mental health problems.[25] It corroborated with the study of Bollettino et al. which described stigma-related

mental disorders as the top two barriers to accessing mental health care in the Philippines.[26]

The findings revealed that respondents have a very high literacy in help-seeking behavior and self-strategy. It contradicted the conclusions from Furnham and Swami, who stated that the general public emphasizes self-help over traditional medical treatment.[24] These literacies can guide individuals in maintaining and seeking correct and appropriate treatment for their mental wellness. The finding also indicates that respondents prefer to seek professional help (e.g., psychologist or psychiatrist) rather than a relative or friend if they or their relative have a mental health issue, which means more people are familiar with the role of psychologist or psychiatrist. In addition, respondents have noted that sleeping well is the most well-known strategy for maintaining mental wellness. It corroborated with the survey from Rakuten Insight in May 2022 that about half of the participants in the Philippines bought products for better sleep, like pillows and eye masks, to improve their mental wellness.[27]

The present study also found a significant correlation among MHL sub-components (e.g., knowledge, attitude, self-help strategies, and help-seeking behavior). These findings aligned with previous studies showing how knowledge and attitude affect help-seeking behavior. For instance, individuals with better mental health attitudes were more willing to seek help.[18] In addition, there is a positive correlation between MH knowledge and attitude toward seeking professional help among college students.[28]

Lastly, the present study also confirmed that socio-demographic profiles (e.g., education, employment, sex, and family income) played a role in influencing overall MHL, similar to some earlier studies; for example, family monthly income predicts community attitude toward mental health problems; a significant difference in MH knowledge between males and females, where females are higher than males; and educational level was significantly related to knowledge and attitude toward mental health.[16,18,28] Factors like socio-cultural and access to health services may have influenced the findings in the present study. For example, a stereotype that males are stronger than females could lead males to be hesitant to look for information about mental health and access to health services even when they are mentally unhealthy. Similarly, those with better income, employment, and education can more easily access information and services related to mental health. This present study recognizes that there is quite a big gap in mental health literacy among groups in terms of family income and education. Therefore, addressing unemployment and keeping children in school may contribute to the increase of MHL levels in the general population in the Caraga Region.

Strengths and Limitations

This was the first assessment of mental health literacy in the general population, specifically in the young and

adult population in the Caraga Region which was a major strength of the study. However, the research proponents also acknowledge several limitations. The sample primarily focused on the age range 18-65 years old; thus, the generalizability of findings to age groups is limited. Second, the cross-sectional survey using a paper and pencil questionnaire may impose the risk of self-reporting bias and only offer a snapshot in time or one single observation. Third, in the sampling procedure, the present study applied purposive sampling instead of random sampling to select respondents for the study. It may have impacted the generalization of the results. Last, as common in face-to-face interviews, there is a risk of interviewer bias, though they have received proper training, like an unclear explanation, unintentionally directing respondents to the answer.

CONCLUSION

The Philippine Mental Health Act 2018 has addressed mental health literacy as one measure for tackling those barriers in the community. This study assessed the extent of mental health literacy among young adults and adults in the five cities in Caraga. This is because more information is needed on MHL in the Caraga Region. Four sub-components are covered in mental health literacy, namely knowledge, belief, help-seeking behavior, and self-strategies.

The respondents in the five selected cities in Caraga appeared to have an awareness of mental health literacy. However, they seemed to have difficulty classifying medicalterms of mental disorders like schizophrenia. Respondents also have adequate positive beliefs/attitudes toward mental disorders. It was different from a few decades ago when mental disorders or illnesses were still perceived as a curse or sin/karma.[29-31] Consequently, they are becoming more open of people with mental disorders and accepting of early treatment from professional/licensed health practitioners. However, education or campaigns about mental health remain needed since certain disbelief and stigmas also appear to respondents, such as depression is not a mental illness and only poor people experience mental disorders.

Socio-demographics (educational level, family income level, employment, and sex) also appeared to have a closer association with MHL. This study revealed that respondents, especially females with higher education and family income, tend to have better mental health literacy. The present study suggests that education and income-generating capability hold a key role in improving MHL. Some examples approach that can be adopted in the policy such as Integrate MHL into formal education: The Department of Education (DepEd) should consider embedding age-appropriate mental health literacy content into the K–12 curriculum, focusing on symptom recognition, debunking erroneous belief, and promoting help-seeking behavior. In addition to supporting the MH campaign, the local government units (LGUs) in the five cities in Caraga can enhance mental health promotion by tapping RA 11036 or the Mandanas-Garcia ruling as a basis for allocating funding for awareness campaigns, mobile mental health services, and training barangay health workers on MHL.[32]

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