Introduction

Mental illness stigma slows down the recovery of mentally ill patients. The negative responses to people with mental illnesses represent the main barrier to the development of mental health reduction programs. In this context, it must be noted that mental illness includes depression, schizophrenia, bipolar disorder, addictive behaviors, and other related conditions. Among these forms of mental illness, depression is a prevalent illness that adversely affects the way of feeling, thinking, and acting. The major causes of depression are a decline in the importance of leisurely activities...
and feelings of sadness. It may lead to diverse mood and health problems and/or reduce effectiveness and productivity at home and college.\textsuperscript{18} Anxiety is another mental health disorder. It can be defined as an emotion accompanied by tension, worried thoughts, and physical changes like increased blood pressure.\textsuperscript{18} Bipolar disease is also a mental problem that leads to unusual swings in mood, energy levels, and the ability to perform routine tasks.\textsuperscript{15} Concerning their prevalence, the World Health Organization estimated that the global prevalence of mental health disorders accounts for 25\%.\textsuperscript{18} Globally, increasing attention has been focused on mental illness among adolescents and young people.\textsuperscript{15, 16} Proper knowledge and public perception aid in the recognition of these patients as community members with specific disorders, and thus, requiring special needs. Therefore, it is necessary to assess gaps in public knowledge toward mental illnesses, risk factors, treatments, and basic needs.\textsuperscript{9} Studies show that help-seeking behavior improves the knowledge related to mental health problems.\textsuperscript{10} The health care workers are required to participate in a better knowledge among community members who will encourage their relatives and friends to seek mental health care without stigma.\textsuperscript{10} Family physicians and general Family physicians and general practitioners are the first line in practicing mental health services health services in addition to spreading awareness among the pioneers of primary health care centers.

A series of national and international studies conducted to evaluate the understanding and beliefs about mental illness produced diverse outcomes.\textsuperscript{8, 11-14} Rayan and Fawaz’s survey among the students of Beirut Arab University revealed that psychiatric patients treated with spiritual interventions report lower levels of stigma.\textsuperscript{12} In a study among Qatar university students, the majority of students believed that mental illness is not like any other illness or that it is a punishment from God.\textsuperscript{13}

In a study in Saudi Arabia, a majority of the participants believed that people with a mental health condition are considered insane, and half of them believed that drugs for mental illness would lead to addiction; one-fifth of the participants were found to have a good background about mental disorders.\textsuperscript{14} Another study investigated the different concepts of attitudes toward mental health-seeking behavior among Latino college students and showed that women support further help-seeking attitudes more than men and that people with an experience of seeking psychological treatment endorse further help-seeking attitudes than those without such treatment experience.\textsuperscript{15}

Given this context, there is a need to evaluate the views of the young generation about mental health. Hence, this study aims to assess the knowledge, attitude, practice, and stigma toward mental illness among the Jazan University students, southwest Saudi Arabia.

**Subjects and Methods**

**Study ethics**

The study followed the ethical guidelines of the National Committee of Bioethics, Saudi Arabia. The approval was obtained by the Jazan University Ethical Committee (Ref# REC40/3-086). The online questionnaire was allowed only by declaring consent to participate after reading the study title and objectives. All students were informed of their right to not participate or withdraw from the study at any time. The data collected were used only for the research purpose, and they were kept confidential.

**Study design, setting, and population**

An observational cross-sectional study was conducted among the Jazan University students. Jazan University was established in 2006, and now it includes 18 colleges with over 50,000 students. The university is in the Y region, which is located in southwest Saudi Arabia and is one of the 13 regions of Saudi Arabia. Our target participants comprised the undergraduate students who registered for the academic year 2018–2019.

