Mental Health during the COVID-19 Pandemic in Italian, Turkish and Vietnamese Communities

30 June 2022

Research commissioned by Mental Health Australia and funded by the National Mental Health Commission

Executive Summary

This study investigated the mental health of three specific culturally and linguistically diverse (CALD) communities over the course of the COVID-19 pandemic. These were the Italian, Turkish and Vietnamese communities.

The communities studied were adversely impacted by the COVID-19 pandemic including loss of support systems, isolation, financial distress, relationship breakdowns, fear and uncertainty.

Additionally, health and mental health information designed to prompt help-seeking during the pandemic did not reach many from these communities. Findings also highlighted that there were increased levels of stigma (both self and social stigma), and a lack of a clear pathway to talk safely about mental health in preferred languages.

This study demonstrates the need for tailored and specific interventions in working with CALD communities. It highlighted the clear need to work directly with CALD communities to develop and implement mental health communication that targets them. For mental health to reach these communities, these lessons must be heeded and acted on in order to provide adequate mental health support in the future.

Recommendations

There is a clear need to provide nuanced and tailored interventions for CALD populations that directly address their cultural and linguistic needs.

1. **Developing a community empowerment strategy.** A thorough community co-design approach involving CALD communities is essential. This includes the designing of messages and choice of communication channels in collaboration with targeted CALD communities. This is pivotal in ensuring that the right communication reaches the right people, and the messages are accepted. This also includes a focus on helping people to provide better support for loved ones, including how to open up conversations in non-stigmatising ways, how to access professional supports, and reinforcing and enhancing existing models of community support that may be impacted by social distancing and isolation requirements during a pandemic. Bicultural and bilingual community health workers and community leaders and key to this process.
2. **Reducing both social and self-stigma is key.** Specific stigma reduction activities for CALD communities need to address culturally specific and derived stigma. Strategies need to be tailored to mitigate the impact of stigma on help seeking within CALD communities. Health literacy material that focuses on the mental health continuum should be used.

3. **Strengthen and develop a multi-lingual psychologically skilled workforce.**
4. **Consider additional communications channels** to communicate about mental health with CALD communities, including community radio, social media channels, community leaders and organisations. These need to be informed by CALD communities as preferred and trusted sources.
5. **Consider a referral pathway for CALD people in Australia facing relationship tensions, as part of providing holistic mental health support** for example InTouch, NIFVSP, White Ribbon, the Domestic Violence Hotline and Windermere.

What our research is about and why it is important

In June 2021 the National Mental Health Commission (the Commission) funded ten projects investigating the impact of the COVID-19 Pandemic on different communities in Australia. This project was selected as part of that process to investigate how the COVID-19 Pandemic impacted the mental health and wellbeing of Italian, Vietnamese and Turkish communities. It is known that people from CALD backgrounds in Australia experience significantly lower access to mental health care and support than the wider community These communities are at higher risk of transmission of COVID-19 and poorer mental health outcomes.

What did we want to find out?

Mental Health Australia sought to better understand how the pandemic has impacted the mental health and wellbeing of CALD Australians, in particular those from Italian, Turkish and Vietnamese communities with respect to:

- The impact of communication on help seeking, and how these communities have accessed appropriate and timely care and information for their mental health during the COVID-19 pandemic; and
- The key communications drivers that have encouraged help seeking and access to services, whether online or face-to-face during the COVID-19 pandemic.

Methodology

This research adopted a qualitative methodology using a range of different data collection approaches and audiences. These included:

12 Stakeholder interviews with people from relevant organisations,

1 x community leader's forum.

6 x discussion groups –1 male and 1 female group in each of the three languages.

12 x in-depth interviews – conducted with older members (55+ years' old) of these communities, using bilingual research assistants

Limitations

The key limitations of this study include:

- The level of diversity in CALD communities across these communities and around the country means that there are differences in age groups and location
- Each CALD community is different, and there are differences of dialect and culture even within individual language groups, resulting in subsequent different barriers and enablers to mental health.

Key Findings

Experiences during the pandemic period

The findings show that the mental health effects of the COVID-19 pandemic appear to have been magnified across the three in-scope CALD communities included in this study.

Across our sample, participants highlighted the impacts of isolation, financial distress, fear, uncertainty, misinformation and increased levels of stress leading to family breakdown and violence. Participants also experienced heightened concerns about transmission of COVID, especially for those with elderly relatives in the home. Parents were also overwhelmed with home-schooling and managing work priorities and concerned about the impacts on their children in terms of both their education and their ability to develop good social skills.

Support and help-seeking

Family and social networks are especially important among Australia's multicultural communities. Often with a stronger 'collectivist' focus, individuals from CALD communities tend to rely on their social networks for support in tough times and the impact of social isolation can be magnified in comparison to the mainstream population.

Effective communications

Few participants had been exposed to mental health communications throughout the pandemic period, although younger participants were more likely to recall having seen advertising for support services like Beyond Blue, Lifeline and others. There was little recollection of government resources such as the Head to Health website.

Opportunities from our research

There are many opportunities to use the findings of this research to tailor interventions to directly meet the needs of CALD communities in COVID -19 mental health support, and more broadly across mental health stigma reduction, health literacy and health promotion with CALD communities.

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Mental Health Australia

Established in 1997, Mental Health Australia is the nation's first independent peak body for the mental health sector. Through this role Mental Health Australia represents a range of stakeholders, including consumers, carers, special needs groups, clinical service providers, professional bodies, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

By representing these diverse segments of the community, Mental Health Australia aims to promote mentally healthy communities, educate Australians on mental health issues, influence mental health reform so that government policies address all contemporary mental health issues, conduct research on mental health issues, and carry out regular consultation to represent the best interests of members, partners and the community.

