

EXPLORING CULTURAL RESPONSIVENESS OF E-MENTAL HEALTH RESOURCES  
FOR DEPRESSIVE AND ANXIETY DISORDERS

by

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## **Abstract**

**Background:** Canada's culturally diverse populations (CDPs) experience difficulties such as language barriers, difficulty navigating the healthcare system, and lack of culturally tailored resources compared to the general population when accessing mental health services. These surmountable barriers may be addressed by e-mental health (eMH) technologies that allow for mental healthcare to be delivered through the Internet and related technologies. However, little attention has been devoted to understanding the cultural responsiveness of these services among CDPs.

**Objectives:** This study investigates the use of eMH among CDPs for anxiety and depressive disorders in an urban area. Our objectives are to (1) explore the experience of eMH services and gauge their cultural responsiveness, (2) examine participants' digital health literacy, mental health status, and usage of eMH; and (3) develop recommendations based on participants' experiences to improve eMH services.

**Methods:** Participants (N=136) completed a survey regarding their eMH use, the severity of their depression and anxiety symptoms, and socio-demographic characteristics. Participants (N=14) shared experiences through semi-structured focus group discussions. From this, we developed a set of guidelines based on the experiences and recommendations from participants for future eMH resources. Participants (N=5) were invited to provide feedback through one-on-one interviews.

**Results:** Survey participants' ages ranged from 19 to 74 years, with 43% within young adult ages of 19 to 24. Of these participants, 65% were women, 22% were men, while 3% identified as

Trans Male, Non-Binary, or Other. Most survey participants identified as South Asian (40%) or Chinese (28%). The majority of participants (68%) indicated that the eMH resources they used, overall, were not culturally tailored. However, most participants (65%) agreed that the resource was available in their preferred language. Focus group discussions revealed themes of facilitators and barriers of help-seeking behaviours and sociocultural contexts. eMH recommendations suggested by participants' responses focused on including culturally tailored content, graphics and phrases, and lived experiences of CDPs while reducing culturally linked stigma.

**Conclusion:** The findings showcase the need for more culturally responsive eMH beyond language translation, while providing healthcare professionals with a greater and nuanced understanding of treatment needs in cultural groups.

## **Lay Summary**

Canada's ethnic minorities experience difficulties beyond language barriers, compared to the general population when accessing mental health services. Technology can improve quality and access to this underserved population through e-mental health (eMH) where the Internet and other technologies deliver services and information. However, these services must be designed with an understanding of participants' cultural background and preferences for effectiveness.

This study's purpose is to learn more about ethnic minorities' experience with eMH resources in an urban area for mental illnesses such as anxiety and depression. We learned participants want more resources that offer images, stories, and languages of ethnic minorities' cultural preferences while working to break down cultural stigma. Importantly, participants felt current eMH resources do not take into full account their cultural preferences, despite resources translated in their preferred languages. The results showcase the need for more eMH resources to improve ethnic minorities' mental wellbeing.

## **Preface**

This thesis is an original, unpublished, and independent intellectual product of Ms. Shawna Narayan (SN). The research work presented in this thesis obtained ethics approval from the UBC Behavioural Research Ethics Board (Certificate Number: H19-01267; Date of Approval: 2019-09-23), Fraser Health Ethics Board (Certificate Number: 2019-077; Date of Approval: 2019-10-08), and Vancouver Coastal Health Ethics Board (Certificate Number: V19-001267; Date of Approval: 2019-10-30), under the project title “Exploring cultural responsiveness in e-mental health resources for depression and anxiety” with Dr. David Kealy as the Principal Investigator. The study procedures outlined in the thesis were designed and carried out by the author (SN) under the supervision of Dr. David Kealy and co-supervisors Drs. Kendall Ho and Hiram Mok. SN has summarized and presented the contents of this thesis at institutional and national conferences as abstracts, oral presentations, and research posters. SN performed all the data collection and data analysis. Undergraduate research assistants—Ms. Julia Sebastien (JS), Ms. Ms. Monika Jandu (MJ), and Ms. Stephanie Quon (SQ)—supported qualitative analysis of data alongside SN to identify the key themes that emerged. The author will develop forthcoming manuscripts from this thesis.

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## **List of Abbreviations**

CDPs	Culturally Diverse Populations
CBT	Cognitive Behavioural Therapy
CRQ	Cultural Relevance Questionnaire
eMH	e-Mental Health
eHEALs	e-Health Literacy Scale
GAD-2	Generalized Anxiety Disorder – 2 item
HCPs	Healthcare Professionals
PHQ-2	Patient Health Questionnaire – 2 item

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*To those in my inner circle  
who have struggled with  
anxiety and depression*

## **Chapter 1: Introduction**

Mood and anxiety disorders are among some of the most common mental illnesses worldwide.<sup>1</sup>

Such mental illnesses have detrimental effects on society, such as social and financial burden, accounting for about 12% of the global burden of disease<sup>1</sup> and being among the top ten causes of disability-adjusted life years in young adults.<sup>2</sup> In Canada, one in five people will experience a mental health problem or illness in any year.<sup>3</sup> By age 40, 50% of Canadians will have experienced a mental illness.<sup>3</sup> With such high prevalence, a significant number of Canadians will search for resources and support for screening, diagnosis, management, and self-care. However, 49% of Canadians who suffer from depression or anxiety have not seen a doctor for treatment.<sup>3</sup> Evidence suggests that lack of knowledge to identify mental illness symptoms, difficulty accessing treatment, and individuals' perceived stigma increase the likelihood of treatment avoidance.<sup>4</sup> Further barriers to treatment access include long wait times to see mental health professionals and high expenses for psychotherapy.<sup>1</sup>

### **1.1 Role of e-Mental Health**

Mental healthcare has traditionally been practiced through in-person services within clinics and hospital settings. Lately, e-Mental Health (eMH) has emerged by applying information and communication technology to maintain and improve mental health through online resources, social media, smartphone applications, and telepsychiatry.<sup>5, 6</sup> eMH has the potential to address

gaps in mental healthcare, such as accessibility challenges, while being just as effective as traditional in-person care.<sup>6</sup> Services in eMH have countless purposes for patient care ranging from psychoeducation and lifestyle management to symptom monitoring and interventions.<sup>7</sup> These eMH services can be further categorized into synchronous and asynchronous technologies. Synchronous technologies involve live video and teleconferencing by utilizing “two-way, real-time interactive communication.”<sup>8</sup> In contrast to synchronous technologies, asynchronous technologies provide more flexibility and accessibility in receiving psychiatric care without communicating simultaneously.<sup>8</sup> Several studies have demonstrated the validity, reliability, and effectiveness of synchronous technologies in a range of illnesses and diseases,<sup>9, 10</sup> including depressive disorders and anxiety disorders.<sup>9, 11-14</sup> However, less is known about asynchronous technologies, as it has only recently been investigated and practised.

Over the past decade, the proliferation of technology has driven developments in eMH programs, notably in asynchronous technology.<sup>15</sup> One example is a study that successfully employed psychoeducation through text messages in a screening and brief intervention for reducing youth who use substances.<sup>16</sup> A randomized control trial examined the effectiveness of a self-guided cognitive behavioural therapy (CBT) mobile app program for university students, which demonstrated the promise of asynchronous mobile interventions for anxiety and depressive symptoms.<sup>17</sup> Other examples of asynchronous eMH care include platforms that infer behaviour from sensors and activities (i.e., fitness watches), applications that provide therapy, social media platforms (i.e., Facebook) that provide peer-support groups, and applications that help users track and journal health vitals and symptoms.<sup>18</sup> Beyond benefits for patients and clinicians,<sup>8</sup> there are

associated cost savings for the healthcare system.<sup>1, 7, 19</sup> Given enough patient volume, asynchronous telepsychiatry is more cost-effective compared to synchronous telepsychiatry and in-person psychiatric consultations.<sup>20</sup> It could generate affordable mental healthcare by lowering overhead costs and increasing healthcare professionals' (HCPs) efficiency and system capacity by a minimum of 30%.<sup>1</sup> Besides reducing geographical limitations for care,<sup>1</sup> it has the capability to provide cultural and linguistic needs for diverse populations.<sup>21</sup> For example, asynchronous care can deliver services from a culturally competent HCP to “refugees displaced from the same origin but dispersed across multiple countries” without being bound to a schedule, thus increasing accessibility for patients and capacity for HCPs.<sup>1</sup> Furthermore, recent research suggests that visible minority groups are more likely to use asynchronous virtual mental health resources.<sup>22</sup> One factor may be due to the heightened stigma that CDP face with mental illness motivating patients to seek eMH as an alternative to traditional in-person care.<sup>22</sup>

While evidence-based eMH approaches are available and apply to the general population, the literature demonstrates a relative paucity of research on eMH strategies tailored to culturally diverse populations (CDPs).<sup>23</sup> Asynchronous eMH resources, in particular, have been the subject of minimal investigation. The lack of real-time, continuous human interaction makes them less adaptable to different users. Hence, this amplifies the urgency to examine how users experience cultural responsiveness when using such technologies—specifically websites, mobile applications, and other online programs.

## 1.2 Cultural Responsiveness

There has been a shift in the complex terms that define culturally responsive healthcare resources and services to serve the growing diversity in the population.<sup>24</sup> First, we define culture as the “integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.”<sup>25</sup> There are two pathways to consider when describing cultural responsiveness (frequently called culturally appropriate, tailored, or sensitive care). The first approach centres on “cognitive aspects of culture, the ‘values, beliefs and traditions’ of a particular group, identified by language or location.”<sup>26</sup> Often, culturally responsive frameworks grounded in this approach suggest learning about other cultural group’s health beliefs and traditional behaviours. Cultural competency aims to build self-awareness, knowledge, and skills of predominantly White HCPs who work with CDPs. More specifically, we describe cultural competency as the “delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs and values.”<sup>27</sup> This is an ongoing process promising self-evaluation and self-critique, accepting limitations of one’s knowledge, addressing power imbalances by collaborating with patients, and partnering with those who advocate for others.<sup>28</sup> Therefore, it is favourable to understand cultural competency as a process that calls for continuing reflection rather than an end product.<sup>28</sup> HCPs should reflect and be cognizant of their culture and beliefs to “facilitate their understanding and acceptance of difference[s].”<sup>26</sup> Although knowledge of different cultures and establishing cultural competence is integral, much more is needed than knowledge acquisition, such as skills and awareness.



The second approach integrates “culture within a wider, structural framework” centred on social location to explain health status instead of fixating on particular behaviours and beliefs.<sup>26</sup> One related concept is cultural humility which is the “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity.”<sup>29</sup> This approach utilizes cultural humility (sometimes defined as cultural safety) in considering perspectives of colonial impacts on patients’ health and healthcare systems. Colonial impacts have harmed the health of Indigenous and ethnic groups.<sup>26</sup> Therefore, this modern approach provides substantial insight into the health status of these groups, besides traditional beliefs and values. Providing culturally appropriate care develops strong rapport between clinicians and patients from contrasting cultural backgrounds and is progressively being prioritized.<sup>30</sup> From leading research in multicultural perspectives and responsiveness in counselling and psychology, we characterize cultural responsiveness as six principles: (1) decolonization, (2) intersectionality, (3) cultural humility, (4) self-awareness, (5) engagement and connection, and (6) activism.<sup>31</sup>

In this study, we focus on the cultural responsiveness of eMH resources which encompasses the approaches described. Explicitly, we define cultural responsiveness as the delivery of services that address the “cultural and linguistic concerns of all racial or ethnic minority groups and non-minority groups, including their psychosocial issues, characteristic styles of problem presentation, family and immigration histories, traditions, beliefs and values”.<sup>32, 33</sup>

Considering that Canada is home to 37.06 million people who may speak one or more of the 200 languages across the country and 20% of Canadians speak in English or French as their second

language, healthcare systems are challenged in providing mental health services to a diverse population.<sup>34, 35</sup> Cultural limitations, such as lack of ethnic or racial matching for patients with HCPs, may introduce difficulties communicating and may contribute to patients not feeling culturally understood, especially for high-income countries like Canada that are observing a rise in global migration.<sup>1</sup> Mainstream mental healthcare struggles to address the values, expectations, and lifestyles of CDPs.<sup>36</sup>

Trust between users and the platforms they use is crucial for positive treatment outcomes. However, cultural and linguistic differences can make this process challenging.<sup>37</sup> Mental illness symptoms are similar across cultures, but how individuals exhibit, express, and decipher their symptoms vary within cultural contexts.<sup>38, 39</sup> While there is a range of research available on cultural competence, there is a lack of focus on concepts of trust and ways to foster this with CDPs.<sup>37</sup> For example, HCPs' low cultural competence may prompt patients to distrust them and potentially avoid care. Nevertheless, adequate cultural representation may provide a solution. It is important to note, while there are diverse languages spoken in Canada, most people are able to speak English.<sup>40</sup> There are also gains in education among refugees and immigrants.<sup>41</sup> Thus, it may be beneficial to address other cultural responsiveness aspects outside of language availability, such as cultural representation. While there are reports showcasing some ethnic groups have a lower incidence of mental illnesses than White populations,<sup>42-46</sup> CDPs who may require care may be reluctant to seek it,<sup>47</sup> perhaps indicative of the lack of cultural responsiveness and prevailing accessibility challenges.<sup>35</sup>

Notably, the use of technology may positively influence the health of CDPs when designed with cultural sensitivity in mind.<sup>48</sup> Such tailoring helps overcome language barriers, difficulty navigating the healthcare system, and lack of culturally tailored resources.<sup>49</sup> There is evidence that hard-to-reach groups, such as CDPs, are less likely to receive appropriate mental healthcare.<sup>4</sup> Cultural tailoring of eMH resources has the potential to enhance the uptake of treatments and reduce stigma among this population.<sup>50, 51</sup> Considering that eMH services tailored for CDPs would lead to a cost efficiency,<sup>35, 52</sup> focused research on eMH for CDPs would be desirable and timely. Thus, there is a need to explore opportunities with culturally responsive eMH.

