Understanding Mental Health and Stigma in Congolese, Arabic-speaking and Mandarin-speaking Communities

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This report was prepared by:
Shameran Slewa-Younan, Klimentina Krstanoska-Blazeska, Andre Renzaho, Ilse Blignault, Bingqin Li, Nicola Reavley

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Disclaimer

This report is a qualitative consultation of community members and leaders and is not representative of the views of all members of these three communities.

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Executive Summary

Background and Aims

Australia is a richly diverse nation, with the most recent national census undertaken in 2021 indicating that just over half (51.5%) of Australians were born overseas (first generation migrant) or have a parent born overseas (second generation migrant; 1). The Culturally and Linguistically Diverse (CaLD) population of Australia encompasses communities of different languages, nationalities, religions, cultures, ethnic backgrounds, cultural beliefs, and family structures. Research has shown that there is low uptake of mental health services among CaLD individuals despite the need to do so. However, understanding the reasons for reduced mental health help-seeking is lacking, with insufficient evidence to inform mental health service delivery and stigma reduction campaigns for CaLD groups. Embrace Multicultural Mental Health, run by Mental Health Australia, provides a national focus on mental health for CaLD individuals in Australia. Funded by Embrace Multicultural Mental Health, this research project endeavoured to deeply understand the barriers to help-seeking and engagement, including those related to mental health literacy and stigma, in three key CaLD groups – Arabic-speaking, Mandarin-speaking (Chinese), and Congolese. The project aimed to provide (1) new insights into the factors that influence mental health related help-seeking (including that of stigma), and thereby build on the national knowledge base for these three CaLD community groups and (2) provide policy recommendations to inform mental illness stigma reduction initiatives in these communities.

Methods

We conducted a series of 8 focus group discussions and 26 key informant interviews with Arabic-speaking, Mandarin-speaking (Chinese), and Congolese community members and leaders residing in Sydney. A qualitative design was used to explore participants views on mental health help-seeking including that of stigma in the three CaLD community groups. Focus group discussions and key informant interviews were conducted online using Zoom. Focus group discussions and key informant interviews were digitally recorded, transcribed, and analysed to identify domains and key themes.

Key Findings

Three salient domains were extracted from the data and provided the organisational framework for the themes identified. Across all three groups, migration and related experiences, both pre and post arrival to Australia, was the common denominator. Notably we found that the pre-migration cultural framework served as the main reference point for how participants viewed mental illness, and consequently how they engaged with the health system.

Domain 1: Conceptualisation of Mental Illness

A lack of consensus in mental illness related terminology was noted across all three communities in both the focus group discussions and key informant interviews. However, it was clear that all three communities generally distinguished between ‘mental illness’ and ‘mental health problem’ with the latter being a common condition related to stressors, whereas ‘mental illness’ was a more severe condition. The impact of traditional beliefs and pre-migration cultural frameworks on conceptualisations of mental illness was evident across all three communities. In the Congolese community, participants regularly reported that the Congolese community does not accept the existence of mental illness and yet described symptoms of mental illness, its management, and stigma related to mental illness in the Congolese community. Furthermore, the impact of traditional beliefs about causes of mental illness were evident in the Congolese and Mandarin-speaking community. In the Congolese community, participants noted the ongoing influence of supernatural causes of mental illness. Furthermore, participants in the Mandarin-speaking community highlighted the importance of harmonious relationships and that interpersonal conflict can lead to mental illness. Supernatural causes were scarcely mentioned by participants in the Arabic-speaking community and only some of the Arabic-speaking leaders identified religious attributions for mental illness. Finally, all three communities discussed causes of mental illness in the context of migrating to Australia and the challenges associated with resettlement in a new country.

The Congolese and Arabic-speaking community described additional unique challenges associated with a refugee and asylum-seeker background.

Domain 2: Barriers to Seeking Help

Stigma was reported to be prevalent in the three communities and a significant barrier to help-seeking. All three communities reported the topic of mental illness is considered 'taboo' and the concept of social distance was evident across all three communities. Furthermore, all three communities described engaging in acts of secrecy and isolation when people were experiencing mental illness. However, our findings also demonstrated the nuanced impact and consequences of mental illness related stigma both between and occasionally, within the groups. For example, several leaders in the Mandarin-speaking community noted stigma is greater among Mandarin-speaking seniors compared to younger generations. In both the Congolese and Arabic-speaking communities participants reported managing mental illness was seen as something done as a collective either at the family or community level. Differing views regarding managing mental illness as a collective were expressed in the Congolese group. Within the Mandarin-speaking community, the concept of 'face' seemed to influence the way mental illness was managed specifically regarding help-seeking. Furthermore, the impact of religion on help-seeking and the nuanced role it played in the Congolese community was strongly evident. Finally, the strong impact of practical and structural barriers on help-seeking were reported by all three communities.

Domain 3: Help-Seeking Preferences

We found a preference for informal sources of help across all three communities including family, social, and community support networks. A belief that mental state is related to the individual's physical and social environment strongly emerged in Arabic focus group discussions and activities that encompassed family members and other forms of group support were most frequently endorsed for management of mental illness. In addition to informal support such as family and friends as well as community-based coping strategies, participants in the Mandarin-speaking community identified self-help and self-directed learning as a primary way of managing mental illness. Additionally, the use of religion as a coping strategy was discussed in all three communities, although religion was found to play a lesser role in understanding and managing mental illness within the Mandarin-speaking community. In the Arabic-speaking community, leaders and focus group discussion participants expressed differing views on the role of religion in addressing mental illness. Although Arabic-speaking focus group discussion participants described the benefit of self-directed religious coping (e.g., prayers) for management of mental illness, religious coping through the direct input of a religious leader was not endorsed by focus group discussion participants. In line with the strong influence of religion in the Congolese community, participants in the Congolese community noted prayer plays a role in managing mental illness and is often the first step in managing mental illness rather than help-seeking.

Recommendations

The overarching principal that should guide stigma reduction interventions for CaLD communities is to undertake a coordinated approach that seeks to meet the needs of each specific community. Our community consultations highlighted frequent requests for educational initiatives, which should be complimented with contact components comprising of opportunities where persons with mental illness or lived experience of mental illness share their stories either via live interactions or stories delivered using multi-media in a supportive and safe manner. As such the first recommendation is to deliver a stigma reduction intervention with tailored education and contact components to the communities. Furthermore, our community consultation findings highlighted that rich diversity of nuances related to mental health stigma exist both between and within CaLD communities, and this should never be ignored when developing interventions. As such, the second recommendation is to ensure community members and leaders have leadership roles in co-designing and evaluating stigma reduction initiatives. Thirdly, a system-based approach that recognises the role multiple parties and settings play in addressing mental health related stigma in CaLD groups is required. Finally, in recognising the longevity needed for real change, there needs to be a commitment to adequate funding for delivery of stigma reduction interventions which require a long-term approach.

Below we outline each of the four recommendations with more specific set of details.

Recommendation 1: Deliver a stigma reduction intervention with culturally specific tailored education and contact components to the communities

- An education component incorporating the specific cultural terms and idioms with knowledge on common mental illnesses to bridge viewpoints and build community mental health literacy
- Target stigma directly by explicitly challenging culture specific stereotypes of mental illness and related beliefs that impede help-seeking by utilising insights gained from the three community consultations
- A contact component supporting persons with mental illness or lived experience of mental illness to share their stories either via live interactions or stories delivered using multi-media
- Deploying the stigma reduction interventions in supportive trusted settings, and using pre-existing established groups and working with community leaders, to enable a soft entry approach

Recommendation 2: Ensure community members and leaders have leadership roles in co-designing and evaluating stigma reduction initiatives

- Defer to and incorporate the expertise of community members and leaders to further develop knowledge on how each community views mental illness and beliefs toward people with mental illness using the 'what matters most' theoretical framework (Yang et al., 2014)
- Provision of adequate funding to ensure community members and leaders have leadership roles in co-designing, implementing, and evaluating stigma reduction initiatives beyond an expectation that such roles will be performed in a voluntary capacity

Recommendation 3: Employ a multi-pronged approach to reducing stigma towards mental illness in the three communities

- Employ a multi-pronged approach when delivering stigma reduction initiatives that targets key groups that act as gatekeepers for each community such as spiritual leaders or community elders
- Increase advocacy for the CaLD communities by bringing knowledge to mental health service providers and clinicians about specific mental illness related stigma beliefs
- Target structural stigma, that is, the limited mental health services available and investment in mental health care for members of the three CaLD communities through the provision of adequate funding to increase the availability of linguistically and culturally appropriate service providers and financial support to access mental health services
- Increase advocacy for the CaLD communities by bringing knowledge to key government organisations that work with migrant communities such as Centrelink and the Department of Home Affairs, Immigration and Citizenship

Recommendation 4: Employ a long-term approach with sufficient funding needed to develop and evaluate stigma reduction initiatives

- Provision of adequate funding to ensure a long-term approach given the longevity needed to change- ideally, 3-5 years initially and then incorporated into core funding
- Empirical evaluation built-in to stigma reduction initiatives and evaluation of effectiveness
- Ensure community members and leaders have leadership roles in the *evaluation* of stigma reduction initiatives
- Create and validate measures of mental illness stigma for the specific communities - Utilise the 'what matters most' theoretical framework (Yang et al., 2014) to identify culture-specific aspects of stigma to understand contextual effects of stigma and to consistently operationalise and test stigma-related outcomes

Project Aims and Objectives

Despite being at higher risk of developing mental health disorders, there is low uptake of mental health services among CaLD individuals (2, 3). The limited evidence to date is insufficient to inform mental health service delivery and stigma reduction campaigns for CaLD groups. To improve mental health treatment seeking and outcomes for CaLD individuals in Australia there is an urgent need to deeply understand the barriers to help-seeking and engagement, including those related to mental health literacy and stigma, in three key CaLD groups – Arabic-speaking, Mandarin-speaking (Chinese), and Congolese.

The objectives of this research project were to provide:

1. New insights into the factors that influence mental health related help-seeking (including that of stigma), thereby building the national knowledge base on these three CaLD community groups
2. Policy recommendations to inform mental illness stigma reduction initiatives in these three communities.

