

FEATURE ARTICLE

# Factors that influence Asian communities' access to mental health care

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**ABSTRACT:** This paper presents the findings of a qualitative study to identify factors that influence Asian communities' access to mental health care and how mental health care is delivered to them. Semistructured interviews were completed with Asian community members/leaders and health-care professionals. Content analysis identified major themes. Participants also completed a demographic data sheet. The research aimed to provide health professionals with an increased understanding of the values and beliefs held by people from Asian communities regarding the cause and treatment of mental illness. Data analysis identified six main themes that influenced Asian communities' access to mental health care and how mental health care is delivered to them. They were: shame and stigma; causes of mental illness; family reputation; hiding up; seeking help; and lack of collaboration. The findings highlighted that people from Asian communities are unwilling to access help from mainstream services because of their beliefs, and that stigma and shame are key factors that influence this reluctance. The findings also highlight that the mental health needs of refugee women are significant, and that they comprise a vulnerable group within Australian society.

**KEY WORDS:** Asian communities, cultural competence and sensitivity, stigma and shame, traditional beliefs, values and beliefs.

## INTRODUCTION

People from Asia first migrated to Australia in the 19th century. Since that time the rate of migration has increased and people born in the three Asian regions (Southeast Asia, Northeast Asia and South and Central Asia) now comprise 5.5% of Australia's population (AusStats 2003). For many migrants, the resettlement

process highlights issues and needs related to alienation, social dislocation and, in particular, problems associated with mental health.

As a consequence of this cultural shift, health professionals require education and skills to enable them to provide culturally competent and sensitive care to effectively address the health needs of migrants. Although it is not the intention of this paper to explore the issue of cultural competence, it is important to clarify the concept and its implications. King *et al.* (2003; p. 3) defined cultural competence as

'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables that system, agency or those professionals to work effectively in cross-cultural situations'.

The notion of cultural competence has long been promoted in health care (US Department of Health and

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Accepted December 2004.

Human Services 2001). However, there remains a wide spectrum of ideas about what constitutes cultural competence. Therefore, health professionals need to gain a better understanding of the relationship between culturally competent health services, patient satisfaction, clinical outcomes and the health status of different communities.

Traditionally, many western health-care interventions have been based on the concept that illness is culturally neutral and, therefore, interventions were applicable to all clients (Burr & Chapman 1998). Nevertheless, research has demonstrated that health and illness are culturally constructed experiences (Manderson 1990), which are manifested in different variations of illness (Balarajan & Soni Raleigh 1993). This assertion is supported by Masha (1995) and Sheikh and Furnham (2000) who stated that the way people conceptualize their level of mental health is related to their cultural beliefs. This conceptualization is influenced by the person's experiences in their country of origin as well as those in their adopted country. According to Sheikh and Furnham (2000), the beliefs in more traditional cultures are deep-rooted and more structured than in many western societies with religion playing a significant role in understanding the cause and treatment of illness. Burr and Chapman (1998; p. 434) claimed that 'within each cultural system, illness, the response to illness and the method of treating illness, have different cultural and symbolic meanings'. However, knowledge of these cultural variations has failed to move health care out of its ethnocentric paradigm (Manderson & Mathews 1985). Despite the Australian Government's efforts to improve the health needs of migrants (Orb 2002), the health-care system remains largely monocultural, thus disadvantaging non-English-speaking clients in terms of quality and access to services. Many migrants find accessing health care to be a stressful experience and the unfamiliar environment may accentuate differences already present, thus increasing the person's perception of alienation (Orb & Wynaden 2001). Unless health professionals recognize the role culture plays in dictating the presentation of illness, morbidity will remain hidden within cultural groups (Gorman *et al.* 2003). In most cases, this recognition requires the health professional to go beyond conventional diagnostic classifications and possess a high level of cultural competence and sensitivity (Burr & Chapman 1998).

The *National Mental Health Plan* (Australian Health Ministers 1992) identified several problems with the provision of mental health care to migrant communities. These problems were related to: (i) beliefs about the causes and treatment of mental illness; (ii) distrust of

psychiatric services; (iii) lack of familiarity with the health system; (iv) trying to cope with the problem within the family; (v) preference to use traditional health-care methods; (vi) communication difficulties; (vii) stigma and shame; and (viii) the perceived cultural incompetence of health-care providers (Fan 1999; Lam & Kavanagh 1996; Shin 2002). These are some of the problems that make migrants reluctant to accept the philosophy of the medical model of health care practised in Australia, thus causing delays in seeking professional assistance for mental health concerns.