Three core objectives drive Mental Health Australia's ambition to promote mentally health people and communities, including:

- Promote a national voice for those with lived experience of mental illness and for those who love and care for them.
- Highlight the social determinants for mental ill health and advocate for lasting changes across the whole ecosystem.
- Deliver value to our members and the wider mental health ecosystem

The Embrace Multicultural Mental Health Project (The Embrace Project)

The Embrace Project is auspiced by Mental Health Australia and provides a national focus on mental health and suicide prevention for people from culturally and linguistically diverse (CALD) backgrounds. It works towards an equitable mental health system which reflects and responds well to the needs of Australia's multicultural population

The Embrace Project aims to put a national focus on mental health within CALD communities, seeking to:

- Increase participation of consumers and carers from CALD backgrounds in mental health services,
- Improve outcomes for CALD mental health consumers, carers and their families,
- Increase mental health awareness, knowledge and capacity in CALD communities, and
- Improve cultural responsiveness and diversity of the mental health workforce.

It is known that people from CALD backgrounds in Australia experience significantly lower access to mental health care and support than the wider community. Different cultures will have different ways of accessing information about what care is available to them.

Those from CALD backgrounds have additional barriers to accessing information about the pandemic and mental health.

These communities are at higher risk of transmission and poorer mental health outcomes.

Consistent with this, Mental Health Australia sought to better understand how the COVID -19 pandemic impacted on the mental health and wellbeing of CALD Australians.

Results from this research will contribute evidence to the National Pandemic Mental Health and Wellbeing Response Plan across three priorities areas:

- **Priority 1:** Meeting immediate mental health and wellbeing needs
- **Priority 6:** Meeting the needs of vulnerable populations
- **Priority 7:** Clear Communication Strategies

Mental health impacts of the COVID-19 pandemic

On January 25, 2020, the first case of COVID-19 infection was reported in Australia, and by March 1 Australia had recorded its first death from COVID-19. As the pandemic spread throughout the country and lockdown and social distancing measures were employed to stop the spread, the wellbeing and mental health of Australians deteriorated.

While the impact of the pandemic on the community was acute (following the introduction of restrictions in March 2020, mental health related PBS prescriptions spiked in March[1]), it has also been long lasting, evolving, and exhausting: on Monday August 3 2021, Lifeline recorded it's highest ever call volume (3,345) in response to outbreaks and consequent lockdowns in Australia's largest cities. [2] The Omnicom variant – which reached Australia in Late November 2021 threw many Australian's end-of-year festivities and holidays into disarray

[1]https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19

[2]https://www.abc.net.au/news/2021-08-04/lifeline-records-highest-daily-calls-on-record/100350522

Due to the pervasive, unpredictable and all-consuming nature of the pandemic, Australians have felt the impact on several fronts, including their outlook for the future, their financial situation, their physical health, their relationships, as well as employment and housing security. Throughout the pandemic there has been an underlying feeling in the community of isolation and loneliness. Not being able to make face-to-face contact with loved ones they would usually regularly see left many feeling stranded and cut-off from their support networks. This has been exacerbated by a widespread hesitation in the community to reach out when struggling, for fear of being a burden to friends and family who might also be doing it tough.

Background to the research project

The Embrace Project invited select tenders to engage a company to conduct a research on mental health during the COVID-19 pandemic in Italian, Vietnamese and Turkish communities. The tender was closed on 21 September 2021, and three applications were received. Whereto Research was the preferred applicant and were contracted to complete the research.

Project Overview - Governance arrangements and key objectives

Following the contract confirmation between Mental Health Australia and Whereto Research, the governance arrangements are:

- Weekly meetings between Mental Health Australia (Embrace Project team) and Whereto research
- Project Steering Committee comprised of key mental health services and CALD community members, representatives from Mental Health Australia and Whereto Research
- Ethics approval process
- Project updates to MHA's governance meetings (including Alliance meetings, Alliance Project Team meetings, Stakeholder Group meetings, Embrace Lived Experience Group meetings, Executive meetings and Board meetings).

- The four phases of the research process are outlined below.

Phase 1 *Project Inception*	Phase 2 *Stakeholder and Community Leader Consultation*	Phase 3 *Community Member Engagement*	Phase 4 *Analysis and Reporting*
• Inception meeting • Steering group formation • Develop detailed project plan and initial reporting outputs • Develop and finalise research approach and instruments	• 10 interviews with key stakeholders • 3-day online forum with community leaders, including faith leaders, community liaison officers and volunteers	• 2x in-language focus groups per language groups (6 in total) with 4-5 participants in each • 4x in-depth interviews per language group (12 in total)	• Michie COM-B behaviour change analysis • Draft and final reports • Knowledge translation workshops
Key achievements: • Project alignment and governance • Project plan delivered • Approved research instruments	**Key achievements:** • Development of initial hypotheses • Foundations for community engagement	**Key achievements:** • Evidence base collection • Transcripts of interview	**Key achievements:** • High quality, easily digestible outputs • Clear directional advice

Research aim and data gathering

The COVID-19 pandemic led to lockdown and social isolation elements creating severe feelings of loneliness and isolation, which impacts on all Australian's mental health. Due to increased levels of social perception and stigma among CALD Australians, conversations about mental health are still challenging, and CALD communities are very hesitant to seek professional support.

