A Literature Review on Mental Health and Stigma in Three Specific Culturally and Linguistically Diverse Communities: Arabic, African and Chinese

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Definitions

Culturally and Linguistically Diverse (CaLD)	In Australia, CaLD individuals typically refers to first-generation migrants from a non-English speaking background, excluding those from an Anglo-Saxon, Anglo Celtic, Aboriginal or Torres-Strait Islander ancestry (1).
Refugee	The 1951 UNHCR Convention defines a refugee as: any person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (2 p14). Such an individual is protected from persecution. Further, s/he cannot be made to return to the country where s/he fears persecution if s/he is unwilling.
Asylum-Seeker	The UNHCR defines an asylum-seeker as any person who: "is seeking international protection. In countries with individualized refugee status determination procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it." (2 p1).
Personal stigma	A person's own attitude toward people with mental illness (3).
Perceived stigma	A person's beliefs about the attitudes of others toward mental illness (3).
Public stigma	The general public's reactions toward individuals with mental illness and encompasses stereotypes, prejudice and discrimination (3).
Self-stigma	The negative attitudes of a person to their own mental illness. Self-stigma is also known as internalised stigma (3).
Courtesy stigma	The public's views of associates (e.g., family members, caregivers, friends, service provider) with a person with mental illness (4).
Affiliate stigma	The self-stigma and corresponding psychological responses of associates (e.g., family members, caregivers, friends) with a person with mental illness (5).

A Culturally and Linguistically Diverse Australia

The Culturally and Linguistically Diverse (CaLD) population of Australia encompasses communities of different languages, nationalities, religions, cultures, ethnic backgrounds, cultural beliefs, and family structures. Australia is a richly diverse nation with the most recent national census undertaken in 2021 indicating that just over half (51.5%) of Australians report having been born overseas (first generation migrant) or having a parent born overseas (second generation migrant; 6). In Australia, Mandarin (2.7%) and Arabic (1.4%) are the two most spoken languages in the home other than English (6). In 2021, China fell within the top three countries of birth for overseas-born individuals; 2.3% of the Australian population were born in China (7). Indeed, Australia has a rich migrant history. Australia's immigration program includes the migration programme, those who arrive via the Family stream (i.e., migration of family members of Australian citizens or permanent residents) or a skills stream for individuals with sought after skills, and the Humanitarian Program. Most migrants in Australia arrive through the Family Stream and Australia's Refugee and Humanitarian Program (8). In this report we are focusing on three communities: Arabic, Mandarin (Chinese), and Congolese. Moreover, we are interested in accessing those individuals from these communities and specifically those who have migrated who have arrived in Australia in the past seven years.

Refugee and Asylum-Seekers

One significant but smaller subgroup within the CaLD communities are those from a refugee or asylum seeker background. Refugees and asylum-seekers are a particularly vulnerable proportion of CaLD individuals. Between 2018-2019 and between 2019-2020, Iraq formed one of the top two countries of birth for individuals granted humanitarian visas (9). Individuals from the Middle East are one of the largest displaced people in the world and due to ongoing conflicts in the Middle East individuals from Iraq, Syria, and Afghanistan continue to form a significant proportion of individuals granted offshore humanitarian visas in Australia (9). The Democratic Republic of the Congo was the other top country of birth for individuals granted humanitarian visas between 2018-2019 and between 2019-2020 (9). Currently, individuals from the Democratic Republic of the Congo form a new and emerging migrant community (10). The amount of humanitarian visas allocated to citizens of the Democratic Republic of the Congo have rapidly increased in recent years (9). The UNHCR recognises the situation in the Democratic Republic of the Congo as an emergency due to worsening civil unrest and violence following the end of the civil war in 2003, particularly in the Eastern part of the country, and the displaced civilians. In 2018, Sub-Saharan Africa had the highest number of internally displaced persons worldwide (11) and Australia has recently accepted a higher number of refugees from African countries.

Mental Health of CaLD Communities

Migrant Mental Health

The burden of mental health problems in Australia remains significant. In 2018, mental health conditions and substance use disorders were among the five disease groups causing the most total burden among Australians (12). Among Australians aged 15-44, mental health conditions and substance use disorders was the leading disease group causing total burden, not physical health conditions. Among females aged 15-44, anxiety disorders were the leading cause of total burden and among males aged 15-44 suicide/self-inflicted injuries were the leading cause of total burden (12). Those with mental illness also experience poorer physical health outcomes (13). Evidently, we must prioritise the prevention and treatment of mental health conditions to reduce the nation's burden of illness and disease. To this day the mental health needs of the CaLD proportion of the population in Australia remain poorly understood and excluded compared to individuals from a non-CaLD background. This is evidenced by the lack of sufficient and accurate data about mental health prevalence rates among Australia's CaLD individuals (14). Without clear

prevalence data, researchers and policy-makers are inadequately informed to meet the mental health needs of diverse CaLD communities, impacting significant funding decisions and policy. Although unclear, insufficient prevalence data for mental disorders among CaLD individuals may be due to several factors including exclusion of such participants from mental health research due to their low proficiency of the English language, complex group membership of CaLD individuals, and application of Western methodology and conceptualisations that may not be appropriate (15). A survey conducted between 1997 and 1998 in NSW found disability arising from psychological distress as measured by the K10 was highest in communities from Southern and South-East Asia, Africa and the Middle East when compared to those from an English-speaking background (16). Although prevalence data is lacking, notable stressors associated with migration such as separation from family members and support networks, social isolation, language barriers, disrupted or loss of identity, racism, socioeconomic difficulties, and acculturation challenges can contribute to poor mental health outcomes (14, 17). Navigating such challenges can result in heightened psychological distress (18). In a sample of young people residing in Melbourne, the treated incidence of First Episode Psychosis was at least three times higher in Sub-Saharan African and Northern African individuals compared to young people born in Australia (19). Further, it has been reported individuals born in Lebanon living in Australia have a rate of experiencing psychological distress double that of the Australian born population (20). Currently, the effects of the COVID-19 pandemic have also adversely impacted the mental health of the migrant, refugee and asylum seeker population (21).

Refugees and Asylum-Seeker Mental Health

There is substantial evidence that refugees are at heightened risk of developing mental health disorders, specifically symptoms of Depression and Post-Traumatic Stress Disorder (PTSD). Among a sample of 8149 refugees in the United States, refugees from Iraq, Sudan, and the Democratic Republic of the Congo reported the highest rates of witnessing traumatic events (22). Ninety-five percent of 225 resettled Iraqi refugees attending English tuition classes in Western Sydney reported experiencing at least one potentially traumatic event before leaving Iraq, and almost 40% demonstrated symptoms of general anxiety and depression (23). Iraqi refugees have been shown to have significantly higher prevalence of PTSD and depression compared to the general Australian public, as well as compared to those in their home country (23, 24). This vulnerability to developing mental illness has been attributed to the combination of pre-migration and post-migration experiences that refugees and asylum-seekers face in their country of origin, as well as the countries they have migrated to (25). Turning to our other research group, it has been shown individuals in the Democratic Republic of the Congo live in an environment of continuous political unrest and human rights violations, trauma, lack of nutrition, disease, and poverty (26). The prevalence of sexual violence experienced by Congolese men and women is significantly higher than in other conflict settings (26). Those who do not reside in the Democratic Republic of the Congo war zone experience significant economic and resource deprivation. After fleeing such an environment the migration process, including indefinite periods of detention and lengthy legal procedures, may contribute to trauma symptoms just as significantly as pre-migration experiences (27). Moreover, African migrants, who are mostly refugees, experience racism, discrimination, and changes to status and identity (28). A recent study among African migrant youths in South Australia revealed stressors including traumatic experiences associated with pre-migration and post-migration experiences, were related to problematic AOD use (29). Although scarce, the research that exists on mental health outcomes in refugee groups suggests a need for accessible, appropriate, and effective mental health care, given their elevated risk of mental illness.