People from Asian communities living in Western Australia are a diverse group and come from a variety of religious and cultural backgrounds and speak many different languages. Globally, studies show that access by these groups to psychiatric services and preventive health screening programmes is limited (Li *et al.* 1999). Klimidis *et al.* (2000) reported that ethnic minority group underutilize psychiatric services. Similarly, Kumari (2004) highlighted the failure of mainstream mental health services to meet the mental health needs of South Asian women. Furthermore, Leong and Lau (2001), in a study on barriers to providing effective mental health care to Asian Americans, also reported underutilization of services by this group. In addition, these authors found that when Asian Americans did access services they terminated the treatment earlier than non-minority consumer groups. Bowes and Wilkinson (2003), in a study of South Asian people with dementia, reported that families displayed negative responses to residential care for their ill family member and, therefore, the ill person had little access to appropriate services. These authors claimed that there is little knowledge and understanding of the experience of dementia in South Asian communities and this area needs further exploration. A retrospective analysis of the cultural backgrounds of clients accessing inpatient mental health services at Fremantle Hospital in Western Australia also confirmed the lack of access to mental health services by people from Asian communities in Western Australia (Orb *et al.* 2001). This current study was designed to further explore the issue of access in order to develop a culturally sensitive, appropriate and competent framework for the delivery of mental health care.

## AIM AND OBJECTIVES

The study aimed to provide health professionals with an increased understanding of the values and beliefs of people from Asian communities about mental illness. This was achieved through the following objectives: (i) to

identify the values and beliefs regarding the cause of mental illness, (ii) to explore the beliefs about the treatment of mental illness in their country of origin, (iii) to identify the perceived willingness to accept mental health care in Western Australia if the participant or one of their family members became ill, and (iv) to identify the willingness to work with health professionals to develop a culturally sensitive and competent health service.

## METHODOLOGY

Qualitative descriptive research methodology was employed in this research using a convenient sample of participants. Participants recruited were prominent members of the Asian community or referred by Asian people because they were knowledgeable about the phenomenon under study. The majority of participants were health professionals. Participants were interviewed between October and November 2003. All interviews were conducted in a private, mutually agreed on location. Each interview lasted approximately 45 min.

Semistructured interviews were used based on the guidelines outlined by Swanson (1986). Each interview began by the researcher asking an open-ended question 'Can you tell me about your country of origin?' Following this, the questions became more focused on the participant's beliefs, values and experiences regarding mental illness. As content analysis was completed on the transcribed data, the questions used in subsequent interviews became more focused on clarifying emerging and recurring themes about participants' experience and beliefs regarding mental illness.

Data were transcribed verbatim and transcripts were analysed using content analysis following the standards of qualitative data analysis procedure, that is, coding, finding categories, clustering and identifying themes (Streubert Speziale & Carpenter 2003). Transcripts were read line-by-line and significant words and phrases were identified and themes formulated (Field & Morse 1994). When content analysis was completed, the research team met to discuss indicators that were used to define and code the data into themes. Validation of the data analysis process was continually carried out by reviewing the data and through the further exploration of concepts with participants. During this stage of data analysis, data were processed theoretically instead of descriptively. This involved a two-stage process: sorting and saturation. Saturation according to Morse (1995; p. 147) is 'data adequacy'. In this study, sampling was continued until saturation, or the failure to obtain new information from participants occurred.

Establishing trustworthiness, credibility and transferability of data is an essential step in qualitative research (Rose & Webb 1998). The credibility of the findings was supported by accounts of similar experiences by the majority of participants. Recurrent patterning of responses from participants also added to the trustworthiness of the findings and these similar patterns of experiences became more evident as themes became consolidated (Muhlbauer 2002). The identified themes in this study were further supported by similarities with existing literature, and by the researcher's memos and reflective notes. Participants also completed a demographic data sheet. Ethical approval to conduct the study was obtained from the Human Research and Ethics Committee at Curtin University of Technology and informed consent was obtained from each participant.

## RESULTS

The results are based on the findings of data obtained from interviews with 10 participants (three women and seven men) whose ages ranged from 30 to 75 years. Participants had lived in Australia, on average, for 19 years. Six main themes were identified: shame and stigma, causes of mental illness, family reputation, hiding up, seeking help, and lack of collaboration.