The aim of the research was to conduct research on mental health during the COVID-19 pandemic in Italian, Vietnamese and Turkish communities, with specific focuses on:

- The impact of communication on help seeking, and how these communities have accessed appropriate and timely care and information for their mental health during the COVID-19 pandemic; and
- The key communications drivers that have encouraged help seeking and access to services, whether online or face-to-face during the COVID-19 pandemic.

The research used a mixed approach to generate the best outcome through engaging with various key stakeholders to provide holistic view for the research:

- Interviews with community stakeholders and CALD participants,
- In-language focus groups with CALD participants, and
- Online forum (bulletin board) with community leaders, faith leaders, liaison officers and volunteers.

Methodology

This project adopted a qualitative methodology to deeply understand the experiences of Italian, Turkish and Vietnamese Australians throughout the pandemic, and their mental health communication needs.

A range of different data collection approaches and audiences were incorporated – allowing triangulation between multiple sources of information to achieve a more well-rounded perspective. These included:

- 12 Stakeholder interviews with people from relevant organisations, including FECCA, COASIT, AMF, DPC (SA), CoHealth, and QLD Health, among others.
- 1 x community leaders' forum which included leaders and connectors from each of the three communities. The forum was held online, over three days, allowing participants the time to deeply engage with the questions and stimulus, and provide considered responses.

- 6 x discussion groups – 1 male and 1 female group in each of the three languages. Participants in the group discussions were all more comfortable having the discussion in English, and were generally aged between 30 and 50 (with a few exceptions). Participants reviewed some in-language material, but across the Turkish and Vietnamese contingents, did not appear to have good in-language reading skills, with only a couple across each group able to read these. All members of the younger Italian cohort were able to review all the materials. Discussion groups were 90 minutes, and included between 5 and 6 participants in each.
- 12 x in-depth interviews – conducted with older members (55+ years' old) of these communities. These interviews were conducted by AMES Australia in language using bilingual research assistants. These interviews lasted for up to two hours each. Translated notes were provided to the Whereto research team, and all moderators attended a de-briefing session to capture the main themes, issues and opportunities.

The online community leaders' forum, in-depth interviews and group discussions explored:

- Experiences and mental health and wellbeing impacts of the pandemic
- How mental health is understood within CALD communities,
- Access of mental health supports throughout the pandemic period
- Awareness of and response to a selection of multi-lingual mental health communications
- The needs of these communities for future communications campaign.

Analysis

Thematic analysis included the following questions:

- The four micro level questions: What's there? What does it mean? What does it all mean? What does it mean for the issue being examined?
- Using content to develop meaning: What does this tell me about the respondent's perspective or assumptions? Of what is this (developing concept) an example?
- Using process to develop meaning: Why this now? What's not being said? What was the respondent's purpose or intention here? What's going on behind the words? What's changed? What differences are there between groups? Why have these differences arisen now?
- Macro interpretation: What does it all mean (theorising)? What does it all mean for the client (applying)? Application of different theoretical viewpoints helps us take a more holistic and rounded view
- See-Feel-Think-Do: once someone sees the execution, what does it make them feel? How do these feelings influence the way respondents think about the issues? Does it all make them want to do anything?

Each of these constructs was accessed through a combination of intuitive/creative techniques (internal workshopping, brainstorming) and more formal analysis (transcript/tape immersion and content).

Limitations

The key limitations of this study include:

- The sheer level of diversity in CALD communities across the country. Each CALD community is different, and there are differences of dialect and culture even within individual language groups. To some degree, each has different barriers and enablers to mental health. This study has shown that CALD communities are more likely to experience increased levels of stigma (both self and social stigma), and a lack of clear and comprehendible language in their own languages to talk safely about mental health. To address this limitation, Where*to* focussed the findings on themes that were more common and consistent across community groups.
- Another limitation is the small sample within language groups. It could be that a larger sample would have revealed different insights or recommendations. However, given the general level of consistency with each CALD cohort, it is concluded that these findings offer valuable insights to other culturally and linguistically diverse groups.

Detailed Findings

Experiences during the pandemic

Across the Italian, Turkish and Vietnamese communities, there were more commonalities than differences in terms of their experiences during the COVID-19 pandemic between March 2020 and April 2022. The sense of isolation and disruption of normal, healthy activities were felt keenly by all across the country – and were the key factors impacting multicultural Australians' sense of mental wellbeing. Due to increased levels of social and self-stigma, cultural norms that place a higher value on community support coming up against enforced isolation, and the lower financial means of recent migrants, the effects were magnified on Australia's multicultural communities during the pandemic.

A number of common themes emerged across the consultations, including:

- Being cut-off from family and friends is especially difficult for Australia's multicultural communities.

Most cultures outside of the Australian Anglo-Celtic mainstream are more collectivist in nature, and rely even more strongly on their social networks for support in tough times. Lockdowns associated with the pandemic therefore had a more pronounced effect with those used to visiting family several times a week.

Those who live with their elderly parents – again more common in many of Australia's multicultural communities – were fearful that their trip to the supermarket or work could result in their parents contracting the virus.

> *"I have elderly parents, quite ill. It was very tough times. Scared, no advice from the government. I isolated and slept from the garage to avoid giving it to family."*
>
> - **Italian community member, male**

For religious people – which in the sample included the Turkish Muslim community, the Italian Catholic community and Christian and Buddhist communities among the Vietnamese speakers, being cut off from group spiritual practice, and meant being cut-off from key support networks.