### **1.3 Culturally Adapted Interventions**

To learn about current studies, we conducted a literature review focusing on culturally adapted asynchronous eMH interventions for culturally diverse (or ethnic minority) adults in North America. We focused on studies in North America as interventions based in a patient's home country may not fit the needs of immigrants and refugees and their first- or second-generation children. Each group has unique challenges and experiences with language barriers and culture shock. Furthermore, there is evidence that acculturation stress affects the mental health of new residents in North America, which CDPs in their home country would not experience.<sup>53</sup> Whereas

in North America, HCPs and researchers should consider these impacts within culturally adapted interventions.

The search revealed four studies, suggesting that research on such interventions is limited in North America. Most studies delivered eMH through a web program,<sup>54-56</sup> while one was a home-based audio-guided mindfulness intervention.<sup>57</sup> One study focused on providing culturally tailored messages to Asian international students in the United States to reduce depressive symptoms and improve related mental health outcomes.<sup>57</sup> This web-based intervention showcased that culturally adapted messages can significantly improve depressive symptoms, help-seeking intentions, and mental health self-efficacy.<sup>57</sup> Another study focused on two group training sessions alongside low-intensity audio-guided (recorded by a Taiwanese organization) mindfulness practice.<sup>57</sup> Participants in the intervention, compared to controls, showed significantly reduced depression, anxiety, and stress and an improvement in sleep quality.<sup>57</sup> A study focusing on African American participants developed an online depression awareness and suicide prevention curriculum with culturally appropriate content, which showed statistically significant improvements in attitudes about depression with further evidence to benefit health promotion in this community.<sup>55</sup> One study took an innovative approach through a trans-media web program called “Catalina: Confronting My Emotions,” which focused on cultural storytelling to support English-Speaking Latinas suffering from mental health challenges.<sup>56</sup> After one week in the intervention, 39% went to get help for their challenges, and 82% discussed the program with others.<sup>56</sup> Across the course of the study, symptoms of depression and anxiety were reduced, and high levels of confidence and importance were reported.<sup>56</sup>

The cultural adaptations reported in two out of the four studies provided little information about the process of adaptation and its degree of cultural responsiveness in the intervention.<sup>55, 57</sup>

However, the trans-media web program provides in-depth information about their cultural adaptation process involving a Latina woman in the storyline, developing the story with a Latino writer-director, validating the content with culturally competent mental health therapists, and casting Latinx actors.<sup>56</sup> Furthermore, the study utilizing a web program for culturally tailored messages was designed, developed, and tested by Asian international students.<sup>54</sup> The limited number of articles resulting from this literature search is alarming – with no studies conducted with ethnic minority adults in Canada. Perhaps due to systemic racism and other underlying factors, it has not been asked enough whether these services are helpful and useful to CDPs. We need more information regarding the importance of culturally responsive eMH services from those who use them. Given the promising but limited evidence of the efficacy of culturally adapted eMH, we sought to understand CDPs' experiences and use of eMH from a cultural responsiveness perspective in the Canadian context.

#### **1.4 Present Study**

This study investigates the experience of eMH use for anxiety and depressive disorders in an urban area. We aimed to identify CDPs' needs for eMH services. Since we know little about their experience with eMH resources, particularly regarding their cultural responsiveness, we took multiple steps to investigate this area. First, we developed an online survey to receive an overview of the types and experiences of eMH services among CDPs and gauged their cultural

responsiveness. Here, we gathered data to examine participants' digital health literacy, mental health status, and usage of eMH. Second, we conducted focus groups discussions to tap into lived experiences and gather more in-depth data about CDPs' experiences of eMH services and their cultural responsiveness. Lastly, we held one-on-one interviews to provide an opportunity for participants to review developed recommendations derived from an inquiry into responses from members of CDPs. Through these methods, we hope to inform the development of eMH services that will meet the needs of CDPs.

## **Chapter 2: Methods**

### **2.1 Participants and Procedure**

Participants eligible for this mixed-method study were persons whom: (1) were searching for treatments for anxiety and depressive symptoms; (2) were over the age of 19; (3) could understand English on their own or with the assistance of a family member or translator; (4) identified as an ethnic minority and may be an immigrant; and (5) were currently a BC resident within Metro Vancouver. Participants that were excluded were persons whom: (1) were not able to give consent due to cognitive issues or other causes and (2) were not part of an ethnic minority population (i.e., Indigenous and White). We made no exclusions based on socioeconomic status, gender, sexual orientation, or religion. We sought to be inclusive of participants who did and did not use eMH. Recruitment strategies for the online survey included purposeful sampling<sup>58</sup> using the criteria above for online approaches (e.g., advertisements on Facebook and Instagram), posters and flyers at both non-clinical (e.g., diverse community organizations and university student groups) and clinical (e.g., community mental health clinics and hospitals) locations. We invited participants to focus groups and interviews from the survey participant pool. Institutional review granted ethics approval for the study through the University of British Columbia Behavioural Research Ethics Board (H19-01267), Vancouver Coastal Health Authority Ethics Board (V19-001267), and Fraser Health Authority Ethics Board (2019-077). Participants provided informed consent for their data to be used in the study.

### **2.2 Survey**

From October 2019 to November 2020, participants (N=136) completed an online survey on the Qualtrics Core XM (<https://www.qualtrics.com/core-xm/survey-software/>) platform. A hard-

copy survey was available upon request at recruitment locations (see Appendix A). Survey participants were entered into a draw to win a \$100 Visa Gift Card.

### *2.2.1 Measures*

The cross-sectional survey elicited participants' eMH experience by inquiring about participants' eMH use and its cultural responsiveness. We employed a combination of open-ended questions (in expectation of varied experiences in perceptions and to avoid limiting participants' response options) and closed-ended questions (for ease of answering and providing valuable, measurable information). Participants were asked about the frequency and length of eMH resources and services, reasons for using or not using the service, perceived benefits of the service, self-reported impact of the service on wellbeing, and perceived downfalls of the service. Alongside these questions, the survey comprised the validated scales described below.

#### *2.2.1.1 Cultural Relevance Questionnaire*

The Cultural Relevance Questionnaire (CRQ) evaluates a culturally adapted psychotherapy intervention.<sup>59</sup> Inspired by Bernal and Helms, this questionnaire is based on cultural sensitivity and ecological validity theory.<sup>38, 59-61</sup> For our study, we modified the questionnaire using only the first section focusing on the cultural responsiveness questions that better address the aims of this study. Based on Helms' categories of functional equivalence, conceptual equivalence, and linguistic equivalence,<sup>60</sup> we evaluated the eight areas identified by Bernal and Sáez-Santiago—language, persons, metaphors, content, concept, goals, methods, and content<sup>62</sup>—using five questions assessed through a 5-point Likert scale.



#### 2.2.1.2 Patient Health Questionnaire

The Patient Health Questionnaire (PHQ-2) is a screening tool for depressive disorders.<sup>63</sup>

Participants responded to a two-item self-report measure inquiring about the frequency of depressed mood and anhedonia over the past two weeks. Participants' scores ranged from zero to six from the Likert scale, with three being the optimal cut-off to screen for depression. If the score is three or greater, clinically significant depressive symptoms are likely.

#### 2.2.1.3 Generalized Anxiety Disorder

The Generalized Anxiety Disorder questionnaire (GAD-2) is a screening tool for anxiety symptoms.<sup>64</sup> Similar to the PHQ-2, participants responded to a two-item self-report measure inquiring about the frequency of nervousness and uncontrollable worrying over the past two weeks. Participants' scores ranged from zero to six from the Likert scale, with three being the optimal cut-off to screen for depression. If the score is three or greater, clinically significant anxiety symptoms are likely.

#### 2.2.1.4 eHealth Literacy Scale

The eHealth Literacy Scale (eHEALS) is an eight-item questionnaire that measures participants' "combined knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems."<sup>65</sup> It has the potential to provide clinicians with

information about patients who may or may not benefit from referrals to online interventions or resources.<sup>65</sup> Aiming to reduce participants' survey fatigue, we chose four of the eight items using a five-point Likert scale (ranging from strongly agree to strongly disagree) for inclusion in our survey to learn about participants' perceived e-health literacy and ability to use online resources.

### *2.2.2 Data Analysis*

We used descriptive statistics to analyze close-ended questions such as sociodemographic characteristics, CRQ scores, GAD-2 scores, PHQ-2 scores, and eHEALs scores. These were calculated using the Qualtrics Core XM survey platform and Microsoft Excel (Version 16.45). The frequencies of the various responses from open-ended questions were derived through the following process. First, the research team familiarized themselves with the data by repeatedly reading responses to open-ended questions. Next, we developed an initial codebook for categorization based on the study objectives. The codebook included codes such as “cultural factors,” “anxiety,” “depression,” “impact and effectiveness,” and “barriers.” We then categorized the responses and counted frequencies using NVivo 12.6.1 qualitative software (<https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>).

## **2.3 Focus Groups and Interviews**

Participants who completed the survey were invited to one of four focus groups to discuss their experiences with eMH resources and services. We recruited focus group participants through an optional question on the survey. Later, focus group participants were invited on a first-come-first-serve basis to one-on-one interviews to discuss guidelines and recommendations developed

from the survey and focus group findings. Interview participants were recruited by contacting previously interested focus group participants through email. Focus group and interview participants received \$20 CAD cash for their time.

### *2.3.1 Procedure*

Phenomenological methods identify phenomena as participants perceive them and explore the depth of lived experiences.<sup>66</sup> We draw upon this descriptive approach as phenomenology is uniquely positioned to support inquiries that aim to learn others' lived experiences,<sup>67</sup> and “acknowledges social, cultural, environmental and politico-economic contexts.”<sup>66</sup> Considering the nature of our study, phenomenology is advantageous in research areas where little is known or is based on a sensitive topic.<sup>68</sup> Phenomenological data collection methods such as open-ended questions and conversational inquiry allow participants to talk about their eMH experience in their own words, without constraints imposed from closed-ended questions. While participants describe their experience, the interviewer (SN, a Master-level student with experience in phenomenological interviewing) learns and guides the inquiry in response to what is said. By asking meaningful questions, we receive valuable, rich responses in participants' own words and can explore their native cognitive constructs.<sup>69</sup> The focus group discussion guide (available in Appendix B) was designed to elicit participant experiences with eMH services. Before commencing the interview, the interviewers explained the study's purpose and obtained participants' written or online informed consent. The first section of the guide was designed to have participants reflect on resources and services they have used for their mental wellbeing (e.g., Would you like to share your experience with eMH services?). We employed prompts like

“Describe how eMH services can be developed to fit the needs of CDPs better” to identify participants’ specific suggestions for future eMH services considering their experiences as an ethnic minority. The interviewer actively listened to participants’ experiences with eMH resources, asked follow-up questions based on their responses, and explored the details of an experience by asking probing questions. We conducted the first focus group in-person at a meeting room at Vancouver General Hospital with two participants. Due to COVID-19, we conducted the following three focus groups through Skype for Business (<https://www.microsoft.com/en-ca/microsoft-365/skype-for-business/>) as per online-ethical protocols. The second focus group had four participants, the third had five participants, and the last focus group had three participants. Each discussion ranged from 42 to 65 minutes. Each participant chose a pseudonym to preserve anonymity.

The semi-structured one-on-one interviews extended the focus group discussions. Findings derived from the survey and focus group data became the basis of recommendations later discussed in this paper. In order to verify participants’ perspectives, refine the developed recommendations, and triangulate (precisely data source triangulation)<sup>70</sup> findings, five interviews were conducted. We invited participants who took part in focus group discussions to share their thoughts about the recommendations developed from the study’s findings. In an effort for participants to member check our recommendations,<sup>71</sup> we used an interview discussion guide (Available in Appendix C) to ask questions such as “What do you think about the recommendations presented?”, “Are there any further recommendations that you feel are missing?” and “Do these recommendations align with your experience as an ethnic minority

accessing mental health services?” The interview followed the same protocol as the focus group sessions. Interview length ranged from 32 to 56 minutes. We held these interviews through Zoom (<https://zoom.us/>) due to COVID-19.