**Sample procedures**

Sampling frames were prepared in consultation with the admission office, and a detailed number of colleges and students in each college were obtained. Stratified random sampling was adopted to select the target colleges. In the first stage, the university colleges were divided into three groups (Medical, Sciences, and Arts). In the second stage, two colleges were randomly selected from each stratum. In the final stage, proportionate sampling was used to determine the number of students in each selected college. The students who were present in their classes during the time of data collection were included in the study. The estimated sample size was approximately 800 students. The estimation was based on the sample size formula for the cross-sectional study design. This estimation used the following parameters: the prevalence of knowledge about mental illness = 50\% (to provide maximum sample size), 95\% confidence interval, and error, not more than 4\%. The study assumed a non-response rate of 25\%. The response rate was high because the expected time to complete all the questionnaires was very short and because the students were very cooperative and welcoming. Besides that, the study was conducted during the examinations period and the attendance of the students was high, accordingly.

**Data collection method**

Data were collected using a standardized self-administered online questionnaire.\textsuperscript{16} The questionnaire included the participants’ demographic characteristics, their knowledge of the etiology of mental illness, their perceptions of people with mental illness, and their willingness to interact with such individuals to identify any stigmatizing behavior, students’ approaches to treatment for mental illness, and treatment preferences. A panel of experts assessed and discussed the validity and suitability of the instrument for use on students. The instrument was pilot tested among 25 students, and then, assessed using Cronbach's alpha and produced a value of 0.695.

**Measures**

In this study, the level of knowledge refers to the participants’ understanding of mental illness, including its etiology, symptoms,
treatment, management, and risk factors. The knowledge of the students was assessed using a 12-item questionnaire, and those who answered 60% of the questions correctly were considered to have adequate knowledge. For the attitude, we define it as attitude perceptions, opinions, views, susceptibility, and seriousness that the students formulated toward mental illness. We evaluated attitude perceptions using a 12-item questionnaire, and those who scored more and less than 60% were considered to have positive and negative attitudes, respectively.

Statistical analysis
The data were analyzed using the statistical package for social sciences (SPSS) version 20 (SPSS, Chicago, IL, USA). Descriptive and inferential statistics were used to analyze and interpret the data. Descriptive statistics involved frequency distributions, simple tabulation, and bar charts. A five-point Likert scale was summarized using frequency and percentages. We segregated the statements regarding the respondent’s attitudes, that is, we grouped the strongly agree and agree responses under agree and the strongly disagree and disagree under disagree. A Chi-square test was conducted to examine the relationships between both adequate knowledge and positive attitudes and selected characteristics for the study population. We conducted a multivariate logistic regression to evaluate the factors associated with adequate knowledge and positive attitudes toward mental illness. The odds ratios (OR) and their 95% confidence intervals (CI) were also computed. All statistical tests were two-sided, and a $P < 0.05$ was determined to indicate the statistical significance.

Results
The survey comprised 778 university students. The response rate was 97.3% (778 out of 800). The gender and age distribution of the students showed that 392 (50.4%) and 257 (48.7%) students were males and females, respectively. Students in the age group of 18–22 years accounted for more than 50% of the sample. The sample included 437 (59.4%), 192 (26.1%), and 107 (14.5%) students from Arts and Humanities, Sciences, and Health-related colleges, respectively. Table 1 presents the sociodemographic characteristics of the sample. Table 2 depicts the respondents’ views on the etiology of mental illness. Five statements were used to assess the respondent’s views on the etiology of mental illness. About 264 (33.9%) students were not sure if mental illnesses were inherited genetically. However, 322 (41.4%) students strongly agreed or agreed that mental illness is caused by a brain disease, and 505 (64.9%) of the student strongly agreed or agreed that a personal weakness causes mental illness. A sizeable number of 510 (65.5%) agreed that mental illnesses are caused by substance abuse, while 669 (86%) students agreed that an individual suffers from mental illness post-traumatic events.