Methods

Design

A qualitative design was used to explore participants views on mental health help-seeking and barriers to help-seeking including that of stigma in the three CaLD community groups. Specifically, a triangulated approach was used, incorporating data (community members and community leaders) and methodological (qualitative individual interviews and focus groups) triangulation (4). Triangulation enhanced data richness or completeness by enabling the researchers to explore a broad range of perspectives and compare and contrast perspectives, about the phenomenon (barriers and facilitators influencing help-seeking). Moreover, triangulation provided a more comprehensive understanding of the phenomenon than could be achieved by using a single data source or data collection method (4).

Participants and procedure

Prior to commencing recruitment, six bilingual health workers from the target communities were employed and trained in the recruitment, screening and interviewing processes. Such an approach is fundamental when seeking to establish community engagement and capacity building within CaLD groups thus fostering policy advocacy (5). Using a combination of purposive and snowball sampling, participants were recruited using the networks and contacts of the relevant investigators in addition to those of the bilingual health workers.

Focus group discussions with people who had lived experience of mental illness, including those of carers, family members or friends, were held across the three CaLD groups. Following dissemination of translated flyers on the study and via networks, interested participants were instructed to contact the bilingual health workers. Individuals were eligible to participate in the focus group discussion if they were Arabic-speaking, Mandarin-speaking (Chinese), or Congolese individuals with lived experience of mental illness including those of carers, family members or friends. All participants were older than or equal to 18 years of age, residing in Sydney and had arrived in Australia no more than seven years ago, with exception of some of the Mandarin-speaking community participants. Namely, due to specifics related to the Mandarin-speaking community, the length of arrival in Australia criteria was adjusted to include individuals who had arrived in Australia earlier the past seven years, but due to back-and-forth travel to China had not spent longer than a total of seven years residing in Australia. Focus groups were drawn from existing networks and included a gender and age mix. Previous research has demonstrated that when researching within migrant and refugee groups on issues related to traditional values, in this case the impact of such values on mental illness and help-seeking, formation of groups from existing networks can generate robust data (6). Key informant interviews were held with community leaders. These participants were identified through their involvement with the community via relevant community-based organisations. Participants were eligible to participate if they were identified as a leader within the three groups. This included both formal and informal roles with examples being community worker, community elder or religious leaders. All were required to be older than or equal to 18 years of age and working in Sydney.

Due to the COVID-19 Delta outbreak in Sydney and restrictions, all focus group discussions and key informant interviews were undertaken remotely using Zoom and digitally recorded. Using the interview guide, the role of first bilingual health worker was to facilitate the group and encourage all to participate. The second bilingual health worker managed the Zoom meeting, the audio recording, and note taking. Prior to the focus group discussions, sociodemographic data of consented participants was collected via a preliminary phone call by a bilingual health worker, during which they also ensured the participant has access to Zoom and understood how to operate it. Focus group discussions were conducted in the relevant language (Arabic, Mandarin, or Swahili) and lasted approximately 90 minutes. At the end of each main section of the discussion, the bilingual health worker summarised the content to ensure the participants' perspectives were obtained and interpreted correctly, a verification process that enhanced the credibility of the findings (7).

The key informant interviews lasted between 20 to 40 minutes and were undertaken by a bilingual health worker using the interview guide in the participants preferred language (English, Arabic, Mandarin, or Swahili). Interview guides were developed from a review of the literature and discussion among the researchers, with open ended questions focused on generating an understanding of factors impacting each community's mental health, their conceptualisation of mental illness, including causes and treatment preferences, barriers to seeking treatment such as stigma among others and any identified enablers of mental health help-seeking. A total of 26 key informant interviews and 8 focus group discussions were conducted across the three CaLD communities. All focus group discussion participants received a $30.00 electronic supermarket voucher as reimbursement for their time in participating in the research.

Ethics

Approval for the study was obtained from the Western Sydney University Human Research Ethics Committee (H14608). All participants provided written consent following an explanation of the study aims and processes.

Data Analysis

An interpretative phenomenological analysis (IPA) approach was undertaken to understand the lived experiences of the three CaLD community groups with respect to their views on mental illness and help-seeking and barriers including that of mental illness related stigma. Analysis was undertaken by the three researchers (KKB, YL and SSY). Regular weekly meetings were held to consider aspects of analysis including that of reflexivity, also addressed through note keeping (7). One transcript and one community were focused on at a time, starting with the Congolese, followed by the Arabic-speaking group and then Mandarin-speaking group, in order to keep the data analysis manageable. The data was analysed using NVivo 12 software package and in accordance with published guidelines for conducting IPA (8). Stage one was familiarisation with the data. All interviews were transcribed into written English by the bilingual health workers, who themselves were immersed in the data by listening to the recordings and subsequently translating the interviews from the original language to English, with the added task of checking and re-checking the translations as required (9). Transcriptions were read several times to check understanding and comprehension of the data. The bilingual health workers and AR were consulted continuously through the process to clarify transcriptions and words. This process was not linear but moved back and forth between members of the team who transcribed (bilingual health workers) and those who were conducting analysis. Stage two was generating initial codes following the examining the transcripts closely. Coding was conducted separately by YL and KKB with consistency and discrepancies resolved at weekly supervision meetings with SSY. At stage three, the initial codes were grouped into categories. The fourth stage was to search for connections between categories thus generating themes and subthemes. This process was then repeated for the next transcript. Once analysis had been completed for each transcript, a final master list of themes was generated. At this stage, thematic analysis across the interview types and community groups was undertaken generating the final results.

Results

The socio-demographic characteristics of the participants are presented in Table 1.

Characteristics	Arabic-speaking Community[#]		Mandarin-speaking Community[^]		Congolese Community[*]	
	Focus group discussion	Key informant Interviews	Focus group discussion^	Key informant Interviews	Focus group discussion	Key informant Interviews
	n	*n*	*n*	*n*	*n*	*n*
Gender						
Male	5	7	6	2	8	4
Female	13	3	15	6	4	4
Age Group						
18-30	3	-	1	-	9	-
30-39	4	-	6	2	2	-
40-49	7	2	3	3	-	4
≥50	4	8	11	3	1	4
Country of Origin						
Middle East**	18	9	-	-	-	-
Australia	-	1	-	-	-	-
China	-	-	21	8	-	-
Sub-Saharan Africa***	-	-	-	-	12	8
Years in Australia						
<5	14	-	6	-	7	-
≥5	4	-	15	-	5	-

Table 1. Sociodemographic characteristics of participants

[#] YM and TH facilitated the Arabic-speaking focus group discussions, YM facilitated the Arabic-speaking key informant interviews

[^] YL and JL facilitated Mandarin-speaking focus group discussions, YL facilitated the Mandarin-speaking key informant interviews

[*] AR and VM facilitated the Congolese community focus group discussions, NZ facilitated the Congolese community key informant interviews

** Iraq, Jordan, Egypt, Lebanon, Syria

***DRC, Rwanda, Nigeria

Key Themes

Three salient domains were extracted from the data and provided the organisational framework for the themes identified. Across all three groups, migration, and related experiences both pre and post, was the common denominator. Notably, we found that the premigration cultural framework served as the main reference point for how participants viewed mental illness and consequently how they engaged with the health system. Table 2 provides a summary of key themes.

Themes	Key informant interviews Congolese	 Arabic-speaking	 Mandarin-speaking	Focus group discussions Congolese	 Arabic-speaking	 Mandarin-speaking
Conceptualisation of mental illness						
Impact of traditional beliefs and cultural frameworks on conceptualisation and explanatory terminology	+	+	+	+	+	+
Impact of migration	+	+	+	+	+	+
Barriers to seeking help						
The impact of stigma	+	+	+	+	+	+
Stigma leads to secrecy and isolation	+	+	+	+	+	+
Managing mental illness and the influence of the collective	+	+	+	+	+	+
Impact of religion on help-seeking	+	+	+	+	–	–
Impact of practical barriers of help-seeking	+	+	+	+	+	+
Help-seeking preferences						
Informal sources of help	+	+	+	+	+	+
Use of self-directed learning to cope with mental illness	–	–	+	–	–	+
The use of religion as a coping strategy	+	+	+	+	+	+
Professional help-seeking	+	+	+	+	+	+

Table 2. Summary of Key Themes

Note. “+” = Mentioned consistently in the group, or at least once by at least one member of the group; “–” = not mentioned in that group

Domain 1: Conceptualisation of mental illness

Theme 1: Impact traditional beliefs and cultural frameworks on conceptualisation and explanatory terminology.

Conceptualisation of mental illness

The impact of traditional beliefs and premigration cultural frameworks on conceptualisations of mental illness, including terminology and causal beliefs, was evident across all three communities. Across both focus group discussions and key informant interviews in all three communities there was a lack of consensus in mental illness related terminology. Participants utilised various terms to refer to 'mental illness' and used these interchangeably with no consistency. Terms utilised included 'mental health problems', 'mental health conditions', and 'mental health illness' however for consistency and ease of interpretation, we have used the term 'mental illness' throughout the results and discussion.

All three communities generally distinguished between 'mental illness' and 'mental health problem' with the latter being viewed as a common condition related to stressors whereas 'mental illness' was considered a more severe condition. This distinction between 'mental illness' and 'mental health problem' was discussed by the Arabic-speaking participants who noted the former to be more hopeless, chronic and an incurable condition. One focus participant stated

> *"In our society, the mentally ill is considered a hopeless condition and will never be treated or recovered. They will not accept it as a common disease, make it a shameful situation." (Arabic FGD1, Female, 35)*

On the other hand, terms such as 'mental health problem' were used to refer to anxiety and depression and regarded as short-lived and able to self-manage. Arabic-speaking focus group discussion participants felt anxiety and depression are common and universal experiences related to their experiences. In the Mandarin-speaking community, a distinction between 'mental health problem' and 'mental illness' was reported by focus group participants with the former being perceived as less serious and not warranting attention or response, however mental illness was automatically denoted as a 'serious matter'.

> *"…They would think that I have mental health problem. I am not mentally ill." (Chinese FGD3, Female, 30+)*

Participants from the focus group discussions regularly reported that the Congolese community does not accept the existence of mental illness and yet symptoms of mental illness, its management and stigma related to mental illness were frequently described. What participants seemed to convey was the existence of a widespread traditional belief that mental illness is taboo and therefore does not exist.

