Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

HEALTH PROMOTION PROGRAMS ON MENTAL HEALTH/ILLNESS AND ADDICTION ISSUES IN ETHNO-RACIAL/CULTURAL COMMUNITIES

A LITERATURE REVIEW

June 23, 2003

By: Branka Agic
Student Practicum II, MHSc in Health Promotion
Department of Public Health Sciences
Faculty of Medicine University of Toronto

Practicum Supervisor: Rena Scheffer
Director, Public Education and Information Services
Communications, Education and Community Health
Centre for Addiction and Mental Health

Executive Summary

The objective of this report is to provide an overview of research literature addressing:

- barriers in access to health promotion programs on mental health/illness and addiction issues in ethno-racial/cultural communities
- guidelines on development of culturally and linguistically appropriate mental health promotion programs

Findings – key points

- Most culturally and linguistically diverse communities have limited knowledge of mental illness and negative effects of drugs and alcohol
- Members of ethno-racial/cultural communities have much lower rate of participation in health promotion/prevention programs
- Potential barriers that impede access to health promotion programs include language and cultural factors, stigmatizing attitudes, mistrust and lack of knowledge of the health system and how it functions
- Immigrants constitute 17% if the Canada's population
- It is estimated that at least 1 in 50 Canadians needs an interpreter for health care
- Health promotion programs that target general population do not reach diverse ethno-cultural groups
- Cultural competence is a key to enhancing the quality and effectiveness of health promotion interventions
- A community's level of readiness is a crucial factor in determining whether a local program can be effectively implemented and supported by the community
- No single approach works for everyone in the community
- Community development is the most promising method for working with ethno-racial/cultural communities
- The content of the message need to be culturally acceptable, but at the same time complete and accurate

- A range of communication tools should be considered including pamphlets, videos, group presentations, mass media, telephone delivered interventions and Internet

Introduction

One of the distinctive features of the Canadian society is the racial and cultural diversity of the population. The proportion of the population that belongs to the minority ethno-racial/cultural groups has increased dramatically over the last few decades, largely due to changing patterns in the origins of immigrants to regions other than Europe. Since 1990 Canada has accepted approximately 230,000 immigrants per year, mostly from countries where English is not the first language [43]. Responding to the needs of immigrants and Canadian-born members of racial and ethnic minority groups is one of the greatest challenges facing Canada's health care system.

Research on the factors affecting mental health status of immigrants indicates that immigrants have, overall, a lower rate of mental disorders than the native-born population [9,13,15]. Even though immigration itself doesn't jeopardize mental health, research suggests that immigrants may be at higher risk for developing mental health problems during the first 10 to 24 months after arrival if the conditions surrounding migration and resettlement experience include stressful experiences prior to coming to Canada, inability to speak one of the official languages, prejudice and discrimination of the host society, low socio-economic status, separation from family and isolation from others of similar cultural background [9,13]. Lack of culturally and linguistically appropriate mental health services further contributes to stigmatization and marginalization of ethno-racial/cultural communities exposing them to additional risks of developing mental health problems [45.]

Review of the literature indicates that there is generally a limited knowledge among immigrants and minorities regarding mental illness, the negative effects of drugs and alcohol and what constitutes addiction [4,6]. Unfortunately, research shows that only a small number of interventions to promote mental health seems to be effective in reaching the ethno-racial/cultural communities[4,41]. Mental health promotion can reduce overall vulnerability and improve the general mental health of the population. However,

the existing services are not sufficient to address the complexity of associated psychosocial needs[37].

There is a growing awareness of the differences that exist in access to health services between the minority groups and the majority population[2,10,16]. Health promotion designed for the general population usually does not reach diverse ethno-cultural groups. The provision of culturally responsive and linguistically appropriate health promotion programs is necessary to address the existing disparities and ensure equal access to all the resources[3,612,31,38].