### Shame and stigma

All participants reported that their communities stigmatized people who had a mental illness and that the ill person experienced feelings of shame. Several Chinese participants elaborated that for the community, the meaning of 'shame' had a very intense and profound meaning. They found it difficult to describe in English the intensity of the expression of the feeling of 'shame' that a person with a mental illness would feel:

They [Chinese] feel shame, the meaning of shame is [non-Chinese people] can't understand the meaning of shame. For Chinese people shame is a very deep meaning. It means that you can't go out and face other people. (P3)

Shame and stigma prevented people from seeking help from mainstream mental health services. The family tried to manage the problem and isolated themselves from the community to prevent knowledge of the family member's illness from becoming public:

They [family] don't want to accept it and those that do [they feel that they] will be stigmatized and bring bad onto the family. . . . migrants that live in Australia still

often live in their own culture. . . . They know that there is a problem but they do not want to accept it. (P5)

A person with a mental illness and his/her family isolated themselves because they believed that they would be labelled as different by their community and viewed negatively:

I think that they [people who are ill] are very sensitive to being labelled being seen as different. You know they are very sensitive to people looking at you in a strange way that you have a mental problem. In Chinese it [a mental problem] is mad! (P3)

### Causes of mental illness

Participants stated that knowledge about the cause of mental illness depended on the person's: (i) level of education; (ii) country of origin; and (iii) age. People who had migrated from countries such as Singapore, with a western lifestyle, were more open to the western concepts of education and scientific information regarding the causes of mental illness. Educated people were also better informed and viewed mental illness as having a genetic/hereditary link. They understood disorders such as depression and schizophrenia. In contrast, migrants from more remote villages who were less educated and elderly migrants held more traditional beliefs.

Religion, and in particular Buddhism and Taoism, was reported to be important in determining the health beliefs of community members. For example, Buddhists believed in reincarnation and, inherent in this belief is, the philosophy of karma. Karma, the law of cause and effect in eastern spirituality, emphasizes that there is a consequence for every action. Therefore, positive actions result in positive reactions and negative actions result in negative reactions in a later reincarnation. Subsequently, people who produced a child who had a mental illness were perceived as being punished for their conduct in their past lives:

Traditionally they [parents] feel they may have done something wrong for this [mental illness] to happen. What you did in your past lives reincarnation – Chin-say [the previous life]. You have not done anything right in your previous life. It is a sin very simply. (P3)

Other beliefs about the cause of mental illness are linked to the person being possessed by evil spirits:

When you are unwell, people will try to treat you with a witch doctor or spiritual leader. . . . They relate psychiatric problems to spiritual causes. (P10)

Traditional beliefs were also reported to have a sociological base. For example, it was a woman's fault if a child developed a mental illness as the illness was passed down to the child from the mother. This belief was associated with the concept of 'bad blood':

In the old times they thought it was some bad blood in your family that caused it [mental illness]. Sometimes if the child has this problem [mental illness] then it must be the mother's fault, not the father. The mother brought all this to the family. It has a lot to do with the sociological thinking at that time society how they see women and men's roles. (P6)

Refugees from China were identified as an extremely vulnerable population because of the traditional beliefs they held. Many of the customs among this group did not facilitate resolution of problems associated with mental illness. For example, the family may not attend funerals of a member who had committed suicide:

The refugee group from China . . . this is the group of people that are really very isolated and have nobody and no support at all. . . . They don't know how to deal with it. We need some resources to help the groups deal with it. . . . Language is a problem culture is another major problem in fact I came across quite a few refugee families and they have a huge problem to adjust to the way of life. (P6)

### Family reputation

The need to maintain family reputation was reported by all participants and was not dependent on peoples' level of education or country of origin:

They are reluctant to talk about it [mental illness] even if you [a general practitioner] ask them questions. It is something to be ashamed of it is a weakness and there is a stigma attached to it. You will be branded. (P9)

Maintaining family reputation was particularly important if the problem was viewed as having a hereditary cause. It was reported that many Asian migrants have high expectations for their children. If these children succeeded it gave a good impression for the family. However, if the child developed a mental illness the family's reputation was disgraced:

If they are middle class they are very attuned to achievement. They want their children to become lawyers, doctors and accountants that kind of thing. They look upon it as something to compensate for their own lives. . . . If someone has a mental illness it is a failure. If your child is below normal intelligence you must be also because if you were good your child would not be like that. (P3)