> *"There is this state of suspicion in my community that people first of all don't recognise that mental health [illness] exists."* (Congolese Interview, Health Care Worker Male 44)

Specifically, participants noted a lack of awareness and dialogue around mental illness in the Democratic Republic of the Congo.

> *"You are born, you grow up you never hear about a certain something [mental illness], they start telling you about that thing you feel like "no," they feel like it is something like kind of taboo."* (Congolese Interview, Community Leader Female 41)

In contrast to the visibility of physical illness, the concept of mental illness is treated with suspicion because it is invisible, yet the consequences of mental illness-related suffering were well recognised by the community. A conversation among the focus group participants further highlighted beliefs about mental illness, specifically as it related to depression. Several participants reported that depression is recognised as something that happens amongst white people only and not in the African community, that is, that African people cannot be depressed.

> *"Can you be depressed? Because they don't believe in things like that. It only whites' people who can do that or who can be depressed…no us Congolese."* (Congolese FGD1, Female, 19)

Overall, participants indicated the hegemonic position is that mental illness is taboo and by reinforcing the idea that mental illness does not exist in the Congolese community, this dominant view is secured and perpetuated.

Beliefs about the causes

Traditional beliefs influenced how the Congolese community and Mandarin-speaking community viewed causes of mental illness. Focus group participants and leaders in the Congolese community acknowledged that when an individual is experiencing mental illness, it may be attributed to supernatural causes not only by Pastors, but also family members and friends. Words such as ‘mapepo’ (Swahili for demonic possession), witchcraft, and poison were used to refer to supernatural causes.

> *“Because when somebody is experiencing something like that, it means the family would start to think it witchcraft rather than thinking it mental illness. Which is a big problem.”* (Congolese FGD1, Male, 59)

By contrast, supernatural causes were rarely described in the Arabic-speaking focus group discussions, with only one participant noting

> *“In our Arabic countries, we believe more in superstitious treatment and magic more than we trust in medical treatment.”* (Arabic FGD2, Female, 41)

This is inconsistent with previous research where supernatural causes of mental illness are reported to be prevalent in Arabic-speaking society (10). Similarly, religious attribution for mental illness, previously reported as common in Arabic speaking communities, was not discussed by our focus group participants. However, some Arabic- speaking leaders did identify “lack of spiritual comfort” or “distant from his spiritual and religion” as contributing to the development or exacerbation of mental illness.

Within the Mandarin-speaking community, participants indicated that mental illness symptoms emerge when “pressures exceed one’s bearable load”. However, they went on to add that pressure and stress are unavoidable aspects of life, and the person must regulate their stress and adjust their emotions, highlighting the notion of personal responsibility. The Mandarin-speaking community highlighted the importance of harmonious relationships, and that interpersonal conflict can lead to mental illness. One participant reported the person with mental illness and individuals around them “mutually affect each other, especially in a family”. Thus, negative interactions between the individual and their social environment, specifically family members were viewed as both a cause and consequence of mental illness,

> *“I think emotion is very important because it will affect the people around the person who is experiencing mental health problems. The people around them, in turn, will also affect the person with mental health problems. They mutually affect each other, especially in a family. If there is one person with a mental health problem in a family, he (she) will affect the rest of the family members. The rest of the family will get upset and then, in turn, affect the person with mental health problems.”* (Chinese FGD1, Female, 40+)

A harmonious family unit was noted as important, with conflict in the parent-child relationship, marriage or other relationships associated with mental illness.

> *“We also investigated some common issues. Parenting was the number one, followed by marriage and then adapting to the Australian environment.”* (Chinese Interview, Community & Organisation Leader, Male, 70+)

Other more culture-specific beliefs about mental illness were offered again emphasising the importance of harmony, this time within the individual.

> *“In Mandarin-speaking people's concept, they always think I may be off-balance. They use 'off balance' to explain many symptoms, whether it's physical or psychological.”* (Chinese Interview, Mental Health Worker, Female, 30+)

Theme 2: Impact of migration

All three communities discussed the challenges associated with migrating to a new country and its impact on mental illness. For example, Mandarin-speaking leaders described migration related stressors such as the loss of support structures as causing mental illness. The Congolese and Arabic-speaking community described additional unique challenges associated with a refugee and asylum-seeker background. Given much of the Congolese community in Australia and particularly those in South-West Sydney are from a refugee and asylum seeker background, exposure to traumatic experiences coupled with shock of adjusting to a new environment were identified as causes. Other psychosocial causes discussed related to experiences with the government policies or laws and the pressure to adhere to Australian cultural practices and beliefs resulting in loss of traditions.

> *"That is because many countries are gathered here in Australia and because different countries are gather here in Australia there is different culture here present. Also, depending on the rule and laws of this country is goes behind or step on so many people's cultures norms or beliefs. Our cultures are then discriminated, and they don't have a space at all. And at the end of the day our cultural beliefs and practices disappear based on the laws of this country."* (Congolese FGD2, Male, 38)

Changes to the traditional family structure and distinct gender roles which were clearly differentiated in Africa were described by some males in one Congolese focus group discussion as contributing to lowered self-esteem and loss of identity for males. As a result, a sentiment that mental illness disproportionally affect males more compared to females was expressed.

> *"When you get here in Australia, you have this thing where, I don't think it necessary a bad thing women too can go and work. They can also go and do these things. This is well and good but then the fact that women can do these stuffs, the role of a men start to get degraded"* (Congolese FGD2, Male, 21)

Similarly, to the Congolese community, Arabic-speaking participants emphasised mental illness being prevalent in the Arabic-speaking community because of exposure to traumatic events such as war and death of family members.

> *"I just want to point out that all the communities are affiliated, like the Iraqi communities, whether they are Muslims, Assyrian, Chaldean, Mandean etc, they live in the same community, the same shell, and almost have the same mental health status. All of such happens as a result of wars consequences, forced displacement effects, the effects of mental stress, and as a result of everything that happened before 2003 and after 2003. These are all accumulations of the difficult conditions that have been experienced by this region and its people."* (Arabic Interview, Community Worker & Religious Leader, Male, 59)

Post migration stressors such as ongoing separation from family members, loss of social support and relationships, job loss, acculturation difficulties, and lengthy waiting processes for visa applications were also highlighted in the Arabic speaking focus group discussions.

Domain 2: Barriers to seeking help

Theme 1: The impact of stigma

Stigma was found to be highly prevalent in the three communities and a significant barrier to help-seeking. However, the manifestation or consequences of stigma was different for each community with the notion of 'what matters most' (11) for each community providing excellent explanatory power.

All three communities reported the topic of mental illness is considered 'taboo' with labels such as "crazy", "fool", and "abnormal" applied to the mental ill within the Arabic and Congolese communities.

> *"In my culture, you can't tell someone that they have mental health [issues], you can't do that, if you do that, because they consider it as being crazy, and if you call someone crazy, their family can sue you"* (Congolese Interview, Health Care Worker Male 44)

Relatedly, the concept of social distance was evident across all three communities. Participants believed that members of the community would stay away from, avoid, or ignore those experiencing mental illness or seeking professional help.

> *"I found from being here within our culture, they avoid me if I speak about my suffering and tell me I have negative energy and avoid me."* (Arabic FGD3, Female, 53)

The direct impact of stigma on accessing help was described in the Arabic-speaking discussion group.

> *"In general, we do not have a good view, we try to hide him away from the social life, and even if he needs a professional advice and mental health therapist, we try to avoid it because of the fear of the community reaction if they hear about this person mental health more than our worries about the mentally ill person condition."* (Arabic FGD2, Female, 41)

Leaders noted that new arrivals were more likely to avoid seeking professional help due to fear of stigma and shame compared to individuals who have been resettled in Australia for a longer time, suggesting process of acculturation was shifting some attitudes to help-seeking in the community.

> *"While working with new arrivals, I sometimes find it very difficult to convince the arriving citizen who migrated from the mother countries such as: Iraq, Syria or any other country from the Middle East, that 'You are not viewed or perceived as before [in homeland] that you are a mentally retarded' "* (Arabic Interview, Community Worker & Religious Leader, Male, 59)

The diversity that exists in the large Mandarin-speaking community in Sydney should be heeded when considering our results. In particular, the focus group discussion participants and community leaders were older and thus the influence this may have played on their expressed attitudes toward mental illness and help-seeking cannot be discounted. Nonetheless, differences between older and younger Mandarin-speaking individuals were described by both leader and focus group participants. Several leaders noted stigma is greater among Mandarin-speaking seniors compared to younger generations and that Mandarin-speaking seniors dismiss experiences of mental illness and avoid discussing mental illness.

> *"This [seeking professional help] happened to young people. Seniors will not do it. The seniors are more stubborn. They will think it's a shame or faceless [losing face] if they have mental health problems. They will not easily discuss it [mental illness] with us."* (Chinese Interview, Community & Organisation Leader, Male, 70+)

Consequently, older Mandarin-speaking individuals were more likely to dismiss of signs of mental illness.

> *"The older people more resist to these issues. They would think that I have mental health problem. I am not mentally ill. They would think of it from a more serious aspect and link it to that. They are reluctant to face the problems and thought that I am not mentally ill. Why would I see a doctor?"* (Chinese FGD3, Female, 30+)

Theme 2: Stigma leads to secrecy and isolation

All three communities described engaging in acts of secrecy and isolation when people were experiencing mental illness to avoid labelling and discrimination. Participants indicated secrecy can occur at the level of the individual, the family unit, and/or the community. This may be representative of a component of personal stigma, the notion 'I would not tell anyone' if experiencing mental illness. However, the motivations and consequences for not telling were nuanced within each community.

In the Congolese community, shame, fear of gossip and negative judgement combined with traditional beliefs that 'mental illness does not exist' appeared to contribute to individual's keeping mental illness a secret.

> *"Also, there is other whose young children might have a problem associated with the brain, but they will continue to hide it so that the community doesn't find out. Because to them they might think, there's others*

> *that thing that when a person has mental illness within their family or among their family is something that is a disgrace, so they hide it."* (Congolese FGD1 Male, 59)

One leader expressed the shame associated with being labelled as mentally ill in African culture is due to associations that a person with mental illness "cannot provide", "I don't look like a strong person who can serve my community", and "can't represent my family" which have direct bearing on expected roles and responsibilities. This was particularly relevant for males with a leader stating men more likely to keep quiet about their mental illness due to pride and traditional gender roles.