Engagement with Mental Health Services

CaLD communities in Australia demonstrate low uptake of mental health services (14, 18). Despite high reports of disability due to psychological distress, those born in Africa, the Middle East, and Southern and South-East Asia were significantly less likely to utilise mental health services for their psychological distress compared to those from an English-speaking background (16). This pattern was also found in McDonald and Steel's (30) seminal epidemiological study investigating mental health in CaLD communities. Interestingly, evidence consistently shows that a higher proportion of CaLD individuals, including those

from the Middle East and China, experience involuntary hospital and acute inpatient unit admissions, and longer length of admission stay (14, 30, 31). Such individuals have also been observed to be diagnosed with psychosis at higher rates to English-speaking individuals (32). Current best practice mental health care advocates for the provision of least restrictive care in the community, with involuntary hospital admissions only to be used as a last resort (33). It is hypothesised this discrepancy in involuntary admissions amongst CaLD groups may stem from a lack of engagement with mental health services in the community. If early and appropriate treatment is not sought it can result in a significant worsening of symptoms that warrant hospitalisation for mental disorders (31). This indicates those from a CaLD background are disadvantaged when it comes to early mental health service uptake and engagement compared to those from an English-speaking background.

Help-Seeking Behaviour

Arabic-Speaking Community

Despite evidence Arabic-speaking individuals experience psychological distress, especially if they come from a refugee or asylum-seeker background, it has been reported they underuse mental health services for psychological issues (30, 34, 35). A 2015 study found of the 58% of Arab Australians who had concerns about their mental health in the last year, only 32% stated they had sought help and if they did seek help, only 18% saw a mental health professional (34). In an Australian study, although 44% of Afghan refugees met PTSD criteria and almost 15% reported symptoms indicating depression only 4.6% sought help from a specialist trauma and torture mental health service (36). A more recent study revealed 35.9% of 803 resettled Iraqi refugees received help for emotional problems (37). It has been hypothesised a preference for informal help may contribute to low levels of engagement with professional mental health services. In one study, although 31% of resettled Iraqi refugees in Australia met PTSD criteria and almost all reported one or more potentially traumatic events, only 19% pursued help for a mental health issue. Of these individuals, 27.2% sought help from a family member, 13.8% from a mental health professional, and 6.5% from their religious leader (23). Informal sources are typically the first point of contact for those seeking help in the Arabic-speaking community if experiencing mental health difficulties. These sources include talking to friends, talking to family, and consulting religious leaders (34, 38). Seeking informal sources of help may be preferred because of language barriers, and due to explanatory models of mental illness. Advice from a religious leader is likely to be sought if mental illness is perceived as a spiritual sickness and Western biomedical mental health services may be perceived as insufficient to treat these problems (39).

Chinese (Mandarin-Speaking) Community

Studies have indicated comparable rates of depression among Chinese and non-Chinese patients in Australia (40) however Chinese immigrants have been suggested to under-utilise mental health services compared to non-Chinese individuals (40, 41). Although there is a strong need for self-reliance when experiencing mental health difficulties (42, 43), it has been shown Chinese people prefer to seek alternative sources of help including family and friends or a traditional Chinese medicine practitioner (42, 44). Chinese migrants interviewed in South-West Sydney emphasised the role family and friends play in providing support for mental health problems and demonstrated preference for seeking support from informal sources rather than professionals (44). Overall, the research suggests Chinese individuals typically will not seek help for general mental health problems and will usually only seek help from family or friends when problems worsen (45).

African Community

African refugees resettled in Australia have been suggested to under-utilise mental health services (46, 47). Although individuals from various African countries migrate to Australia, the studies reviewed in this report include participants who have primarily migrated from Sub-Saharan African countries. It has been stated

African migrants with a refugee background who have migrated to Australia hold similar cultural beliefs and practices in relation to mental illness (48). Among 15 women from the Democratic Republic of the Congo and 16 women from Somali who identified as a refugee or asylum seeker in the USA, 88.7% had never sought help from a mental health professional and approximately 42% stated they were uncertain they would seek help if they were very depressed (49). The existing research suggests African migrants turn to informal social networks for support rather than seek mental health services (49, 50). Mental health problems are only acknowledged when an individual's behaviour is significantly out of the norm (49). Up to this point, informal social networks are a significant protective factor for mental illness and preferred to seeking professional help (50, 51), including among the youth refugee population (52). Compared to Australian females, West African refugee females living in Western Australia were more likely seek help for stress from self-help groups, religious leaders, and community elders (53). It is common for individuals to turn to faith and religious leaders when experiencing mental health difficulties as mental health services are perceived to be insufficient to treat mental illness (54). This pattern of help-seeking may be attributed to traditional and cultural beliefs about mental illness which prevail among African migrants resettled in Australia and are discussed below.

Barriers to Help-Seeking

Structural Barriers

Structural barriers such as limited transportation, financial cost of mental health care (55), low English proficiency (15),and anticipated problems with visa and immigration renewals (52, 55) can hinder contact and engagement with mental health services (44). The Australian mental health system is challenging to navigate especially for individuals who migrate from countries with very different mental health systems or lack thereof (44, 52, 56). Individuals report not knowing the available services or how to access them (52, 54). Additionally, a distrust of Australian mental health services has been reported to adversely affect disclosure of mental illness and professional help-seeking among migrants (55-57). Particularly, there may be a lack of trust in the cultural competency of mental health services (46, 57) as well as wariness that same-language interpreters and professionals will maintain confidentiality (52). Finally, there may be concerns disclosures may result in involuntary hospitalisations and restrictive treatment (52).

Mental Health Literacy

In addition to structural barriers the notion of mental health literacy is a useful concept that can be used to understand how a range of factors may interact to contribute to patterns of help-seeking. The definition of mental health literacy is: "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking." (58 p182). A range of these factors, in relation to the Arabic, Mandarin (Chinese), and Congolese communities, are discussed below.

Conceptualisations of Mental Illness

African Community

In much of Africa, mental health problems or mental illness are equated with symptoms that may be in line with psychosis (49, 50). Psychosis is a symptom of severe and complex mental illness typically characterised by delusions, hallucinations, and disorganised behaviour (59). Mental illness is usually associated with

individuals who 'run down the street naked' or 'remove their clothing' (46, 49), and are described as 'crazy' and 'dangerous' (50). This cultural association means individuals do not justify professional help-seeking for general mental health problems (52). Beliefs in supernatural causes of mental illness are common (54, 60). Mental illness may be attributed to 'mapepo' (demonic/spiritual possession in Swahili), punishment from God, witchcraft, or a spiritual attack, rather than biopsychosocial models (46, 49, 61, 62). These negative associations contribute to pervasive denial and rejection of the terms 'mental illness' or 'mental health problems' when presented to individuals (57).