### 2.3.2 *Analysis*

We applied a phenomenological approach for qualitative data analysis with a focus on individuals’ lived experiences within the lifeworld. Here, lifeworld is “the idea that individuals’ realities are invariably influenced by the world in which they live.”<sup>72</sup> Being aware of the lifeworld, how we interact with others, and absorbing the importance of our place in the world provides a better understanding of lived experiences.<sup>73</sup> Closely linked to understanding lived experiences is the idea of the intentionality of consciousness (how meaning is experienced) and our natural attitudes of experiences.<sup>73</sup> Foremost, we recognize that when researching lived experiences, an emphasis must be placed on the phenomena while also being open to the lifeworld. The research team adopted an open stance to the meaning of lived experiences while being observant, attentive and sensitive to the expression of the experiences.<sup>74</sup> We reflected on preconceptions and judgements concerning the world.<sup>73</sup> Alongside this openness, the research team recognized and questioned their pre-understanding by “identifying and becoming aware of preconceptions that might influence the analysis.”<sup>73</sup> Engaging in critical reflection facilitates awareness of how research members influence the research process.<sup>73</sup> These methodological concepts (i.e. emphasizing openness, questioning pre-understanding and adopting a reflective

attitude) relate to phenomenology's ontological and epistemological foundations and guide our thematic analysis.<sup>73</sup>

The thematic analysis aims to identify, analyze, and report patterns within data.<sup>75</sup> These patterns are ascertained through a rigorous process of data familiarization, coding, theme development, and revision. The focus group interviews and one-on-one interviews were audio-recorded and transcribed verbatim. We followed Braun and Clarke's six steps of thematic analysis,<sup>75</sup> while aligning with the philosophical underpinnings of descriptive phenomenology.<sup>67</sup> First, data was anonymized, securely filed electronically with identifying details removed, and managed using NVivo 12.6.1 qualitative software. Each transcript was verified for accuracy by SN, repeatedly read with an open mind for familiarization by JS, MJ, SN and SQ while searching for meanings and patterns.<sup>75</sup> This step demonstrates the principle of openness, intending to open our mind to the data and its meanings.<sup>73</sup> Second, we created codes that reflect key features of data relating to the study objectives. The focus group codebook was developed based on the aim of the focus group interview guide; it included codes such as "race," "psychotherapy," "online," "goals and intentions," and "stigma." The codebook for the one-on-one interviews was developed based on its interview guide, which included codes such as "recommendations," "stakeholders and knowledge users," and "specific changes." Research members (JS, MJ, SN, SQ) coded the raw data line-by-line while considering recurring and contrasting codes across the data. The credibility of the analysis was further enhanced by having two members analyze each transcript. Third, we examined codes and collated data to identify potential themes. The methodological concepts discussed earlier reminded research members to keep a reflective mind while meanings

are developed into themes. Differences between interpretations and reflection of the analysis process were addressed through a debriefing meeting with research members. Fourth, we checked the applicability of themes to the data. For each theme, the quotations were synthesized to bring out the key ideas. Fifth, we provided informative names of the themes. Lastly, we wrote the data results to outline intrinsic meanings from participants' described experiences.

## Chapter 3: Results

Below, we present our findings in two sections similar to the layout of the study methodology.

We offer quotations from participant surveys and focus group transcripts showcasing significant features of these narratives (shown in *italics*). Each quote briefly describes the participant's sociodemographic profile presenting their age range, gender, and ethnicity. Participants chose pseudonyms for focus groups and interviews, and researchers assigned numerical identifiers for surveys.

### 3.1 Survey

#### 3.1.1 *Description of Participants*

Completed surveys were received from 136 participants with sociodemographic characteristics shown in Table 1. There were respondents from 12 municipalities across Metro Vancouver, British Columbia. One-third (33%) of the sample was made up of Vancouver residents, 29% were from Surrey, and 14% lived in Burnaby. Participants' ages ranged from 19 to 74 years, with a little less than half (43%) within the young adult ages of 19 to 24. Most participants (80%) had some experience with post-secondary training or education. Almost half of the participants were students (49%), with 58% of students attending the University of British Columbia and 18% attending Simon Fraser University. Participants' mental health status varied. About one-third (32%) of participants reported an HCP diagnosed them or treated them for an Anxiety Disorder, 28% for a Depressive Disorder, and 18% for another mental illness. The remaining 22% did not disclose a mental health diagnosis. According to the PHQ-2 assessment, more than a third (37%) of participants had a score of three or higher, indicating a likelihood of clinically significant depressive symptoms. Similarly, almost half (42%) had a score of three or higher, indicating a



likelihood of clinically significant anxiety symptoms based on the GAD-2 assessment. Of the respondents, about two-thirds (65%) were female, less than a quarter (22%) were male, and a few (3%) identified as a trans male, non-binary or other. Participants identified their ethnicity as South Asian (40%), Chinese (28%), White (6%), West Asian/Arab (6%), South East Asian (4%), and Filipino (3%).

Table 1. Sociodemographic characteristics of the survey sample

Sociodemographic Characteristics	
<b>Participants</b>	136
<b>Age<sup>1</sup></b>	
19 – 24 years	<b>59</b> (43%)
25 – 34 years	<b>40</b> (29%)
35 – 44 years	<b>12</b> (9%)
45 – 54 years	<b>12</b> (9%)
55+ years	<b>5</b> (4%)
Did not disclose	<b>8</b> (6%)
<b>Gender</b>	
Male	<b>30</b> (22%)
Female	<b>89</b> (65%)
Trans Male	<b>2</b> (1%)
Non-Binary	<b>2</b> (1%)
Other	<b>2</b> (1%)
Did not disclose	<b>11</b> (10%)
<b>Ethnicity<sup>2</sup></b>	
White	<b>9</b> (6%)
Arab/West Asian	<b>8</b> (6%)
Chinese	<b>40</b> (28%)
Filipino	<b>5</b> (3%)
South Asian	<b>57</b> (40%)
South-East Asian	<b>6</b> (4%)
Other	<b>13</b> (9%)
Did not disclose	<b>6</b> (4%)
<b>Diagnosis<sup>2</sup></b>	
Anxiety Disorder	<b>67</b> (32%)
Depressive Disorder	<b>59</b> (28%)
Other Mental Illness	<b>38</b> (18%)
Did not disclose	<b>46</b> (22%)
<b>PHQ-2</b>	
Positive (Score of 3 or higher)	<b>47</b> (35%)
Negative (Score below 3)	<b>86</b> (63%)
Did not disclose	<b>3</b> (2%)
<b>GAD-2</b>	
Positive (Score of 3 or higher)	<b>54</b> (40%)
Negative (Score below 3)	<b>79</b> (58%)
Did not disclose	<b>3</b> (2%)

<b>Education</b> <i>Some secondary schooling</i> <i>High school graduate</i> <i>Post-secondary training</i> <i>Some college</i> <i>Bachelor's degree</i> <i>Master's degree</i> <i>Doctorate degree</i> <i>Professional degree (e.g., MD, JD)</i> <i>Did not disclose</i>	<p><b>2</b> (1%)</p> <p><b>15</b> (11%)</p> <p><b>3</b> (2%)</p> <p><b>34</b> (25%)</p> <p><b>48</b> (35%)</p> <p><b>21</b> (15%)</p> <p><b>2</b> (1%)</p> <p><b>3</b> (2%)</p> <p><b>8</b> (8%)</p>
<b>Residency</b> <i>Burnaby</i> <i>Coquitlam</i> <i>Delta</i> <i>New Westminster</i> <i>Richmond</i> <i>Surrey</i> <i>Vancouver</i> <i>Other areas of Metro Vancouver</i> <i>Did not disclose</i>	<p><b>19</b> (14%)</p> <p><b>3</b> (2%)</p> <p><b>6</b> (4%)</p> <p><b>3</b> (2%)</p> <p><b>6</b> (4%)</p> <p><b>39</b> (29%)</p> <p><b>45</b> (33%)</p> <p><b>5</b> (4%)</p> <p><b>10</b> (8%)</p>
<sup>1</sup> Participants chose an age range as a response <sup>2</sup> Participants could choose more than one option	

### 3.1.2 eMH Use

The majority of survey participants (79%, N=108) survey participants have used eMH resources before. Most participants (43%) use mobile applications at least once per week. Other eMH resources and services used were websites (41%), online videos (41%), online programs (25%), and wearable technology (22%) at least once per week. Further details on eMH use are shown in Table 2. Participants (N=104) reported that anxiety disorders (33%), depressive disorders (15%), and managing their overall wellness (11%) were their primary reason for using eMH resources. Participants also indicated using eMH for relaxation techniques (28%) or coping with symptoms (12%). A tenth of participants (10%) specifically stated to use eMH to help others or themselves. About a fourth of participants (24%) were interested in gaining more knowledge about mental health to learn about themselves, their condition, or specific resources. Few participants (6%) appreciated the ability to track and monitor their symptoms through eMH. Some examples include mindfulness exercises, breathing control, heart rate monitoring, sleep tracking and mood tracking. A little over a third (34%) of participants also mentioned seeking mindfulness or meditation. A few participants shared they use eMH because of its accessibility (4%), for specific apps (5%), or use with a smartwatch (3%).

Of the 21% that do not use eMH resources, half of them (50%) shared they were unaware that such resources and services were available. Other participants said that they did not use eMH resources due to their skepticism of eMH. Over a quarter of participants (27%) did not use eMH resources because they thought they did not need such help (i.e., self-help resources), while a few participants (8%) rather use in-person services. One participant stated eMH is “*too difficult*

*to start using, and the benefits are not as obvious or proven”* (Participant ‘O20200406120’, West Asian/Arab, aged 19-24, male).

*Table 2. eMH use results*

<u>Participants e-Mental Health Use</u>	
<b>How often do you use online programs?</b>	
Never	31% (34)
At least once a week (daily/weekly)	25% (27)
Once per month-year	44% (47)
No Response	0% (0)
<b>How often do you use websites?</b>	
Never	6% (7)
At least once a week (daily/weekly)	41% (44)
Once per month-year	52% (56)
No response	1% (1)
<b>How often do you use online videos?</b>	
Never	19% (21)
At least once a week (daily/weekly)	41% (42)
Once per month-year	42% (45)
No Response	0% (0)
<b>How often do you use applications?</b>	
Never	20% (22)
At least once a week (daily/weekly)	43% (46)
Once per month-year	35% (38)
No Response	2% (2)
<b>How often do you use wearable technology?</b>	
Never	71% (77)
At least once a week (daily/weekly)	22% (24)
Once per month-year	6% (6)
No Response	1% (1)

### 3.1.3 Positives of eMH Use

Many participants indicated that they liked the fact that the eMH services they utilized were accessible (42%), convenient (25%), and free (12%). For example, Participant ‘O20200403114’—a 25-34 aged Chinese female—shared that they find eMH services “*easily accessible*” and enjoyed having “*access to [their] own data*” while using services at “*[their] own pace and find what works for [them]*.” Participant ‘O2020010739’—a 25-34 aged South Asian female—shared that eMH services gave them a sense of control and empowerment, especially those that provide access to health data. eMH helped monitor changes while also allowing for “*a level of accessibility that the current healthcare model does not provide (i.e., cost, travel barriers, appointment wait times)*.” The participant shared that “*these are complementary tools that [they] use with other mental health resources [and] allow [them] to see mental health as something beyond medicine*.” Alongside these responses, some participants endorsed sundry qualities of eMH services. Some participants (15%) enjoyed the privacy of eMH services granting them to use eMH services discreetly without fear of judgement from family, friends and strangers nearby: “*I liked that it was relatively low-commitment and that I could access them in the privacy of my own home. The latter being more important for me, as much of my culture is based around the idea of ‘saving face’ and not displaying signs of weakness*.” (Participant ‘O201910171’, 19-24 aged Chinese female). Additionally, 14% of participants referred to eMH services as timely and flexible, permitting the use of services at a time and location that is best for them, provided they have a stable internet connection. Other participants (13%) liked the usability of the eMH services. About a tenth (9%) liked the informative nature of services. It was uncommon (7%) for participants to share their likeness of eMH functions that allow them to track their mood for personal progress. Similarly, only 7% of participants indicated their

enjoyment with having various resources available to them as part of eMH. Overall, participants appreciated eMH for accessibility and convenience, while a few other features were valuable for only some participants.

### 3.1.4 *Negatives of eMH Use*

The most frequent negative attribute of eMH services described by participants was the abundance of the general information provided (19%), signifying the scarcity of personalized information in eMH. For example, a 25–34-year-old Non-binary/Woman-flux Participant ‘O2020020560’ shared: *“Some apps can be very obviously limited in their ability to aid in my specific needs. Many are neurotypical centric or aimed at cisgender heterosexual and binary persons without including the needs for those outside of those assumptions.”* Many online eMH services opted to use a *“one size fits all approach”* and neglected to acknowledge that each individual has unique needs. Furthermore, some participants described searching through many resources before finding what worked for them. Besides the general information, few participants stated their resources are *“wordy”* and often used *“scientific language”* that is hard to understand and intimidating. Some participants shared their dislike for the nonexistent personal connections (17%) and ineffective services (11%). Other unpopular qualities were costs related to resources (11%), more effort than expected to utilize resources (9%), lack of credible information (4%), no accountability functions (5%), and lack of cultural context within these resources (4%). These responses unveil desired improvements for eMH, notably personalized and tailored eMH services for CDPs.

