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Mental Health Literacy: Past, Present, and Future

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The Evolution of Health Literacy as a Guidepost for Mental Health Literacy Development

Mental health literacy (MHL) is a construct that has arisen from the domain of health literacy (HL) and must be understood in that context. The development of HL was initially informed by observations that low functional literacy was associated with numerous poor health outcomes.[1,2] In its early definition, HL was considered primarily within the health care environment, focusing on the ability of people to be able to understand and make effective use of medical information, particularly to better understand and better adhere to medication treatments. For example, the American Medical Association defined HL as the "ability to read and comprehend prescription bottles, appointment slips and other essential health-related materials required to successfully function as a patient."[3] In 1998, the World Health Organization (WHO) expanded the definition of HL to include "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health."[4] The Canadian Public Health Association has used these historical developments to inform their own and more expanded HL definition, noting that HL is "the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course."[5]

More recently, understanding of HL has evolved into a broader construct that is considered fundamental to improving a person's health outcome, decreasing health inequities in populations, and enhancing the operation of health systems and the development of health policy.[6,7] Thus it is now recognized as necessary to improve health outcomes at both the individual and population levels.[4,6,8,9] For example, Kanj and Mitic[4] proposed a tiered HL model comprising functional HL (generic skills applied by people within health care environments), conceptual HL (generic skills applied in social contexts), and HL as empowerment for people in social and political contexts. The Wagner Chronic Care Model, and other current approaches to chronic illnesses require the enhancement of HL as a core competency for people receiving health care to enhance the likelihood of provision and receipt of effective and collaborative health care.[10,11] In this context, HL has evolved from a risk factor for poor health outcomes as a result of inadequate treatment adherence to an asset that can be enhanced through educational strategies.[12]

Recent research continues to demonstrate that poor HL is related to numerous negative health and social outcomes, including but not limited to: increased rates of chronic illness; decreased use of health services; increased health care costs; and early mortality.[13,14] The WHO has identified that HL is perhaps the most important component of the social determinants of health, noting that it is "a stronger predictor of an individual's health status than income, employment status, education and racial or ethnic group."[6, p 7]

Currently, HL is understood to include the following components: the competencies needed by people to help obtain and maintain health and identify illness; understanding how and where to access and how to evaluate health information and health care; understanding how to properly apply prescribed treatments; and, obtaining and applying skills related to social capital, such as understanding rights related to health and health care and understanding how to advocate for health improvements.[4,6] Further, HL is understood necessarily to be developmentally appropriate; contextually applied; involving multiple related stakeholders; and, available through existing institutional and

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social vehicles, such as schools, the workplace, and mass media.[4,6,12]

The Evolution and Ongoing Development of Mental Health Literacy

The construct of MHL, arising from HL, is also evolving. Originally MHL was conceptualized as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" [15, p 182] Jorm et al[16] later refined the definition to include knowledge that benefits the mental health of a person or others including: knowledge of how to prevent a mental disorder; recognition of disorders when developing; knowledge of effective self-help strategies for mild-to-moderate problems; and first aid skills to help others. In Canada, the Canadian Alliance on Mental Illness and Mental Health highlighted the health promotion aspects of MHL as "the range of cognitive and social skills and capacities that support mental health promotion,"[17, p 36] and later made suggestions for policy considerations they considered to be useful in addressing MHL.[18] More recently, informed by previous definitions of MHL and current definitions of HL, MHL has been defined as: understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities).[19,20]

This definition of MHL is an extension of previous constructs,[15-19] is consistent with the evolving construct of HL,[4-16] includes the concept of stigma which has historically often been separately considered,[21-24] and extends Jorm's concept of self-help strategies[16] to the wider construct of help-seeking efficacy. This evolving definition is based on considerable earlier refinements of our understanding of MHL[25] and both a robust literature that well describes the interrelationship between mental health knowledge and various types of stigma,[26-31] as well as recent stigma theory constructs,[32] where the lack of knowledge is considered to be a driver of prejudice (negative attitudes) that then influences behaviours (discrimination).

Further, similarly to HL, it is important that MHL be context specific (for example, developed and applied in everyday life situations), developmentally appropriate (for example, tailored in its application across the lifespan), and effectively integrated into existing social and organizational structures, such as schools and community organizations.[19,20,33,34] Within this context, it may be important to conduct research to compare stand alone mental health information sessions, such as single events designed to raise mental health awareness and mental health information sessions provided outside of everyday contexts, with programs sustained and embedded in the community, such as MHL in school curriculum. Further, when applied, MHL interventions ideally could be appropriately evaluated and demonstrated to improve all components of the construct: mental health knowledge, attitudes or stigma, and help-seeking efficacies.[19,20]

Challenges Pertaining to Mental Health Literacy Intervention Outcomes

Understanding how to appropriately determine impact on MHL has been an ongoing challenge with the implementation of MHL interventions. However, to date, most evaluations of MHL interventions found in the literature have not simultaneously addressed all of the components of MHL, which we argue can be measured concurrently, as these components are so closely connected within the defined rubric of MHL.[19,20] It remains unclear which types of interventions currently being applied may be expected to most comprehensively improve MHL, rather than just address a limited number of components of MHL. Further research should be designed to help answer that question.