"The inability to see family and friends and being stuck at home has made many people upset. The added inability to go to attend the mosque in this time also tore people away from uniting with their community but also from the spiritual atmosphere of being in a religious venue."

- **Turkish Leader**

"COVID-19 has had major impacts on the Vietnamese Eucharistic Youth Movement programs across Australia. My youth group in particular had to transition to online practices during the time, making it difficult for retention of attendees and maintain engagement."

- **Vietnamese Leader**

"Lunar new year is most important day for Vietnamese – having that cancelled di impact a lot of families. My parents live with my brother, can't see their grandkids, they were going insane, driving my brother insane. We had to stockpile food – they kept on stockpiling – wouldn't listen – hard for them to cope, for families."

- - **Vietnamese community member, female**

- Others found their perceptions of Australia had shifted through the successive lockdowns and the imposition on their freedom of movement and association

"Quite difficult for me as well – my family is in Victoria, so it was hard for me to travel to visit them. Also I don't really enjoy having restrictions on where you can travel, where and when. Definitely changed my perception of Australia. Just because of the fact that many Vietnamese said that Australia was a country with a lot of freedom – you can do a lot of things, many opportunities, But the fact that because of the lockdown, as well as restrictions, it's just you feel like there's not much freedom anymore."

- **- Vietnamese community member, male**

- The pandemic was harder on older people, and families with young children.

With the threat of severe illness and death more severe for older Australians, older members of these communities felt 'locked in', and were scared to leave the house – even for essential trips. The sense of isolation was amplified for older Australians who were unable to go about their normal social lives.

"During COVID we didn't do the groceries - I was scared and my children were scared for mine and husband's health. Didn't want to get covid. Daughter would do shopping for them and leave on the verandah. Never came in the house."

- **Older Italian, female**

"I don't want to be around 150 – 200 people, they all want to kiss you when they see you."

- **- Older Italian, female**

"I think seniors may have found this time a bit more tough due to limitations with technology use and isolation from family. Whilst some seniors weren't as isolated during this time, socialising is an important part of life for them so the time in lockdown has been hard on most."

- **Turkish Leader**

Families facing home-schooling and young children at home found the balancing act between work and family responsibilities difficult and stressful to manage. They worried about the amount of screen time their children were having and their lack of ability to socialise and learn with peers.

"More the kids not seeing their cousins – my brother in law normally brings the kids over – that frustrated them. We're between houses at the moment – haven't got a big backyard and the kids like to be playful, can't sit still. Even school – home-schooling – my wife doing all that, me coming home kids to the kids all cooped up and going crazy"

- **Turkish community member, male**

- People were cut off from the normal joys, and time to prepare for new family members.

Participants included several CALD women who themselves or had daughters or relatives who gave birth in 2020-21. Classified as high-risk and not allowed to venture out to go shopping and make preparations for the birth, these women were even more isolated than others at a time they would usually expect to be more connected. Women from these communities would normally rely on a great deal of family support to welcome a joyful addition to their families, but instead they were cut-off, isolated and rushed out of hospital post-birth with little support. Given the risks of post and ante-natal depression, this lack of support increased risk substantially.

> *"My daughter, she had a baby in the middle of the pandemic. I couldn't do anything to help – I couldn't be there, I couldn't help her at all. It was really distressing for me because in my community, that's what we do when our family has a baby. Now I feel like I barely know my grandson, and my daughter is more distant [than before the pandemic]"*
>
> - **Turkish Community member, female**

- Those with relatives overseas (or out-of-state) were cut-off and unable to help.

The pandemic tended to have a more significant impact in other countries, for example in Italy, where the situation became dire very early-on in 2020. Cut-off from being able to visit or help, Australian Italians (with similar experiences noted across the other communities) felt hopeless and fond the situation extremely stressful. Many travel to home countries annually, and the inability to do so – especially when they felt their family and friends needed additional support – caused significant stress. People with family members interstate faced similar difficulties, but were less worries about their safety.

> *"I wasn't able to travel to see my parents – I was worried about my mum and dad in Turkey – it looked pretty full-on over there."*
>
> - **Turkish community member, male**

"My family in Italy were freaking out – the situation was very serious, many people died – me, my brother and sister were very worried about mum."

- **Italian community member, male**

My father died in Turkey – I still haven't been able to get over there to support mum."

- **Turkish community member, female**

- Many social norms have changed, and people feel a sense of loss.

Those in Italian and Turkish communities often embrace or kiss in greeting or in farewell – have been directly and perhaps permanently affected. Participants mentioned that they have not returned to their traditional ways, and that this has introduced a sense of awkwardness and distance in their social gatherings. Others talked about how they used to spend more time in shopping centres, browsing and wandering around, but now (in 2022) feel unsafe doing so.

"Some things you've lost and you don't go back to"

- **Older Italian, female**

"In our community, when we see each other we hug, we kiss – now we don't do that anymore and it all feels different, a bit awkward."

- **Turkish community member, female**

"Definitely changed the way I interact with other people, I find it very difficult to get to know people, make friends, hard to go to events to meet new people, because everyone is so used to being at home, spending more time with family. Feels like everywhere you go, have shields up –very strange."

- **Vietnamese community member, male**

- Many experienced financial distress.

Several participants either themselves lost jobs and work, or had close friends and family do so. Their families were placed under additional financial strain which impacted on their mental health. Stakeholders noted this was a widespread phenomenon: those working in hospitality and retail had nowhere to go, nothing to do, and barely enough to service. Those working in healthcare experienced extremes of stress, burn-out and fear of contracting COVID. Small business owners perhaps had the worst time of all – many faced closure of their businesses, having to lay off or furlough staff and extreme disruptions to their normal trade.