### *3.1.5 Perspectives of Cultural Responsiveness*

Through the adapted Cultural Relevance Questionnaire, the majority of participants (68%) indicated that the eMH resources they used, overall, were not culturally tailored (results are shown in Table 3). Furthermore, participants disagreed that specific aspects of the resource were culturally tailored. The resources participants used did not include expressions (61%), symbols and concepts (68%), phrases (71%), and people (56%) from their cultural group. Interestingly, most participants (65%) agreed that the resource was available in their preferred language. Those who did not use eMH resources and services (N=28) shared that resources should include expressions familiar to their cultural group (75%), people in their cultural group (89%), symbols and concepts shared by their cultural groups (75%), phrases used by their cultural group (79%), and their preferred language (89%). Overall, the majority of those who did not use eMH resources and services felt it was important to have the resource culturally tailored to users.



Table 3. Adapted CRQ results

<b>Cultural Relevance of eMH Resources Used</b>	<b>Participants who use eMH (N=108)</b>			<b>Participants who did not use eMH (N=28)</b>	
	<b>Agree</b>	<b>Neither</b>	<b>Disagree</b>	<b>Some Importance</b>	<b>No Importance</b>
<i>The resource involves expressions familiar to your cultural group</i>	13% (14)	26% (28)	61% (66)	75% (21)	25% (7)
<i>The resource includes people in your cultural group</i>	20% (22)	24% (26)	56% (60)	89% (25)	11% (3)
<i>The resource includes symbols and concepts shared by your cultural group</i>	15% (16)	18% (19)	68% (73)	75% (21)	25% (7)
<i>The resource includes phrases used by your cultural group</i>	10% (11)	19% (20)	71% (77)	79% (22)	21% (6)
<i>The resource was available in your preferred language</i>	65% (70)	11% (12)	24% (26)	89% (25)	11% (3)
<i>Overall, the resource was culturally tailored to you</i>	12% (13)	20% (22)	68% (73)	89% (25)	11% (3)

To learn more about the types of cultural adaptations participants prefer, we analyzed open-ended questions asking participants what they would like to see in future eMH services considering their status as an ethnic minority. Approximately one-third (32%) described cultural factors frankly mentioning the need for culturally appropriate, competent, and sensitive resources, focusing on specific cultures, recognizing how culture impacts mental health, and considering cultural barriers. About a quarter of participants (23%) wished to see more resources, information, advice, and promotion for CDPs in the future. Participants (17%) described the need for improved translations and increased language offerings for resources. A little over a tenth of participants (12%) hoped for future eMH resources to focus on family orientation and structure as well as spirituality and religion. For example, a 19–24-year-old South Asian female (Participant ‘O2020011252’) shared a desire for “*more resources to support [them] when encountering stigma from family, and ways to help [their family] understand [her] perspective and needs.*” Alongside participant ‘O2020011252’, few participants (5%) precisely wished for mental health stigma to be addressed through eMH.

Moreover, participants (13%) described a need for greater representation of diverse cultures suggested the integration of stories of people of similar backgrounds going through similar issues. One-tenth of participants (10%) suggested having resources to address challenges affected by generational and nativity status. For example, a 19–24-year-old participant ‘O2019110617’ said, “*First-generation folks like me struggle a lot with cultural values that clash (heavily) at times. It's a very big source of stress. Most people can sympathize but really can't empathize.*” Similarly, a memorable quote from participant ‘O2020040111’, a 35–44-year-old

South Asian male stated: *“I am not 'Indian' I am not exactly mainstream 'Canadian.' I would like to see more content created specifically for second or third generation South Asian Canadians. Our experience is unique and cannot be imported from India.”*

Negative experiences with mental healthcare providers and culturally linked stigma were described as barriers that could be addressed in developing future eMH resources. For example, participant ‘O2020032186’, a Chinese female, said:

*[There is a need for] more representation in mental health service providers; I've definitely felt racism and cultural gaps when dealing with some Caucasian providers, while fellow Asian providers have been more effective. Part of it is understanding the specific cultural implications and how it changes dynamics, and the other part is openness and understanding, instead of assuming or categorizing my mental health issues without fully understanding it.*

As such, some participants (8%) hoped future eMH resources would address experiences of inter-generational trauma, discrimination, and racism.

Participants who did not use eMH services suggested that their motivation to use eMH could be improved with increased accessibility (31%) of the resources, more promotion to enhance awareness of existing resources (27%), and improvements with usability (15%). It is crucial to consider participants’ digital health literacy and its influence on the accessibility and usability of eMH. As reported by the modified eHEALs scale (Table 4), most participants (79%) were knowledgeable in using health information from the Internet for support. 78% of participants

reported knowing how to find helpful health resources on the Internet. 72% were skillful in evaluating health resources. Roughly two-thirds of participants (63%) felt confident in using information from the Internet to make health decisions. Overall, participants were relatively secure in their perceived abilities to use technology.

*Table 4. Modified eHEALS results*

<b>Digital Health Literacy (N=136)</b>	Agree	Undecided	Disagree	No Response
<i>I know how to find helpful health resources on the Internet</i>	78% (106)	10% (13)	10% (14)	2% (3)
<i>I know how to use the health information I find on the Internet to help me</i>	79% (108)	6% (8)	13% (17)	2% (3)
<i>I have the skills I need to evaluate the health resources I find on the Internet</i>	72% (98)	14% (19)	12% (16)	2% (3)
<i>I feel confident in using information from the Internet to make health decisions</i>	63% (86)	18% (24)	16% (22)	3% (4)

## **3.2 Focus Group and Interviews**

The focus group discussions emphasized and further supported survey findings relating to eMH use, advantages and disadvantages of eMH resources, participant perspectives of cultural responsiveness, and suggestions for eMH. In focus group discussions, participants described using various programs and services to support their mental wellbeing, such as women empowerment groups, networking groups, YouTube channels, resources and websites, mobile apps, and chats. In this section, focus group participants are presented using a pseudonym of their choice.

### *3.2.1 Description of Participants*

Fifty-nine (43%) participants were interested in sharing their eMH experience in a focus group. After following up with those interested, 14 participants completed consent forms, scheduling requests, and sociodemographic questionnaires. The average age of focus group participants was 38 years old (standard deviation = 17 years), ranging from 19 to 73. Most focus group participants identified as female (64%), while 14% identified as male and 14% decided not to share their gender. One focus group participant identified as a woman flux, non-binary person. In a similar pattern as survey results, 36% of participants identified their ethnicity as South Asian, 36% as Chinese, and 14% as Southeast Asian. One participant chose not to share their ethnicity. Another participant identified as mixed-race, Latin American and White.

### 3.2.2 Key Themes

Analysis of the focus group data yielded two key themes: (1) facilitators and barriers of help-seeking behaviour, and (2) sociocultural contexts. Note: There are some areas in which subthemes overlap. Below, we further discuss these themes.

#### 3.2.2.1 Facilitators and Barriers of Help-Seeking Behaviour

##### Facilitators of Help-Seeking Behaviours

Many participants emphasized the benefits of eMH resources and services that facilitate care. Most of these narratives echo the suggestions of survey participants. A 61-year-old South Asian male named Gary captured many of the advantages of eMH. He said that flexibility in accessing resources allows users to “*not be constricted by office hours or availability of a person who’s going to provide those resources*” by choosing when “*you want to get those resources*” while “*in the safety of [your] safe environment.*” This way, those who use eMH can avoid difficult or overwhelming experiences. Gary further suggested that sitting in an office, and other health settings, can overwhelm those who have anxiety or panic disorder. One advantage of eMH is the ability for users to end the session whenever they want, without further explanation or difficulty.

While some do not consider social media as an eMH resource or service, there are online groups and chats explicitly for peer-support mental wellness services similar to eMH interventions for CDPs. The main difference is the platform used (ex. Facebook vs researcher-created website) and content monitoring. Nevertheless, participants shared experiences that can be extrapolated for preferences of eMH. For instance, stories from social media users of the same cultural

background were valuable to participants. Participant Orange—a 25-year-old, Woman-flux/non-binary, White and Latin American participant—enjoyed a chat app specific for gamers (i.e., Discord) and support groups as part of their mental healthcare. They shared that there were advantages of being a part of informal and formal support groups and that integrating these aspects into eMH can be beneficial:

*...it's still allowing the benefits that both can offer. So, that way, if someone can't go to the formal group, they might still be able to talk in the informal group about things that were talked about without going into specifically who talked about them, for example, to keep confidentiality in the formal group from interfering with that.*

Orange's narrative is similar to what other participants suggested regarding integrating eMH with in-person care to have a more comprehensive and in-depth mental healthcare plan to support their wellbeing. Diamond—a 23-year-old Chinese female—shared her experience using a website to help manage her symptoms, complete “*Quality of Life assessments*,” and “*maintain stability*” for bipolar disorder. On the other hand, 59-year-old South Asian female, Mary, needed mental healthcare that could “*come to her*” as her mobility challenges required her to access eMH resources at home. She enjoyed browsing the plethora of resources available as these resources were not limited to geography. Similarly, for a 22-year-old female Southeast Asian named Alana, virtual access was conducive for counselling sessions as she felt she did not need to “*disclose to others*” about her treatments. Since it was based online, she could use services from the convenience of her home without an intimidating experience to find services in person. The accessibility and privacy features of eMH were common facilitators of help-seeking behaviours described by participants, matching with the responses of survey participants.

### Barriers of help-seeking behaviours

Participants revealed some negative experiences with eMH services, often revealing help-seeking barriers. For example, affordability was a concern for many focus group participants.

Participant Alana shared her experience as a student receiving online counselling and her disappointment with the cost:

*I think it's just really expensive to get counselling either online or offline, and I found the online mental health resources that I tried to access for about the same price as in-person mental health resources, and they weren't quite beneficial to me either. So, I felt a bit more depressed as I was losing money, and it didn't even really work out.*

Another help-seeking barrier was difficulty in finding credible, accessible information online.

Taking this initial first step, as described by Gary, was a “*frustrating process*.” Several participants shared their path to find resources often resulted in a lengthy process to find appropriate, evidence-based information. Here, Wendy—a 51-year-old Chinese female—shares her perspective in finding resources through a search engine, which may be precarious for other individuals:

*...Trying to filter what website to use for the information can sometimes, there's a lot of, you know, contradiction there. So for me, I do know how to select and get to the right one, but for people who actually have no medical knowledge or anything at all, it could be quite difficult because also, like Google would list, whoever paid for services or whatever...So, I think if it's like e-platform that are built through the channel for health authority based or university-based, you know it has gone through strenuous you know, review by the selected, right group of people.*

Wendy advocates for evidence-based eMH supported by a reputable institution, which other participants also mentioned. Alongside challenges of finding credible information from a reputable organization, a 25-year-old Southeast Asian called Sinnie shared that eMH can “*feel*



*like there's some connection lacking when it comes to communicating.*" Some participants enjoyed aspects of in-person services and hoped to feature this personability and feeling of accountability into eMH. Other barriers of eMH included the use of academic languages and lack of diversity in languages. Here, Mary discusses how ample promotion of eMH and more diverse languages could help bring awareness:

*It would be really nice to have it in, in other languages, just advertised or put out when it's on bus shelters the way they put different things, something where just going to the grocery store or whatever there would be notices saying, in different languages saying almost like a helpline you know?... So, to be able to see multiple times, sort of an outreach, like a hand, even if just in the other language, you can call, if you need help you can call, or you can go to the site, like an invitation. I think seeing that multiple times on a way to a grocery store or the neighbourhood, or community newspaper or online. Something that would reach out to say, 'It's okay to try this out'.*

Considering that about half of the survey participants who do not eMH services were not aware of eMH services, Mary's suggestion may help reach ethnic communities and gives light to the lack of cultural diversity, specifically language diversity in resources and services. This language gap was a mutual challenge Diamond experienced through her work in Chinatown. If monolingual elders required support, *"they wouldn't know where to look."* There are limited resources and promotional materials that are provided in languages other than English. While these barriers hindered help-seeking behaviours, further barriers relating to sociocultural contexts—such as the lack of language diversity discussed by Mary—are shared in the next theme.