> *"Like men, for example, with men feel proud of themselves rather than coming up and say I'm suffering from this, they would rather keep quiet, and the more they keep quiet, that particular mental health [illness] keeps eating them up."* (Congolese Interview, Health Care Worker, Male 44)

Leaders also highlighted the delicate balance needed between providing assistance in a community where stigma and fear of being labelled can lead to the suppression and denying symptoms of mental illness.

> *"I realized that the member of my community is suffering from severe mental health, but when I approached, they became uncomfortable and the guy thought that I was trying to give them the illness that they don't have, and some say ok you are trying now to call me a fool or a crazy person"* (Congolese Interview, Community Leader, Female, 44)

Fear of stigma and shame were also noted by the Arabic-speaking community as contributing to individuals experiencing mental illness keeping it a secret.

> *"Most of those who suffer from a mental condition refuse to seek treatment due to fear, shame, or shyness from others"* (Arabic FGD3, Male, 35)

This results in individuals denying mental illness and excluding themselves from social interactions or else the individual will try to appear "normal" and hide their experience of mental illness.

> *"In my social gathering among my friends and family members, if we discuss the mental health issue, I would say I have nothing wrong, and they see this. But deep inside me I have a hundred of problems, even I would not realise I have something wrong with me, so many times suddenly I get angry or watch a TV show and I cry for example. So, if I go to see a doctor it is normal issue, without letting the people know and they say, 'he is sick be careful'. Our communities deal with these things in this way especially if we know each other."* (Arabic FGD1, Male, 46)

Community leaders reflected on how pre-migration cultural framework and experience plays a significant role in their community's decision to seek help. Paradoxically, as a consequence of self-stigma and shame, which can lead to a neglect of mental health needs and delayed help-seeking, outcomes are likely to be poorer thereby further reinforcing the belief voiced by Arabic-speaking focus group discussion participants that mental illness is a "hopeless" or chronic condition.

> *"Because of how they look at the mental health [illness] in the community, the person would avoid saying a thing even if it is a simple matter afraid of how people will treat him and will not get the treatment he deserves."* (Arabic FGD2, Female, 28)

Even the act of help-seeking and the location of where it takes place can play a prominent role suggesting soft-entry approaches to mental health services may be more appropriate.

> *"The community, for example, if they see me at a psychologist clinic, they will point out that I am crazy and tell my kids that your mother is crazy, and this is a reality in our country and still happening. In our Arabic countries this stigma plays a role in this point."* (Arabic Interview, Community Leader, Male, 63)

Arabic-speaking participants frequently described secrecy at the level of the family unit. This was seen as being related to the belief that experiencing or seeking help for mental illness leaves a 'mark' on one's identity as well as their family's identity. Mental illness is perceived as a defect and brings dishonour - 'shame' - to the individual and family. Thus, the value of individual, and by extension, the family's reputation in Arab culture is impacted by mental illness. Consequently, participants reported families will hide the individual with mental illness or presence of mental illness in the family from the community to maintain reputation and social status. Participants alluded to the strong presence of affiliate stigma in the Arabic-speaking community, that is, the extension of stigma to the family members of the person with mental illness, further motivating need for secrecy.

> *"The mentally ill person daughters or sisters will lose the opportunity in getting married even his relatives will lose a good chance in getting married"* (Arabic Interview, Community Leader, Male, 56)

Others reflected on situations where families avoid socialising with others to prevent others discovering the existence of mental illness in the family and to prevent gossip.

> *"His family tries to hide it from the community, they are aware of any rumours that could spread because of this and the reputation will be that this person in the family is mentally ill."* (Arabic FGD2, Female, 34)

Furthermore, participants conveyed family members will avoid applying the label of 'mental illness'. Driven by benevolence and care, family members will keep mental illness a secret from both the individual experiencing mental illness and the community to protect the individual and their family. There was a belief that if family members do not explicitly label the individual's experience as mental illness, the person with mental illness will remain calm and symptoms will improve with increased family care.

> *"They try to hide him [individual experiencing mental illness] and deal with the issue without disturbing him or attracting his attention."* (Arabic FGD1, Female, 61)

Secrecy and isolation at the community level was described by one participant, noted to exacerbate mental illness related suffering.

> *"In general, in our society we always try to hide this matter and deal with it in secrecy and if a person is mentally ill, we make him completely disappear from the community. It is the family total shame. Then this person would develop weird phases, act strangely, due to the isolation. The mentally ill person in this case as a result would not be able to communicate and fear the presence of others around him, can you imagine, if a normal person does not communicate with anyone, then he is negatively affected, so what about the person who suffers from a mental illness condition?"* (Arabic FGD2, Female, 41)

Secrecy and denial of mental illness was also discussed in the Mandarin-speaking community. Both focus group participants and leaders reported people in the Mandarin-speaking community would not tell anyone they are experiencing mental illness and would refuse to seek treatment for mental illness.

> *"I don't think that Mandarin-speaking people will tell anyone that they have mental health problems."* (Chinese Interview, Community & Organisation Leader, Male, 70+)

Participants in the Mandarin-speaking community also alluded to secrecy occurring at the family level. Individuals will not tell others about their own experience of mental illness and family members may hide mental illness from others because they anticipate negative judgement and behaviour from others.

> *"A lot of people think that's a family matter. If a person has this kind of matter, they will not tell others. They will store all problems at home. Their family members may know it and help them a bit."* (Chinese Interview, Community Leader, Male, 60+)

Several participants mentioned it is 'taboo' in Chinese culture to speak about or seek professional help for mental illness. Both leaders and focus group participants tied the reluctance to admit mental illness and seek help to the ongoing influence of traditional beliefs which hold that mental illness should be kept a 'family matter' and thus solved at home.

> *"I think the stigma is a big barrier. People always have negative attitudes towards the label of mental health. In addition, in the Chinese tradition, the main problems should be solved at home. So there is also a little bit of this traditional view in this regard."* (Chinese Interview, Community Leader, Male, 60+)

Theme 3: Managing mental illness and the influence of the collective

Managing mental illness as a collective either at the family or community level, was noted in the focus groups and leader interviews for both the Congolese and Arabic communities. This model encompassed the provision of increased support from family and/or community, encouraging prayer and visiting each other to reduce isolation, although specifics varied by the community.

Friends, Pastors, elders, community groups, including church groups, and other leaders were seen as part of this collective network of support in the Congolese community and the act of visiting the person with mental illness was seen as a provision of care.

> *"From my community when we, elders especially, find that someone has a change in their behaviour for example, when we ask from the community is to increase their care to the people. Sometimes if the person lives alone, we may find that the change in their behaviour is due to the isolation of the person in the community or in the family. So we try to bring that person closer to the member of their family."* (Congolese Interview, Community Worker, Male, 57)

It is important to recognise that although some participants viewed such acts as providing care and reducing isolation, other participants felt differently. Instead, the involvement of this collective network was viewed by some as a way of controlling those who might be affected by mental illness by keeping care, often in the form of prayer, within the family unit. As such decisions for the individual were made as part of a larger network of family and community. However, leaders recognised that while their role was to assist, the final decision for treatment is left to the family.

> *"Our Congolese Community the leader is the one to be the first one to be contacted if there is any issues of sickness they will call the leader and ask president of Community leader we have a problem so and so, us as leaders we talk to the families but the families are the one to make the decisions"* (Congolese Interview, Community Worker, Male, 57)

Moreover, participants from the Congolese focus groups discussed the tension between those who accepted the traditional model of collective care and those who did not. These practices were viewed by some, primarily the younger participants, as an invasion of privacy and promotion of gossip. For these individuals, self-isolation and withdrawal from visits or community church may be a protective measure from others' judgement or gossip.

> *"That is why it is so hard to identify people who are mentally ill in the Congolese community, because you won't know if this person is staying home because they are depressed or because they're running away from gossip."* (Congolese FGD1, Female, 19)

Managing mental illness through a collective model of care was also described by Arabic-speaking participants, albeit at a family level. Participants expressed mental illness is considered a private matter that should be managed within the family home. In this way, individuals' agency was overridden by attitudes of paternalism and authoritarianism.

> *"They try to control him [individual experiencing mental illness]. They try to hide him and deal with the issue without disturbing him or attracting his attention."* (Arabic FGD1, Female, 61)

Family is seen as the first, and in some cases, the only step in managing mental illness. While this can stem from the sense of secrecy, it also reflects the genuine belief of the healing role of the family and family environment plays.

> *"The communication with the family, family should give him trust, talk calmly and with passion and he gains confidence. This could even help him to avoid future medical treatment, the family are the medicine."* (Arabic FGD2, Female, 53)

Within the Mandarin-speaking community, the concept of 'face' seemed to influence the way mental illness was managed specifically regarding help-seeking. Focus group participants and leaders reported individuals may be afraid of losing 'face', in line with a traditional view that 'domestic shame' should not be made public.

> *"Maybe they are afraid of losing face. The traditional mindset is that domestic shame should not be made public."* (Mandarin FGD1, Female, 39)

A leader conveyed there is usually an attitude of contempt toward individuals with mental illness because mental illness is associated loss of occupational or social functioning and therefore threatens personhood. This is because of the importance placed on 'face' and its relationship to social capital and reputation. Moreover, although not all mental illness will affect an individual's functioning in obvious or observable ways, because of the value placed on 'face' and reputation in the community and because mental illness is associated with loss of 'face', any label of mental illness, despite severity, is denied.

> *"One important thing is that if someone has been diagnosed with mental illness, they will not tell us, and their children will not tell us either, as many Mandarin-speaking people care about their 'face.'"* (Chinese Interview, Community & Organisation Leader, Male, 70+)

A catalyst for conflict between parents and children was the failure to demonstrated appropriate respect in line with cultural expectations. This was viewed by some as contributing to the development of mental illness and having implications for the management of mental illness and help-seeking, particularly amongst the older Mandarin-speaking community members.