Other concerns focus on MHL measurement tools themselves. One of the authors recently searched and reviewed the literature, identifying over 400 MHL research studies (including those that focused on knowledge, attitudes, and help-seeking respectively) and identified that most did not use assessment tools of adequate psychometric properties. This makes it difficult to determine the validity of the results reported. Additionally, many of the measurement tools currently being used to evaluate MHL may not sufficiently capture all the components of MHL. In particular, those studies that have used the diagnostic vignette approach popularized by Jorm et al where participants are provided brief vignettes about people with depression or schizophrenia (sometimes also including attention-deficit hyperactivity disorder or anxiety disorder) and are asked to identify the disorder and answer questions about its etiology or treatment (for a recent Canadian example see Marcus and Westra[35]). Clearly the entire domain of what constitutes MHL cannot be evaluated by this method which focuses on a small number of disorders, does not consider mental health promotion, and neglects the importance of being able to distinguish a mental disorder from a mental health problem or even the experience of daily distress.[36] The widespread application of these diagnostic vignettes as research outcome tools does not provide evidence that those interventions can be considered to have actually improved MHL. Research using other evaluation techniques such as true or false answers to questions covering multiple domains of MHL are less prevalent, but may provide a more robust evaluation of the entire MHL construct. However, further research is required to clarify this important issue.

Other concerns include, but are not limited to: sample characteristics of most studies (frequently conducted with university students, with relatively less research in younger populations and significantly less research in educators, immigrants, seniors, and other well defined groups); application of the same intervention to different unique groups

without demonstrated content or cultural adaptation of the intervention; concerns about transparency regarding the endorsement, marketing, and evaluations of various MHL interventions;[37,38] and, paucity of evidence-based and developmentally appropriate MHL resources (for example, MHL for primary school students and MHL for post-secondary school students).

Future Directions

The importance of MHL in helping to improve health outcomes for people and populations has been recognized, and some positive initial interventions directed at this goal have been applied.[16,19,26] Given the situation as it currently stands, numerous future directions for the further development and deployment of MHL should be considered. MHL constructs should be better informed by developments in HL and should not stand alone apart from HL. Increased participation of key Canadian MHL thought leaders in national HL activities should be a priority for the development of MHL in Canada. For example, no MHL interventions were described in a recent publication of Canadian HL examples,[39] suggesting that MHL is not well integrated into national HL activities. Perhaps an appropriate role for the Canadian Psychiatric Association to play in this regard would be to develop a section on MHL within the organization that could effectively link with the Canadian Public Health Association to better address this issue.

MHL interventions need to be contextually developed and applied. That is, although the core components of MHL interventions need to be considered in all situations, how these are developed and applied must fit the context in which they are to be deployed. It may not be reasonable to argue that MHL interventions are a one-size-fits-all shoe. For example, MHL interventions for teachers cannot be the same as MHL interventions for police officers, although they should reflect the same core MHL principles (knowledge, attitudes or stigma, and help-seeking efficacies).

MHL interventions need to be developmentally appropriate and applied within the most suitable development context. For example, MHL interventions addressing adolescents should not only frame MHL constructs in appropriate lifespan domains but should be delivered within educational settings (such as schools) using intervention strategies that are known to enhance literacy competencies, are pedagogically familiar to educators and students alike, and that use modern electronic delivery platforms.[19] In this context, MHL delivery methods could also be designed to concurrently impact MHL needs of teachers and students within a common curriculum framework.[19,20,34]

MHL interventions must apply robust, contextually appropriate, developmentally informed, valid and reliable psychometrics in measurement so that their evaluation can be properly determined. For example, while the diagnostic vignette evaluation approach may have been useful in the early stages of MHL conceptualization, its continued application to the evolving definition of MHL is now, in our opinion, not sufficient. Alternative measures are available but these require further evaluation and validation to determine if they adequately and appropriately capture current understanding of MHL.[33] Perhaps the Public Health Agency of Canada could consider supporting the development of context informed and developmentally appropriate valid MHL measures as part of their Innovation Strategy.

A corollary arising from the evolution of the MHL construct is that interventions primarily addressed at decreasing stigma should be compared in appropriately designed trials to wider MHL interventions in which stigma is addressed as part of a comprehensive MHL approach.

MHL intervention research should not be published, reviewed, or marketed without clear and transparent notice of conflict of interest and acknowledgement of endorsements that may be biased by revenue considerations. For example, materials that are published or distributed by people or organizations that may serve to benefit from their sale should clearly identify a potential conflict of interest. This is not a problem unique to the marketing of MHL interventions. In the absence of a national regulatory framework for non-pharmacological health interventions, such conflict of interest challenges frequently arise. Perhaps a broader health intervention regulatory framework could be developed and applied by Health Canada to address this issue.

Conclusions

MHL is an evolving construct, increasingly informed by a developing and more comprehensive approach to HL. Enhanced understanding of MHL and the development of contextually and developmentally appropriate interventions, which are independently evaluated using validated measurements, may be expected to help achieve improvements in both individual and population mental health outcomes in the future.

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