The Western biomedical label of 'depression' is stated to be unaccepted by much of Africa (51). Qualitative studies conducted with individuals from the Democratic Republic of the Congo indicated the term 'amutwe alluhire' translatable to 'tired head' in Nande in the Democratic Republic of the Congo encompasses many symptoms in line with the Western biomedical conceptualisation of major depression such as excessive sadness, social withdrawal and irritability (63, 64). In one study involving individuals from the Democratic Republic of the Congo psychosocial causes of 'amutwe alluhire', such as poverty, were endorsed rather than supernatural causes. However, demonic possession ('mapepo') has also been identified as a common cultural explanation for depression in Sub-Saharan Africa (65), particularly if symptoms are seen as chronic and severe. The concept of 'alluhire' may not be perceived as a form of mental illness but rather a cultural expression of distress (50, 64). Experiences of excessive sadness and 'alluhire' may be perceived as normal reactions to adverse social factors such as isolation, loss, and stress (49, 50). The preferred method of treating excessive sadness or social isolation is by reconnecting with family and community. An individual's support network may intensify efforts to visit the person experiencing social isolation (50). In an Australian study of Sudanese, Somali, Eritrean, and Ethiopian women resettled in Western Australia, participants attributed the low prevalence of depression in their countries of origin to close-knit communities (50).

If an individual experiences mental health problems, family and friends are typically consulted (55). Informal support and encouragement provided by family and friends, may include advice to seek formal help (55). In the context of a spousal relationship, participants interviewed from various African countries, including the Democratic Republic of the Congo, Somalia, South Sudan, and Liberia, reported husbands are the decision-makers in the spousal relationship and whether the female seeks informal (e.g., community) or formal support is decided by the male (46). In an Australian study, Sub-Saharan African migrant youth and their parents discussed the significance placed on strong community support. As Sub-Saharan African communities become more established in Australia, there is increased capacity to find comfort and support within the strong community networks and formal help may be sought under the guidance of the community network (46).

Another important factor that influences perceptions about mental illness is religion. Specifically in the Democratic Republic of the Congo, the Pew Research Centre estimates almost 96% of the population identify as Christian, 1.5% identify as Muslim, and 1.8% identify with no religious affiliation (66). However, it has been noted overlapping religious affiliations are common and co-occur with traditional beliefs. Islamic Somali refugee women resettled in Australia stated the influence of faith impacted whether they would seek professional help (57). Traditional healers and religious leaders commonly treat mental health problems in Africa (51) and much of the population will turn to traditional healers for treating mental health problems. Reliance on religious and informal methods of treating mental illness are understandable given the lack of resources and funding allocated to mental health care in Africa (51) as well as prevailing explanatory models of mental illness. After resettling in Australia, seeking help from religious leaders such as an Imam or Pastor is common (67). Like informal social networks, religion is perceived as a significant protective factor for mental illness. Community members and a religious leader will pray for an individual experiencing mental health problems (46). In a study of refugee youth from Iran, Afghanistan, Sudan, the Democratic Republic of the Congo, Ethiopia, Tanzania, Cote d'Ivoire, and Pakistan resettled in Australia, an African participant reported there is widespread belief that regular prayer and support from the community will cure symptoms of mental illness (52).

Chinese (Mandarin) Community

Like other non-Western communities, the Western biomedical definitions of depression and anxiety are not well understood in China (68). It is important to note that the views presented here are not comprehensive and likely vary between generations and levels of acculturation. In the mental health literacy literature, lower percentages of recognition of depression among Chinese community members in Australia were found compared to a general Australian public sample (69, 70). It has been stated in China mental illness or emotional problems are not considered a medical illness or disease (71). Health professionals and community workers in Australia have observed among older Chinese immigrants that mental illness is perceived as a sign of weakness rather than an illness (68). Members of the Chinese community in Australia associated mental illness with an inability to tolerate and adjust to life's stressors (44). The association between mental illness as a sign of weakness and inability to tolerate stress can be viewed in the context of Chinese culture. There is an understanding that emotional problems are an inherent part of life and Chinese culture places value on learning to co-exist with negative emotions such as sadness or fear (45). A strong preference for self-reliance when experiencing mental health problems (72) has also been observed among Chinese migrants. The value placed on self-coping and ability to tolerate distress may hinder the expression of mental health problems in Chinese communities (71). Expression of emotions, which encompasses emotional suffering, is not usually accepted (45, 71). In a recent systematic review, a strong need for self-reliance emerged as the biggest barrier to seeking mental health services which may also be related to fears of disclosure (42). It has been suggested mental illness is usually denied in Chinese communities (42, 45) and only when problems significantly worsen may help be sought from family members or close friends (72).

Traditional Chinese values may also influence interpretations of mental illness. A qualitative study in Melbourne demonstrated traditional Chinese values in line with Confucianism of interpersonal harmony, hierarchical family structure, and filial piety influenced interpretations of Chinese migrants' and their caregivers' experience of mental illness. Individuals may perceive misconduct by ancestors as causing mental health problems (45). Moreover, integration with family and community is understood as a sign of good mental health (44). Whereas interpersonal stress, such as family conflict, is perceived as a particularly negative form of stress among Chinese individuals which can provoke and exacerbate mental health problems (73).

Those who experience emotional problems or mental illness have been observed to describe their experiences somatically, initially referring to physical symptoms such as fatigue and sleep problems (68). This may lead them to seek help from a general practitioner (74). A tendency to somaticise has been attributed to the notion that expression of somatic symptoms is more culturally acceptable than expression of emotional symptoms. For example, the Chinese term for neurasthenia 'shenjing shuairuo' was a long-standing culturally acceptable term in the Chinese community to describe the somatic/physical symptoms associated with the Western definition of depression (45, 68). The notion of balance may also influence interpretation of illness, and imbalance of 'qi' (Chinese term for vital energy) may be seen as contributing to emotional difficulties (71). Chinese herbal medicines may be sought to help restore balance between environment and the individual. While these beliefs exist, there is also evidence Chinese migrants in Australia do not acknowledge non-western natural or supernatural explanatory models as the origin for mental illness (44). In a study comparing the mental health literacy of the general Australian public and Chinese from Australia, China, Hong Kong and Taiwan, helpfulness of professionals such as psychiatrists and clinical psychologists for mental illness were endorsed by both groups at similar levels. Moreover, Chinese traditional healing methods were not endorsed by many in the Chinese group as helpful compared to psychosocial interventions for depression and schizophrenia (69, 70).

Arabic Speaking Community

Religion has been noted to play a significant role when considering perceptions of mental illness in Arab communities (75, 76). Relatedly, approximately 90% of the Arab population identify as Muslims (77) and there has been work looking at the influence of Islam on perceptions of mental illness among Arabic-speaking individuals (78, 79). However, it must be recognised Muslims are not a homogenous group and

views as presented below may not be reflective of all Muslims. When Arabic-speaking individuals interviewed in Western Sydney were asked about their perceptions of mental illness they categorised their own mental health difficulties, or those of their family members, as "illness of the self" as opposed to "mental illness" (80). This conceptualisation makes sense within an Islamic perspective due to the interconnected nature of body, spirit, and 'nafs' (soul/psyche/self in Arabic). To maintain satisfaction and inner peace individuals strive to achieve a balance between body, spirit, and 'nafs' (78). However, an individual's 'nafs' is vulnerable to surrendering to evil desires or abnormal behaviour. Using one's intellect is required to protect one's 'nafs' from turning toward evil (79). Due to the interconnected nature of body, spirit, and 'nafs', psychological problems are perceived to manifest in the body through somatic symptoms and are perceived as a spiritual sickness (79). Arabic-speaking individuals have been observed to experience and express their psychological distress as somatic symptoms. This expression of distress is stated to elicit less stigmatising responses by others (81).