Cultural diversity in Canada – Facts and Figures

- Since the WWII approximately 7.8 million immigrants have arrived to Canada
- Immigration has outpaced the natural birth rate, and now accounts for 53% of overall population growth.
- Immigrants constitute approximately 17% of the Canada's population
- Almost half of the immigrant population lives in Ontario, making up over a quarter of its population
- 59% of new immigrants in 2001 arrived to Ontario
- 43.7% of Toronto residents were foreign-born.
- 44% of 250,346 new immigrants that arrived to Canada in 2001 spoke neither English nor French
- More than 100 languages are spoken in Canada

(Sources: Statistics Canada: 2001 Census population; CIC, 2001)

Potential Barriers to Effective Health Promotion

There is compelling evidence that people from different linguistic and cultural background represent disadvantaged groups in terms of their accessing health information. Studies show that immigrants and minorities have much lower rate of participation in health promotion and prevention programs due to substantial socio-cultural barriers such as language and communication barriers, health messages that differ from their own beliefs and traditions, stigma associated with mental illness within families and communities, discrimination and mistrust of health care institutions and lower level of awareness of programs and services available[1,2,9,16,18,21,23,33]. To reduce the

burden that mental health and addiction problem impose on ethno-racial/cultural communities and improve the mental health of the population, the existing health system should respond to the needs of the increasingly multicultural and multilingual society.

Culture

Populations in Canada represent a diverse range of cultures with different health values, beliefs and understanding of mental health, addictions and mental problems. A "mismatch" between the culture of the health system and the needs of members of ethno-racial/cultural communities is a significant barrier to effective health promotion programs[10,25]. What is considered mental illness is influenced by cultural and religious factors, and the Western definition of mental illness is not always applicable to individuals from different ethnic and cultural backgrounds. Mental disorders have similar symptom profiles across cultures, but manifestations of mental illnesses and how people describe and interpret their symptoms vary with race, ethnicity and culture[10]. For example, many Asian cultures do not make a distinction between body and mind and mental health problems are more likely to be present in the form of somatic complaints. Moreover, because of the high level of stigma associated with mental illness, it is considered culturally more acceptable to express emotional distress through the body than the mind[2,55]. Cultural meaning of mental illness defines how people receive health promotion messages, what is considered to be a mental health problem and what kind of help is preferred.

It is important to note that all people do not identify with their cultural background. Socio-cultural environment influences people's health beliefs and values, so different individuals and generations within the same family may have different health beliefs and perception of health problems. Some people adopt dominant cultural values through the process of acculturation, while others maintain their traditional beliefs[25].

Substance abuse exists in all cultures and penetrates across cultural differences. However, there are differences in drug and alcohol problems among different ethno-cultural groups. What constitutes a "drug", perception of addictions and beliefs about the cause of addiction is culturally defined[4,12]. Research on substance abuse programs in Canada stressed that programs developed for English-speaking Canadians are not successful in delivering messages to diverse ethno-cultural groups[4].

Stigma

Stigma towards mental illness exists in every society. The roots of stigmatization of people with mental illnesses, and reasons for its continuation, are complex and embedded in individual cultures. Stigma is generally considered a major barrier that discourages minority individuals and their families from getting the help that they need as much as it does for dominant groups[10]. The extent of stigma varies according to the cultural and sociological backgrounds of community. Tackling stigma is an important first step in reducing the public-health burden of mental illness[26,37]. Findings suggested that education on mental illness can produce positive changes in negative attitudes toward mental illness and is essential to the reduction of stigma[35].

Because of the cultural diversity inherent in stigmatization of mental illness, it is necessary to develop new culturally sensitive ways of reducing stigma. Substantive data suggest that designing programs to meet the specific needs of ethno-racial/cultural groups will improve access and utilization of health promotion programs and, consequently, reduce stigma and disability burden from mental illness and addictions[10,11,16].

Mistrust

Although there is very little research on this topic, mistrust was identified by some studies as a major barrier to receipt of mental health services by racial and ethnic minorities[10,1]. It stems from discrimination and perceived mistreatment, and therefore communities that have experienced racism are more suspicious and distrustful of messages that are not sensitive to their cultural norms and beliefs. Furthermore, the concept of health promotion and prevention may be new to some people, especially those who come from poor countries with scarce health care resources[25].