> *"In relation to Covid-19 and restrictions, the past two years have been hard for many people, families, business owners particular small business owners in my community. Many small businesses were closed, particularly those were newly set up early 2020."*
>
> - **Turkish Leader**

> *"Community members losing their jobs and have to rely on Centrelink benefits, emotions experienced feelings of hopelessness and not being able to provide for ones family. Many worried about not being able to pay their mortgage and possibly being bankrupted."*
>
> - **Turkish Leader**

- Families experienced breakdown under the stress.

There were several instances of family and relationship breakdown observed across the sample as the increased stress of 'living on top of one another' impacted people's ability to manage their emotions. Although the sample included a single instance of family violence, community leaders during the 3-day forum affirmed that they felt it was far more widespread and much more difficult to prevent manage due to the pandemic. The broader literature notes that women from CALD communities can be at heightened risk of experiencing family violence due to a range of factors.

"Women in my community reported extreme loneliness, depression, added pressure of home schooling their children and in many cases acceleration in family violence and family disputes. There was record increase in divorce rates in our community. Everyone being at home 24/7 caused problems between spouses and parents and children.
They lost avenues of socialisation."

- **Turkish leader**

- Fear, uncertainty and misinformation was rife.

The uncertainty that extended lockdowns brought to people in NSW and Victoria was another aspect of the pandemic that was keenly felt across these multicultural communities. With no indication as to how long they would be extended, many felt lost, hopeless and despaired about the future. Leaders across each of the communities noted that many -especially older people reliant on in-language communications developed outside of Australia – were exposed to misinformation about the virus and the vaccines.

This led to increased unnecessary fear and to people taking unhelpful actions.

"Being away from my parents in Melbourne, and their understanding of everything – out here in Lakes entrance was nice – parents in Melbourne, hearing fake news – on YouTube – watching stuff on that with all the algorithms, it just rolls onto the next thing. Made it hard all us boys being away from them and not being able to realign all the information"

- **Vietnamese community member, male**

"There is still a fear amongst the community of getting sick and not recovering. Also 'Gossip' has also spread fear amongst the community and untruths about Covid."

- **Turkish leader**

The mental health experiences of CALD communities during the pandemic

The pandemic had certainly impacted the mental health of almost all those who participated in the study, to varying degrees. Initially, the impacts appeared to be more severe: the restrictions on normal daily routines and social lives saw them retreating into isolation and seclusion, overwhelmed by the daily news reports and the fear of the potential of the virus to impact them personally.

> *I didn't appreciate the media – they're fear mongers ... They didn't make people comfortable – put paranoia into people's heads. Everyone really different: some people protest against it, others are confused. What are the rules today? Not clear enough: the politicians did a bad job – every single week something different. The media didn't do a good job.*
>
> - **Turkish community member, female**

As time wore on, some adjusted to 'new normal' routines – working from home, while initially difficult became easier, more productive, and they saw the benefits in reduced commute times and more time with immediate family.

> *"Initial impact was quite severe – especially for people who have to work from home – lose the routine. To me, for the first 3 months, I felt quite different, found it really hard to work from home – but once you learn to do it, start to like it more, save a lot of time for travelling – less disruptive.*
>
> - **-Vietnamese community member, male**

Others began to suffer more. The isolation became oppressive and their inability to socialise, to go on dates or catch up for coffee with friends caused deep frustration.

> *"I was the one who needed help more than my other friends – I was alone, I've got other issues as well, normally I am in depression – they are always calling me up are you ok? – I appreciated that."*
>
> - **Turkish community member, female**

Stigma and Perceptions of good and poor mental wellbeing

Similar to the broader Australian community (as found over years of work with Beyond Blue), we found these communities lack effective, non-stigmatising language for describing poor or deteriorating mental health. There is a recognition – especially among younger people – that there is little helpful language with which to have effective conversations about mental health, and no commonly-known frameworks or conceptions of mental health that can help them have these conversations with friends and family members about whom they are worried.

> *"A lot of the words we need to translate don't exist at all – we need to come up with new words and ways [of talking about mental health]"*
>
> - **Younger Italian community member, female**

Among CALD community members we spoke to, we found that conversations about mental health were more likely to be shrouded in taboo and shame – especially among older generations. This stigma – and in particular the stigma passed on from 'stoic' older generations for whom mental health is a sign of weakness, is likely to be the most significant barrier to communicating about mental health among these communities. As a key example, this study found it particularly difficult to recruit older members of the Italian and Turkish community who were willing to talk about mental health – most simply weren't interested in having a conversation about it. Instead they remain stoic, rely on faith and worship, and struggle on without reaching out for help.

> *"We don't talk about it, we bottle it up"*
>
> - **Italian older person**

> *"When dad broke his leg, he was having trouble managing his pain – the physio told him he needed to see his GP about how he was managing his pain mentally and he said, there's nothing wrong with my head, just need to fix my leg."*
>
> - **Italian leader**

"Not reaching out, being in denial, not recognising that you do need some support, thinking things are ok, when they are not. Not being self-aware. Having barriers to having mental health support. Don't see a need to speak to someone about mental things."

- Vietnamese community member, male

"With my particular family, we really a lot on our faith to get through the hardships – we ask god for help when we're struggling, get through the hardships through payer and committing to worship… But how would I talk to them? [my friends] It's not really spoken about it openly like Anglo western people – but it is good to speak about it and be aware of things."