> *"I once have met a family, and I am very close to that family. The parents have always told me that their children were unfilial and asked them to do many things. Sometimes, they quarrel with each other badly. Then, I'll help them mediate their conflicts. Their children realise that it is not good to treat the seniors. For young people, " If I have a bad temper, I may have mental health problems". The young people are willing to see a psychologist, but for the seniors, they won't. The seniors always say, "I am this kind of person. My children are supposed to be kind to me. They are supposed to do this and that". They blame a lot of the problems on their children and refuse to admit what problems they have. Maybe they are irritable, but they just won't admit that they may have mental health issues."* (Chinese Interview, Community & Organisation Leader, Male, 70+)

Theme 4: Impact of religion on help-seeking

Impact of religion on help-seeking and the nuanced role it played in the Congolese community was strongly evident. Whereby some individuals found great relief in their faith, others viewed religion and most notably religious leaders as barriers to effective management of mental illness.

> *"My comforter was my Pastor, he comforted me and gave me strength and peace and got strength to say that everything will be fine. The words and comfort that the pastor gave me provided me with strength and not to pay too much attention toward what I was being told at the hospital and I started overlooking what I was being told… So, when it comes to the day, I gave birth and nothing happened, thank to God. So for me personally, I would believe pastor because during those times for me. During that time, he was the one that comforted me and gave me the strength I was looking for and she ended up with a good outcome. I would like to say pastors have their own things that they can handle so as counsellors. They also have their own things that they can handle."* (Congolese FGD2, Female, 27)

> *"I think people come to you and tell you these things [mental health issues] straight out they don't they don't really hide it but I think – this might sound bad I like to be a rational person usually – I think that religion yeah kind of cloud our judgement. How does it cloud our judgement? I come to you and tell you aunty life, life is difficult I am going through all these stuffs and at school I am not doing well. You know our child, God is there go there and there. You know they start making it about prayers…we use religion to dismiss it."* (Congolese FGD2, Male, 21)

Participants reported that even when help was sought from friends or family, the advice received was to pray to God. The leaders interviewed regularly acknowledged the highly revered role of Pastors who often act as a first point of contact when seeking help for mental illness, a traditional role that is maintained following resettlement in Australia. They described the duties performed by Pastors such as informal supportive counselling, the provision of information, taking the individual to a doctor or another service, and provision prayers for the individual. It should be noted that while faith was seen as providing solace, some participants in the focus group viewed the strong influence of faith in the community as a barrier to acknowledging and accepting mental illness thus act as impediment to recovery. In particular, some of the younger focus group participants expressed a desire for a broader perspective of mental health and illness.

> *"There needs to be a little organisation in our community for people that just understand this stuff. Like they were talking about some people would rather go and do prayers and all these stuffs because in our community it is programmed to be that way that what we are used to. That what we are using to viewing mental health. We need people that view that have a different perspective on mental health. A lot of our people don't have that, right now almost 95% of our people don't have that. They don't have a good perspective on mental health, they are not educated. I am not trying to say uneducated because that a bit rude, but they are not aware of stuff like this"* (Congolese FGD2, Male, 21)

The role of religious leaders in managing mental illness in the Arabic community was also highlighted in the community leaders interviews however this was not reflected in the Arabic focus group discussions.

> *"They usually talk to religious person; they have trust in them, and their secret is safe with them"* (Arabic Interview, Community Leader, Male, 56)

Theme 5: Impact of practical barriers on help-seeking

All three communities discussed the impact of practical barriers to help-seeking, which included financial concerns regarding the prohibitive cost of seeking professional help and transportation difficulties, however the most frequently reported practical barrier to seeking help was language.

Congolese leaders felt the language barrier faced by community members can hinder them from seeking informal (e.g., from an English-speaking neighbour) and formal help. Despite this, leaders also observed a significant issue is that community members are often shy to communicate with a same-language interpreter due to fears around trust.

> *"And then, because they are shy to communicate with someone who can interpret for them, this becomes a barrier, they can't do anything*." (Congolese Interview, Community Leader, Female, 45)

The language barrier was noted to be a problem also in the Mandarin-speaking community, especially for the seniors. Most Mandarin leaders stated although people will seek professional help, there are very little Mandarin-speaking mental health services, and this point was echoed among focus group discussion participants.

> *"I know there are kinds of Women's help, which also provide counselling service and includes everywhere. You can make an appointment. I think it's including general psychology. In Western society, they have such services available in general health centres, but no Chinese service is available. It's covered by Medicare. As Mandarin speakers, because we have a language barrier and can't express our feelings clearly, we are unable to enjoy such Medicare-covered services. Many people are reluctant to see a specialist because a specialist is expensive, and they can't get your point. So, many people would just give up."* (Chinese FGD1, Female, 40+)

Language barriers and the challenges associated with the use of interpreters were also discussed by the Arabic-speaking community leaders.

> *"Sometimes they prefer, and you might be aware, the person who speaks their own language. If the person talks to them with the same language, they appreciate and accept, but if the person is speaking in English language with an interpreter they don't accept. They have refused many people and I inform*

> *them prior that there will be instant free interpreting, but they reject."* (Arabic Interview, Community Leader, Female, 49)

Domain 3: Help-seeking preferences

Theme 1: Informal sources of help

Family, social, and community support networks were highlighted by all three communities as playing an important role and often the preferred sources of help. As already noted for the Congolese community, managing mental illness was perceived as something done as a collective occurring either at a family or community level. Friends, Pastors, elders, community groups, including church groups, and other leaders were seen as part of this collective network of support. However, as previously mentioned not all focus group participants perceived increased care from the collective as a positive.

Within the Arabic-speaking community, some participants described balancing the perceived importance of keeping mental illness a secret from the individual to ensure symptoms do not worsen, and from the community to evade stigma and discrimination, with the awareness the person experiencing mental illness should not be isolated from the community, requires support, and should be involved in activities. A belief that mental state is related to the individual's physical and social environment was strongly evident in Arabic focus group discussions. Participants described that if a person experiencing mental illness is placed in a different physical and social environment, their mental illness may resolve. Activities that encompassed family members and other forms of group support were most frequently endorsed for management of mental illness and notion that changing the environment by taking the person on an outing was strongly highlighted.

> *"There are sort of people he prefers their company and feels comfortable around them then we leave him with them for the longest possible time after a month or two, we back to check on the person and see if any progress by talking to the person himself enquire if he feels better or not, if he is alright with the companions and give him the choice if like to change this atmosphere or stay in, depends, because we do not want him to go back for his problematic mental illness atmosphere"* (Arabic FGD1, Female, 42)

Participants from the Mandarin-speaking community also endorsed informal support such as family and friends as well as community-based coping strategies.

> *"We didn't know how to seek help from others and that family member who was deeply troubled was unwilling to seek help. Therefore, the main approach we took at that time was family companion, tolerance and understanding. At the same time, we actually encouraged him/her to try meditation and sports, which I think helped."* (Chinese FGD1, Female, 35+)

Mandarin-speaking participants described WeChat as an effective platform to access social support from family and friends. WeChat was also utilised to promote arts based activities such as painting and calligraphy workshops and sharing poetry. Clear indications of the importance of community-based coping strategies, such as the arts, exercise activities, and support groups provide insights as to how Mandarin-speaking community can be further supported in their mental health. It was noted community activities facilitate a sense of social support and belonging for migrants who are separated from social support in China. Such groups can be formed to assist newly arrived Mandarin-speaking people in reducing their isolation when not migrating with their parents. Participants mentioned that other vulnerable groups such as seniors were targeted in workshops run by the Sydney Seniors Learning Society such as handicraft workshops, singing, art groups, and dancing.

> *"In Asian Women at Work Inc, we used to have a membership system in which clients needed to pay a membership fee to attend activities. We charge only a token fee of $5, but clients don't need to pay the membership fee to attend our activities. We won't treat them differently. We had about 1200 registered Chinese-speaking clients at that time. Our activities are not only for new immigrants, but old immigrants can also join us."* (Chinese Interview, Community Leader, Female, 40+)

Participants expressed the desire for accessing support via a soft entry approach to mental health system that can be offered by cultural organisations if such services were co-located. Providing a one stop place to go if they have problems was highly valued. An example provided by the focus group participants was the newly formed non-crisis hotline from Chinese Australian Services Society (CASS H-Line) offers one-on-one assistance, protects privacy, and can offer practical advice when required.

Theme 2: Use of self-directed learning to cope with mental illness

Participants in the Chinese community identified self-directed learning as a primary way of managing mental illness. This included engaging in hobbies and activities which can help increase feelings of achievement as well as regulate negative emotions. Participants also described participating in self-directed learning about mental illness and management of mental illness via seminars on YouTube, professional videos, attending psychological workshops, and reading articles.

> *"I think there is no need to go to the psychologist because there are many seminars that target cases like me on YouTube. The seminars are quite comprehensive and pretty much cover everything. I personally find that what the psychologist said to me is as same as what I watched online. So, seeing a psychologist is just an opportunity for me to talk to someone. From my own perspective, I have known the problems already."* (Chinese FGD2, Male, 39)

The role of self-reliance when dealing with mental illness was also highlighted from both the focus group discussions and interviews.

> *"Mandarin-speaking people intend to put up with all things themselves. It is about endurance. For example, if you have some problems, you will regulate them yourself or deal with it yourself."* (Chinese Interview, Community Leader, Female, 50+)

Other factors mentioned by Mandarin-speaking focus group discussion participants potentially contribute to a preference for self-directed learning. These include extensive wait-list times to see mental health professionals and the language barriers previously discussed, wanting immediate and practical advice, and low perceived benefits of seeking professional help over self-directed learning.

> *"Psychologists also can help, but the psychologists would just listen to you. They cannot solve the problems at the end of the day."* (Mandarin FGD3, Female, 60+)

Doubt in the competency of Mandarin-speaking and China trained psychologists due to perceived lack of expertise compared to Australian trained psychologists were voiced by some focus group discussion participants.