### **3.2.2.2 Sociocultural Contexts**

#### **Culturally Linked Stigma & Familial Challenges**

Stigma within participants' cultures was extensively discussed. A 37-year-old Chinese female named Natasha shared that topics of mental health and substance use are generally stigmatized in society, but perhaps more so in ethnic communities. Despite resources being translated, she felt it was difficult to feel culturally accepted just through translation. Relating to a 73-year-old South Asian female called Gulshy, some people may be experiencing denial and struggle to accept their mental illnesses due to their cultural background or lack of knowledge. These experiences can contribute to stigma within CDPs. While participants discussed stigma in the community generally, there were also instances of stigma within participants' families. Participants shared that mental health and related illnesses are not spoken among culturally diverse populations to "save face" or uphold family reputation and honour. Participants shared their hesitance in accessing resources in person due to culturally linked stigma. However, here Wendy describes using eMH to work around facing stigma in their culture:

*I'm Chinese, and there is a big stigma around [the] Chinese community, as well as, I mean not just older generation, but younger generation as well and the Asian, you know the Asian community on a whole, have a stigma about mental health... If you're accessing, like psychiatric support, you're being seen as a 'mental patient,' so there's a huge stigma around it. So from my journey, learning about their platforms online and you can talk to a counsellor or anyone on the phone is brilliant. Or material like CBT materials can turn you to tune in every day. So you feel like there's a contact point, and you're not alone, and then the exercise with CBT can take you through every day. And I think that's a very good thing, and if people are still worried about stigma, they can do it in the privacy of their own home without anyone knowing or they can go somewhere else, so I think I can see a lot of positiveness within that.*

Some participants shared that they did not feel they could openly discuss their mental health with their family members. For example, a Chinese female participant, Aiden, said:

*I think one big thing from my culture is that there is a lot of shame when it comes to getting help for mental health because having mental health issues is seen as like a shortcoming or a character flaw. And I think a lot of people are scared to access those, or scared for their peers, or their families to know that they're accessing those resources, because I can tell you when I was diagnosed and I had to put on medication, my parents flipped out. They were like, 'What's wrong with you?' And I think that stopped a lot of people from getting help. But I also think that stopped a lot of people from getting properly diagnosed.*

Inter-generational familial conflicts were discussed among participants. Older generations did not openly talk about mental health challenges, and treatments, such as medication, were not accepted. Many participants agreed that resources must address how to discuss mental illnesses with families that perpetuate stigma. Diamond specifically mentioned how her family suggested religious or spiritual services to help her:

*Before I got hospitalized two years ago, my parents were telling me to go to the Buddhist temple. So I think there's [sic] many aspects that would have to be targeted... just like more kind of general education, that's like broadcasted more so people see. Like, I think visibility is a very big thing, which is why I talk about my bipolar very openly because I think if I had seen more Chinese women, even if I had seen one Chinese woman talk about her experience with bipolar and like research papers on it, or whatever, things like different health resources on it, then I would've been like, 'Oh, even if my family doesn't think that this is a legitimate thing yet, I know it is for a fact. And there are these resources that [I] can still seek or are still accessible to me.'*

Diamond's desire for more representation was common across all focus group discussions, and further pointed to having more family-specific resources in helping to manage participants' mental wellness. Further in the discussion, she and other participants shared the commonality of cultural populations being “*silent about mental illness*.” For many, mental illness is not acknowledged or believed and becomes shameful for their ethnic families. By not talking about mental illness and its effects, many feel society is “*moving backwards*” as more people will not

seek care if people do not talk about it. Leading into the next subtheme, we share 19-year-old South Asian female participant MK's suggestion for future eMH: Having someone who *“speaks the same language as you, and second of all, that understands, maybe, the metaphors used in your culture”* can help mitigate stigma and barriers in help-seeking behaviours. By having *“someone from the same culture or background,”* CDPs can receive the help they need.

### Cultural Competency & Representation

Stories supporting the urgency for culturally competent eMH services were frequently conveyed in focus group sessions. Some participants shared positive experiences with synchronous eMH (i.e. virtual counselling) relating to this. For example, MK's experience with their streamlined university eMH service efficiently helped to find an HCP with cultural familiarity:

*From my navigation of the 'My SSP' app, I see that they accommodate different languages... They had partnered with them to kind of allow you to speak with someone of your own ethnic group who understood your own cultural background, so when you're signing up for the... 'My SSP' app, they ask you all these questions like 'What's your ethnic background?' and 'How important it is for you to be with someone who is of your own culture?' and stuff. So that, I found that was great.*

Many participants underscored their desire for cultural responsiveness in eMH by describing previous experiences of in-person care in which cultural competence was lacking. Sinnie requested more cultural competency training for counsellors, online and in person. She felt they were *“not as inclusive”* and that she *“could feel their judgement.”* She suggests that this may be due to the systemic challenges since the services seemed *“provider-centred versus patient-centred”* and were resistant to change for the benefits of the patient (ex. *“This is how [we have] done it forever, and this is how we're going to keep it.”*) She felt that if HCPs were upfront about their lack of knowledge about a patient's culture and *“just admit[ted] it,”* patients would be

happy to tell them more to help facilitate the learning process. She added that if a “*person feels more safe with a blanket, then go and buy a blanket.*” These little things “*mean everything to the patient.*” Adding to this, Alana’s suggestion of having culturally diverse counsellors could help provide adequate eMH care:

*I think adding counsellors from different ethnic backgrounds would really help. Counsellors who actually know the kind of things from different backgrounds or cultures because they went through similar things. They were just like cultural differences between people from different cultures—between say Chinese, Indian, Asian and White culture—it’s actually just very different and knowing that there are counsellors who are able to relate to people from different backgrounds would be very helpful. Just having their bios up there, and maybe the person would be able to choose who to talk to.*

Her recommendation hopes to showcase biographies of counsellors available at virtual clinics through their website. This aligns with some participants’ experiences, highlighting the importance of having access to ethnic minority mental healthcare providers for their wellbeing, in-person and online. Another suggestion by participants Neil and Diamond was to use testimonials showcasing the efficacy of eMH resources and further promote the representation of diverse people by sharing their cultural backgrounds. These in-person narratives describe the commitment for eMH to avoid replicating the lack of diversity within emerging resources.

Participants indicated that traditional mental health services are not always centred on patient needs and cultural sensitivity, suggesting the potential for eMH to ameliorate this problem by becoming culturally responsive. For example, Diamond shared a challenging in-person experience that may apply to eMH services that include HCPs:

*...I'm Chinese, and I feel like the doctors, the multiple doctors, psychiatrists, and like, psychologists that I had were primarily White men... There was one main incident in my hospitalization where it took me four visits to different hospitals before anybody would take me seriously...I had, like people who I just felt like they culturally didn't understand some of the things that I was talking about.*

Participants indicated additional challenges faced by immigrants in obtaining mental health resources, highlighting the prospect of eMH becoming not only culturally responsive but tailored to the adjusting needs of culturally diverse immigrant communities. Diamond added that fostering a sense of community and the “*not feeling alone aspect*” is necessary for minorities, especially “*immigrants who might not have a very big support network, to begin with here.*” Neil agreed with this, sharing that for new immigrants, “*no matter which culture they come from,*” they are already facing challenges “*adjusting to life in Canada, and they might not be aware of all the resources that are available.*” He added that adjusting to the incoming language is a challenge that may lead to difficulties in finding eMH resources.

Like some survey responses, MK shared that their experience as a child of a first-generation immigrant should be reflected in future resources. Those who have immigrated may have unique experiences dealing with acculturation stress, cultural assimilation and cultural bereavement. Furthermore, older people in ethnic cultures would have different mental health challenges and experiences that need to be addressed. Natasha suggested this could be improved by “*connect[ing] with and get[ting] feedback from different cultural communities,*” not just at the point of developing these resources but also, after implementing these resources, to improve cultural communities’ engagement for sustainability further. The inclusion of CDPs within the development and evaluation processes allows users to feel represented while also considering their specific needs.

### *3.2.3 Validity Check: Interview Results*

The focus group revealed meaningful suggestions for the development of eMH, improving cultural responsiveness in mental healthcare, and breaking down cultural barriers in healthcare systems and society. The research team developed set recommendations extracted from focus group and survey qualitative data in combination with literature knowledge about health disparities CDPs face. First, survey responses specifically pointing to a suggestion were recorded in a separate document. Similarly, narratives from focus group discussions describing a suggestion or recommendation were recorded in the same document as the survey suggestions. One research team member (SN) tailored the suggestions for inclusion in a set of recommendations which was reviewed and edited by other research members (JS, MJ, SQ). Once a completed draft was developed, we held individual interviews to ensure the recommendations reflected participants' needs and gave an opportunity for them to refine further and review the recommendations (see Appendix D).

As a snapshot, many of the recommendations aim to promote the development of culturally responsive mental health resources by developing resources and services that (1) avoid hetero-normative, cisgender, Western culture assumptions, (2) address contextual challenges to mental wellbeing that may run parallel to and exacerbate symptoms for CDPs, mixed-race individuals and second-generation immigrants, such as inter-generational trauma, discrimination, and racism, (3) and reflect the lived experiences and unique mental health challenges of a variety of ethnic groups.

We invited five previous focus group participants on a first-come-first-serve basis to take part in one-on-one interviews. The average age of interview participants was 42 years old (standard deviation = 15 years), ranging from 22 to 61. Three focus group participants identified as female while the rest identified as male. Two participants identified their ethnicity as South Asian, two as Chinese, and one as Southeast Asian.

Participants said that the language was academic but appropriate as the audience for these recommendations may be policymakers, community program staff, and HCPs. There were suggestions to make a lay summary for community organizations and public use. While participants felt the recommendations were comprehensive, they also suggested examples could help avoid ambiguity. Alongside some participants, Neil felt it would be helpful to have an endorsement or approval statement by a reputable HCP or organization, further improving the resource's credibility. This type of certification could help CDPs effortlessly recognize information backed by someone with credentials, thus assisting participants in finding credible and evidence-based resources. One suggestion Alana mentioned was to develop resources for each cultural group separately instead of grouping ethnic groups together, especially considering those who may be of mixed races:

*There are a lot of different cultures, so would there be a different, a resource for each different culture there? ...I'm just thinking, is there something specific for, say, Asian or then, do you have like all of those subsets, like, you've got Chinese, and Korean, and everything like that?*

Ensuring culturally responsive eMH reflects the complexities of cultural experiences and the intersection with mental health was a focus for interviewees. For example, Alana also suggested



that individualistic and collectivist families should be considered in the creation of these resources. As such, the orientation of the family should be included in the mental health resource. Relating to this, Tasha demands the improvement of eMH to have “*consistent and ongoing engagement with patients and families with a lived experience.*” This could be implemented in eMH resources through an open call for peer supporters and advisors to be available to the development team while also connecting with the community at different points of the process. Ultimately, CDPs will access and navigate these services, so reaching out to engage and learn about the dynamic needs of CDPs is crucial. Gary shared that while visual representation is essential for these resources, he also felt that it should reflect Metro Vancouver communities. For example, he said:

*If in our community, we have people from South Asia, we've got from East Asia, we've got from Europe, we've got from South America. So, there should be a mix of everyone in that as far as visuals are concerned. So, it doesn't show that it is only for a particular community. So, it should make me feel that I'm in my community. So, if I'm in the Lower Mainland, I'm in my community of the Lower Mainland. I - I'm not being transported to New Delhi.*

One other suggestion was for the format and platform of resources to be available in various ways. This allows users to “*feel more comfortable accessing it,*” as described by Gary. He shared that some people may be comfortable reading on the Internet about mental health supports while others may be visual learners or prefer audio resources. He suggests that if the content is available in the preferred format for users, they will be more likely to use it. A critical consideration that Tasha brought up for eMH content was for resources to be maintained and kept up to date, as this is often overlooked. Participants also provided suggestions for integrating

eMH resources within the traditional mental healthcare system. For example, Tasha shared some anecdotes about transitioning from different mental health services:

*Something that I hear quite often, not just pertaining to mental health or people navigating the mental health system, is especially dealing with issues that come with transition points. So, for child youth mental health, it, I think is up to maybe, I want to say age of 18. And then, and then youth is covered from I think 18 to I want to say 24, but I could be totally mistaken. And then from what I have understood in terms of sort of the government, or the healthcare, health authorities, and the - even the school systems, K-12 and up, it's - it's oftentimes very unclear from my experience to see, 'Okay, so what next? What next? What next?' After you move onto this next transition point. And so, you know, that could be, I guess, facilitated, I realized, and streamlined in many different ways... Rather than sort of right now, what it seems that people are—some people might be feeling all alone in dealing with these transition points.*

Her suggestion points to an immense challenge within British Columbia's mental health system, which eMH resources can address by providing more information for navigation based on these age transitions. Tasha's suggestion can be an area for Gary's unique idea in using health data to suggest resources based on the user's health data pre-emptively. On an opt-in basis, centred on user's health information, eMH resources could suggest specific resources:

*Another idea that I had was that the health authorities, they have a lot of medical information on individuals in the province... Someone is seeing my data. They might say that 'Okay, for this person, he, he might be at risk for these - this, this, and that.' ...Material is pushed towards me through social media or through other electronic media. So, I can start getting motivated into taking steps even before I get into that situation.*

Considering this, psychiatric assessments, combined with health data, could aid in sifting through resources to find one that may work. However, this brings concerns over privacy and confidentiality. Alana felt location-based resources were acceptable, but functions such as location-tracking may be concerning.