- **Turkish community member, male**

Self-stigma and social stigma are clearly significant barriers to effective help-seeking and community support for Australia's CALD communities.

- Stigma impacts on the use of translators for services like Beyond Blue and Lifeline and perhaps explains the low uptake of translation services. Because translators are seen as members of the communities in which they work, people are worried that their conversations about mental health may not be confidential.
- Stigma also impacts on people's willingness to use supports like their family GPs due to fear of judgements or gossip about their family if mental health issues were revealed.

Younger generations and migrant communities that have been in Australia longer tend to have a more helpful conception around mental health – as something that people can recover from like physical illness or injury, and something that can benefit from effective treatment.

- Notably, the younger (those under 45 years of age) portion of the sample across all communities appear to have lower levels of stigma associated with mental health, and therefore offer potential as champions and translators for the wider community. This was true across each of the communities' in-scope for this project.
- Younger people understand that their parents hold a different world-view and different life experiences that mean they have little room for consideration of mental health. But they can see when their parents are struggling or in need of support – and are usually willing to step in when needed.

"The older [Vietnamese] just say 'you've got food, you've got a home – you don't know what real trouble even looks like – and you say you've got depression!' and it's true, we aren't living in war-time, our family and friends are relatively safe. But they [my parents] weren't happy, they weren't well."

- **Vietnamese community member, male**

Despite these issues, this study found that, common to all participants and community groups, people can more readily identify with the external symptoms of poor mental health, for example: not eating or sleeping well, self-isolating or having trouble with communication. These are issues that most have experienced at some stage – they know how it feels and because it is not explicitly ties to mental health, it is easier for people to talk about and engage with.

Support and help-seeking

Family and social networks are especially important among Australia's multicultural communities. Most cultures outside of the West are more collectivist in nature; even more so than people within mainstream Australian culture, individuals from CALD communities tend to rely on their social networks for support in tough times. Our evaluation findings showed that multicultural communities are very willing to support those close to them who are experiencing poor mental health.

"For me, turning to my family, I knew my family cared, they really loved me, but sometimes, other people might not have that. A level of knowledge, understanding, but can't give the care and love that your own family gives you."

- **Turkish community member, male**

However, the lack of effective language to tackle mental health discussions, and a lack of knowledge about how to support people to seek and receive mental health support are key barriers for effective interventions.

- There is an important tension here – community members are very willing to support those around them who may be experiencing poor mental health, but stigma prevents people from 'being open' to talk and have these conversations. This was a commonality between this research and our work with Australian men around mental health over the last decade: most are willing to help, but most also believe that their friend or family member may get upset or insulted if they suggested they felt something may be wrong and that professional help may be required. Those experiencing issues don't want to ask for help because of the stigma, fear of judgement, fear of placing their own troubles on their friends, and a worry that it may affect their relationships.

I don't think they [my friends] talk much about that sort of stuff. If they did bring it up, you could go on with the conversation, but you wouldn't ask them if they didn't – it would be insulting"

- **Turkish community member, male**

- Further, many community members are not well equipped to provide good advice for those who are struggling. They may rely on notions of stoicism or faith practices that can, but won't always work – or they may lack good familial support networks.

"People that don't have strong ties to the elders in their family, people who don't have the right type of support. I'm sure there are Turkish people who have toxic parents who are backwards, protective, oppressive – especially if you're a girl."

- **Turkish community member, male**

In our sample, there were several good examples in each of the communities of people who had either sought help themselves, or who were good at providing helpful support in a sensitive and caring way, but also examples of those who lacked the skills, empathy, knowledge or bravery to do so.

- Good, effective examples of successful personal or interpersonal intervention included:
- One Vietnamese young man had recommended several of his friends seek professional support via a counsellor or psychologist. He told us that his friends had followed through and were in a much better place as a result.
- Others in this community were also able to provide friendly support to their friends and family members – with several recommending they see a GP.

> *"Point them in the right direction – send them to a doctor – but comes down to whether they really want help: it's down to them to make the final decision. Being Vietnamese, a lot don't believe in mental health – they think it's imaginary, not a real thing – it can turn heated – they think you're calling them crazy."*
>
> - **Vietnamese community member, male**

- One Turkish man had called a range of different helplines seeking support until he found one (Beyond Blue) that worked for him. His particular background in social work gave him a strong grounding and an understanding that seemed a little at odds with the stoicism and religiosity of the others in that group discussion

> *"The response I got from my family was always – there's nothing wrong with you, you're a lovely young man – it was all true – but it wasn't enough, I need someone that understands what I'm going through. So I turned to the hotlines to see if they could help."*
>
> - **Turkish community member, male**

- Several participants in the Turkish women's group had sought or recommended their friends and family seek a counsellor to chat to when they had been very anxious or stressed.

"I think it's important to have someone to talk to. She had a baby during lockdown, trouble with her husband – I told her maybe you do need to see a counsellor or psychologist – she's doing much better, still seeing them."

- **Turkish community member, female**

"I would say to them maybe go and see a counsellor if it was my sister or someone I was really best friends with – but I wouldn't have the confidence for others. I would go and get a self-help book. I've tried once or twice to go to a psychologist, but I didn't feel comfortable with them."

- **Turkish community member, female**

- Several members of the Italian group male discussions were aware of the mental health supports available – and had reached out to some on behalf of their parents

"COASIT. Lot of work around Welfare around Italian communities. Some part has been mental health. Getting in can be tricky. Waiting list, about who you know. Helped with my brothers, now they've gotten a lot better particularly for older people."