Another participant gave a similar example:

The higher up in society your family is the less likely they are to admit that they are fathers or grandfathers of people who have gone 'nuts' [have a mental illness] because of the probable backlash from society. They do not want to be labelled as the dad or grandfather of someone who is 'mad'. (P10)

### Hiding up

Hiding up involved keeping the mental illness hidden from the community and/or not doing anything about the ill person's behaviour:

There is still a large group of people who hide their [mentally ill] children away. They refuse to believe that they have a history of mental illness . . . They hide them [the child] they let them stay in the house and they do not let them leave the house. (P2)

Hiding up meant that the family would not actively look for treatment and they would hide the ill person away hoping that as the child matured the problem would go away. The family would not bring people into their home, they would keep to themselves:

A lot of Chinese families [with a family member with a mental illness] hide up, they do not come out and they do not feel comfortable in going out. . . . If you get an illness like a mental illness you do not understand and it has connotations and there is a lot of pressure to keep it hidden. If a family has mental illness they never want to talk to it. Only the family people know about the illness. (P3)

### Seeking help

Seeking help was a difficult process and it was usually left until the ill person's behaviour was so bad that it could not be managed any longer within the family:

People who get treatment do it as the last resort. (P5)

Generally, participants in this study considered that people from Asian communities would not voluntarily seek help from mainstream health services. Instead they preferred to use prayer and visit temples and churches. Taoism was an important religion as it provided direction about the cause and treatment of mental illness. The family sought help when they were not able to manage the ill person. Some accessed help from a general practitioner (GP) from their country of origin because they believed that the GP would be more likely to understand. Others went to a non-Asian GP to maintain family confidentiality and prevent the risk of information being leaked to their community:

Firstly the culture is such that they don't want people to know. For instance they shy away from going to someone from their own background. They prefer to go to someone who does not know them. (P4)

Language barriers were experienced by people accessing non-Asian doctors and the use of interpreters was costly:

Language is a big problem. . . . Most people will go to their private GP and they will not be able to come across any interpreter service if the GP or medical service will not pay . . . (P5)

### Lack of collaboration

Participants explained that health professionals had to reach into the community to access people if they wanted to demystify mental illness:

You have to have an outreach program you need to go out and see these people and make them aware that you can help them and that you are available. (P9)

One way was to make contact with spiritual/religious leaders as places of worship played a very important role in determining the health belief of these communities:

I think you should go to the temples and spiritual temples. Talk to the priests. This is a way of networking. Talking to the priest to make changes. He knows who is coming and making all of the prayers. (P5)

Health professionals needed to understand the impact of mental illness on the family:

[Health professionals need to] develop more understanding of how Asian people feel about having a family member with a mental illness. If they can understand the traditional thinking, how people think about it. Health professionals can support them and let them know that they are not difference. . . . You need to make them feel that they are not disrespected. (P3)

Also viewed as important were the interpersonal skills of health professionals:

Health professionals have to act with compassion, establish rapport and maintain confidentiality. (P8)

Information should be made available to community groups. Leaflets and written material could be left at temples, churches, community centres and cultural associations for people to read. Other ways of disseminating information is to offer seminars and use ethnic radio stations. It was important to have the information in the language of the audience:

[Disseminate information] through the ethnic communities, church ministries and other ethnic associations. Go

and talk to people have pamphlets in their own language that this is the right place for them to go to and that we [health professionals] are sincere in helping them that it is confidential and that we will do our best. Ask them to try it has to be translated into their own language and you have to be very careful in the word translation. Through [a local community association] they have hours of air-time. (P3)

## DISCUSSION

The results of this study confirm existing documented problems regarding the delivery of mental health care to migrant communities (*National Mental Health Plan* (Australian Health Ministers 1992); Gorman *et al.* 2003)). Participants in this study reported that people from Asian communities seek help within their own cultural networks rather than accessing care from the formal health and welfare sector. This finding is consistent with other research (Gorman *et al.* 2003). Traditional cultural networks provide support along with social and emotional resources to community members during times of stress. To gain access to these communities, health professionals need to collaborate and work with traditional/spiritual and community leaders, acknowledging the importance of these networks on the daily lives of community members. This increased collaboration between community leaders and health professionals would facilitate a more culturally sensitive health service and increase the potential for early intervention with people from Asian backgrounds.