Overall, the terms "mental illness" or "mental health problems" are highly stigmatised in Arabic-speaking communities and typically provoke a desire to distance oneself from the individual with mental illness (78). The Arabic word 'majnoon' has been stated to be associated with mental illness among Arabic-speaking individuals (39, 78). The word 'majnoon', put forward as a culturally determined term, is translatable to 'madness/insane' (39, 78) and is applied as a label if an individual's behaviour is overtly out of norm or out of control. 'Majnoon' is perceived to arise from an imbalance of psychological and spiritual states (78) and is associated with concealment of intellect. Due to its historical association with supernatural explanatory models of mental illness, to be labelled 'majnoon' in Arabic culture is extremely stigmatising and drives denial of the label of mental illness (82). Mental illness may also be associated with deviation from religion, black magic, and satanic powers (39, 78, 79). Due to the negative connotations associated with the term "mental illness", the term "psychological illness" has been stated to be more accepted than the term "mental illness" among Arabic-speaking people (39). Professionals such as a psychiatrist or psychologist are also viewed negatively due to their association with mental illness and are typically treated with suspicion (83).

In relation to perceptions of depression and anxiety, Arabic-speaking individuals perceive these experiences as very common and may not label them as mental illness. Thus, treatment is not usually sought (39). When Arabic-speaking people experience excessive sadness it is usually attributed to social factors such as unemployment and financial problems and perceived as a part of life (39). Interestingly, there are some positive meanings attributed to experiencing psychological difficulties. A common belief may be that mental illness is a "test from God" (39). This meaning making process of mental illness allows for opportunities to connect with God including through regular prayer, reading from the Quran, or visiting a religious leader. Islamic tradition values holistic care. Holistic care encompasses spiritual care because of the importance placed on the interconnected nature of body and mind (78). Maintaining connection to God is a protective factor and maintains wellbeing (79).

Islamic tradition also values duty of care towards the sick. Mental health care is a family matter in the Arabic-speaking community, and whether mental health treatment is sought is a decision made by the family, particularly men and elders (39, 84). Over-protection of those with mental illness by family members has been acknowledged by Arabic-speaking individuals and General Practitioners interviewed in South-Western Sydney (39). Although family members will typically keep mental illness within the home to ensure it is kept a secret and evade stigmatisation (75), the family is also responsible for providing the primary support and care for the mentally ill person. Reliance on family and community is also an avenue for healing from mental illness (79). Further in some cases it was noted that seeking professional psychiatric help was associated with weakness (39). Managing mental illness within the family may also emerge due to structural barriers encountered in many Arab counties. Namely, there is insufficient formal mental health services available in many Arab nations (81, 84). For example, in Iraq there is a low proportion of psychiatrists available for the population; with only 100 psychiatrists and two mental health hospitals (in addition to psychiatric in-patient wards in general hospitals) available in 2020 (85, 86). Thus, access to psychiatric services is typically limited to those with severe and complex mental illness. The help of traditional and cultural sources including family, friends, traditional healers, and religious leaders are likely to be sought before psychiatrists (85). Also, community mental health care is said to be non-existent (85).

Individuals experiencing mental illness are typically looked after in the home by family members in the first instance and psychiatric services may only be sought when symptoms significantly worsen and are observable to others (85, 87).

Stigma

Attitudes toward mental illness can either facilitate or impede recognition of mental illness and help-seeking. The concept of stigma is used to refer to negative attitudes toward mental illness that impede recognition of mental illness as well as help-seeking. Stigma toward mental illness has been linked to low self-esteem, reduced self-efficacy, poor quality of life (88, 89) and has been consistently shown to be a significant barrier to help-seeking (90). Many studies across the globe have demonstrated the general public hold negative attitudes toward people with mental illness (91-93). Of relevance to this current project are studies that have shown stigma toward mental illness and help-seeking to be particularly pronounced among our three CaLD communities (48, 56, 94). Collectivistic values are inherent in African (55, 95), Chinese (73, 96), and Arabic-speaking communities (97) and there is usually an obligation to make decisions as a family. A sense of self is interconnected with family wellbeing and decisions regarding mental health problems are made by the family not just the individual. Collectivism as a significant cultural influence needs to be considered when evaluating the consequences of stigma in these communities and how it relates to help-seeking behaviour. Bringing shame to family is a strong deterrent to disclosing mental health problems and seeking help outside of the family (39, 48, 97).

African Community

Several studies involving individuals from various Sub-Saharan African countries (including participants from the Democratic Republic of the Congo) discuss stigmatising stereotypes of mental illness including that mentally ill people are dangerous to society (57, 98), unpredictable, and hopeless (99). A systematic review investigating stigmatising attitudes and beliefs toward people with mental illness in the Sub-Saharan African population found people with mental illness are widely perceived as strange and abnormal (60). Consistent with data from the general Australian public (100), disorders such as schizophrenia have been reported to be more stigmatised than depression in the African community. In relation to explanatory models of mental illness in an African context, supernatural causes of mental illness are prevalent, including in Central Africa (60, 61). Beliefs that mental illness is caused by demonic or spiritual possession are associated with negative attitudes toward people with mental illness and higher stigmatisation (60). Indeed, individuals across different Sub-Saharan African communities who endorse supernatural causes of mental illness are more likely to display high levels of social distance (101-103). Social distance measures assess an individual's willingness to participate in various hypothetical relationships with a person with mental illness (104). An individual will also distance themselves from people with depression to evade courtesy stigma and social rejection (65). Overall, negative attitudes toward people with mental illness and stigmatisation are widespread among Sub-Saharan African communities (60).

Stigma is consistently discussed as a barrier to disclosing mental health problems as well as seeking help among African migrants resettled in Australia (48, 55, 56, 99). Among 31 first-generation Somali refugee women resettled in Melbourne, public stigma and self-stigma were significant barriers to disclosing mental illness (57). Individuals may experience stigmatising responses from family members (52) as well as within their informal African migrant communities (55) hindering informal help-seeking. Fears of being socially isolated and ostracised due to mental illness as well as not wanting to bring shame to the family or community (55) contributes to denial of symptoms. This fear may be particularly pronounced due to the relatively smaller size of African communities in resettlement nations such as Australia (46). Compounding the issue of stigma is that if individuals are ostracised following disclosure this is likely to exacerbate existing mental health problems (46). In the African context, individuals who seek help from a religious leader or traditional healer for mental illness are reported to elicit empathy and compassion among community members (51). On the other hand, those who seek professional help may be viewed as deviating from religion and/or stigmatised (52). The combination of stigma and low mental health literacy usually results in personal problems, particularly mental health problems, being kept within the family

home. Emergency or mental health services may only be contacted when mental health symptoms have significantly worsened or progressed to a crisis (67).

Chinese (Mandarin) Community

Studies conducted in Chinese communities indicate that Chinese individuals may commonly endorse stereotypes that people with mental illness are dangerous and untrustworthy (105, 106). Chinese individuals have been shown to endorse stigmatising beliefs about mental illness, particularly mental illness being a sign of weakness (44, 68). This perception may also lead to discriminatory behaviour toward people with mental illness. In a cross-cultural study conducted in the USA, relative to USA employers, Chinese employers were more likely to view people with mental illness as having a weak work ethic (107) and there is also evidence Chinese employers are less likely to hire individuals with mental illness (108). In relation to explanatory models of mental illness, it has been suggested popular Chinese culture asserts mental illness is caused by wrongdoing in a previous life, or by ancestors (109, 110), or a punishment from God for bad behaviour (111, 112). Such cultural perspectives may assign blame for mental illness on an individual as well as their family (113). In a systematic review of Asian American (primarily Chinese Americans) stigma studies (n = 21) Misra and colleagues (114) noted affiliate stigma, including the extension of stigma to families, emerged in qualitative studies. The family lineage of a person with mental illness may be perceived as tainted which has also been reported to negatively affect romantic and marriage prospects (44, 108).

