HEALTH LITERACY, IMMIGRANTS AND MENTAL HEALTH[1]

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ABSTRACT

This article defines health literacy and its implications for immigrants in Canada. Existing evidence about health literacy, health outcomes, language proficiency, gender and social and cultural barriers that affect immigrants' health literacy is noted. Mental health literacy, stigma and culture are discussed. The article concludes with suggested health literacy interventions.

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Good mental and physical health, defined simply as feeling good and functioning well in daily life, is a key outcome of successful immigrant settlement and integration. Newcomers to Canada must obtain new information about health issues and services while experiencing resettlement stress and often new health needs. "Health literacy" describes the ability to obtain, process, understand *and use* health information to make appropriate decisions about health (Ad Hoc Committee 1999). There are many definitions of health literacy, but the most clear and comprehensive definition includes the ability to seek information, learn, appraise, make decisions, communicate information, prevent diseases and promote individual, family and community health (Rootman, Frankish, and Kaszap 2007). Current definitions of health literacy encompass a critical understanding of health issues and knowledge of how to use the health care system (Nutbeam 2000), and emphasize the responsibility of health and educational institutions to smooth the two-way communication process and help people obtain needed health care (Nielsen-Bohlman, Panzer and Kindig 2004). According to the Canadian Public Health Association, attention should be paid to health literacy among immigrants because these are areas in which immigrants are especially disadvantaged (Rootman and Gordon-El-Bihbety 2008).

International literacy surveys, such as the *International Adult Literacy and Skills Survey* (IALSS), have assessed individual and collective health literacy skills in the areas of health promotion, health protection, disease prevention, healthcare maintenance and system navigation (Canadian Council on Learning 2007, 2008). Three basic levels of health literacy skills have been identified: the first, involving reading and numeracy, the second, interactive skills, i.e., knowing how to converse with a busy health professional about symptoms and concerns and a third, *critical* health literacy, describing the ability to analyze and use health information to exert greater control over life situations. From this perspective, health literacy is seen as a right and an issue of equity and citizenship (Nutbeam 2000; Kickbusch, Wait and Maag 2005).

The basic idea behind health literacy appears straightforward: the greater a person's ability to learn about health, the better that person's health. But health literacy is not just a personal ability or a one-way process that depends upon the individual's linguistic proficiency or comprehension of written information such as a doctor's prescription. Rather, it is a complex, multidimensional communication process that also involves health-care providers' competencies, the "legibility" of the health care system for diverse groups and appropriate

policy and programs to achieve effective communication (Kickbusch et al. 2005). Health literacy is a complex interaction that goes beyond reading; it is affected by education, culture, and language (Nielsen-Bohlman et al. 2004). Immigrants arrive in Canada having had different health and health care experiences and knowledge of health issues in their homelands. The resettlement experience involves cultural adaptation, which produces new health challenges as well as new opportunities for knowledge exchange about health in family life, schools, neighbourhoods and the workplace. Enhancing health literacy therefore applies not only to medical settings, but also to a variety of settings across one's life span and throughout settlement and integration.

HEALTH LITERACY AND IMMIGRANTS IN CANADA

Results of the IALSS, which surveyed 23,0000 Canadians, showed that 60% of adults in Canada lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions (Canadian Council on Learning 2007). Health literacy is a strong predictor of overall health status and self-reported health status is, in turn, a reliable indicator of health outcomes. Canadians with the lowest health literacy scores are 2.5 times as likely to perceive themselves as being in fair or poor health compared to those with higher health literacy scores. This statistical relationship holds even after removing the impact of age, gender, education, mother tongue, immigration and Aboriginal status (Canadian Council on Learning 2008).

There is cause for concern because low health literacy may have a long-term impact on population health. Those individuals with lower literacy skill levels are 1.5 to 3 times more likely to experience negative health outcomes and difficulties managing chronic diseases, although it is difficult to disentangle the effects of poor literacy and poor access to health care (DeWalt, Berkman, Sheridan, Lohr and Pignone 2004). Other outcomes of low literacy and health literacy include lower income and less community engagement--outcomes that are also associated with poorer health and quality of life. These outcomes may affect disproportionately recent immigrants who are not well established. Recent immigrants, those with lower levels of education and with low French or English proficiency, seniors and people receiving social assistance tend to have lower levels of literacy and health literacy (Rootman and Gordon-El-Bihbety 2008, 21).

Barriers to health literacy, such as lack of meaningful multilingual information about health issues, knowledge of where to find the right health care or how to access preventive services contribute to the deterioration in health status of immigrants in Canada over time (Zanchetta and Poureslami 2006). While existing evidence demonstrates that immigrants experience many linguistic and cultural barriers in accessing health care in Canada (Bowen 2001; Gagnon 2002), we still do not know enough about how social and cultural barriers actually affect health literacy or health outcomes. Although more research is needed, there is sufficient evidence to suggest practical ways to enhance immigrants' health literacy skills, including using clear and multiple forms of communication, community-based development and delivery methods and increasing cultural competence in providers of health and social services.