Language

Language is identified as one of the greatest barriers in access to health promotion programs for people of non-English speaking background. Lack of language skills represents an initial barrier to health information. Research suggests that official language proficiency is in itself a determinant of health and may interact with other determinants, including race, culture and ethnicity[16]. The material insensitive to language and levels of education is ineffective in delivering health promotion messages.

Language barriers in Canada are generally considered to be “newcomer” and “settlement” issues. However, a significant proportion of “old” immigrants living in Canada for more than 20 years have limited English language skills. The Report on Language Barriers in Access to Health Services (2001) indicates that a significant proportion of Canada’s population experiences language barriers in access to health services. It states that, at least, 1 in 50 Canadians requires an interpreter for health care, but it is believed that this number is actually much higher. Even those who are fluent in an official language may have difficulty fully understanding health education materials due to highly technical medical jargon. Language barriers, if not addressed, pose a risk of individuals misinterpreting key concepts and misunderstanding health information.

The link between low literacy and poor health is generally recognized in the literature[44]. People with low literacy skills have difficulty understanding vital health information presented in written form. Although low literacy is correlated with low education level, research shows that low literacy is also found among individuals with higher level of education who have limited English proficiency[16]. Furthermore, a number of non-English speakers may have low literacy or even be illiterate in their own language.

Knowledge of the health system

Research reveals a low level of awareness among minority groups of available mental health and addictions programs. This is particularly true for the non-English speakers as well as those who have limited English proficiency since most organizations advertise their services in English[4,21].

Guidelines for Developing Culturally Competent Health Promotion

There is compelling evidence that health promotion interventions have the capacity to reduce the risk, stigma and burden of mental disorders and addiction, and to promote mental health of the population. However there is a growing awareness that people from culturally and linguistically different background are disproportionately affected by mental health problems and addiction because of the gap of effective and available information and programs[37].

A number of studies of minority ethno cultural groups' access to health services highlight a need for health promotion programs on addictions, mental health/illness and the issue of stigma in the context of culture that reflect the existing cultural and linguistic diversity[5,7,8,9,18,21,40]. Many models of culturally competent services have been described in the literature. All of them indicate that reaching and efficiently serving people of diverse cultural and linguistic background require:

- Understanding the community level of readiness
- Familiarity with population subdemographics
- Recognition of the needs of the target population
- Awareness of existing resource and gaps in services
- Knowledge of preferred methods of communication[2,41,54]

Implementing a new program requires community support. The research shows that support will increase if the community members recognize the problem and participate in the development and implementation of appropriate health promotion strategies to address them[50]. **Building a coalition** with ethno-cultural groups and community-based organizations is the best strategy to meet the needs of increasingly diverse population and develop culturally sensitive health promotion programs. Studies show that effectiveness of health promotion programs addressing mental health and addictions issues depends largely on the way in which they are offered. It is challenge to choose the right tone and words so that information is culturally appropriate, but at the same time complete and accurate.

Literature affirms that every health promotion initiative should be based on needs assessment of the target audiences, in terms of their willingness to hear (emotional and tonal qualities which will mobilize individual and communication predisposition) and their willingness to listen (determine best communication channels required to achieve desired goals)[47].

The content of the message directed at ethno-racial/cultural groups need to be formulated carefully. What constitutes a drug is culturally determined and use of one substance may be acceptable in one culture but not in others. For example, many European and Indo-Chinese cultures may not regard alcohol or prescribed pharmaceuticals as drugs[12].

Attitudes toward mental illness differ between cultures. In many Asian cultures mental illness is highly stigmatized [2,51,56] . A study on the Vietnamese understanding of mental health finds that the way in which terminology is used and presented is very important in this culture. Because of their traditional reluctance of seeking outside help, it is difficult to find words that adequately describe mental health professionals. “Bac si Tam Than” is the term used for psychiatrist whose role is confined to treating “mad” people and a “Bac si Tinh Than” is a doctor who provides emotional support. It is not same as “Bac si Tam Than” but this term is often used to reduce the stigma and encourage compliance with treatment. For the same reason “worries or bad thoughts” are culturally more acceptable than “mental illness and psychological problems”[56].

Information on mental illness and addictions should be disseminated through trained community representatives and community leaders since they are considered to be more trustworthy to promote health messages and behavioral change in target group[4].