Participants felt it was crucial for health authorities, post-secondary institutions, mental health-oriented community groups, and governments to consider these implications when asked about whom participants would like these recommendations to be seen. Gary reiterated that HCPs ought to be aware of these eMH resources as “*sometimes even [HCPs] are not aware that it is available.*” He feels that anyone working in primary care should be aware of eMH resources, as they can be the point of contact to impart these resources to patients: “*If the awareness is not there, no one is going to use it. So, again, the decision-makers that decide as to how the information is disseminated to different health sectors. Those decision-makers need to be aware of the findings of the study.*” Like the rest of the participants, Wendy stressed the need for the government to invest in culturally responsive eMH resources. Overall, participants felt the recommendations were vital, general yet comprehensive, and encompassed what participants had shared.

## Chapter 4: Discussion

Our study investigated participants' use of eMH for anxiety and depressive disorders to understand CDP's needs for eMH. The sample was predominantly composed of young South Asian and Chinese female participants. Most participants were clinically diagnosed or treated for a mental illness from the information gathered from their mental health status. In exploring CDPs' experiences of eMH and their usage, we discovered that most participants use mobile applications for their mental wellbeing at least once per week. Participants' digital health literacy was rated highly, with the bulk of participants feeling confident in their abilities to identify helpful and reliable health information on the Internet to manage their wellbeing.

More importantly, participants' perceived cultural responsiveness of the eMH resources and services they used was reportedly poor. Moreover, such perceptions of weak cultural tailoring were reported despite most participants agreeing that resources were available in their preferred language. Thus, while language representation may be a significant feature of cultural responsiveness, other factors outside of the lack of language availability in eMH may significantly impact cultural responsiveness. The findings propose that lack of adequate representation of cultural experiences and attention to culture-based stigma may constitute substantial barriers for adequate eMH care among CDPs.

While participants shared many facilitators of help-seeking behaviours through focus group interviews (i.e. accessibility, flexibility, and privacy of eMH), they also identified various

barriers. Despite participants feeling strongly about their abilities in finding credible information online, some shared that the eMH information available lacked credibility. There was discussion about participants' lack of knowledge and awareness of the variety and types of eMH services available. Interestingly, participants described affordability as a facilitator and a barrier to help-seeking behaviour. For example, some participants used eMH services without cost, while others used paid services, likely due to mobile application costs and online counselling costs, which are not covered by healthcare plans. Focus group interviews revealed further barriers in discussions about sociocultural contexts. Culturally linked stigma was a familiar challenge participants encountered. Participants connected this to familial challenges, including the perpetuation of stigma, leaving some participants attempting to find social support while dealing with mental health problems. Clearly, there was a desire for more representation of CDPs within eMH. Without sufficient culturally responsive mental healthcare options, CDPs may choose between receiving culturally improper and irrelevant care or receiving no care at all.

Another aim of this study was to develop recommendations for future eMH. Implications were derived from participant experiences and responses that focused on the inclusion of culturally tailored content, graphics and phrases, lived experiences of CDPs, and specific content on tackling culturally linked stigma. There were detailed requests for eMH functionalities and content topics. Outside of culture-based recommendations, participants suggested eMH resources could be an avenue to support follow-up care from therapy via a community group chat or individual check-ins by an HCP. This can provide users with opportunities to have personalized

relationships (i.e., mental health professionals or community support groups) and meaningful interpersonal engagement.

From this study, there is evidence that there continue to be disparities for CDPs considering the quality of mental healthcare delivered through technological means. It is imperative to note that culture affects several mental health areas, ranging from views of health and illness, expression and manifestation of symptoms, styles of coping, the role of social supports, and help-seeking behaviours.<sup>76-78</sup> In the next section, we structure the discussion based on six interconnected principles of cultural responsiveness: decolonization, intersectionality, cultural humility, self-awareness, engagement and connection, and activism.<sup>31</sup> Collectively, these principles alongside our study findings can inform eMH services, resources, and research to promote cultural perspectives and responsiveness.

#### **4.1 Decolonization**

The study data can be interpreted in meaningful ways by utilizing a decolonization lens towards culturally responsive eMH care, primarily since much of the theory and practice of mainstream mental healthcare originates from Western culture and Western understanding of mental illness.<sup>76, 79</sup> While monocultural constructs have contributed to dominant resources and services, these same resources and services can be problematic when applied to CDPs without considering various cultural contexts and their impacts on mental health.<sup>76, 80</sup> There are reports that there are consequential ways that biases and stereotypes affect the treatment of CDPs, which can

negatively impact their health outcomes.<sup>81</sup> From our study, this relates to participants feeling not understood by HCPs, perhaps by their intrinsic biases and stereotypes towards patients. Behaviours, practices, and symptom presentations that do not fit western measures are more likely to be seen as dysfunctional.<sup>82</sup> For example, some psychiatric assessments (ex. *DSM* checklists) are known to be culturally biased in their measures.<sup>82</sup> Many of these assessments are administered as a pre-appointment check-in online, which can be done through a phone or tablet. Considering that eMH may house these psychiatric assessments, it must examine the biases within the assessment and use alternative measures. One suggestion is to use a culturally appropriate assessment like the Chinese Depression Scale for Chinese patients instead of utilizing a DSM checklist.<sup>83</sup>

Historically, studies have indicated that CDPs have struggled with access to adequate mental healthcare.<sup>39</sup> This study confirmed key barriers (i.e. difficulty navigating the healthcare system) to accessing mental health services and revealed barriers CDPs experience specifically with online services. However, considering that our sample is digitally literate, the accessibility barriers described may be woven into other challenges, such as culturally linked stigma and culturally insensitive HCPs—a reoccurring narrative within this study. Such barriers to mental healthcare access are common in communities where mental illness is stigmatized, potentially due to distrust of mental health services given historical traumas experienced by CDPs. These concerns may be reinforced by clinician bias and stereotyping.<sup>84-86</sup> It is imperative to note that this can also be in relation to the impact of colonization and historical mistreatment of CDPs in

the healthcare system. In fact, some participants called for resources and services to address cultural insensitivity as a result of mistreatment by HCPs. Participants shared eMH fails to acknowledge the deep-rooted racism within healthcare settings,<sup>87, 88</sup> which may reflect systemic racism in the design and delivery of treatment. Marginalization of CDPs results in hurdles to obtain “full and timely access and use of health services.”<sup>89</sup> It is crucial for eMH resources not to replicate this. Participants indicated that eMH should consider CDPs’ disproportionate experiences of racism, discrimination, inter-generational trauma as there is evidence these adversely impact mental health.<sup>76, 90-92</sup> Furthermore, HCPs, researchers, and others who may administer or develop eMH must advocate for intersectional and anti-racist resources and services.

## **4.2 Intersectionality**

Recognizing the complex and cumulative ways that various experiences combine, overlap, or intersect for CDPs is pivotal in providing culturally responsive care.<sup>31</sup> Participants shared several cultural contexts that should be coordinated into eMH content. One desire was for recognition that cultural groups are not homogenous entities.<sup>80</sup> Those who provide eMH services should recognize that not all members of a given cultural group are identical; they should understand that there are within-group differences—that is, that there are intricacies within cultural groups that lead to unique identities and views among members of the same group.<sup>82</sup> These within-group variations have influential treatment implication, as described by participants who share differing views from their family members, considering their varying nativity status and ages.<sup>82</sup>



More explicitly, eMH resources should recognize that race, social position (i.e., class and ability), and microaggressions affect mental health, and these experiences differ for each person. Instead of providing general information, more personalized information that addresses CDPs' authentic experiences and needs is necessary.

Previous studies acknowledged the challenges language barriers bring to accessing mental healthcare.<sup>93, 94</sup> The ability to express oneself is challenging when English is not one's primary language. Many participants felt that the language in eMH resources and services was not suitable for the public, making it difficult for CDPs to understand medical terms and other scientific jargon. This has consistently been a problem for CDPs in accessing care,<sup>95-101</sup> but specific culturally tailored eMH resources available in one or more cultural languages can help provide appropriate information. As remarked by our participants and support from the literature, it is desirable to have credible information accessible in their preferred language while also being able to communicate in their language of choice.<sup>96, 97, 99, 101</sup> eMH resources developed for English-speaking audiences must be linguistically and culturally translated for CDPs. Various methods should be utilized, such as back-translation (i.e. the translated text is translated back into English). To provide more effective and appropriate care in this manner, we can utilize eMH in novel ways, as shown in a study with non-English-speaking patients.<sup>21, 102</sup> Here, researchers tested the feasibility and reliability of asynchronous psychiatric consultations.<sup>21</sup> This specific eMH service was successful by using store-and-forward-based Spanish to English translations through uploaded videos.<sup>21</sup>

Regardless of our participants being able to use resources in their preferred language, participants reiterated lack of diverse languages as a barrier to mental health services—likely stemming from their reflection of members in their culture and community. Lack of knowledge and awareness of mental health services is a significant barrier to seeking care.<sup>103</sup> How could CDPs know about treatments and services if it is not promoted or advertised in their language? In relation to what participants have shared, they request culturally tailored mental health promotion and increased advertising of eMH to bridge this gap.

Alongside variations in ethnicity, age, mental illness stigma, another intersection to consider is digital health literacy. For eMH to successfully adapt and integrate traditional forms of mental healthcare, patients must be comfortable with various aspects of technology.<sup>30</sup> Technological abilities seem to be related to age and education where young users and high levels of education have had greater exposure to technology leading to greater comfort with eMH.<sup>30</sup> In our study, participants indicated they were able to use technology with ease based on their adapted eHEALs scores. Furthermore, our sample is fairly educated and mainly consists of young adults. Some older generations may have difficulty with technology to manage their mental health because of their technological knowledge and abilities. Despite this, evidence shows that rurality and ethnicity can be negative indicators of technology exposure.<sup>104, 105</sup> As such, it is essential for eMH to be developed in a way that is tailored for different age groups and technological abilities.

The takeaway here is that “one size does not fit all.” CDPs live in different contexts, and their nativity status can bring unique experiences, including differing rates of illnesses.<sup>106</sup> We must recognize intersectionality within eMH.<sup>107, 108</sup> There are clearly limited eMH resources and services for intersectional groups, as noted by participants. Quality care delivered via eMH should not be generalized but should acknowledge the intersections and fluidity of identity, as well as the relationship between HCPs and clients and their social location.<sup>107-110</sup>

One way that eMH is well suited to consider intersectionality is by efficiently providing an assessment or screening that can point CDPs to useful information and treatments based on their identity and experiences. This way, CDPs do not need to sift through the general mental health resources provided online but can be given one through a quick assessment of their ethnicity, age, nativity status, necessities for mental healthcare, and more. Once this assessment is complete, a page with appropriate resources and services is shared online. This is similar to a website called MindHealthBC (<http://www.mindhealthbc.ca>); yet eMH should include a greater emphasis on cultural questions and other sociodemographic characteristics for more suitable resources and services.

### **4.3 Cultural Humility and Self-Awareness**

Ethnocentrism—“the natural tendency or inclination among all people to view reality from their own cultural experience and perspective”—has been an issue considering the varying attitudes

from one's culture about mental health.<sup>111</sup> A relativist approach uses a comparison of cultures in a "less punitive way."<sup>112</sup> Adopting this approach is a fundamental step to providing culturally responsive eMH, combined with other concepts such as cultural competency and humility. Cultural humility challenges the view that HCPs can become entirely culturally competent in another culture and reminds them to be aware of limitations of their knowledge.<sup>113</sup> Additionally, it encompasses engaging in self-reflection, self-critique and committing to becoming a lifelong learner in multicultural perspectives.<sup>31</sup>

Cultural competence training effectively increases knowledge among healthcare providers and satisfaction among CDPs.<sup>114, 115</sup> Fortunately, more health services aim to deliver more "linguistically appropriate, culturally competent, and culturally safe services,"<sup>116</sup> but these adaptations must be evident in eMH resources, especially since some cultures may not recognize symptoms associated with mental health challenges. Instead, these views may be limited to culturally unacceptable behaviours—which, as described by participants in this study—push individuals to social isolation.<sup>39, 117</sup> Thus, CDPs have difficulty communicating mental health challenges among their social supports such as family and friends—a potential area for eMH to tackle by specifically creating integrative programs that can include family members in mental health planning for patients or by providing resources that advise patients on discussing mental health challenges with family members.

Moreover, eMH should be culturally competent alongside the designers and deliverers (i.e. HCP, community organizations, researchers) of eMH. These efforts enhance their knowledge about sociocultural factors, health beliefs, and behaviours among a variety of cultural groups. Those who develop eMH should recognize their inherent biases. Alongside this, there should be cultural competency education for the designers and deliverers of eMH about mental health challenges rooting from cultural stigmas, racism, and intergenerational trauma. For eMH services that utilize HCPs, participants were fond of the idea to have information about their HCPs background. For example, as users come across the eMH landing page or introduction, there is information about who developed the service, which HCP is involved, their cultural background, and their expertise and credentials. This may help facilitate care as CDPs feel more comfortable discussing challenges and communicating with an HCP that recognizes and understands (from an outside view) their culture.

#### **4.4 Engagement and Connection**

Creating meaningful engagement opportunities for CDPs to shape mental health services contributes to the cultural responsiveness of it.<sup>31</sup> When CDPs are included in the stages of eMH service and resource development, it helps to ensure that it meets the needs of the cultural group or community. HCPs and researchers may not conceptualize culturally responsive care in the same way that their intended audience does.<sup>118</sup> Therefore, it is essential to ask those that use eMH to share their expectations and needs regarding the care they receive and what would make this care culturally sensitive and competent.