Figure 1 illustrates the participants’ perceptions about people with mental illness. One-third of the participants, 256 (32.9%), agreed that they can now identify mentally ill people by their appearance. While 38.8% agreed that mentally ill people can be dangerous, 212 (27.3%) disagreed. The majority of the participants agreed that mentally ill people can work, 511 (65.7%) and that anyone can suffer from a mental illness 594 (63.7%). Table 3 presents the knowledge level and attitude toward mental illness, according to selected characteristics. Using the total knowledge score, we classified the participants as having appropriate knowledge or not and having positive or negative attitudes toward mental illness and ill persons. The table showed that the appropriate knowledge level on mental illness was 44.1%, and almost half of the respondents had a positive attitude (52.2%) toward mental illness. The female students (55.9%) exhibited a significantly higher positive attitude than the males (48.4%) ($P = 0.038$). The students’ level of knowledge significantly increased with an increase in their academic year ($P = 0.010$) and age ($P = 0.014$). The students from urban places showed a higher level of knowledge (50.5%) than those from the rural areas (40.5%) ($P = 0.007$). Students from health-related colleges (59.7%) showed higher positive attitudes, but without statistical significance ($P = 0.104$) than those from colleges. Table 4 presents the students’ attitudes toward people with mental illness and their treatment. The first 12 statements were used to assess the attitude toward mental illness, generally. A total of 618 (89.4%) students expressed the highest disagreement for “I would be ashamed if people knew

| Variable               | Frequency | %     |
|------------------------|-----------|-------|
| Age Group              |           |       |
| Under 18               | 8         | 1.0   |
| 18-22                  | 465       | 59.8  |
| 23+                    | 305       | 39.2  |
| Gender                 |           |       |
| Male                   | 386       | 49.6  |
| Female                 | 392       | 50.4  |
| Colleges               |           |       |
| Arts and Humanities    | 437       | 59.4  |
| Sciences               | 192       | 26.1  |
| Health-related         | 107       | 14.5  |
| Marital Status         |           |       |
| Single                 | 645       | 82.9  |
| Married                | 120       | 15.4  |
| Divorced/Widowed       | 13        | 1.7   |
| Academic Year          |           |       |
| First                  | 152       | 19.5  |
| Second                 | 97        | 12.5  |
| Third                  | 124       | 15.9  |
| Fourth                 | 173       | 22.2  |
| Fifth                  | 84        | 10.8  |
| Sixth                  | 148       | 19.0  |
| Residence              |           |       |
| Rural                  | 499       | 64.1  |
| Urban                  | 279       | 35.9  |
| Monthly Income (Saudi Riyal) |   |       |
| <5000                  | 212       | 27.2  |
| 5000-99999             | 264       | 33.9  |
| 10000-19999            | 207       | 26.6  |
| +20000                 | 95        | 12.2  |
| Total                  | 778       | 100   |
In this context, our study tried to assess knowledge, attitudes, and stigma toward mental illness. Generally, this is in the same line with the findings of similar populations in terms of the slightly high positive attitudes toward mental illness. Generally, this is in the same line with the findings of similar populations in terms of the slightly high positive attitudes toward mental illness.

Recent research suggested a strong association between mental disorders, disability, and early death. In this regard, it is well-documented that increased mental illness awareness can promote help-seeking behavior and reduce mental health disorders. In this context, our study tried to assess knowledge, attitude, practice, and stigma toward mental illness among Jazan University’s students.

The findings show that 44.0% of the study participants possessed adequate knowledge of mental illness. It must be noted that it is difficult to compare the findings of mental illness literacy studies owing to the differences in methods and measurement tools. When we compare our findings (44.0%) with the related studies, we find similarities with the outcomes of the studies conducted in the Kingdom of Saudi Arabia (KSA), the Middle East, Ethiopia, and India.

Our participants did not differ from the majority of other similar populations in terms of the slightly high positive attitudes toward mental illness. Generally, this is in the same line with the studies conducted in KSA, Qatar, Ethiopia, and Nigeria. However, the difference is evident in the role of gender in mental literacy, given that females are associated with a higher mental health literacy level. A series of international studies documented that women have a better ability to recognize mental health disorders. Conversely, other groups did not report significant differences.