> *"I think that there are not many Chinese psychologists. Secondly, their expertise and knowledge are far below the level of the psychologists from other countries."* (Chinese FGD1, Female, 39)

While the value of self-reliance in the Mandarin-speaking community was commonly conveyed in focus group discussions and interviews, the potential impact to delay professional help-seeking was identified by one leader who explicitly stated

> *"There's the fact that all the people, most people think I'm okay, or although I have a small problem, I can study. I can read and I can attend seminars or training workshops. It's like as if they could understand everything after attending seminars. So, many people still use the way of learning instead of asking for help."* (Chinese Interview, Mental Health Professional, Female, 40+)

Theme 3: The use of religion as a coping strategy

In the Arabic-speaking community, leaders and focus group discussion participants expressed differing views on the role of religion in addressing mental illness. Although focus group discussion participants described the benefit of self-directed religious coping (e.g., prayers) for management of mental illness, religious coping through the direct input of a religious leader was not discussed by the focus group participants.

> *"If a person is restless and anxious, as soon as he performs the prayers, his psyche relaxes and starting to feel better"* (Arabic FGD2, Female, 28)

Conversely, leaders reported seeking help from religious leaders such as Imams is common in the Arabic-speaking community. Leaders reported community members trusted religious leaders to maintain confidentiality.

> *"In my experience, the religion side plays a big role in this topic. People in general believe that the religious figure will keep the secret and will provide the right advice based on religion knowledge."* (Arabic Interview, Community Leader, Female, 59)

A concern expressed by the Arabic-speaking leaders was the potential harm those who mix religion and superstition play in the Arabic speaking community and that these people termed 'charlatan' would take advantage of those seeking spiritual assistance.

> *"We found an increase in charlatans providing desperate people unrealistic solutions. There is a person I know is mixing the religion with superstitions, people should know the difference and seek help from medical professionals not religious figure or charlatans."* (Arabic Interview, Community Leader, Male, 56)

Charlatans were not specifically mentioned in the focus groups, except for one participant alluding to the presence of such figures stating

> *"In our Arabic countries, we believe more in superstitious treatment and magic more than we trust in medical treatment. I believe that ignorance is rampant within a group of people in the community, and they are not ashamed of it"* (Arabic FGD2, Female, 41)

The importance of religion for the Congolese community has already been noted. In terms of being a coping strategy, participants in the Congolese community noted prayer plays a role in managing mental illness and is often the first step rather than help-seeking. Individuals will pray to resolve issues and family and friends may also pray for an individual experiencing mental illness. Another leader stated people will open up to members of their Church as they feel comfortable around them.

> *"If you go to that closest person you have, they are going to tell you I am going to keep you in my prayers."* (Congolese FGD2, Male, 21)

By contrast, religion was seen to play a lesser role in understanding and managing mental illness within the Mandarin-speaking community. Leaders painted a nuanced picture of the positive and negative consequences of religion in the Mandarin-speaking community. For example, one leader described how a Church did not conceptualise a child's mental illness through the biomedical model but rather through faith and religion.

> *"The priest kept telling him (her) that it was a devil. You had the devil in your body right now. So, this kid looked at everything and saw the world in a way that this world was full of devils. Then, they went to the hospital. The hospital said that you had hallucinations and delusions as you could see devils. The hospital prescribed the kid a lot of medicines. So, I can see the influence of faith on this kid and why he could not express what he was experiencing. Therefore, there are pros and cons. I cannot say that faith plays a key role in helping the Chinese community. That is not what I see."* (Interview, Community, Organisation Leader & Academic, Female, 30+)

The influence of religion and moreover the church was highlighted as positive by others. In particular, finding support within a church due to lack of other forms of social support when newly arrived was discussed. These church groups were seen as providing members with a sense of belonging and support when experiencing mental health issues.

> *"We helped her connect with a local church. Then, she went to the church to attend some activities, such as dancing, and a group of people accompanied her. I don't know if it fits her, but I think if there's such a problem, the church is definitely a good place to provide resources."* (Chinese Interview, Community Worker, Female, 40+)

Theme 4: Professional help-seeking

While prayer and informal care was endorsed amongst the Congolese focus group discussion participants, professional sources of help such as general practitioners and counsellors were also identified sources of help-seeking.

> *"If you are not feeling well mentally or your health you would go to your GP and you would tell them how you are feeling and after that the GP would refer you and if there is any counsellor. That counsellor would then tell you how you could go about your situation."* (Congolese FGD2, Female, 27)

> *"The young ones, who are brought up in Australia, have a different understanding of what is mental health. So they are seeking support, they do go see few counsellors, and they do seek referrals from different organisations, but those who came from Africa, like their parents... seeking help to what I can easily tell you is very rare. They just go to the pastors, speak to them but seeing them to go see a counsellor or speak to a mental health practitioner, it's very few that I've seen myself."* (Congolese Interview, Community Leader, Male, 50)

Arabic-speaking participants described seeking professional help for mental illness particularly if the symptoms worsen.

> *"There was a person once that we wanted to take to see the doctor but without letting him know that he is going to see a psychologist. For example, we are his family, and we know that he is sick, but we try to take him to see the psychologist but without telling him that he is going to see a psychologist. We bring the doctor home without his knowledge to see him at home. Most people deal with this issue in this way."* (Arabic FGD1, Male, 46)

As already noted, most Mandarin-speaking focus group participants described a preference for self-directed learning as opposed to professional help-seeking, there were still other participants who discussed their experiences of seeking professional help.

> *"Well, I went to my GP first, and my GP referred me to a psychologist, who has helped me a lot. He/she has helped me improve a lot. I like my psychologist very much." (Mandarin FGD1, Female, 35)*

Discussion and Recommendations

A series of eight focus group discussions and 26 key informant interviews were undertaken with community members and leaders to inform stigma reduction initiatives and promote mental health related help-seeking for the three CaLD communities being those who speak Arabic, those who speak Mandarin, and the Congolese. Firstly, we found the three communities generally distinguished between 'mental illness' and 'mental health problems', with the former term denoting more severe conditions and the latter term denoting more common conditions such as anxiety and depression. This is consistent with findings in the general Australian public (12). Our findings provide insight into some of the corresponding cognitions, emotional reactions, and behaviours that may be associated with each term or label and thus have important implications for the creation of stigma reduction initiatives for these communities. We also found a strong theme of mental illness related stigma in all three communities. Moreover, participants endorsed stigma as a significant barrier to help-seeking. However, our findings also demonstrated the nuanced impact and consequences of mental illness related stigma both between and occasionally, within the groups, indicating the need for a tailored approach to reducing stigma in the three communities.

Stigma Reduction Initiatives in Australia for CaLD Communities

In 2020, Reavley and colleagues undertook a review of existing Australian stigma and discrimination reduction initiatives and their evidence of effectiveness (13). At the time of the review, they did not identify any Australian initiative that was developed and directly targeted to reduce stigma and discrimination towards mental illness in the Arabic-speaking, Mandarin-speaking, and Congolese community in Australia. The review did however note the application of Mental Health First Aid (MHFA) training to Chinese community in Australia. MHFA was established in 2000 and considered a best practice program to reduce stigma in the general Australian public. Two studies evaluated Mental Health First Aid (MHFA) training in Chinese communities in Australia (14, 15). Positively, significant improvements were identified for measure of social distance toward schizophrenia over time (15) and pre-post delivery of the course (14). Significant improvement was also reported for measure of perceived stigma pre-post (14). However, the MHFA training was not tailored or adapted for the Chinese community. Subsequent to the review, two mental health literacy programs developed by Slewa-Younan and colleagues for the Arabic-speaking community have since been evaluated and published (16, 17). The first sought to examine the effectiveness of a culturally tailored mental health literacy program for Arabic-speaking refugees in South-Western Sydney, and found improvements in knowledge and attitudes, including that of stigma towards trauma related mental illness which were maintained at 3-months follow-up (17). The second program, targeted at improving mental health literacy of Arabic-speaking religious and community leaders, also demonstrated improvement in recognition of trauma related mental illness and attitudes including increased likelihood to promote professional help-seeking (16). To our knowledge, these are the only two examples of mental health literacy programs developed specifically for the Arabic-speaking community which encompass educational components targeting misinformation related to mental illness, thereby challenging stereotypes and other aspects of mental illness stigma. An intervention titled 'Tell Your Story' (TYS) targeted to Arabic-, Farsi- and Tamil-speaking refugee men with PTSD symptoms was evaluated by Nickerson and colleagues (18). While results indicated greater help-seeking in the month following the intervention compared to those in a waitlist control group, the generalisability of the results was limited as the intervention was broadly refugee males with PTSD symptoms and not specific to the Arabic-speaking community. There are currently no anti-stigma initiatives directly targeted to the Mandarin-speaking and Congolese communities in Australia.

Therefore, given the scarcity of stigma initiatives for CaLD populations, our overarching recommendation is the need to commence work on a coordinated approach to reduce stigma in the three CaLD communities by leveraging this project's findings and developed networks. The predominant principal that should guide stigma reduction interventions for CaLD communities is to undertake a coordinated approach that seeks to meet the needs of each community. Our community consultations highlighted frequent request for educational initiatives, which should be complimented with contact components. As such, the first recommendation is to deliver a stigma reduction intervention with tailored education and contact components to the communities. Furthermore, our community consultation findings highlighted the rich diversity of nuances related to mental health stigma that exists both between and within CaLD communities and this should never be forgotten in developing interventions. We recommend that a national body such as Mental Health Australia coordinate the development of a CaLD specific stigma initiative framework, and that this work be led by CaLD community representatives with lived experience to oversee the implementation of the strategic directions. The second recommendation is to ensure community members and leaders have leadership roles in co-designing and evaluating stigma reduction initiatives. Thirdly, a system-based approach that recognises the role that multiple parties and settings play in addressing mental health related stigma in CaLD groups is required. Initiatives need to be multi-pronged and work across various settings such as with the community members, and gate keepers such as religious leaders and others who provide services to these groups. Finally, longevity is required to shift entrenched beliefs, along with provision of adequate funding and evaluation as an imperative. Below we outline each of the four recommendations with more specific set of details.