Truly successful health promotion programs must be culturally competent, relevant and consistent with the level of readiness of the community to implement an intervention[48,50]. It requires recognition of and respect for culturally specific health values and beliefs and understanding of community health needs[3,4,20,25]. However, resources, strengths and challenges vary from community to community and what works in one community may be ineffective in another community.

It is important to recognize that **no single approach works for everyone**. The community subgroups differ in age, English language proficiency, education, level of acculturation, family situation and other characteristics, and no single outreach strategy will work for all members of the ethno-racial/cultural community. Effective outreach often requires multiple strategies aimed at specific community subgroups and their [4]. For example, a few research studies on the health needs of Chinese community suggest that young people prefer to seek out information on the web while seniors may favor other communication channels such as mass media, community center meetings and group presentations during community events[8,52].

Literature indicates that the community’s level of readiness is a crucial factor in determining whether a local program can be effectively implemented and supported by

the community[49]. **Community readiness** is the extent to which a community is adequately prepared to implement a health promotion or prevention program[48]. Ethno-racial/cultural communities are at many different stages of readiness for implementing such programs. Some communities refuse to acknowledge that health problem exists, other clearly recognize that there is a local problem and that something needs to be done about it[48]. The research shows that the higher the level of readiness, the greater the degree of program success.

The community readiness theory is based on the assumption that ethno-racial/cultural communities could **be mobilized** to develop and implement effective health promotion and prevention programs. Once a community has achieved a higher stage of readiness, local community teams can be trained to operationalise its own programs. They can then develop culturally specific initiatives that use local resources to guide the community to more advanced levels of readiness, eventually leading to long-term sustainability of local community efforts[48,49].

The community readiness model is built on **community development,** the process of encouraging and enabling disadvantaged communities to take action in improving their health. It is the "bottom-up approach" that allows communities to identify their own needs and engage in the planning and development of health promotion initiatives in culturally and linguistically appropriate manner [20,25,26]. Community development seeks maximum participation of the community members in all phases of the planning and designing of programs aimed at raising awareness of mental health/illness and addiction issues in ethno-racial/cultural communities. It is a dynamic process during which communities gradually change power in their favor. This requires access to various resources, including professional staff, sustainable funds, space and program materials. There is compelling evidence that community development is the most promising method for working with ethno-racial/cultural communities[4,49,50].

Health promotion includes **a wide range of activities** meant to provide information, encourage positive health behavior and contribute to health gain. A strategy that is most appropriate to achieve desired results varies from community to community. The research indicates that the effective programs aimed at ethno-racial/cultural communities must take place within the community using the strategies that reflect the values,

concerns and culture of the target group[11]. Community participation and collaboration with community-based agencies generate information about what practice is most appropriate in given situation and the preferred ways of communication of the target group.

Various **communication channels** can be used in cross-cultural health promotion:

- Written materials such as leaflets and hand-outs
- Audiovisual materials such as posters, displays and videos
- Mass media: local television, radio and newspapers
- Group presentations
- Fotonovelas/booklets
- Telephone delivered interventions and Internet

Written materials are an effective way of reaching a large number of people. However, good communication is a key to effective health promotion strategies. Whenever a significant percentage of the target population has limited English proficiency, written materials should be provided in the language of the target community[24]. There are two general approaches to provision of resources in other languages:

  - translation from the English material or
  - development of original resources based on community needs assessment

Ideally, health information should be developed in the native language of the community reflecting the dialectic and cultural nuances, as well as education and literacy level of the target population[26,31]. Many experts believe that developing written material from scratch in the target language in collaboration with community representatives is more efficient in delivering health promotion messages. This is particularly important when the materials are used to motivate behavioral changes[45,46].

When translating existing resources, Multilingual Health Education Net emphasizes the importance of starting with the English version that is written at grade 4-6 literacy level. Professionally accepted standards for translation of English health education materials include, at a minimum, translation by trained individual, back translation and review by

health professionals for the accuracy of health information and the target community for the comprehensiveness[45,46].