Regarding the mental illness etiology, most of our participants attributed mental illness to substance abuse, personal weakness, and traumatic events in the past. However, they also stated brain disease as an important determinant of mental illness; this was inconsistent with a study conducted in India. Our study revealed that the students’ level of knowledge significantly increased with an increase in the academic year, and participants in the fifth and sixth years scored higher than students in their first, second, or third years. This finding is consistent with recent studies conducted in KSA.

**Discussion**

The WHO estimated that around 20% of the children and adolescence were reported to suffer from mental problems.[17]
Table 3: Knowledge level and attitude based on selected characteristics

| Variables          | Knowledge Level | Attitude | P   |                |                | P   |
|--------------------|----------------|----------|-----|----------------|----------------|-----|
|                    | Inadequate     | Adequate |     | Negative attitude | Positive attitude |     |
| Gender             | Male           | 222 (57.5) | 164 (42.5) | 0.372 | 199 (51.6) | 187 (48.4) | 0.038 |
|                    | Female         | 213 (54.3) | 179 (45.7) |       | 173 (44.1) | 219 (55.9) |       |
| Age (years)        |                |          |     |                |                |     |
| <18                | 7 (87.5)       | 1 (12.5)   | 0.014 | 4 (50.0)       | 4 (50.0)       | 0.475 |
| 18-22              | 274 (58.9)     | 191 (41.1) |       | 214 (46.0)     | 251 (54.0)     |       |
| 23 and more        | 154 (50.5)     | 151 (49.5) |       | 154 (50.5)     | 151 (49.5)     |       |
| Colleges           |                |          |     |                |                |     |
| Science Colleges   | 106 (55.2)     | 86 (44.8)  | 0.875 | 92 (47.9)      | 100 (52.1)     | 0.104 |
| Health related     | 81 (54.4)      | 68 (45.6)  | 0.020 | 60 (40.3)      | 89 (59.7)      | 0.205 |
| Arts and Humanities| 248 (56.8)     | 189 (43.2) |       | 220 (50.3)     | 217 (49.7)     |       |
| Academic years     |                |          |     |                |                |     |
| First              | 101 (66.4)     | 51 (33.6)  | 0.010 | 74 (48.7)      | 78 (51.3)      | 0.733 |
| Second             | 62 (63.9)      | 35 (36.1)  |       | 44 (45.4)      | 53 (54.6)      |       |
| Third              | 67 (54.0)      | 57 (46.0)  |       | 53 (42.7)      | 71 (57.3)      |       |
| Fourth             | 92 (53.2)      | 81 (46.8)  |       | 82 (47.4)      | 91 (52.6)      |       |
| Fifth              | 42 (50.0)      | 42 (50.0)  |       | 42 (50.0)      | 42 (50.0)      |       |
| Sixth              | 71 (48.0)      | 77 (52.0)  |       | 77 (52.0)      | 71 (48.0)      |       |
| Mode of Living     |                |          |     |                |                |     |
| Rural              | 297 (59.5)     | 202 (40.5) | 0.007 | 245 (49.1%)    | 254 (50.9%)    | 0.383 |
| Urban              | 138 (49.5)     | 141 (50.5) |       | 127 (45.5%)    | 152 (54.5%)    |       |
| All Student        | 435 (55.9)     | 343 (44.1) |       | 372 (47.8%)    | 406 (52.2%)    |       |