One way to begin this conversation is by gathering information from leaders with key connections within culturally diverse communities. By offering these community leaders to voice their concerns, there is an opportunity to include them in decision-making and planning efforts while allowing their participation to support the development of eMH and further understand CDPs' needs.<sup>102</sup> Formal involvement (i.e. community-based researcher, peer advisor, steering committee member) can help inform the scope and goals of specific eMH programs, services, and resources.<sup>102</sup> Informal involvement (i.e. public forums, town-halls) can also be beneficial in gathering community feedback.<sup>102</sup> It is paramount to understand that CDPs contain the knowledge needed for the success of culturally responsive eMH. Further conversations with CDPs will help gauge its potential impacts on their mental health status and overall wellbeing.<sup>102</sup>

Ethnic matching—"the use of culturally competent bilingual clinicians who have the same ethnic and cultural background as their respective patients"<sup>119</sup>—is a desirable way (and endorsed by our participants) to address language barriers and cultural disparities.<sup>120</sup> In-person services may have challenges implementing ethnic matching. However, since eMH services do not require individuals to be restricted by location and offer a level of personalization, ethnically matching HCPs can be readily available to CDPs.<sup>119</sup> Studies show that "not only linguistic but also cultural and even racial concordance affect patient satisfaction as well as the satisfaction of the providers and are associated with better patient compliance, better adherence to treatment, and higher patient and provider satisfaction."<sup>93</sup> Participants requested more

representation of CDPs in mental healthcare, including those who develop and administer eMH resources and services, stemming from their synchronous eMH (i.e. virtual counselling) experiences with ethnically discordant HCPs. CDPs are considerably underrepresented among HCPs in mental health and likely reflecting a larger underrepresentation in the eMH realm. With the exception of Asian-American psychiatrists, other cultural groups are still poorly represented among psychiatrists leading to less CDP healthcare professionals administering and developing eMH.<sup>121</sup> This lack of diversity and representation can hinder the quality-of-care CDPs receive. Therefore, the hiring and training of more ethnic, religious, gender, sexual, and language minorities as physicians, counsellors, and other HCPs may motivate CDPs to seek care since (1) they can receive care from someone of the same cultural group or who speaks their primary language and (2) potentially access more culturally responsive eMH resources developed by CDP professionals. As described from participants' perceptions and experiences, there are a number of ways to improve the cultural representation in eMH which may, in turn, reduce barriers to treatment such as the (1) inclusion and adaptation of more diverse languages, (2) delivery of stories and testimonials from CDPs with lived experience (3) inclusion of images of diverse people; (4) practice of cultural metaphors and phrases; (5) adaption of content to integrate cultural constructs.

## **4.5 Activism**

Activism can take a variety of forms but often originate from providing solutions to the inequalities and challenges people face. One challenge is the stigma that CDPs experience. The stigma around mental health challenges is prevalent in many cultures and it is not uncommon that those that suffer from mental health challenges experience shame and fear. There may be a

denial that the mental health challenges are a problem—individuals may not recognize it inhibits areas of their life,<sup>35</sup> and may hide these problems to avoid the judgement of others.<sup>122</sup> Some may choose not to seek care as they may feel discriminated by their social supports, such as friends, family, or cultural group.<sup>98</sup> For example, as described by some participants, those with mental illnesses are considered a “mental case” in their culture, which reinforces sentiments that individuals with mental illnesses are dangerous, leading them to be outcasted.<sup>123</sup>

In line with the growing literature highlighting ethnic variations of mental illness stigmatization and perceptions of mental health,<sup>76, 124-131</sup> several participants highlighted and emphasized the prevalence of mental illness stigma among their cultural group. Many individuals who identify with Western cultures are highly individualistic, while those who identify with collectivist cultures (like many Asian cultures) find group harmony and cohesion of central importance.<sup>112, 132</sup> This brings a different view of mental health problems on an individual level, where mental illnesses fall outside of societal expectations, perpetuating shame and stigma.<sup>131, 132</sup> Participants hoped for eMH to provide advice on including family involvement in mental health planning, dealing with culturally linked stigma, and sharing mental health problems with family members. Understanding how race and ethnicity impact people’s conceptualizations and experiences of mental illness stigma have important implications for individuals’ overall health and wellbeing, especially because racial and ethnic minorities are more likely to have unmet mental healthcare needs.<sup>125</sup> A “critical understanding of global attitudes” towards mental health is crucial for providing culturally responsive eMH.<sup>112</sup>



There were nuances in participants' suggestions to mitigate stigma. Many participants specifically shared that White HCPs have difficulty understanding their mental health problems. On the other hand, some responses stated that mental illness is widely stigmatized in their culture. Yet, there is a sense that someone from the same culture can mitigate stigma. To put this more clearly, CDPs who understand the challenges of stigma within their cultural groups, or have lived experience, would be valuable as designers and deliverers of eMH. In contrast, culturally diverse professionals who perpetuate mental health stigma are likely to harm patients' mental health. Therefore, understanding, sympathy, and kindness should be integrated into HCPs' and eMH's approaches in promoting CDPs' mental wellbeing.

#### **4.6 Limitations, Strengths, and Future Directions**

There are a few notable limitations to discuss in this study. First, discussing mental health in a research setting is difficult for many, and stigma poses a challenge to research. The challenges CDPs face with accessing healthcare also occur with research recruitment.<sup>133</sup> Historically, culturally diverse populations can be challenging to engage in research due to language barriers and low literacy rates.<sup>133</sup> It is also possible that the lack of trust in the healthcare and research community may contribute to the unwillingness to participate in research considering previous misrepresentation and ascriptive inequality.<sup>134</sup> The relatively small sample size was a limitation and reduced generalizability. While we had built connections with community clinics and groups, further liaising with cultural leaders and active involvement of ethnic minorities as patient partners may help limit future recruitment barriers.<sup>89</sup>

Another challenge is that participants may be compelled to answer affirmatively and conform to society's norms, especially when recognizing barriers established by stigma. Several biases are prevalent in the study, such as self-selection bias, observer bias, selection bias, response bias. Participants were able to select themselves to participate, meaning less proactive people may be unintentionally excluded. Similarly, those who do not have access to computers, smartphones, or Internet would also be excluded. One paper suggests that those who may be digitally excluded are likely to be elderly, individuals who are disabled, ethnic minorities, and those who are chronically sick.<sup>105</sup> While our study focused on ethnic minorities and most of our sample felt confident in their ability to use technology, our sample mostly comprised young adults, impacting our findings. For example, a more representative sample (i.e. more senior participants) may not have the same technical abilities, which would impact their eHEALs scores. Another challenge is that many participants also faced survey fatigue due to the lengthy survey and may have avoided answering questions that required more time to complete.

Despite some similarities in experiences of racialization and discrimination, Indigenous peoples' traumatic experiences with colonialism contribute to unique circumstances that affect their mental health.<sup>35</sup> While we recognize and acknowledge these differences, we do not address them in this study. We chose to exclude this population and focus solely on ethnic minorities or CDPs. Our sample mainly consists of Chinese and South Asian young adults, limiting generalizability when also considering their age and immigrant status. More critically, the study was only conducted in English due to resource limitations, potentially excluding those who are monolingual in a language other than English and those who do not have interpreter/translator aides.

Regardless, this study has several strengths, such as the several methods employed to gather rich, insightful data for scientific rigour. The method of triangulation enhances the validity of findings. Furthermore, the research team member (SN) involved in conducting research activities identifies as an ethnic minority from this region. This study provides HCPs with recognition of treatment needs of CDPs in addition to supporting technology companies and researchers with the development of culturally responsive eMH resources and services. Overall, our findings provide a leading step for the future development of culturally responsive eMH resources while adding to the literature about cultural responsiveness of eMH and, overall, to the paucity of multicultural e-health research.

Future studies should provide surveys in various languages and perform focus groups and interviews in languages other than English to gather a larger, more representative sample and further cultural insights. It is important to see how eMH resources could be tailored for older adults and seniors. While our sample is relatively small, the findings may not be fully representative of the views of CDPs. However, exploring the experiences and perceptions of CDPs through in-depth discussions is an opportunity to obtain rich data in the under-researched area. Individuals from different cultures have varying experiences and perceptions which should be explored further. As noted in the literature, there is little research on non-immigrant, culturally diverse populations in Canada—perhaps a focus on this population can provide more information on their specific needs.<sup>106</sup> Future studies may reproduce this study in a different culturally diverse area and rural areas where mental health services are scarce. An interesting next step of the study is to apply the findings and recommendations to create a culturally

responsive eMH service. Once developed, it should be tested to gauge the impact and effectiveness on patient outcomes.

## Chapter 5: Conclusion

This study revealed participants' perceptions of low cultural responsiveness of eMH resources and services that CDPs use. It identified and confirmed key barriers relevant to CDPs and provided recommendations developed from their experiences and challenges to improve mental healthcare. The survey responses, narratives, and perspectives reflect CDPs' experiences with e-mental health services and currently point towards disrupting inequitable structures, which overlook CDPs from adequate mental healthcare. Furthermore, the strategies and recommendations discussed should be multi-faceted and coordinated to reach CDPs effectively.

Despite the technological and healthcare advances, there has been a limited effort to create policies that support culturally responsive eMH. The findings disseminated could motivate eMH efforts and inform e-mental health strategies for culturally diverse populations. Providing quality, culturally appropriate eMH will continue to become more critical. Using eMH to provide culturally responsive services is likely to entail an increase of funding and attention from the academic and mental health community. Nevertheless, it is an essential endeavour, considering the cultural diversity of our population rapidly increases.<sup>112</sup>

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## Appendices

### Appendix A: CREDA Survey

#### CREDA Study Survey

**e-Mental Health** involves using programs, websites, videos, applications, or devices developed from technology to support your mental wellbeing.

Using a Fitbit to practice deep breathing techniques for anxiety is an example of e-mental health.

Other examples of e-mental health resources include:

- Online programs such as the Canadian Mental Health Association's Bounce Back program
- Websites such as [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)
- Online videos such as meditation videos from YouTube
- Mental health applications such as MindShift CBT, Headspace, or Calm
- Wearable technology such as Apple Watches, Fitbits, Fitness Trackers, Muse Headband, and Virtual Reality

*For the purposes of this research, virtual clinics, online counselling, text messaging programs, group chats, and other human-supported interventions, are not included in the definition of e-mental health*

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1. Have you used e-mental health resources before?

- ☐ Yes (Continue with the questions below)
- ☐ No (Go to question 9)

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**Please answer questions 2-8 if you have used e-mental health resources before.**

2. What was your primary purpose of using of e-mental health resources?

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3. How often do you use the following e-mental health resources?

	Multiple times per day	Once per day	Once per week	Once per month	Once every 6 Months	Once per year	Never
Online programs							
Websites							
Online videos							
Mental health applications							
Wearable technology							

4. What do you like most about the e-mental health service(s) you used?

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7. Please check (✓) the option that best represents your experience with the e-mental health resource(s) you have used.

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
The resource involves expressions familiar to your cultural group					
The resource includes people in your cultural group					
The resource includes symbols and concepts shared by your cultural group					
The resource includes phrases used by your cultural group					
The resource was available in your preferred language					
Overall, the resource was culturally tailored to you					

8. Please check (✓) the option that best reflects your OVERALL satisfaction with the e-mental health resource(s) you have used.

- ☐ Extremely satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Extremely dissatisfied

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**If you answered no to question 1, please begin here. If you answered yes to question 1, please skip questions 9 to 11.**

9. Why did you choose not to use e-mental health resources?

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10. As a visible minority, what would motivate you to use e-mental health resources?

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11. Please choose the option that best represents how important each of the statements are for future e-mental health resources.

	Extremely important	Very important	Moderately important	Slightly important	Not at all important
The resource involves expressions familiar to your cultural group					
The resource includes people in your cultural group					
The resource includes symbols and concepts shared by your cultural group					
The resource includes phrases used by your cultural group					
The resource was available in your preferred language					
Overall, the resource is culturally tailored to you					

**Please answer the following questions.**

12. Have you been diagnosed or treated by a health professional for any of the following?

- ☐ Anxiety disorder
- ☐ Depressive disorder
- ☐ Other mental health illness

14. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				

15. Please check (✓) your level of satisfaction for the health services listed below on their ability to provide mental healthcare.

	Very satisfied	Slightly satisfied	Neither satisfied nor dissatisfied	Slightly dissatisfied	Very dissatisfied	Never Used
Family Physician						
Psychiatrist						
Psychologist						
Registered Counsellor						
Emergency Room Visits						
Crisis Lines						
Community Programs						
Other, _____						



16. How important do you think e-mental health resources are for people dealing with anxiety and depression?

- ☐ Extremely important
- ☐ Very important
- ☐ Moderately important
- ☐ Slightly important
- ☐ Not at all important
- 

17. For each statement, please check (✓) which response best reflects your opinion and experience.

	Strongly agree	Somewhat agree	Undecided	Somewhat disagree	Strongly disagree
I know how to find helpful health resources on the Internet					
I know how to use the health information I find on the Internet to help me					
I have the skills I need to evaluate the health resources I find on the Internet					
I feel confident in using information from the Internet to make health decisions					

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18. Which ethnicity do you identify with?