Recommendation 1: Deliver a stigma reduction intervention with tailored education and contact components to the communities

- An education component should incorporate the specific cultural terms and idioms with knowledge on common mental illnesses to bridge viewpoints and build community mental health literacy
- Target stigma directly by explicitly challenging culture specific stereotypes of mental illness and related beliefs that impede help-seeking by utilising insights gained from the three community consultations
- A contact component supporting persons with mental illness or lived experience of mental illness to share their stories either via live interactions or stories delivered using multi-media
- Deploying the stigma reduction interventions in supportive trusted settings, and using pre-existing established groups and working with community leaders, to enable a soft entry approach

The first recommendation is to deliver a stigma reduction intervention with tailored education and contact components to the communities. There is strong evidence to suggest that education campaigns with contact components can help correct myths and misconceptions as well as dispel stereotypes associated with mental illness that impede help-seeking (19). The need for further mental health education was highlighted by all three communities but it needs to be accompanied with well supported contact opportunities. We would argue for broad mental health education rather than narrow mental health education. Particularly, as illness such as depression, anxiety, and trauma related disorders are more prevalent than uncommon mental illness, such as bipolar and schizophrenia, with the latter often screened for at the point of migration.

Broadly speaking, we recommend applying a ‘what matters most’ theoretical framework when working with CaLD communities (11). In this framework, it is proposed that ‘what matters most’ to lay individuals in a certain cultural context shapes the effects of stigma for individuals. Such culture-specific aspects of stigma are likely to be the most acutely felt aspects of stigma for individuals within a certain cultural group. For example, the strong impact of affiliate stigma, particularly family stigma, was noted by participants across all three communities. Moreover, the significant role of family in managing mental illness should also be incorporated in stigma reduction interventions to facilitate help-seeking. This may include information on how to support a family member at risk of developing mental illness or displaying symptoms of mental illness, how to encourage a family member to seek help or a focus on healthy communication strategies. Attention to language and terminology used could assist in the uptake educational initiatives and thereby may have positive impact on help-seeking**.** Our findings suggested that community members found a focus on specific symptoms such as “stress” and “feeling sad” more digestible than diagnostic labels. Other more specific findings noted for each community and the role they may play when developing a tailored stigma reduction initiative are presented below.

Congolese Community

When consulting the Congolese community, some culture-specific aspects of stigma conveyed include the traditional belief that ‘mental illness does not exist’; mental illness is taboo; only white people can be depressed; attributions of mental illness to supernatural causes and concerns about confidentiality and gossip. The ongoing influence of the traditional belief that ‘mental illness does not exist’ despite evidence to the contrary should be explicitly targeted in awareness and education campaigns. Younger participants voiced a desire a broader perspective on conceptualisations of mental illness and treatment arguing that the belief ‘mental illness does not exist’ should be made visible and explicitly challenged rather than avoided. Elaborating on our recommendation for a multi-pronged approach when delivering stigma reductive initiatives that targets key groups that act as gatekeepers for each community, for the Congolese community this would be Pastors and other religious and community leaders. Trustworthiness of help-seeking sources was discussed with some participants raising concerns regarding confidentiality when consulting with Pastors and other religious leaders.

Following on from this, it is clear that mental health education tailored to the established networks and gatekeepers of the community, such as Pastors, and other community leaders may wish to reflect on trust, confidentiality and encouraging professional help-seeking where needed. Specifically, consultations of the community stressed the importance of increasing collaboration between leaders and mental health professionals in order to overcome beliefs that prayer can cure mental health illness and to recognise mental illness requires professional help.

Arabic-speaking Community

Within the Arabic-speaking community, some culture-specific aspects of stigma conveyed include keeping mental illness a secret due to fear of stigma and shame, which extends to the family and the belief a person with mental illness cannot recover and mental illness is a hopeless condition. Consultations highlighted the belief that individuals with mental illness are perceived as fragile, highly sensitive, and reactive. Moreover, there was a perception that mental illness is a "hopeless" and incurable condition. Such beliefs can be targeted in education campaigns that are supported with contact components which highlight lived experience stories of recovery. Relatedly, participants conveyed there is low perceived benefits to seeking professional help because they doubted the ability for a mental health professional to "cure" a person with mental illness. The preference for informal sources of help such as close friends as well as non-mental health specialists such as general practitioners was discussed. This further highlights the importance of fostering a recovery-based understanding from mental illness in the community and further developing knowledge on 'cure' vs 'healing' from mental illness. Utilising the arts such as music to convey messages and stories in an acceptable and appealing manner was highlighted by leaders. The notion of trust in facilitating help-seeking also came up in the Arabic-speaking discussions and interviews. A foundation of trust in a relationship is important. When encouraging family members or friends to seek help, the importance of language was again highlighted. Community members described being sensitive in their approach, utilising alternative terminology to 'mental illness' to increase insight such as 'you might be a little stressed', stories of recovery, education on early intervention, and assuring privacy. Finally, in line with our recommendation that stigma reduction initiatives target key groups that act as gatekeepers for each community, for the Arabic-speaking community this would be religious and community leaders, taking approaches such as those developed and evaluated by Slewa-Younan and colleagues (16).

Mandarin-speaking Community

Culture-specific aspects of stigma noted from the Mandarin-speaking community consultations include the belief that it is 'taboo' to speak about or seek help for mental illness; mental illness is a family matter and is associated with losing 'face' thus should not be made public and that interpersonal stress and conflict can cause mental illness. Focus group discussion participants report low confidence in their understanding of mental illness symptoms and so were reluctant to advise family or friends to seek intervention as because lack of awareness of early signs of mental illness. Participants expressed a desire to learn about early signs of mental illness and management of mental illness, further supported by their reports of self-directed learning. For example, education packaged in a way that is tailored and inclusive of Mandarin-speaking community interest and values (utilising terms such as harmonious family and healthy child development rather than domestic violence and elder abuse/child protection) was suggested to encourage uptake as well as utilising platforms such as WeChat. Offering remote access in addition to live opportunities was also discussed. The need to ensure education is delivered in targeted fashion was strongly emphasised by leaders. Leaders stated education should be tailored to old and young Mandarin-speaking individuals as they have different needs and levels of knowledge. Consultations also highlighted the importance of knowledge on how to navigate the mental health system, particularly knowledge about Medicare rebated sessions and referral pathways.

Recommendation 2: Ensure community members and leaders have leadership roles in co-designing and evaluating stigma reduction initiatives

- Defer to and incorporate the expertise of community members and leaders to further develop knowledge on how each community views mental illness and beliefs toward people with mental illness using the 'what matters most' theoretical framework (Yang et al., 2014)
- Provision of adequate funding to ensure community members and leaders have leadership roles in co-designing, implementing, and evaluating stigma reduction initiatives beyond an expectation that such roles will be performed in a voluntary capacity

The importance of a collaborative and collective approach highlighted in all three community groups consulted is our second recommendation. Community members including leaders and existing organisations are knowledgeable about their community and can provide expert input on how to engage with the community when developing and delivering stigma initiatives. In response to managing mental illness in the context of a Western mental health system that is unfamiliar and difficult to navigate and access, all three communities discussed their identified pathways and response systems. These established networks have many parts and comprise of friends, family, community and religious leaders, generalist health service providers as well as organisations, which may include government organisations such as transcultural mental health services as well as religious and ethnic-based organisations such as CASS, Sydney Seniors Learning Society. We need to work with all parts of the community network, particularly trusted leaders and organisations with grass roots access to the communities and hard to reach sub-groups, to ensure stigma reduction interventions are culturally responsive and will be accepted by the community (20).

Recommendation 3: Employ a multi-pronged approach to reducing stigma towards mental illness in the three communities

- Employ a multi-pronged approach when delivering stigma reduction initiatives that targets key groups that act as gatekeepers for each community such as spiritual leaders or community elders
- Increase advocacy for the CaLD communities by bringing knowledge to mental health service providers and clinicians about specific mental illness related stigma beliefs
- Target structural stigma, that is, the limited mental health services available and investment in mental health care for members of the three CaLD communities through the provision of adequate funding to increase the availability of linguistically and culturally appropriate service providers and financial support to access mental health services
- Increase advocacy for the CaLD communities by bringing knowledge to key government organisations that work with migrant communities such as Centrelink and the Department of Home Affairs, Immigration and Citizenship

The community consultations highlighted the importance that systems around CaLD communities play in mental health provision and in advocating stigma reduction. Therefore, our third recommendation is the need to employ a multi-pronged approach to reducing stigma in the three communities. Leaders frequently mentioned the role of government organisations when discussing the management of mental illness. Entities such as Centrelink and immigration while not directly providing health care were seen as playing an important role in people’s wellbeing. The extent to which an individual feels integrated in the general Australian community and an effective member of society will impact their decision to seek help for mental health problems. Being an effective member of society encompasses an ability to learn the English language, find employment, confidence and trust in the public system and services, and financial support. Being an effective member of society increases feelings of self-efficacy and confidence and can counteract the effects of mental health related stigma.

At the clinician level, knowledge regarding the importance of trust in CaLD communities needs to be emphasised. Language and gender preferences need to be considered to increase acceptability and accessibility of professional mental health services. Individuals may prefer bilingual speaking providers while others may not. Some individuals may refuse interpreter services due to fears around confidentiality. Overall, clinicians should keep in mind that participants placed importance on trustworthiness of help-seeking sources. Moreover, clinicians should not make assumptions about the individual’s adherence to cultural values and the extent to which they embrace certain conceptualisations of mental illness and models of care. As evidenced by the consultations, the experience of participants is nuanced. One such example was the views conveyed by some of the younger participants in the Congolese community in relation to how they view the collective model of support and role of religion in managing mental illness. Our findings support the utility of cultural responsiveness in clinical practice rather than cultural competence. That is, clinicians should aim to be flexible and person-centred in their approach as making assumptions based on pre-conceived stereotypes and biases places the individual with mental illness at risk of feeling ostracised and misunderstood from both members of their community as well as Australian service providers. Parallel to implementing a coordinated approach to reducing stigma toward mental illness in the three communities, the government needs to focus on building qualified labour supply in the mental health field to match the mental health needs of the three communities. If we reduce stigma in the three communities and thus promote mental health related help-seeking, we need to ensure there are sufficient qualified mental health professionals that can match the uptake of mental health services by community members. Otherwise, we risk reinforcing the structural barriers to seeking help.