Table 4: Attitude toward people with mental illness and their treatment

| Statement                                                                 | Agree n (%) | Neutral n (%) | Disagree n (%) |
|---------------------------------------------------------------------------|-------------|---------------|----------------|
| The mentally ill should be prevented from having children.                | 98 (12.6)   | 164 (21.1)    | 516 (66.3)     |
| The mentally ill should not get married.                                  | 95 (12.2)   | 182 (23.4)    | 501 (64.3)     |
| One should avoid all contact with the mentally ill.                       | 31 (4)      | 82 (10.5)     | 665 (85.5)     |
| The mentally ill should not be allowed to make decisions, even those concerning routine events. | 110 (14.2)  | 192 (24.7)    | 476 (61.2)     |
| I could maintain a friendship with someone with a mental illness.         | 603 (77.5)  | 130 (16.7)    | 45 (5.8)       |
| I could marry someone with a mental illness.                             | 229 (29.4)  | 266 (34.2)    | 283 (36.4)     |
| I would be afraid to have a conversation with a mentally ill person.     | 151 (19.4)  | 249 (32)      | 378 (48.6)     |
| People with mental health illnesses should have the same rights as anyone else. | 562 (82.8)  | 135 (17.4)    | 81 (10.4)      |
| I would be upset or disturbed about working on the same job along with a mentally ill person. | 82 (10.5)   | 197 (25.3)    | 499 (64.1)     |
| I would be ashamed if people knew that someone in my family has been diagnosed with a mental illness. | 71 (9.1)    | 89 (11.4)     | 618 (89.4)     |
| If I was suffering from a mental health illness, I would not want people to know about it. | 399 (51.2)  | 179 (23)      | 200 (25.7)     |
| I can be generally caring and sympathetic toward people with mental illness. | 479 (61.5)  | 174 (22.4)    | 125 (16.1)     |
| I am concerned that the information I share with a psychotherapist (counselor) will not remain private. | 311 (40)    | 187 (24)      | 280 (36)       |
| I would feel embarrassed or ashamed to see a psychotherapist (counselor). | 132 (17)    | 151 (19.4)    | 495 (63.6)     |
| I am afraid of what people would think of me if I went to a psychotherapist (counselor). | 223 (28.6)  | 141 (18.1)    | 414 (53.2)     |
| Mentally ill individuals should socially distance themselves from their family. | 55 (7)      | 79 (10.2)     | 644 (82.8)     |
| Mental health services available in my community                           | 361 (46.4)  | 165 (21.2)    | 252 (32.4)     |
| Mental illness cannot be cured.                                           | 37 (4.8)    | 109 (14)      | 632 (81.2)     |
| Mentally ill people should be in an institution where they are under supervision and control | 187 (24)    | 184 (23.7)    | 407 (52.4)     |
| Mental illness can be treated outside a hospital.                          | 542 (69.6)  | 159 (20.4)    | 77 (9.9)       |
| Information about mental illness is available at my public health center (PHC). | 174 (22.3)  | 232 (29.8)    | 372 (47.9)     |
| The majority of people with mental illnesses recover.                      | 484 (62.2)  | 237 (30.5)    | 57 (7.3)       |
| Primary health care clinics can provide good care for mental illnesses.    | 147 (18.9)  | 275 (35.3)    | 356 (45.8)     |
| If I was concerned about a mental health issue, I would feel comfortable discussing it with someone at my PHC. | 382 (49.1)  | 202 (26)      | 194 (25)       |
| I would not tell my physician if I was feeling down or depressed.         | 83 (10.7)   | 132 (17)      | 563 (72.4)     |
| It would be difficult to get transportation for weekly appointments.       | 291 (37.4)  | 259 (33.3)    | 228 (29.3)     |
| Psychotherapy (counseling) is too expensive.                              | 329 (42.3)  | 291 (37.4)    | 158 (20.3)     |
an increase in age or experience contributes toward an increase in knowledge.

Regarding the attitudes toward people with mental illness, most participants reported that they could maintain friendships with a person with mental illness. This is consistent with Ibrahim et al.[30] who found that most participants in Jeddah, KSA, are willing to continue a relationship with a friend who developed a mental health problem. In our study, the positive attitudes of the participants toward mentally ill patients were also clarified by their responses that mentally ill persons should have the same rights as anyone else and that they are not dangerous. Moreover, a large proportion suggested that mentally ill persons can perform a job and that anyone can have a mental illness; this is in the line with the results of a similar study conducted in Iraq.[16] A majority of the students did not express a problem in working on a job with a mentally ill person similar to a study in Qatar.[13] However, a significant proportion of students reported negative attitudes, such as mentally ill persons should not get married and should be prevented from having children; these responses are the same as in the findings on studies conducted in India.