Chinese migrants interviewed in Australia reported shame and stigma associated with mental illness was identified as a barrier to help-seeking (108). Notably, the experience of mental illness related stigma among Chinese individuals may be associated with the concept of 'face' (110). Having a mental illness diagnosis has been associated with loss of 'face' (73). In the Chinese cultural context, 'face' refers to an individual's social status, image, and integrity. One's 'face' is cultivated through interpersonal interactions. If an individual's behaviour or interpersonal dynamics deviate from the norm, the integrity and cohesion of the group may be threatened. Meeting the standards for Chinese society and culture defines a person and reflects on their family (73). These cultural beliefs influence perceptions of mental illness among Chinese people and having mental illness reflects badly on the family just as much as the individual and motivates secrecy of mental illness. Maintaining one's social status and integrity is essential and can be a deterrent to admitting an experience of mental illness (68). Saving one's status and integrity is postulated to contribute to hesitancy to seek professional mental health services (115). It is important to note various sociodemographic factors affect perceptions of stigma in and across Chinese communities (116).

Arabic Speaking Community

Turning to the Arabic community, stigmatising attitudes and beliefs are prevalent among Arabic-speaking communities. Negative explanatory models of mental illness include mental illness originating from evil supernatural forces or religious reasons such as punishment from God (117-120) and mental illness as originating from personal weakness (117). Iraqi refugees resettled in Australia were more likely to endorse higher external powers as causal factors of mental illness more than Australian participants (121) and Afghan participants (122). Arab-Muslim individuals with positive attitudes toward seeking mental health care in the USA were less likely to identify with cultural and traditional explanations and treatments of mental illness, such as supernatural causes/possession (123). Consistent with research in African and Chinese communities as well as general Australian population, stereotypes that mentally ill people are dangerous and unpredictable have been endorsed across many studies investigating mental illness related stigma in the Arabic community (103, 120). Negative labelling of people with mental illness also occurs among health professionals in Arab countries including Jordan (124) and UAE (125), although sociodemographic factors influenced beliefs. High levels of social distance toward people with mental illness are also endorsed by Arabic-speaking individuals (103, 126).

Stigma is identified as a significant barrier to help-seeking for members of the Arabic-speaking community. Almost all Arabic-speaking individuals interviewed in Sydney stated professional help-seeking for mental illness was not accepted by the Arabic-speaking community. Moreover, if an individual seeks help, they

were stated to be perceived as "mad" (39). Rather, an individual with mental illness is kept within the home and professional help-seeking is discouraged to prevent others finding out about the presence of mental illness (39). Like findings in the African community, seeking informal help from religious leaders (39, 123) or from traditional healers (84, 127) is reported to be perceived as more acceptable than seeking professional help.

Facilitators to Help-Seeking

Despite the presence of various barriers to accessing professional help, there are factors which may facilitate professional help-seeking. African refugees resettled in Australia have been shown to place importance on practical interventions, such as engaging with the community, providing money, and addressing unemployment rather than talking therapy to alleviate emotional symptoms (52, 98). This is consistent with the understanding that symptoms of depression primarily arise from psychosocial stressors that are out of one's control including discrimination, racism, and unemployment (50). Practical solutions are of critical importance and should be incorporated given the racial barriers and discrimination experienced by resettled refugees which perpetuate psychological distress.

A recent study involving African migrants and service providers in South Australia discussed the following strategies for improving mental health service delivery for African migrants, primarily refugees: education on mental health, disseminating information on mental health services in the community, inclusion of community and religious leaders in information sessions as well as mental health education, consideration of the impact of gender in acceptability of seeking mental health services, increasing African service providers, and the integration of religious and cultural values (54). A noteworthy example of the delivery of mental health education to improve mental health service uptake is the African mental health learning circle established in 2016 in NSW. The learning circle offers community members, leaders, and service providers to conduct group discussions to learn about mental health issues as well as help-seeking options. Additionally, McCann et al. (128) developed and evaluated the effectiveness of a health promotion resource that encouraged parents of African migrants in Australia to support their child to seek help for mental health problems. The resource was evaluated in four adult migrant education service students and in two community-based sessions with parents of African background and was well-received and described as helpful and appropriate. Turning to the Arabic community, facilitators to help-seeking among Arabic-speaking refugees and asylum-seekers has been a focus of research in recent years. As leaders are often the first point of contact for individuals experiencing mental health problems (39, 129), improving the mental health literacy of leaders has the potential to help facilitate professional help-seeking in the Arabic-speaking community (129, 130). Positively, levels of mental health literacy have been shown to be improved with intervention among Arabic-speaking religious and community leaders (129) as well as community workers who aid Iraqi refugees (131). Finally, culturally appropriate modifications to an internet based Cognitive-Behavioural Therapy program was successful in engaging Chinese individuals and led to effective outcomes (132).

Stigma Reduction Initiatives

Generally, stigma reduction initiatives broadly fall under three categories: education, contact, and protest (133, 134). Interventions comprising direct or indirect social contact with people with mental illness and education to address misconceptions about people with mental illness are stated to be more effective compared to other categories of stigma reduction interventions (133, 135, 136). Although meta-analyses of stigma reduction interventions are limited in quantity, they indicate small-moderate effect sizes (135, 137). Despite a growing understanding that specific racial minority and CaLD communities experience higher levels of mental health related stigmatisation, stigma reduction interventions have primarily been evaluated in general Western population groups in high-income settings. Authors consistently note the scarcity of research evaluating stigma reduction interventions in low- and middle-income countries (100, 114, 135-138). Stigma reduction intervention research involving CaLD communities appears to be primarily conducted in the USA and Australia (135). The interventions that have been evaluated in low- and middle-

income countries often have significant limitations including poor design quality and short-term follow-up to assess the effectiveness of stigma reduction initiatives (137). Further complicating the interpretation of findings of stigma reduction initiatives are the different measures utilised by researchers to assess outcomes (139). Positively, in their recent systematic review Clay and colleagues (138) concluded the overall quality and number of studies investigating stigma reduction interventions in low- and middle-income countries has improved in recent years.

To our knowledge there is no evaluation of a mental health related stigma reduction intervention for African migrants in Australia. A recent narrative review conducted by Rivera et al (140) found 6 studies in the USA investigating stigma reduction interventions where the majority of participants were African American or Black population. In Vinson et al (141) 158 African American college students were non-randomly assigned to either attend an in-person presentation in which an African American male shares his experience with panic disorder, treatment and recovery or assigned to view a video recording of this presentation. Although desire for social distance and negative attributions toward people with mental illness significantly decreased for the whole sample, this finding was not sustained at 2 weeks follow up. Overall, the studies reviewed by Rivera et al. (140) in narrative format demonstrated several limitations and significant variations in design. Clay and colleagues (138) identified 11 studies conducted in Sub-Saharan Africa investigating stigma reduction interventions. Most studies had a pre/post design and most were conducted in Nigeria. There was one randomised-control trial conducted in Nigeria which was rated as moderate quality (142). A high quality pre/post study conducted in southeast Kenya involved 2305 participants from various health facilities. Participants were health care workers, faith and traditional healers as well as health service users (community members, family and friends). The intervention was based on WHO mhGAP-intervention guide and comprised several community education sessions, residential training, and additional training. There was a significant reduction in unfair treatment scores, overcoming stigma scores and positive treatment scores after the intervention measured by The Discrimination and Stigma Scale (DISC-12) with a small to medium effect size (143).