- **Italian community member, male**

"I have approached these before. Concern mainly for people who are older. Stigma of visiting psych – admitting to something that is shameful. My father in law needs to see someone but he won't. Not sure of Beyond Blue have translators."

- **Italian community member, male**

- Examples of less helpful or useful approaches were also common. However, this did not come from a bad place – most are well-meaning and want to help. However, due to the personal and perceived stigma of raising mental health issues, many were only comfortable in talking 'sideways' – asking how their friends and family are and providing reassurances and friendly support. For the Turkish and Italian communities, this inevitably means 'going for a coffee' – an activity that was severely impacted by the pandemic restrictions. Many wouldn't risk a friendship by accusing their friend of needing a mental health intervention.

This analysis shows that (especially older) CALD community members are less likely to either know of or access the range of free mental health support services available. Social and self-stigma appear to be the greatest barriers – few are willing to engage with the topic of mental health, let alone admit they may have even a nascent mental health problem, which prevents them looking for help.

It's also worth noting that some forms of professional support may not be understood as culturally relevant, and across our sample, there was a widespread belief that it is difficult to find good, available in-language mental health support.

- A lack of in-language psychological support means that people are reliant on translators. These translators are also inevitably members of the community, and many people worry that (despite the translators' code of conduct which explicitly prohibits this) their private secrets or mental health issues could become community gossip. This suggests a need to develop and deploy a cohort of psychologists and counsellors from different backgrounds who can provide support directly.
- The extreme stigma associated with mental health across these communities meant that families may not be willing to talk about mental health with their own GPs for fear that their family would be judged poorly. We heard stories that parents would prefer that their adult children visit a GP several suburbs away to avoid this risk of 'losing face' for the family. Despite this, GPs are highly regarded across each of the communities included in this study, and a suggestion to see a GP comes with less stigma attached, given they are also concerned with physical health. The degree to which in-language GPs are able to provide good psychological support is, however, questionable: GPs get scant training on the issues, and tend to understand mental health through a biological, rather than a bio-psycho-social frame.

> *"Those in our CALD communities who have accessed services say language barriers are a huge problem. As carers and family members often have to play the advocacy role, pushing already over-burdened health services, completing long and difficult forms in English, negotiating the mental health 'black hole' of services, where requests disappear, forms are not found, case files go AWOL, it is truly heart breaking and extremely hard to find solutions"*
>
> - **Italian community leader**

"Most people, however highly educated or illiterate, rich or poor, have issues discussing mental health. They will gladly discuss gross physical ailments at length but shy away when sometimes talks of their mental health issues. It is a sad commentary on human society. I recommend that we have to address the 'elephant in the room' and speak plainly of mental health being as important as physical health, that both go hand in hand for holistic healing. No point just resorting to prayer and offering food and money in temples and mosques if there is reluctance to take the person to a GP. Education of the masses, as well as of cultural and faith leaders [is needed here]. We have used this methodology for prevention of family violence with CALD communities and have held workshops and forums with communities together; the same is needed for mental health."

- **Community Leader**

"I noticed that it is not easy to talk about mental health in culturally and linguistically diverse communities across Australia due to many reasons. Some of them are:

1. cultural sensitivity,

2. language barriers,

3. being afraid that people will look down on them,

4. fear of things going wrong if they talk about their mental stage,

5. desire not to disclose their experience,

6. lack of knowledge about support available,

7. no idea where to approach to ask for help,

8. feeling of helplessness

9. think wrongly that it should not be spoken out, and

10. isolation."

- Community Leader

Towards a community empowerment strategy

This analysis suggests that a community empowerment strategy focussed on helping people provide better support for loved ones – including how to access professional supports - could be an effective way to start reducing the significant social stigma around mental health discussions while reinforcing and enhancing existing models of community support.

- The core objective of such a strategy would be to empower community members by equipping them with better knowledge about how to recognise and support a friend or family member who may be experiencing mental ill-health. This should include reference to non-stigmatising language, ways in which community members can help directly, and the range of stepped care approaches that may be appropriate for them to recommend and support people to engage with.
- Ideally this would be based on a thorough community co-design approach that involves the different communities in designing what such an approach may look like for them. While we would suggest the overall strategy could be similar across different language groups, there are likely to be subtle differences and variations - such as religion or the way the community gathers and communicates – that need to be considered and incorporated into the approach for each language group.
- The strategy could build on other recommendation to develop community champions and translators – typically the younger generations are seen as having a more useful conception of mental health.

Mental Health Communications

Reaching communities

Few across the sample could recall seeing or hearing any communications about mental health support services. A few of the younger (under 40 years old) were aware of various non-governmental organisations like RUOK, Beyond Blue, Lifeline, Men's Helpline and others, but tended to believe that these would not be appropriate for their older relatives who are less comfortable in English, and with directly addressing mental health. Those who worked consistently called out their workplace EAP, or their private health insurance provider as offering good mental health services that are 'no judgement'. Older participants were consistently unable to name any relevant organisations.

Given the lack of awareness about the range of free supports available for those experiencing even minor levels of discomfort or feeling unsettled, they made a range of suggestions to get the message out there more effectively, including:

- Using community radio, and in-language newspapers as a cost-effective way to reach a wide audience.
- Using SBS radio (especially for Turkish community members).
- Using relevant Facebook groups (e.g. Vietnamese women in Melbourne, where other supports may be offered).
- Distributing via relevant GP clinics in areas with strong multicultural populations.
- Targeting specific groups (e.g., students, recent migrants) directly through relevant support organisations.
- Distributing via community leaders, church groups and language / culture clubs.