Recommendation 4: Employ a long-term approach with sufficient funding needed to develop and evaluate stigma reduction initiatives

- Provision of adequate funding to ensure a long-term approach given the longevity needed to change- ideally, 3-5 years initially and then incorporated into core funding
- Empirical evaluation built-in to stigma reduction initiatives and evaluation of effectiveness
- Ensure community members and leaders have leadership roles in the *evaluation* of stigma reduction initiatives
- Create and validate measures of mental illness stigma for the specific communities - Utilise the 'what matters most' theoretical framework (Yang et al., 2014) to identify culture-specific aspects of stigma to understand contextual effects of stigma and to consistently operationalise and test stigma-related outcomes

Our final recommendation stems from the recognition of participants, specifically leaders, that reducing stigma in the communities will require a long-term and dedicated approach from all stakeholders. Leaders also recognised limited advances in efforts to address stigma and improve help-seeking in the communities is a result of inadequate funding. The coordinated approach to reducing stigma in the communities put forward in this report must have a built-in empirical evaluation process. An empirical evaluation process is critical to ensure the acceptability and success of the coordinated approach and most importantly the up-scaling of grass roots programs. As noted in Part 1 Literature Review, a significant methodological shortcoming of stigma related studies and stigma reduction initiatives is a lack of consistent definitions and measures of stigma towards mental illness, and this shortcoming is even more pronounced in studies with CaLD individuals as there is a paucity of appropriated measures of stigma. Thus, the need to create and validate measures for mental illness stigma for specific communities is required in order effectively evaluated stigma reduction initiatives. It is also crucial to recognise and undertake further research on the unique challenges of CaLD individuals who are impacted by both pre-migration cultural frameworks or traditional beliefs, and Australian systems and how this impacts stigma.

Limitations and Strengths

Several limitations are important to note when interpreting the current findings. The sample size and sociodemographic characteristics of the participants impact the generalisability of the results. Although we used a triangulation approach to explore broad perspectives, the sociodemographic characteristics of participants should guide interpretation of the findings. For example, participants in the Mandarin-speaking community were generally older in age. Additionally, participants resided in metropolitan Sydney and the generalisability of our results to community members residing outside the Sydney region are limited. Barriers to help-seeking such as a scarcity of culturally and linguistically appropriate mental health services reported by participants in the current study are likely even more pronounced for CaLD individuals residing outside metropolitan Sydney. Additionally, we primarily included participants who arrived in Australia in the past 7 years and the views of the participants in the current study may not generalise to individuals who have been residing in Australia for longer periods of time. This is particularly important to consider given the participants identified the impact of acculturation on mental health related attitudes and help-seeking. Also, sociodemographic characteristics such as educational level of participants were not recorded and thus we were unable to ascertain whether such characteristics mattered when interpreting the findings. Although recruitment was enhanced through a combination of purposive and snowball sampling using the networks and contacts of the investigators and bilingual health workers, the possibility remains that individuals who are more active members in the community such as those who attend Church groups were recruited as opposed to members less active in community networks. In terms of methodological limitations, participants did not have the opportunity to review and check transcripts due to time and funding constraints, however interviewers did summarise the content of what was discussed at the end of each of the main sections of the interviews to ensure the participants' perspectives were obtained. Furthermore, there is a possibility of social desirability bias in the results given key informant interviews were conducted with community and religious leaders whose views are well regarded in their respective community. Notwithstanding these limitations, the current study had several strengths. Firstly, the research team and chief investigators were well integrated in the respective communities allowing trust. Secondly, the interviews and focus group discussions were held in the respective language for each community which allowed for the inclusion of newly-arrived individuals who may have otherwise been excluded due to low English proficiency. Finally, in undertaking community consultations by training bilingual health workers, we were able to build capacity within the CaLD groups and foster advocacy skills. Subsequently, the novelty of the current study is a key strength. To our knowledge, the current study is one of just a few studies looking at three communities at the same time, and no study to date has unpacked the similarities and differences in mental health related help-seeking and stigma among the Arabic-speaking, Mandarin-speaking, and Congolese community in Australia.

Conclusion

The mental health needs of CaLD communities in Australia are poorly understood compared to individuals from a non-CaLD background. The findings of this research project provide crucial insights into the factors that influence mental health related help-seeking including that of stigma in the Arabic-speaking, Mandarin-speaking and Congolese communities in Sydney. Across all three groups, we found migration and related experiences both pre and post arrival to Australia, was the common denominator influencing mental health related help-seeking, as well as manifestation and consequences of stigma. Notably, we found richly diverse nuances in the experiences of participants both between and within the communities. Our study highlighted the diversity that exists within the CaLD communities in Australia and builds on the knowledge base for these three communities. By leveraging the findings of this research project, we put forward a clear set of policy recommendations to inform mental illness stigma reduction initiatives and provide a foundation to commence work on a coordinated and long-term approach to reduce stigma in these three CaLD communities.

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Appendices

Appendix A: Glossary of key terms used in the interviews

Arabic

Mental illness	Marad nafsi	مرض نفسى
Mentally ill	Mareed nafsi	مريض نفسى
Mental health	Alsahha Alnafsiyah	الصحة النفسية
Mental Health Problem	Mushkelat Alsahha Alnafsiyah	مشكلة الصحة النفسيه
Stigma	Wasmat Aar	وصمه عار
Crazy	Majnoon	مجنون
Defect	Mukhtal	مختل
Shame	Aár	عار
Shyness	Khajal	خجل
Charlatan	Dajal or sha'wathah	دجل وشعوذة

Swahili

Mental illness	ugonjwa wa akili
Mentally ill	Mgonjwa wa akili
she/he's mentally ill	Ana ugonjwa wa akili
Mental health	afya ya akili
Mental health problem	tatizo la afya ya akili
Stigma	unyanyapaaji
Crazy	mwehu
Taboo	mwiko
Witchcraft	uchawi
Poison	sumu
?Demon possession	mapepo

Mandarin

Mental illness	精神疾病
Mentally ill	（患有）精神疾病的
Mental health	精神健康
Mental health problem	精神健康问题；精神健康方面困扰
Psychologist	心理医生
Abnormal	不正常的
Stigma	污名化
Filial Piety	孝顺 or 孝心'

The old Mandarin-speaking people	老华人
The new Mandarin-speaking people	**新**华人

Appendix B: Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Domain 1: Research team and reflexivity	
Personal characteristics	
1. Interviewer/Facilitator	**Which author/s conducted the interview or focus group?** YM, TH, AR, VM, YL, JY, NZ
2. Credentials	**What were the researcher's credentials?** All researchers had qualifications in health, or a health-related discipline obtained in their country of origin, Australia or in both countries.
3. Occupation	**What was their occupation at the time of the study?** Associate Professor (SSY; IB) Distinguished Professor (AR) Professor (BL; NL) Research Assistants (KKB; YL; JY; NZ; YM; VM; TH)
4. Gender	**Was the researcher male or female?** Female (SSY; KKB; IB; NC; BL; TH; VM; YL; JY) Male (AR; YM; NZ)
5. Experience and training	**What experience or training did the researcher have?** Researchers were experienced in conducting qualitative research. SSY and KKB provided training to bilingual health workers.
Relationship with participants	
6. Relationship established	**Was a relationship established prior to study commencement?** Yes, during the screening procedure and subsequent phone calls.
7. Participant knowledge of the interviewer	**What did the participants know about the researcher? e.g. personal goals, reasons for doing the research** Participants were informed of reasons for doing the research at screening and at the beginning of the focus group discussions/informant interviews.
8. Interviewer characteristics	**What characteristics were reported about the interviewer/facilitator?** See participants and procedure section.
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and Theory	**What methodological orientation was stated to underpin the study?** An interpretative phenomenological analysis (IPA) approach
Participant selection	
10. Sampling	**How were participants selected? e.g. purposive, convenience, consecutive, snowball** A combination of purposive and snowball sampling
11. Method of approach	**How were participants approached? e.g. face-to-face, telephone, mail, email** Telephone and email
12. Sample size	**How many participants were in the study?** 77
13. Non-participation	**How many people refused to participate or dropped out? Reasons?**

	One participant completed the screening procedure and preparation phone calls but did not attend the scheduled focus group discussion
Setting	
14. Setting of data collection	**Where was the data collected? e.g. home, clinic, workplace** Workplace and home as interviews and focus group discussions were conducted online via Zoom due to the COVID19 outbreak
15. Presence of non-participants	**Was anyone else present besides the participants and researchers?** No
16. Description of sample	**What are the important characteristics of the sample? e.g. demographic data, date** Sociodemographic characteristics presented in Table 1
Data collection	
17. Interview guide	**Were questions, prompts, guides provided by the authors? Was it pilot tested?** Yes
18. Repeat interviews	**Were repeat interviews carried out? If yes, how many?** No repeat interviews were carried out
19. Audio/visual recording	**Did the research use audio or visual recording to collect the data?** Audio recording was collected
20. Field notes	**Were field notes made during and/or after the interview or focus group?** During and after
21. Duration	**What was the duration of the interviews or focus group?** The FGDs lasted approximately 90 minutes and the KII lasted between 20 to 40 minutes.
22. Data saturation	**Was data saturation discussed?** No – *as this was not part of the data collection approach used*
23. Transcripts returned	**Were transcripts returned to participants for comment and/or correction?** No
Domain 3: Analysis and findings	
Data analysis	
24. Number of data coders	**How many data coders coded the data?** Three – KKB, SSY, YL.
25. Description of coding tree	**Did authors provide a description of the coding tree?** Yes
26. Derivation of themes	**Were themes identified in advance or derived from the data?** Derived from the data as well as the theoretical knowledge and practical experience of the data analysts
27. Software	**What software, if applicable, was used to manage the data?** NVivo 12 Software for Windows
28. Participant checking	**Did participants provide feedback on the findings?** No
Reporting	
29. Quotations presented	**Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number** Yes – see results section
30. Data and findings consistent	**Was there consistency between the data presented and the findings?**

	Yes – see results section
31. Clarity of major themes	**Were major themes clearly presented in the findings?** Yes – see results section
32. Clarity of minor themes	**Is there a description of diverse cases or discussion of minor themes?** Yes – see results section

Appendix C: Bilingual health workers and researchers team photo

From left, top row: Noel Zihabamwe, Klimentina Krstanoska-Blazeska, Dr Yiran Li

From the left, middle row: Tahni Husari, A/Prof Shameran Slewa-Younan, Jocelyn Yu

From left bottom row: Dr Yaser Mohammad, Victoria Mbuto