All cultures have a health belief system that determines how members will respond to illness, when they seek help, presenting symptomatology, the methods used to treat illness, and the expected treatment. In some cultures, health belief systems are based more on supernaturalistic aetiologies and as such differ from western explanatory models that are predominantly biological and pathological in origin. It is important to acknowledge that when western explanatory models are applied to some people from Asian communities, misdiagnosis may occur because there are multiple cultural aspects that may influence and impact on the person's behaviour. Conversely, it is also important not to make judgements based solely on the premise that the person is a product of culture. Health professionals need to assess for multifactorial causes of mental illness.

This study found that people from Asian communities who have a mental illness often access the health-care system with predominantly physical complaints. Health professionals treat these complaints but they may not

associate the symptoms with a mental illness. This is supported by Li *et al.* (1999) who found that health professionals perceived most people's symptoms to be of somatic rather than psychiatric origin. Hence, understanding cultural issues is important in obtaining accurate assessments and in providing ongoing mental health care. To assist in the early diagnosis and treatment of mental illness, GPs and other front line health professionals require specific education to assist in the recognition of common cultural manifestations of mental illness in Asian patients. Additional support, in the form of specialist multicultural mental health staff, is also warranted to facilitate the referral of these people to culturally appropriate specialized mental health care.

There is a need for community education programmes for people from Asian communities regarding the causes of mental illness and its treatment. However, based on the findings of this study, the programmes must address the stigma and traditional beliefs held by many people from these communities towards mental illness. Specifically, culturally appropriate education should try to lessen the 'shame' and 'blame' experienced by Asian people who have a family member with a mental illness, as these were major factors impacting on help-seeking behaviours. The findings of this study showed that community members were more likely to 'hide up' the family member and hope that the illness would disappear rather than seek early intervention. Kokanovic *et al.* (2001) also identified that stigma was one of the major issues affecting people's willingness to seek professional help for fear of ostracism from the community. As early psychosis intervention programmes have demonstrated that both family burden and consumer self-related scales of psychopathology are significantly improved after 6 months of intervention (Preston *et al.* 2003), this issue needs urgent attention from health professionals. Families need to be assured that health professionals will maintain confidentiality and educated that early intervention ensures better management of the illness, thus allowing the person to live and work more effectively within their community.

Health professionals working together with members of Asian communities need to identify and develop culturally sensitive material that can be used in educational programmes. This will ensure that the material is translated accurately and has cultural relevance preventing misinterpretations from occurring. Ideally, this material should be made available in culturally appropriate places identified by community members.

The traditional beliefs about the cause of mental illness held by many migrants, make women from Asian

communities particularly vulnerable to mental health problems. In addition, traditional cultural beliefs can exert powerful control over women, for example, by way of arranged marriages and their general social position in society. Any assessment and exploration of the mental health experiences of Asian women must be grounded in an understanding that gender discrimination is present in some of these women's lives. Balarajan and Soni Raleigh's (1993) English epidemiological research adds support to the vulnerability of migrant women. These authors identified that the suicide rate among Asian women (Pakistani and Indian) aged between 15 and 24 years living in England was more than double the national average. For women between 25 and 35 years, this increased to 60% higher. Similarly, the findings of this study highlight the susceptibility of Chinese refugees to depression, feelings of alienation, and suicide. These women's circumstances are often exacerbated by their communities' lack of understanding of mental illness. Therefore, health professionals need to collaborate with community and social workers to identify strategies to increase the level of service provision to this vulnerable group. The impact of mental illness on family life can create a domestic situation that may invoke violence, rejection, discrimination and/or isolation to the woman, her husband and children. Finally, health-care professionals' sensitive and compassionate attitudes may ease the burden that Asian families carry in relation to mental illness. A supportive and caring approach towards members of the Asian community who have a mental illness may facilitate their understanding that they are not alone.

### LIMITATIONS OF STUDY

This study has limitations. Although saturation was reached, some communities making up the Asian geographical area were not represented by participants of this study. Further limitations arose because the researchers were from a different cultural background than participants and experienced difficulties in recruiting participants from Asian communities. As a result, the majority of participants were health professionals and they were well-educated and knowledgeable about the health-care system. While these limitations are recognized by the researchers, data obtained were saturated, comprehensive and expansive. Therefore, the findings add to the available literature on the social context of health behaviours of people from Asian communities living in Australia.

### ACKNOWLEDGEMENTS

The authors would like to acknowledge the assistance of the City of Melville who provided funding for this study through a community grant awarded in 2003.

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