Several mental health related stigma reduction interventions have been conducted in China. In one study, Yang et al. (144) conducted and evaluated a pilot brief anti-stigma intervention consisting of psychoeducation, countering experienced and internalised stigma (affiliate stigma) among 11 Chinese caregivers of individuals with psychosis. The intervention consisted of three sessions and the 7-item Self-Stigma of Consumer Families Scale was administered prior to the intervention and immediately post-intervention. High overall attendance was achieved however internalised stigma was not significantly reduced post-intervention. In 2015-2016, Li and colleagues (145) conducted a randomised control trial in Guangzhou City in China with 199 participants diagnosed with schizophrenia in the intervention group and 185 participants diagnosed with schizophrenia in the control group. The community-based intervention was conducted over 9 months and involved several components including strategies against stigma and discrimination such as education to address misunderstandings of schizophrenia and anti-stigma skills training. There was no significant reduction in self-stigma scores at 9 months measured by the Internalised Stigma of Mental Illness although there was significant effect for anticipated discrimination at 9 months and overcoming stigma at 6 months and 9 months as measured by the Discrimination and Stigma Scale (DISC-12).

Mental health related stigma reduction intervention studies conducted with Arabic-speaking individuals in the Middle East are scarce. One relevant study was conducted by Sadik and colleagues (146) who evaluated a 10-day primary care training program to improve mental health related knowledge, attitudes, and practice in primary health care centres across Iraq with a pre/post intervention questionnaire. A total of 317 healthcare workers participated in the training programme and demonstrated significant improvement in mental health knowledge post intervention as well as in practical skills demonstrations assessed by psychiatrists. In an Australian context there are several studies exploring stigma reduction interventions involving Arabic-speaking participants, primarily from a refugee background. Slewa-Younan and colleagues conducted research to improve mental health literacy (encompassing stigmatising attitudes) among Arabic-speaking refugees. Slewa-Younan and colleagues (147) evaluated a culturally appropriate mental health promotion program to improve key aspects of mental health literacy among 33 Arabic speaking refugees resettled in South-Western Sydney. Participants demonstrated significant

reductions in social distance from pre- and post-intervention as well as from pre-intervention to follow-up at 3 months. Nickerson and colleagues (148) conducted a randomised control trial to reduce mental health stigma and increase help-seeking among refugee men resettled in Australia. The authors created an online intervention titled 'Tell Your Story' (TYS). One hundred and three Arabic, Farsi and Tamil-speaking refugee men resettled in Australia presenting with PTSD symptoms participated in the trial. Results indicated greater help-seeking in the month following the intervention in the TYS intervention compared to those in a waitlist control group. In terms of self-stigma, compared to waitlist control TYS resulted in significantly smaller increases in self-stigma for seeking help from post-treatment to follow-up. Based on preliminary findings there are promising interventions to reduce components of stigma and improve help-seeking among our three CaLD communities, however more research into the effectiveness of the interventions is needed.

Overview of Measures of Stigma

This next section seeks to provide an overview of measures of stigma more broadly and their application to CaLD populations where available. It should be noted that while a systematic and exhaustive review of all existing measures of stigma is outside the scope of this report, we have reported on some of the most widely used. Specifically, Table 1 describes details of measures of stigma toward general mental illness (as opposed to specific mental illness such as Attention-Deficit Hyperactivity Disorder, Substance Use Disorders) that were developed in Western context. Table 2 outlines measures of stigma developed in non-Western contexts and some include culture-specific components. However, before describing the measures of stigma, a brief consideration of the construct of stigma is required.

Construct of Stigma

It is well recognised that stigma as it pertains to mental illness is a complex construct. Erving Goffman first formally defined stigma in his book published in 1963 (4). Since Goffman's formal definition, research on mental illness or health related stigma has been growing. Authors Edward E. Jones, Bruce G. Link, and Jo C. Phelan produced formative work on conceptualising mental illness stigma. Of note, some of the most seminal work was provided by Corrigan and Watson (91) who posited two key types of stigma. The first type is referred to as public stigma and relates to the public's attitudes toward mental illness. Attitudes themselves consisted of three dimensions being stereotypes (e.g., mentally ill people will lash out), prejudice (e.g., experiencing an emotional reaction such as fear or anger in response to a people with mental illness), and discrimination (e.g., not employing someone with mental illness). The second type of mental illness related stigma noted by Corrigan and Watson was referred to as self-stigma and encapsulates the negative attitudes toward mental illness held by a person with mental illness. Self-stigma is also known as internalised stigma and occurs when people with mental illness have internalised negative stereotypes, prejudice, and discrimination resulting in low self-esteem and reduced self-efficacy.

Due to the multifaceted construct of stigma, various measures of stigma have been created to assess the different components of stigma. For instance, a measure of stigma may assess personal stigma, a person's own beliefs toward people with mental illness, or perceived stigma, a person's beliefs about most people's beliefs toward people with mental illness. Even under the umbrella term of personal stigma complexities exist, for example, a person may endorse stigmatising stereotypes about mental illness but may not behave in discriminatory ways toward people with mental illness. Despite the large number of measures of stigma, there are certainly measures that have been more cited and validated (139, 149). In 2018 Fox and colleagues systematically reviewed and evaluated 140 measures of stigma and found stereotypes were the most measured component of stigma followed by discrimination (139). One of the most widely cited measures is the Depression Stigma Scale (DSS) by Griffiths and colleagues (150) which measures personal stigma and perceived stigma using a vignette of a person with depression. The DSS contains 18 items assessing personal and perceived stigma and participants indicate to what extent they agree with the item on a 5-point scale (ranging from strongly disagree to strongly agree). The DSS contains questions to assess stereotypes of people with mental illness, including depression is a sign of personal weakness and people with depression are dangerous (139). The DSS can also be adapted to assess personal and perceived stigma in relation to other mental disorders using a vignette of a person with another mental disorder. The

Internalised Stigma of Mental Illness Scale (ISMI) by Ritsher and colleagues (151) is the most cited measure assessing self-stigma or internalised stigma. The ISMI contains five subscales including stereotype endorsement, alienation and social withdrawal. The ISMI contains 29 items and participants indicate to what extent they agree with the item on a 4-point scale (ranging from strongly disagree to strongly agree). The Social Distance Scale (SDS) by Link and colleagues (152) is the most cited measure of discrimination in stigma (139) and is valid and reliable cross-culturally (153). The SDS is an indirect measure of a respondent's desire to interact with a person with mental illness. The SDS contains 7 items and participants indicate to what extent they would be willing to interact with a person with mental illness across a range of hypothetical relationships on a 3-point scale. There have been adaptions of the SDS such as the 5-item scale developed by Link and colleagues in 1999 and integration of vignettes to describe someone with mental illness prior to presenting the SDS items (139). Vignettes describe characters who vary on aspects of gender and mental disorders such as depression, PTSD or schizophrenia.