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19. Please choose the best option the describes you.

- ☐ I was born in Canada; Both of my parents were born in Canada
- ☐ I was born in Canada; One of my parents was born in Canada while the other parent was born outside of Canada
- ☐ I was born outside of Canada
- ☐ I do not wish to disclose

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20. Which area of Metro Vancouver do you live in?

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21. What is your age?

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22. What gender do you identify with?

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23. What is the highest level of education you have completed?

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24. Do you currently attend post-secondary school? If yes, which post-secondary school do you attend? If no, please write N/A.

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## Almost done!

Another phase of the study is to conduct focus group interviews. Focus group interviews help us gather further details about your experiences with e-mental health resources. At this focus group, we will also discuss recommendations for future e-mental health resources. Focus group interviews are held in a group and are approximately 45 to 75 minutes long. We will be holding focus groups in various areas of the Lower Mainland. If you choose to take part in the focus group, you will be provided with \$20 which will cover any costs incurred, such as transit or parking. The following questions will not be connected to your survey data.

26. Would you be interested in sharing your experience with e-mental health resources through a focus group? **If yes, please fill out the following personal information to be contacted for the focus group.** If no, please leave this section blank. This information will not be connected to your survey data.

- ☐ Full Name \_\_\_\_\_
- ☐ Email Address \_\_\_\_\_
- ☐ Contact Number \_\_\_\_\_
- ☐ Birth Year \_\_\_\_\_

27. Please fill out the following information in the case you are the winner of the Visa gift card. This information will not be connected to your survey data.

- ☐ Full Name \_\_\_\_\_
- ☐ Email Address \_\_\_\_\_
- ☐ Contact Number \_\_\_\_\_

28. Would you be interested in receiving the research results to provide any feedback? If yes, we will use your contact information for the draw to connect with you.

- ☐ Yes
- ☐ No

**Thank you for participating in the research study: Exploring cultural responsiveness in e-mental health resources for depression and anxiety.**

Your participation will help improve e-mental health resources for culturally diverse populations!

## **DO YOU NEED SUPPORT?**

In this research study, we asked you questions about sensitive topics and about your mental state. As researchers, we do not provide mental health services. It is possible that we will not view your responses for several days or weeks after you complete the surveys. If you would like to talk to someone about how you are feeling, please see the resources below.

If you require any mental wellness resources or support, feel free to consult the following resources or speak with a mental health nurse by dialling 811:

- Anxiety: <https://anxietycanada.com>
- Crisis Centre BC: [www.crisiscentre.bc.ca](http://www.crisiscentre.bc.ca)
- Canadian Mental Health Association: <https://cmha.ca/resources>
- UBC: <https://students.ubc.ca/health-wellness>
- Mental Health Support Line: Call 310-6789 (do not add 604, 778 or 250 before the number)
- Fraser Health Crisis Line: Call 604-951-8855, 24 hours a day

If you are in an emergency, please contact someone immediately:

- Call 911 for help right away. Speak to your doctor, or go to your nearest hospital emergency room, walk-in clinic or community health centre.
- Call 1-800-SUICIDE (1-800-784-2433). If you are thinking about ending your life or are concerned about someone who may be, you can call for help any time of day or night, from anywhere across BC. It's a free call.

## **Appendix B: Focus Group Discussion Guide**

### **CREDA STUDY**

#### **FOCUS GROUP DISCUSSION GUIDE**

**Welcome** and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

**Introduction:** This focus group discussion is designed to assess your current thoughts and feelings about the e-mental health resources and your recommendation for culturally responsive resources. The focus group discussion will take no more than two hours. This discussion will be recorded.

**Anonymity:** Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

#### **Ground rules**

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
- There are no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you
- You do not have to agree with the views of other people in the group
- Does anyone have any questions? (answers).
- OK, let's begin

#### **Warm up**

- First, I'd like everyone to introduce themselves. Can you tell us your name?

#### **Introductory question**

I am just going to give you a couple of minutes to think about your experience of e-mental health services. Is anyone happy to share his or her experience?

### **Guiding questions**

- What are your thoughts on the content of the resources?
- When thinking back to how the resource was introduced to you, are there ways that could have been introduced to make it easier/better for you?
- What are the barriers to using e-mental health? What are the enablers?
- Did you feel comfortable with using e-mental health?
- How would you make it easier to use/implement for culturally diverse people?
- Were there any barriers to you seeking treatment? What were they?
- Did the resources help you? What kind of services would help you better?
- Does being ethnic affect your experience of the treatment or resource?
- What things would search for in culturally relevant mental health resource?
- What are things you disliked with the mental health resource you used?

### **Concluding question**

- Of all the things we've discussed today, what would you say are the most important recommendations for future e-mental health resources?
- Is there anything you would like to add before we wrap up?

### **Conclusion**

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the study
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please contact the Principal Investigator or speak to me later
- I would like to remind you that any comments featuring in this report will be anonymous
- Before you leave, please hand in your completed personal details questionnaire
- Please remember to maintain confidentiality of the participating individuals by not disclosing their names and the information discussed today.

*Adapted from the WHO Safe Childbirth Checklist Collaboration Template for Focus Group Interviews: [www.who.int/patientsafety/implementation/checklists/instructions\\_focus\\_group.doc](http://www.who.int/patientsafety/implementation/checklists/instructions_focus_group.doc)*

## Appendix C: Interview Discussion Guide

### CREDA STUDY

#### INTERVIEW DISCUSSION GUIDE

**Welcome** and thank you for volunteering to take part in this interview. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

**Introduction:** This discussion is aims to gather your current thoughts and feelings about the guidelines developed from the recommendations that participants have made during the course of the study. The interview discussion will take no more than an hour and this discussion will be recorded.

**Anonymity:** Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the interview will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so. **Do you have any questions before we begin?**

#### Warm up

- First, can you tell us your pseudonym? What brings you to volunteer with the study?

#### Introductory question

I am just going to give you a couple of minutes to review the guidelines. Can you share your thoughts on the content?

#### Guiding questions

- When thinking about your experiences with online mental health services, do you think these guidelines will improve future experiences? What about in-person services?
- How do you think we can improve these recommendations?
- Is there anything you feel that we are missing?
- Are your preferences reflected in this document?
- Who are the most important people that you would like to get involved in this effort?
- What's the importance of this work to you?

#### Concluding question

- Of all the things we've discussed today, what would you say are the most important thing to include in the guideline?
- Is there anything you would like to add before we wrap up?

## **Conclusion**

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the study
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please contact the Principal Investigator or speak to me later
- I would like to remind you that any comments featuring in this report will be anonymous

*Adapted from the WHO Safe Childbirth Checklist Collaboration Template for Focus Group Interviews: [www.who.int/patientsafety/implementation/checklists/instructions\\_focus\\_group.doc](http://www.who.int/patientsafety/implementation/checklists/instructions_focus_group.doc)*



## **Appendix D: Original Recommendations for Interview Participants**

### **RECOMMENDATIONS FROM ETHNIC MINORITIES FOR MENTAL HEALTH SERVICES**

#### **CONSIDERATIONS FOR THE DEVELOPMENT OF FUTURE ONLINE RESOURCES, PROGRAMS, AND SERVICES**

##### **Topics:**

- Develop treatments and resources that avoid heteronormative, cisgender, Western culture assumptions
- Create resources that acknowledge and/or address contextual challenges to mental wellbeing that may run parallel to and/or exacerbate symptoms for ethnic minorities, mixed-race individuals and second-generation immigrants, such as inter-generational trauma, discrimination, and racism
- Create resources that reflect the lived experiences and unique mental health challenges of a variety of ethnic minorities, mixed-race individuals and second-generation immigrants
- Create resources that educate individuals about how to discuss mental illness with family members who may retain and/or perpetuate culturally-linked stigma
- Provide information on cultural responses to grieving and seeking help for specific mental health diagnoses

##### **Content and Supporting Ideas:**

- Recognize that race, social position (i.e. class and ability), and microaggressions affect mental health, and improve awareness of cultural sensitivities
- Develop customizable resources for different experiences and needs, such as age-, location- and culture-specific resources
- Incorporate opportunities for users to have a personalized relationship to a mental health professional such as including optional counselling sessions via video conference
- Allow users the opportunity to have some kind of meaningful interpersonal engagement within the resource, either through voice, video, or community discussion
- Ensure adequate follow-up care is provided after therapies through a community group chat or individual check-ins by a healthcare professional
- Integrate user accountability to help support the user's continuation in using resources
- Use images and stories that reflect and are relatable to a wide variety of racial, cultural, sexual and gender identities
- Provide resources and services that approach wellbeing holistically, integrating spirituality, mind, and body
- Provide avenues for users to work together with their collectivist and/or conservative families in a cultural context
- Provide resources for promoting family involvement in mental health planning

- Set mental health resources against a culturally appropriate backdrop
- Provide questionnaires and exercises for users to self-administer at their own pace to support mental wellbeing
- Discover ways to build community through resources and platforms

#### Usability, Accessibility, Credibility:

- Provide location-targeted resources for ease of access (ex. location tracking to connect you to nearby resources)
- Provide multiple expense levels and flexible payment plans; use publicly-funded subsidies and/or users' health insurance payments where possible
- Develop web content that is easily adapted on different platforms, devices, media
- Ensure new e-resources are visually compelling with large text, words that stand out, and use conversational, jargon-free language with potential to be discrete enough to use in public
- Develop resources in a variety of languages and translate resources developed for English-speaking audiences linguistically and culturally
- Safeguard users' confidentiality, privacy and inconspicuousness while accessing and using newly developed resources, and that privacy policies are clearly described to users.
- Allow flexible formats for e-mental health resources to provide users with a variety of options (e.g. video conferencing, phone calls, chat groups, etc.) depending on their comfort levels, digital literacy, access to devices, and high-speed internet
- Utilize governmental or health authority sites to develop a credible portal to host e-mental health resources
- Ensure websites provide up-to-date and quality, evidence-based information
- Improve awareness of cultural sensitivities and share stories of lived experience

#### CONSIDERATIONS FOR HEALTH AUTHORITIES, MINISTRY OF HEALTH, AND COMMUNITY PARTNERS

- Promote and distribute e-mental health resources more actively and extensively within cultural communities (i.e. advertisements, campaigns)
- Actively include people with different lived experiences (e.g. cultural, religious, racial, sexual, and gender identities) in the development process of resources and services
- Continue to reach out to cultural groups to update and inform new resources
- Have mental health resources endorsed by key health professionals
- Invest more funding in the development of mental health resources and culturally tailored services
- Improve affordability of services by including counselling and other mental health treatments under the medical service plan
- Provide early mental wellbeing education to ensure youth have adequate skills to cope with mental health challenges
- Develop a database with available counsellors and their biographies for patients to choose from
- Create efforts to normalize treatment through medication

- Provide in-depth information on websites about healthcare professionals through a biography that describes their background and areas of expertise
- Make lists of wait times for mental health services available to the public
- Aim to reduce waits by developing more timely resources and services
- Hire and train more ethnic, religious, gender, sexual, and language minorities as physicians, counsellors, or other healthcare professionals so individuals can receive care from someone of the same cultural group and/or who speaks their primary language
- Recognize that mental health experiences differ for each person
- Develop dynamic resources that can follow along users' stages of life mental illness progression
- Ensure assessments and resources are accessible and usable for rural populations, non-English speakers, different physical and mental abilities, and people of different ages
- Develop a service that pairs you with a physician, counsellor, or other healthcare professional that is from the same cultural group as you and/or can speak your primary language
- Integrate e-mental health resources and services with in-person care by allowing individuals to disclose information to healthcare providers voluntarily
- Advocate for intersectionality and anti-racist resources and services
- Educate healthcare professionals about mental health challenges rooting from cultural stigmas, racism, and intergenerational trauma

# Recommendations

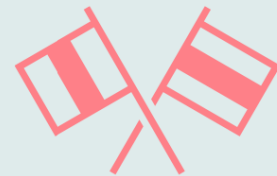
for culturally responsive  
e-mental health resources

*These are recommendations developed by ethnic minorities who participated in the CREDA Study. The suggestions listed are for the development of e-mental health resources for ethnic minorities, specifically for content development.*

**Develop treatments and resources that reference non-western cultures**



**Create resources that are developed for mixed race individuals & 2nd generation immigrants**



**Address underlying challenges such as discrimination, inter-generational trauma, and racism as contributing factors**

**Provide holistic resources and services that integrate spirituality with mind and body wellbeing**



**Provide resources for working with families that are collectivist and families that are conservative in a cultural context**



**Inform individuals how to discuss mental illness with family who perpetuate culturally linked stigma**



**Provide resources for promoting family involvement in mental health planning**



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**Figure D1: Infographic for visual representation of select recommendations**