Community leaders reinforced the need for multi-pronged approaches that repeat messages through a wide variety of channels until they stick.

Effective messaging

A range of examples of communications messages were used as stimulus for the discussion around what effective messaging for mental health might look like. In the group discussions (people aged 30-55), on average only a couple of the participants in each group had a preference for receiving ore reviewing information in-language. In the on-on-one interviews (generally people 55+), all had a preference for in-language materials.

These materials included:

- translated Embrace materials developed by mental health Australia,
- pamphlets and posters from the transcultural mental health centre, and
- a mental health continuum model developed by the centre for rural and remote mental health (in English)

The materials included in the study are shown in appendix.

Overall, the strongest piece tested was the English version of the mental health continuum.

The formal evidence base for the use of mental health continuum models for public health communications is still weak – but it is growing. Findings suggest that stronger continuum beliefs are associated with less stigmatising attitudes. However, results vary depending on the issue; participants generally endorsed a continuum conceptualisation for depression, but for more stigmatised disorders such schizophrenia and alcohol dependence, rates of agreement were not as high.

Some studies have found evidence in support of an association between continuum beliefs and positive attitudes towards people with mental illness, lower stereotypes, less discrimination, greater prosocial reactions and less desire for social distance. Overall, these studies concluded that content on the 'continuous nature' of psychopathological symptoms – and hence a reduction in perceived separation – may be useful in anti-stigma campaigns. However, other evidence is more mixed, and some studies have found little or no effect. Much work remains to be done on understanding the benefits and role of continuum models in public health communications.

This study however, found that the simple nature of the continuum model presented, the easy-to-understand language, the layout that allows the viewer to easily categorise themselves, and the clear instructions on what one can do at each stage of the continuum made this piece of communications highly effective.

Figure 1: Centre for rural and remote mental health continuum model

Participants were near-unanimous in their verdict that this was more useful than the more wordy and dense pamphlets and posters tested.

It invites readers to self-reflect and evaluate their own feelings, stress level, outlook, work, sleep, energy, activity and social connections.

In the group discussions and interviews it was found that individuals were able to identify themselves as being 'mostly in the yellow' or 'mostly in the light blue' stages – and this prompted a level of self-realisation for some. They were able to see that perhaps they were not as happy and well as they had assumed, and liked the fact that simple action they could take are clearly spelled out.

They suggested that this would be useful in a range of public places, including workplaces, community centres and clubs, GP offices and even places of worship, and felt that it provides a new level of understanding about mental health and what they can do to identify when they may have an issue, and what steps they can take to resolve it.

In comparison the other pieces tested – all in-language – were felt to be a little less useful for someone experiencing psychological distress.

Figure 2: A selection of (from L to R) MHA Embrace, Multicultural mental health Australia, and NSW Health Italian mental health communications examples

The reason for this was primarily the amount of text involved in full parsing these materials. While the language in each case was found to be warm, engaging, relatively easy to understand and non-judgemental, as well as providing a good explanation of the ideas and concepts, participants told us that if they were feeling distressed (experiencing depression or anxiety), they did not feel they would have the mental capacity to sit and read all of it.

They told us the materials were good, and there was nothing fundamentally wrong with what was being said, but that these more dense materials may be better for people who were supporting someone with poor mental health – and in particular someone with a diagnosed condition who was already seeing a doctor. In this case, the more detailed information would be useful for them to better understand the condition and what their loved one was going through.

- The lack of imagery on some (e.g. Embrace, NSW Health) makes them less appealing and engaging. The amount of text on the page creates a barrier to engagement.
- While the imagery on the Multicultural mental health Australia example is helpful in driving engagement with the piece, and the smiling faces makes it feel warm and inviting, the amount of text over 6 pages makes true engagement with it overwhelming – especially, they imagined for someone already experiencing a high degree of stress.

A common thread found in this evaluation that may prove useful in drawing out conversations about mental health was that across each of these more established communities, people can more readily identify with the external symptoms of poor mental health such as not eating or sleeping well, self-isolating or having trouble with communication.

- These symptoms can be used to build a conversation that can gradually steer towards an underlying issue. The mental health continuum could therefore be particularly pertinent to these communities, as it often describes physical and behavioural symptoms of poor mental health (i.e., increased reliance on drugs and alcohol, changes in sleeping habits, diet, exercise, etc.)

Overall, participants felt that the mental health continuum (MHC) would be a particularly helpful resource if translated into their languages, and almost unanimously requested translated copies for use in their communities. They told us it would both help them self-identify when they needed support and help identify when their loved ones needed it as well.

There are a range of additional issues that arise when creating translated messages of this kind, including:

- The range of dialects spoken in Australia means that translations into a single version did not always meet their intended message. Vietnamese in particular has a range of different dialects that made the translations presented a little awkward for some participants.
- Many words do not translate directly, and the meaning is changed in translation -

Conclusion

The Italian, Turkish and Vietnamese communities studied were more adversely impacted by the COVID-19 pandemic. Like many other communities around the country the mental health of these close-knit communities was affected by specific issues including loss of support systems, isolation, financial distress, fear and uncertainty.

Additionally, health and mental health information designed to prompt help-seeking during the pandemic did not reach many from these communities. However, some younger members of these communities did come across relevant communications.

There are many lessons that can be drawn from this study demonstrating the need for tailored and specific interventions in working with CALD communities. If health services wish to reach these communities, these lessons must be heeded and acted on in order to provide adequate mental health support in the future.