Noteworthy research has been conducted in Australia to explore the structure of stigma. In earlier work, Jorm and Wright (154) found that a four-dimensional model of stigma comprising items from the SDS and DSS varies across different mental disorders. This was validated in a sample of 3,746 young adults and co-resident parents in Australia. Utilising a Principal Components Analysis the authors found four dimensions of stigma: Social distance, Weak-not-Sick, Dangerous/Unpredictable, and Stigma perceived in Others (i.e., Perceived Stigma). Therefore, Jorm and Wright proposed the existence of three distinct dimensions (Weak not Sick, Dangerous/Unpredictable, and Stigma Perceived in Others) rather than two dimensions (Personal and Perceived Stigma) as proposed by Griffiths and colleagues utilising items from the DSS and SDS. In 2014, Yap and colleagues further extended the structure of stigma and built upon Jorm and Wright's findings with a large sample size. Yap et al. (155) used data from two large national Australian surveys of mental health literacy and stigma (156, 157) to elucidate the structure of stigma as measured by the DSS and SDS across a range of mental disorders using vignettes. One sample was of the general community aged 15 years and older (n = 6019) and the other sample was of young people aged 15 to 25 years (n= 3021). The findings indicated Personal and Perceived Stigma are distinct dimensions and argued to measure both Weak-not-Sick and Dangerous/Unpredictable factors separately for Personal and Perceived Stigma. These dimensions of stigma have been measured in studies involving Arabic-speaking refugees and Arabic-speaking leaders in Australia conducted by Slewa-Younan and colleagues (129, 147). The authors utilised a modified vignette to be culturally appropriate for the participants followed by questions assessing Social Distance and Personal Stigma (i.e., made up of subscales assessing weak-not-sick, dangerous/unpredictable, I would not tell anyone).

Table 1. Measures of stigma developed in Western contexts

No.	Authors & Year	Measure of stigma	Assess for	General/Specific Population	Utilised with CaLD population	Adaptions for CaLD population
1	Angermeyer & Matschinger, 2003 (158)	Emotional Reactions to Mental Illness Scale	Public Stigma (Prejudice) 9 items 5-point scaled items	General	✓	-
2	Baker et al., 2005 (159)	Attitudes Toward Acute Mental Health Scale (ATAMHS)	Public Stigma (Stereotypes) 33 items 7-point scaled items and semantic differentials	Specific – Nursing Staff Sample	✓	Korean version by Gang, 2014 (160)
3	Baker et al., 2005 (159) Cleary et al., 2005 (161)	Measure of attitudes of nursing staff working in acute mental health care units	Public Stigma 33 items 7-point scaled items	Specific – Nursing staff	✓	-
4	Barney et al., 2010 (162)	Self-Stigma of Depression Scale	Self-Stigma 16 items 5-point scaled items	General Public	✓	-
5	Botega et al., 1992 (163)	Depression Attitude Questionnaire (DAQ) Revised-DAQ by Haddad et al., 2015 (164)	Public stigma (Stereotypes) DAQ - 20 items on a visual analogue scale	Specific – General Practitioners	✓	-

			R-DAQ – 22 items 5-point scaled items			
6	Cohen & Struening, 1962 (165) Struening & Cohen, 1963 (166)	Opinions about mental illness (OMI)	Public Stigma 51 items 6-point scaled items	Specific – Healthcare Providers & Hospital Staff	✓	OMI Chinese by Ng & Chan, 2000 (167) 45 6-point scaled items
7	Corrigan et al., 2001 (168)	The Attribution Questionnaire (AQ)	Public Stigma 27 items 9-point scaled items	College Students	✓	-
8	Corrigan et al., 2006 (169)	Self-stigma of Mental Illness Scale (SSMIS)	Self-Stigma 60 items 9-point scaled items	Specific – People with Mental Illness		Chinese version by Fung et al., 2007 (170)
9	Day et al., 2007 (171)	Mental Illness Stigma Scale	Public Stigma 28 items 7-point scaled items	General Public	-	-
10	Evans-Lacko et al., 2010 (172)	Mental Health Knowledge Schedule	Public Stigma	General Public	✓	-

11	Evans-Lacko et al., 2011 (173)	Reported and Intended Behaviour Scale (RIBS)	Discrimination 8 items	General Public		RIBS Japanese version by Yamaguchi et al., 2014 (174)
12	Gabbidon et al., 2013 (175)	Questionnaire on Anticipated Discrimination	Anticipated stigma 17 items 4-point scaled items	Specific – People with Mental Illness	✓	-
13	Gilbert et al., 2007 (176)	Attitudes Toward Mental Health Problem Scale	Perceived, Anticipated and Self-Stigma	General Public	✓	-
14	Griffiths et al., 2004; 2008 (150, 177)	Depression Stigma Scale (DSS)	Personal and Perceived Stigma 18 items 5-point scaled items	General Public	✓	-
15	Griffiths et al., 2011 (178)	Generalised Anxiety Stigma Scale	Personal Stigma	General Public	-	-
16	Kanter et al., 2008 (179)	Depression Self-Stigma Scale	Self-stigma and Public Stigma 32 items 7-point scaled items	General Public	✓	-

17	Kassam et al., 2010 (180)	The Mental Illness Clinicians' Attitudes Scale (MICA-2)	Public Stigma 16 items 6-point scaled items	Specific – medical students, healthcare professionals	✓	-
18	Kassam et al., 2012 (181)	Opening Minds Stigma Scale for Health Care Providers (OMS-HC)	Anticipated Stigma and Public Stigma 20 items 5-point scaled items	Specific – Health care providers	✓	-
19	Link & Cullen, 1986 (182) Link et al., 1987 (152)	Perceived Dangerousness	Public Stigma (Stereotypes) 8 items 6-point scaled items	General Public	-	-
20	Link, 1987 (183)	Perceived Devaluation-Discrimination Scale (PDD)	Perceived stigma (stereotypes, discrimination) 12 items 4-point scaled items	General Public	✓	-
21	Link et al., 1987 (152) modified from Bogardus 1933 (184)	Social Distance Scale (SDS)	Public Stigma (Discrimination) 7 items 4-point scaled items	General Public	✓	-
22	Link, 1987 (183)	The Devaluation–Discrimination Scale (DDS)	Public stigma 12 items 4-point scaled items	General Public	✓	Adaption into Turkish by Şahin & Topkaya, 2021 (185) PDD-Swedish version by Bjorkman et al., 2007 (186)

23	Link et al., 1997 (187)	Link's Rejection Experiences Scale (Link RE)	Experienced stigma 12 items multiple choice items	Specific – People with mental illness	-	-
24	Luty et al., 2006 (188)	Attitudes Toward Mentally Ill Questionnaire	Public stigma (Stereotypes and Discrimination) 5 items 5-point scaled items	General Public	✓	-
25	Mak et al., 2014 (189)	Stigma and Acceptance Scale	Public Stigma	General Public	✓	-
26	Pinel, 1999 (190)	Stigma Consciousness Scale	Anticipated Stigma	General Public	✓	-
27	Quinn & Chaudoir, 2009 (191)	Anticipated Stigma Scale	Anticipated Stigma 15 items 7-point scaled items	General Public	✓	-
28	Ritsher et al., 2003 (151)	Internalised Stigma of Mental Illness (ISMI)	Self-Stigma 29 items 4-point scaled items	Specific – People with mental illness	✓	ISMI Chinese by Chang et al., 2014 (192) ISMI Arabic by Kira et al., 2015 (193) ISMI (South Africa) by Sorsdahl et al., 2012 (194)