LANGUAGE PROFICIENCY, GENDER AND HEALTH LITERACY

Despite the high educational levels of many immigrants and refugees, it is not surprising that health literacy levels are low in the early years of settlement. As the 2003 IALSS results show, about 60% of immigrants fell below Level 3 in prose literacy (considered the minimum level for coping with the demands of everyday life and work in a knowledge economy) compared to 37% for the Canadian-born population (Canadian Public health Association 2006, 27). The IALSS estimated that 32% of foreign-born women have extreme difficulty with, and only limited use of printed materials compared to 24% of foreign-born men and approximately 10% of Canadian-born women and men (Rootman and Gordon-El-Bihbety 2008,17). Immigrant women's lower levels of health literacy can have a wide impact on information exchange about health and help-seeking for immigrant communities because women often play a central care giving role in families and other social networks. Longitudinal research with Southeast Asian immigrants in Canada identified English fluency as a significant determinant of both depression and employment, particularly for immigrant women (Beiser and Hou 2001), and found that when women participate in formal language training they benefit more than men.

Analysis of the Longitudinal Survey of Immigrants to Canada (LSIC) has shown that self-reported poor health was significantly related to lack of improvement in language proficiency over time for both immigrant men and women (Pottie, Ng, Spitzer, Mohammed and Glazier 2008). This finding has implications for increasing the availability of language training as well as improving health care for immigrants. A lack of affordable English or French as a Subsequent Language (ESL or EFL) programs for adults is a barrier for newcomers to Canada who wish to improve their literacy and health literacy skills, which in turn promote social integration and wellbeing. Without basic literacy skills, new immigrants have difficulty becoming health literate enough to

manage health-relevant information within the context of the Canadian health system (Rootman and Gordon-El-Bihbety 2008, 26).

STRUCTURAL AND CULTURAL BARRIERS TO HEALTH LITERACY

Common sense suggests that providing written information alone is not enough to ensure good health. The social and cultural context in which information is exchanged, ways of communicating and the timing of health information also matter. Information about employment, housing and other immediate needs are often priorities in the early years in Canada; however, information about health is one of the top needs of longer established immigrants (Caidi 2007). Immigrants report more barriers to health care than non-immigrants and perceive that existing health services and information are not sensitive to the cultural, faith, language or literacy needs of diverse communities. Barriers identified by immigrants include fear of speaking English; suspicion of authority; isolation and sense of being an outsider; reliance on children (who may have inadequate experience and language proficiency themselves) to find accurate information; lack of familiarity with Canadian information sources; cultural differences; and absence of knowledge of how to ask for services (Caidi 2007). Factors that affect health literacy for immigrants may include, but are not limited to, language proficiency, prior education about health issues in the country of origin, cultural beliefs about illness, familiarity with the health care system in Canada and perceptions of cultural awareness among health service providers and institutions. When service providers think of health literacy only in narrow terms of verbal skills during their interactions with immigrants, the social and cultural context of communication is neglected and the meanings of important messages are lost.

Consideration of cultural diversity in health literacy has to extend beyond language to a broader appreciation of cultural values, help-seeking beliefs and community engagement. Most health care providers have a very limited understanding of immigrants and refugees' experiences and special health needs. Often the first need is not primarily "medical," but the need to improve trust, comfort and communication, which highlights the two-way nature of health literacy as a social process and an agent to help break down structural and cultural barriers (Anderson Scrimshaw, Fullilove, Fielding, Normand and the Task Force on Community Preventive Services 2003; Vissandjee and Dupere 2000; Weerasinghe 2001). Some mental health care practitioners in Canada are also raising awareness and developing professional training about how to work with immigrants and culturally diverse groups (Fung, Andermann, Zaretsky, A. and Lo 2008; Guruge and Collins 2008). There is also growing recognition that safe and effective mental health care requires the provision of trained cultural or community interpreters (Abraham and Rahman 2008).

MENTAL HEALTH LITERACY, STIGMA AND CULTURE

Mental health literacy poses particular challenges. Lack of public awareness about mental health and stigma against people suffering from mental illness are widespread problems in Canada (Bourget and Chenier 2007); new policies and program initiatives are required to meet these challenges (Standing Senate Committee 2006). Mental health literacy may be defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention (Jorm 2000). It entails knowledge and beliefs about mental health disorders that emerge from general pre-existing belief systems. Lack of mental health literacy results in delays in seeking appropriate treatment and creates difficulties communicating with health professionals. Lay people generally have a poor understanding of mental illness. They are unable to identify mental disorders, do not understand what causes them, are fearful of those who are perceived as mentally ill, have incorrect beliefs about treatment, are often reluctant to seek help for mental disorders and are not sure how to help others (Canadian Alliance on Mental Illness and Mental Health 2008).