When planning health promotion initiatives, it is necessary to assess the literacy level of the community and consider **alternatives to written information**, such as symbols, audiovisual formats and public service announcement[47]. If a percentage of community members are illiterate in their language of origin, information should be communicated orally or visually. It is important to acknowledge that some colors in particular countries hold special meanings. For example, red color stands for good luck and happiness. Black is strongly associated with mourning throughout the Western world, but in certain oriental cultures it is white that signifies morning[53].

Mass media, which includes ethnic television, radio, magazines and newspapers, can be successfully used to promote awareness among local community groups about the importance of the particular health issue due to their ability to reach very large audiences. A study on mental health needs of the Somali community identified local radio programs as preferable and most efficient way of communicating health messages[18].

Literature suggests that health promotion programs could be effectively organized around community celebration and festivals incorporating different types of ethnic music and art into the activities. In Asian culture food is very important and programs incorporating community lunch have been successfully used to convey heath promotion messages[8]. Experiences from Third-World countries also provide usefull information about culturally specific health promotion initiatives[53]. In rural India community mental health programs involving teachers, village and religious leaders and using local folklore, dance and music were successful in increasing population's awareness on mental illness.

English –as-a- Second Language (ESL) classes represent a great opportunity to explain Canada's health services to new immigrants and improve their knowledge about mental health/ illness and addictions [53].

New communication technologies have been increasingly used to impart health information. Their potential for reaching people of diverse cultural and linguistic background should not be underestimated. There is substantial evidence that telephone-delivered interventions (TDIs) have been efficient across populations. However, research shows that they are underused by diverse populations. For some groups, especially recent immigrants from rural areas, telephone conversation can not replace communication in person and information received in this way may not be acceptable[52,55]. The Internet has been identified as one of the most powerful communication tools available, but a large number of people still lack access to it. Barriers include cost, low literacy, limited English language proficiency and lack of culturally appropriate information. Recent studies find ethnic differences in attitudes towards Internet use. However, research indicates that, in general, older people are less likely than younger to use Internet[55].

Culturally competent health promotion has been identified as a key to raising awareness on mental health/illness and addictions issues in ethno-racial/cultural communities. It incorporates skills, attitudes and policies to ensure that all programs are effectively addressing needs of people from different cultural and linguistic background[11,24,25]. Literature indicates that health organizations should ensure that staff at all levels receive appropriate knowledge and training in culturally and linguistically sensitive service delivery.

References

1. Johnson, M.R.D, Carroll, M. Dealing With Diversity: Good practice in drug prevention work with racially and culturally diverse communities. Centre for Research in Ethnic Relations. University of Warwick. (1995).
2. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service Administration, Center for Mental Health Services
3. Kreps, G.L., Kunimoto, E.N., Effective Communication in Multicultural Health Care Settings. SAGE Publications, Thousand Oaks, California (1994)
4. Masi, R., Mensah, L., McLeod, K.A. Health and Cultures. Exploring the Relationships. Programs, Services and care. Mosaic Press, Oakville, On (1993)
5. S. Noah, I. Hyman, H. Fenta. (2001). Pathways and Barriers to Mental Health Care for Ethiopians in Toronto. Culture Community and Health Studies Program, Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto
6. Providing Alcohol and Other Drug Services in a Multicultural Society. NSW Health Department, New South Wells, Australia. (1993)
7. Marshall, C., Open Windows, Opening Doors: Ethnoracial/Ethnocultural Communities Addiction and Mental Health. Report on Consultations With Francophone Ethnocultural/Ethnoracial Communities in Toronto. CAMH (2002)
8. H.T. Lo, R. Lee. Community Mental Health – The Hong Fook Model. (1992)
9. Canadian Task Force. After the Door Has Been Opened. (1988) Health Canada
10. Metropolis Project: Canadian Research on Immigration and Health. (2001) Health Canada
11. Aspell Reference Group. (1998) Community Health: Culturally Competent Health Promotion. Education and Promotion Manual. Aspen Publishers, Inc. Gaithersburg, Maryland
12. Alcohol handbook: A Multicultural Approach to Drug and Alcohol-Related Issues and Problems. Australian Department of Health and Ageing http://www.health.gov.au/pubs/drug/alc_hand/alc_c15.htm
13. Hyman, I. Immigration and Health – Working Paper. (2001). Health Canada
14. Report on the Health Status of the Residents of Ontario. (2000) Public Health Research, Education & Development Program
15. Statistical Report on the Health of Canadians. (2001) Statistics Canada
16. Bowen, S. Language Barriers in Access to Health Care. (2000) Health Canada
17. McEwan, K. Goldner, E.M. Accountability and Performance Indicators for Mental Health Services and Supports – A Resource Kit Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health. (2001). Mental Health Evaluation and Community Consultation Unit Department of Psychiatry, University of British Columbia
18. Elmi, A.S. A Study on the Mental Health Needs of the Somali Community in Toronto. (1999). York Community Services & Rexdale Community Health Centre.
19. Making It Happen: A guide to Delivering Mental Health Promotion (2001). Department of Health, London, UK
20. Cultural Competence in CAMHS. Multicultural Mental Health Australia. http://www.mmha.org.au/library/services/specialist_reports/camhs_back.html