						ISMI (Parent) by Zisman-Ilani et al., 2013 (Israel) 17 4-point scaled items (195) ISMI revised (Assefa et al., 2012; Ethiopia) 24 4-point scaled items (196)
29	Segal et al., 2013 (197)	Attitudes Toward Persons With MI Scale	Public Stigma (Stereotypes, Discrimination)	Specific – People with mental illness	-	-
30	Struening et al., 2001 (198)	Devaluation of Consumer Family Scale	Perceived Stigma 7 items scaled items	Specific - Caregivers of people with mental illness	✓	The Arabic Stigma Devaluation Scale (SDS) by Dalky, 2012 (199) 12 4-point scaled items
31	Struening et al., 2001 (198)	Devaluation of Consumers Scale	Perceived Stigma 8 items scaled items	Specific - Caregivers of people with mental illness	✓	The Arabic Stigma Devaluation Scale (SDS) by Dalky, 2012 (199) 12 4-point scaled items

32	Taylor & Dear, 1981 (200)	Community Attitudes Towards Mental Illness (CAMI)	Public Stigma (Stereotypes, Discrimination) 40 items 9-point scaled items	General Public	✓	CAMI Chinese for mental health professionals by Sevigny et al., 1999 (201)
33	Thornicroft et al., 2009 (202)	Discrimination and Stigma Scale Revised (DISC Revised)	Experienced and Anticipated Stigma 32 items 7-point scaled items and 4 interview questions	Specific – People with schizophrenia	✓	Translation and cross-cultural adaption across 27 countries by Thornicroft et al., 2009 (202)
34	van der Heijden, 2012 (203)	Nurses' Perceptions of Mental Health Care	Perceived Stigma	Specific - Students	-	-
35	Vogt et al., 2014 (204)	Endorsed and Anticipated Stigma Inventory	Personal and Anticipated Stigma 40 items 5-point scaled items	Specific – Military Personnel	-	-
36	Wahl, 1999 (205)	Consumer Experiences of Stigma Questionnaire (CESQ)	Anticipated and Experienced Stigma	Specific – People with mental illness	✓	Adapted into Polish by Switaj et al., 2013 (206)

37	Wahl et al., 2011 (207)	Knowledge and Attitudes about Mental Illness	Public Stigma and Anticipated Stigma	Specific - Adolescents	✓	-
38	Watson et al., 2005 (208)	Attitudes Toward Serious MI Scale (Adolescent Version)	Public and Anticipated Stigma 24 items 5-point scaled items	Specific - Adolescents	✓	-
39	Weller & Grunes, 1988 (209)	Attitudes toward the Mentally Ill	Public Stigma	General Public	✓	Translated to Arabic and revised to include socio-cultural aspects of Omani society by Al-Adawi, 2002 (117)
40	Yanos et al., 2017 (210)	The Clinician Associative Stigma Scale (CASS)	Associative Stigma 18 items 4-point scale items	Specific – Mental Health Clinicians	✓	-

Cross-Cultural Measures of Stigma

Cross-cultural research on mental illness related stigma have questioned the validity and accuracy of, primarily Western, measures of stigma toward mental illness. Yang and colleagues (113) postulated the theory that 'what matters most' to lay individuals in a certain cultural context shapes the effects of stigma. Yang and colleagues used the theory to explain differences in stigma across cultures and advocated for the creation of culture-specific stigma measures. In communities where stigma is collectively felt by the family, the notion of family or affiliate stigma may be more important (5, 211). There is also growing interest in whether cultural identification (e.g., the extent to which an individual is collectivistic versus individualistic) is significantly related to stigma (212, 213). The manifestation of self-stigma and consequences of self-stigma may vary depending on individualistic versus collectivistic values (38, 213). For instance, Lam and colleagues proposed Chinese individuals with mental illness may be more vulnerable to internalised stigma compared to individuals from individualist cultures (211). Lay theories of mental illness in Chinese culture such as the concept of fate and destiny may interact with stigma to exacerbate low self-esteem and reduced self-efficacy. Despite these distinctions, the development of culture-specific stigma measures is rare. In 2014, a systematic literature review of studies investigating mental health stigma related concepts revealed 77% of studies used adaptions of Western based stigma measures to CaLD groups, 2.0% used quantitative stigma measures developed in a non-Western cultural group and 16.8% of studies used qualitative methods to discover cultural aspects of stigma in non-Western groups (113).The first systematic review from the USA into cultural aspects of stigma and mental illness among CaLD minority groups was only just published in 2021 and revealed findings were limited around stigma reduction or resistance interventions. The researchers found just four culturally tailored stigma reduction interventions in over 30 years in the USA (114). A review of Australian initiatives to reduce stigma toward people with complex mental illness only found a few interventions targeted for CaLD populations (100) as previously noted in this report. To develop appropriate and effective stigma reduction initiatives in specific CaLD communities, measures of stigma must be reliable and sensitive to the nuances of the specific CaLD communities, however as noted from Table 2, such measures are comparatively scare.

Table 2. Measures of stigma developed in non-Western contexts

	Authors & Year	Measure of stigma	Assess for	General/Specific population	Country developed in
1	Aromaa et al., 2010 (214)	Depression is a Matter of Will	Public stigma (Stereotypes) 16 items 4-point scaled items	General Public	Finland
2	Karidi et al., 2014 (215)	Stigma Inventory for Mental Illness	Anticipated stigma 12 items 5-point scaled items	Specific – People with mental illness (Schizophrenia)	Greece
3	Kulhara et al., 2000 (216)	The Supernatural Attitudes Questionnaire (SAQ)	Public stigma 28 items	Specific – Caregivers of those with mental illness	North India
4	Lai et al., 2001 (217)	Stigma Questionnaire	Anticipated, experienced and self-stigma	Specific – People with mental illness	Singapore
5	Lee et al., 2005 (218)	Psychiatric Stigma Experience Questionnaire (PSEQ) In Chinese	Interpersonal stigma, work-related stigma, anticipated stigma, and emotional reactions to stigmatisation 137 items	Specific – People with mental illness (Schizophrenia)	Hong Kong

6	Mak & Cheung, 2008 (5)	Affiliate Stigma Scale (ASS)	Affiliate stigma 22 items 4-point scale	Specific - Caregivers of people with intellectual disability or mental illness	Hong Kong
7	Mak & Cheung, 2010 (219)	Self-Stigma Scale–Short Form	Self-Stigma 9 items 4-point scaled items	Specific – People with mental illness, recent immigrants from Mainland China, and sexual minorities	Hong Kong
8	Ng & Chan, 2000 (167)	Opinion about Mental Illness in Chinese Community Attitude Scale for MI	Public Stigma (Stereotypes and Discrimination)	Specific – Secondary school students	China
9	Pang et al., 2017 (220)	Social Tolerance Scale	Social tolerance (Social distance and responsibility for mental health issues) 11 items	General Public	Singapore
10	Siu et al., 2012 (221)	Attitudes Toward Mental Disorders	Public Stigma 23 items 5-point scaled items	General Public	
11	Tsang et al., 2003 (222)	Questionnaire on Mental Illness	Public stigma toward mental illness (incorporates issues affecting family and people with mental illness) 31 items scale	General Public	Hong Kong
12	Xiong et al., 2021 (223)	Interpersonal Distance Scale (IDS)	Interpersonal Distance	General Public	China

			40 items scale		
13	Xiong et al., 2021 (223)	Occupational Restrictiveness Scale (ORS)	Occupational restrictiveness – how suitable it is for individuals with mental illness to assume different types of work 40 items	General Public	China
14	Yen et al., 2005 (74)	Self-Stigma Assessment Scale (Taiwanese Version)	Self-Stigma 8 items 5-point scale	Specific – People with Mental Illness	Southern Taiwan
15	Zane & Yeh, 2002 (224)	The Loss of Face Scale (LOS)	Loss of face concern 21 items 7-point scale	General Public	-

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