The Canadian Alliance on Mental Illness and Mental Health has identified immigrants as a priority group for mental health literacy interventions. New Canadians tended to identify life stress, such as the challenges of cultural adaptation, as the primary cause of mental health problems (Canadian Alliance on Mental Illness and Mental Health 2008, 21). Although immigrants in general tend to suffer from depression and alcoholism in lower proportions than Canadian-born citizens (Ali 2002), the early years after resettlement are especially stressful. For many immigrants, resettlement stresses such as discrimination and underemployment experienced after arrival in Canada add substantially to the risks of experiencing psychological distress (Beiser 2005). Moreover, many refugees have acute unmet needs for mental health care because of traumatic pre-migration experiences. The problem comes not from the health of newcomers, but from the fact that immigrants and refugees have less access to mental health information and services when they need them. Newcomers may not be familiar with formal mental health services, not only due to a lack of mental health care in some countries of origin, but also due to linguistic barriers and lack of culturally appropriate mental health promotion and services in Canada (Beiser, Simich and Pandalangat 2003; James and

Prilleltensky 2003). In some languages, there are no specific equivalent terms for mental illnesses (Littlewood 1998), and talking about them may be considered *taboo*. To overcome the negative impact of stigma in immigrant communities, it is necessary as a first step to talk more openly about mental health in collaboration with communities and to increase mental health literacy through community-based education (Simich, Maiter, Moorlag and Ochocka 2009).

Culture is of particular interest with regard to mental health literacy because there are significant cultural variations in how people recognize, explain, experience and respond to mental disorders. People in all cultural groups experience depression, but they may talk about it differently (Jadhav, Weiss and Littlewood 2001). Their mental health experiences are often closely connected to social support, expectations about how others will respond and to fear of shame and social isolation, which can delay help-seeking (Lauber, Nordt, Falcato and Rossler 2004). Current research on mental health with ethnocultural and immigrant groups in Canada, however, suggests that they would like greater access to mental health information that is community-based and culturally responsive (Simich et al., 2009).

HEALTH LITERACY INTERVENTIONS FOR IMMIGRANTS

Health literacy interventions appear to help counteract factors such as poverty, unequal access to quality health services, lack of preventive health care and culturally and linguistically relevant health services. In general, using participatory educational methods for learners to identify and learn about health issues results in an improvement to most aspects of health literacy (King 2007). Shohet and Renaud (2006) distinguish three domains of good health literacy practices: first, clear writing; second, oral communication (between patients and health care professionals, and training for health professionals targeting low-literate groups), and third, visual tools such as video and other non-written means of communication. The most promising practices combine multitasking approaches and direct inter-personal communication, usually by an educator who is linguistically competent and culturally acceptable to the community involved. In addition, relying on a variety of public outreach sites is important for immigrant communities for whom language classes, community health centres, ethnic associations, places of worship and shopping malls are often points of contact. Some health literacy initiatives in Canada are using a broad range of approaches including communication, education, community development, organizational and network development. For example, one Canadian project developed a photonovella about nutrition as a health literacy tool with ESL-speaking immigrant women (Nimmon 2007). The British Columbia Health Literacy Research Team has carried out projects focusing on Farsi-speakers (Poureslami, Murphy, Nicol, Balka and Rootman 2007) and is currently looking at ways to help Spanish-speaking immigrants develop health literacy skills.

Health literacy initiatives targeting mental health and immigrants are still rare, but one popular resource produced by the Centre for Addiction and Mental Health with funding from Citizenship and Immigration Canada in Ontario is the booklet, *Alone in Canada: 21 Ways to Make it Better*. This booklet has been used widely in ESL language classes in Ontario since 2002. The content for *Alone in Canada*, which focuses on ways for newcomers to adapt and to reduce mental distress during settlement, was developed in each target language by focus groups of immigrants and refugees who shared their personal experiences and coping strategies. The content was written in plain language, translated and edited by ethnolinguistic community experts and again verified by community focus groups (Simich, Scott and Agic 2005). *Alone in Canada* is available in 18 languages in print and on line at www.camh.net and at www.settlement.org. Also available online from CAMH are a number of other resources: multilingual educational fact sheets about mental health and addictions problems, including the types of problems and what contributes to them, information on asking for help when things are not right and on coping with stress.

CAMH fact sheets can be found at: http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html.

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FOOTNOTES

[1] Longer versions of this article were published in 2009 as a Policy Brief by the Public Health Agency of Canada and in Contact, the journal of TESL Ontario.

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