21. Bergin, B. Equality is the Issue: A Study of Minority Ethnic Group Access To Health and Social Services in Ottawa-Carlton. (1988) Social Planning Council of Ottawa-Carleton, Ottawa, Canada
22. Seah E, Tilbury F, Wright B, Rooney R, Jayasuriya P. Cultural Awareness Tool (2001) Transcultural Psychiatry Unit, Curtin University and the Royal Australian College of General Practitioners WA Research Unit, Perth, Australia
23. Yuan, L., Rootman, I., Tayeeh, A: Health Status and Health Care Access for the Arab Community in Toronto: a Pilot Study to Assess Health Needs. http://ceris.metropolis.net/
24. Guidelines for the production of Multilingual Health Resources, Multicultural Health Communications, NSW Health Department, New South Wells, Australia http://www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs/resources/index.html#guidelines
25. Achieving Health for All: A Framework for Health Promotion. Health Canada
26. The World Health Report: 2001: Mental Health: new understanding, new hope. World Health Organization 2001]
27. Hanvey, L. Risk, Vulnerability, Resiliency – Health System Implication. (1996) Health Canada, Ottawa, Ontario

23 Cochrane, J., Durbin, J., Goering, P. Best Practices in Mental Health Reform: Discussion Paper (1997) Health System Research Unit Clarke Institute of Psychiatry, Toronto, Ontario

24 Stephens, T., Dulberg, C., Joubert, N. Mental Health of the Canadian Population: A Comprehensive Analysis. Volume 20, No. 3 - 1999 (1999) Health Canada, Population and Public Health Branch, Ottawa, Ontario

25 Cultural diversity package. (1998) Queensland Health, Queensland Government, Queensland Health Electronic Publishing Service, Brisbane, Australia

26 Resources for Cross – Cultural Health Care. Diversity Rx. http://www.diversityrx.org/

27 CulturedMed. SUNY Institute of Technology. http://www.sunyit.edu/library/html/culturedmed/

28 Family Psychoeducation Program. Transcultural Mental Health Centre. New South Wells, Australia http://www.tmhc.nsw.gov.au/projects/psychoeducation.htm

29 Cultural Competency Assessment Tool. Vancouver Ethnocultural Advisory Committee of the Ministry for Children and Families, Government of British Columbia (2001) http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm

30 lue A. V. The Provision of Culturally Competent Health Care. Medical University of South Carolina College of Medicine (2000) http://www.musc.edu/deansclerkship/rccultur.html#Top

31 NSW Multicultural Health Communication Services. Translation Guidelines.http://mhcs.health.nsw.gov.au/health-public-affairs/mhcs/resources/index.html#guidelines

32 Berger J. T. Culture and Ethnicity in Clinical Care. Vol. 158, pp. 2085-2090, October 26, 1998

33 Bridging the culture and language gap in the Delivery of Mental Health Services. The Center for Multicultural and Multilingual Mental Health Services, Chicago, Illinois http://www.mc-mlmhs.org/default.htm