The health care systems must play their role through best practices to provide the beneficiaries mental health services, spread awareness, and build an integrated health system.[10] This must start with the primary health care centers. Family physicians should work with behavioral and mental health professionals whenever possible to ensure the best care for their patients. Family physicians and general practitioners should educate themselves and stay up-to-date on mental health practices. Family physicians should participate in eliminating the stigma that accompanies poor mental health and support health policies that improve access to mental health services.[32] Although our research might provide updated information on mental illness literacy at the level of undergraduate students in KSA, some limitations should be reported. First, the study is an observational cross-sectional survey, and hence, the associations revealed by this study should be interpreted with caution. Second, the study was conducted among the students of only one university, which decreases the generalization of the results to other regions or populations.

**Conclusion**

Although students showed a favorable attitude towards mental illness, their knowledge level can be improved. Hence, the research outcomes can be utilized by their families, relatives, and friends by advising them to seek mental care with less stigma in the early stages of the diseases. The health centers must play a more significant role in providing mental care services and spreading awareness about them, and also, to design health educational interventions to enhance university students’ participation in decreasing mental stigma in the community. Our new addition is that good knowledge of mental disease causes and treatment is a cornerstone for alleviating the stigma and seeking support and mental care.

**Ethical considerations**

The ethical approval for the current study was obtained from the Ethical committee of Jazan University (Ref# REC40/3-086), Jazan University.

**Acknowledgments**

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![Table 5: Factors associated with adequate knowledge and positive attitudes toward mental illness](image-url)
Department at Jazan University for their general assistance in conducting this study.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient (s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