34 Lavizzo-Mourey, R., Mackenzie, E. Cultural Competence: Essential Measurements of Quality for Managed Care Organizations.1996; 124:919-921. Annals of Internal Medicine
35 The Open Mind Research Group. Determining Best Practice in Information Provision to People of Diverse Cultural & Linguistic Backgrounds: A Qualitative Report. Australian Transcultural Mental Health Network http://www.atmhn.unimelb.edu.au/research/guidelines/infoprov.html
36 Simons, R. C. Introduction to Culture-Bound Syndromes. Psychiatric Times, November 2001, Vol XVIII. Issue 11
37 Mental Health Global Action Programme: Close the Gap, Dare to Care. (2001) World Health Organization, Geneva, Switzerland
38 Promotion, Prevention and Early Intervention for Mental Health. Commonwealth Department of Health and Aged Care 2000, Canberra, Australia
39 Kirmayer, L. J., Galbaud du Fort, G., Young, A., Weifeld, M., Lasry, J.C. Pathways and Barriers to Mental Health Care in an Urban Multicultural Milieu: An Epidemiological and Ethnographic Study. (1996) Culture & Mental Health Research Unit Sir Mortimer B. Davis – Jewish General Hospital
40 Giger, J.N., Davidhizar, R., Johnson, J.Y., Poole, V.L. Health Promotion among Ethnic Minorities: the Importance of Cultural Phenomena. Rehabil Nurs 1997 Nov-Dec;22(6):303-7, 310
41 Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. The Office of Minority Health, Public Health Services, US Department of Health and Human Services http://www.omhrc.gov/clas/finalcultural1a.htm
42 Betancourt, J. "Unequal Treatment": The Institute of Medicine's Findings and Recommendations on Healthcare Disparities. Harvard Health Policy Review. 3(2), 2002
43 CIC. Research and Statistics. Immigration Overview 2001. http://cicnet.ci.gc.ca/english/research/index.html
44 Health Canada. Population Health http://www.hc-sc.gc.ca/hppb/phdd/docs/social/appendix_b.html
45 Overview of Models and Strategies for Overcoming Linguistic and Cultural Barriers to Health Care. Diversity Rx. http://www.diversityrx.org/HTML/MOVERA.htm
46 Translated Materials (Mandate). Office of Minority Health. Department of Health and Human Services USA. http://www.omhrc.gov/issamples/query2.idq?CiRestriction=translated+materials&CiScope=%2Finetpub%2Fwwwroot&CiMaxRecordsPerPage=10&TemplateName=query2&CiSort=rank%5Bd%5D&HTMLQueryForm=query2.htm
47 Appendices and Community Synopses: Determining Best Practice in Information Provision to People of Diverse Cultural & Linguistic Backgrounds: A Qualitative Report Australian Transcultural Mental Network. http://www.mmha.org.au/research/policies/infoprov2.html
48 Building a Successful Prevention Program. Center for Substance Abuse Prevention http://www.unr.edu/westcapt/bestpractices/commread.htm
49 Edwards, R. W., Jumper-Thurman. P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: Research to practice. Journal of Community Psychology, 28(3), 291-307.
50 Community Readiness: A Promising Model For Community Healing. The University of Oklahoma Health Services Center, 2000.

51 Reducing Stigma About Mental illness in Transcultural Settings: A Guide. Australian Transcultural Mental Health Network. http://www.mmha.org.au/research/papers/stigma1.html
52 Speaking of Health: Assessing Health Communication Strategies for Diverse Populations (2002) Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations. Institute of Medicine (IOM) of the National Academies. The National Academic Press. Washington, D.C.
53 Thompson, P.R. MacDonald, J.L. Multicultural Health Education: Responding To The Challenge.
54 Six Steps toward Reaching and Serving Diverse Communities. Vermont Department of Health. Division of Drug and Alcohol Abuse Program http://www.state.vt.us/adap/Cultural/SixStepsTowardReaching.htm
55 Waxler-Morrison, N., Anderson, J.M., Richardson E. (1990). Cross-Cultural Caring: A Handbook for Health Professionals. Vancouver: UBC Press.
56 Cultural Competence In CAMHS. Report on the Usage of Child and Adolescent Mental Health Services by NESB Adolescents and their Families http://www.mmha.org.au/library/services/specialist_reports/camhs_back.html