References
1. Stuart H. Reducing the stigma of mental illness. Glob Ment Health (Camb) 2016;3:e17-e. doi: 10.1017/gmh.2016.11.
2. Health NIoM. Mental health information: Bipolar disorder. National Institutes of Health, 2020.
3. Vahia VN. Diagnostic and statistical manual of mental disorders 5: A quick glance. Indian J Psychiatry 2013;55:220-3.
4. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: Evidence for action. Lancet 2011;378:1515-25.
5. Mansfield R, Patalay P, Humphrey N. A systematic literature review of existing conceptualisation and measurement of mental health literacy in adolescent research: Current challenges and inconsistencies. BMC Public Health 2020;20:6067.
6. Hunt J, Eisenberg D. Mental health problems and help-seeking behavior among college students. J Adolesc Health 2010;46:3-10.
7. Pedrelli P, Nyer M, Yeung A, Zulafa C, Wilens T. College Students: Mental health problems and treatment considerations. Acad Psychiatry 2015;39:503-11.
8. Griffiths KM, Christensen H, Jorm AF. Mental health literacy as a function of remoteness of residence: An Australian national study. BMC Public Health 2009;9:92.
9. Abolfotouh MA, Almutairi AF, Almutairi Z, Salam M, Alhashem A, Adlan AA, et al. Attitudes toward mental illness, mentally ill persons, and help-seeking among the Saudi public and sociodemographic correlates. Psychol Res Behav Manag 2019;12:45-54.
10. Sanghvi PB, Mehrrota S. Help-seeking for mental health concerns: A review of Indian research and emergent insights. Journal of Health Research. Available from: https://doi.org/10.1108/JHR-02-2020-0040. 2021
11. Kamimura A, Trinh HN, Johansen M, Hurley J, Pye M, Sin K, et al. Perceptions of mental health and mental health services among college students in Vietnam and the United States. Asian J Psychiatr 2018;37:15-9.
12. Rayan A, Fawaz M. Cultural misconceptions and public stigma against mental illness among Lebanese university students. Perspect Psychiatr Care 2018;54:258-65.
13. Zolezzi M, Bensmail N, Zahrah F, Khaled SM, El-Gaili T. Stigma associated with mental illness: Perspectives of university students in Qatar. Neupropsychiatr Dis Treat 2017;13:1221-33.
14. Jelaidan M, AbuAlkhair L, Thani T, Susi A, Shuqdar R. General background and attitude of the Saudi population towards mental illness. Egypt J Hosp Med 2018;71:2422-8.
15. Mendoza H, Masuda A, Swartout KM. Mental health stigma and self-concealment as predictors of help-seeking attitudes among Latina/o college students in the United States. Int J Adv Couns 2015;37:207-22.
16. Sadik S, Bradley M, Al-Hasoon S, Jenkins R. Public perception of mental health in Iraq. Int J Ment Health Syst 2010;4:26.
17. WHO. Adolescent mental health. WHO website: 2021. Available from: https://www.who.int/news-room/factsheets/detail/adolescent-mental-health
18. Kelly CM, Jorm AF, Wright A. Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. Med J Aust 2007;187(S7):S26-30.
19. Wright A, Jorm AF, Harris MG, McGorry PD. What's in a name? Is accurate recognition and labelling of mental disorders by young people associated with better help-seeking and treatment preferences? Soc Psychiatry Psychiatr Epidemiol 2007;42:244-50.
20. Mahfouz MS, Aqeeli A, Makeen AM, Hakami RM, Najmi HH, Mobarki AT, et al. Mental health literacy among undergraduate students of a Saudi Tertiary Institution: A Cross-sectional study. Ment Illn 2016;8:6806.
21. Mariam MG, Bedaso A, Ayano G, Ebrahim J, Knowledge, Attitude and Factors Associated with Mental Illness among Nurses Working in Public Hospitals, Addis Ababa, Ethiopia. J Ment Disord Treat 2016;2:108.
22. Arundev U, Gupta S, Sharma K, Chadda RK. Mental health literacy among university students from University of Delhi. Indian J Psychiatric Nurs 2017;13:1-7.
23. Bose R, Sivaparaksh B, Sarkar S, Backer A, Eswaran S. An observational study to assess mental health literacy among undergraduate students from Tamil Nadu. Arch Med Health Sci 2020;8:230-5.
24. Gureje O, Abdulmalik J, Kola L, Musa E, Yasamy MT, Adebayo K. Integrating mental health into primary care in Nigeria: Report of a demonstration project using the mental health gap action programme intervention guide. BMC Health Serv Res 2015;15:242.
25. Kristina SA, Mardea NA, Ramadhani F, Aliyah H. Mental health literacy among university students in Yogyakarta. Mental Health 2020;25:2243-9.
26. Reavley NJ, McCann TV, Jorm AF. Mental health literacy in higher education students. Early Interv Psychiatry 2012;6:45-52.
27. Ashley S, Catherine C, Bayyavarapu BS, Shannon W, Xibiao Y, Colleen M, et al. The acceptability of E-mental health services for children, adolescents, and young adults: A systematic search and review. Can J Commun Ment Health 2015;34:1-21.
28. Poredi V, R BI, Thimmaiah R, Math SB. Mental health literacy among caregivers of persons with mental illness: A descriptive survey. J Neurosci Rural Pract 2015;6:355-60.
29. Miles R, Rabin L, Krishnan A, Grandoit E, Kloskowski K.
Mental health literacy in a diverse sample of undergraduate students: Demographic, psychological, and academic correlates. BMC Public Health 2020;20:1699.

30. Ibrahim N, Abaalkhail B, Al-Ahmadi J. Public stigma, knowledge and behaviors of the attendees of outpatient clinics towards people. J Pharm Res Int 2020;32:16-27.

31. Xierali IM, Tong ST, Petterson SM, Puffer JC, Phillips RL, Bazemore AW. Family physicians are essential for mental health care delivery. J Am Board Fam Med 2013;26:114-5.

32. Miller BF, Druss B. The role of family physicians in mental health care delivery in the United States: Implications for health reform. J Am Board Fam Med 2013;26:111-3.