
*Demystifying Mental Health
in Ethnic Communities*

Multicultural Mental Health Project Evaluation



Patrycja Toczek
Australian Polish Community Services

In collaboration with:

Bella Ochana, Victorian Arabic Social Services
Nary – Sam, Cambodian Community Welfare Centre Inc.
Mei Yu, Chinese Health Foundation of Australia
Lena Kocevaska, Macedonian Community Welfare Association Inc.

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Australian-Polish Community Services Inc.
77 Droop Street,
Footscray 3011, Melbourne, Australia.
(03) 9689 9170
email: info@apcs.org.au
www.apcs.org.au



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Wendy Bennett
Sustainability Manager
On behalf of APCS

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Definitions

- CALD – Culturally and Linguistically Diverse
- MMHP – Multicultural Mental Health Project
- NESB – Non-English speaking background
- QTPU – Queensland Transcultural Psychiatry Unit
- VTPU – Victorian Transcultural Psychiatry Unit

Relevant Mental Health Service Providers:

- ADEC – Action on Disability in Ethnic Communities
- DHS – Department of Human Services
- MMHA – Multicultural Mental Health Australia
- MRC – Migrant Resource Centre
- Prahran Mission, beyondblue, Clinical Areas of Mental Health

Relevant Networks:

- Inner South East Partnership in Community and Health (ISEPICH)
- Health Committee at Ethnic Community Council of Victoria (ECCV)
- Inner South Transcultural Network

Executive Summary

Staff in ethno-specific agencies continue to see members of their communities struggling to deal with the long and short term impacts of involuntary and voluntary migration and of the upheaval that led to migration in the first place. Many communities carry stigma, cultural and spiritual beliefs about mental health and mental illness that results in failure to address needs in a timely and supportive manner. Consequently, many individuals come into contact with support services at a time of crisis and have negative perceptions of the system as a result.

Australian Polish Community Services (APCS) has sought strategies to respond to the mental health needs of the Polish community over a number of years. Rather than continuing to approach the issue from the perspective of a single community we made the decision to explore the possibility of a collaborative approach. As a result we identified four other community groups who were under-represented in the utilisation of mental health services and who had had similar issues around the migration experience ie. Community members were forced to leave their countries of birth as a result of war, political conflict and other traumatic events.

Accordingly, APCS invited Cambodian Community Welfare Centre Inc, Chinese Health Promotion Foundation, Macedonian Community Welfare Association and Victorian Arabic Social Services to join us in a proposal for a Multicultural Mental Health Project targeted at de-stigmatising mental health issues, raising awareness and improving access to mental health services prior to situations reaching crisis point. All of this was to be achieved by working together to provide support and direction whilst addressing the issues in a culturally and linguistically appropriate manner, thus respecting the differences as well as the similarities for each community. A proposal was put to The William Buckland Foundation and funding was received. Additional funding was sought to cover the shortfall in the initial budget and a further grant was received from the Coles Group Community Grant program.

During the project, the project workers utilised a number of strategies to reach members of their communities and disseminate information. Communities shared their knowledge, attitudes and experiences related to mental health and mental illness and were informed of the supports available. The need to recognise traditional responses / treatments to address mental health issues was voiced alongside the need to find a way to make modern, western approaches effective and culturally responsive.

Twelve months is a very limited time to undertake such a project and in reality just touches the tip of the iceberg. However, it was able to demonstrate that there is a need for this type of program to be adequately funded and resourced and to

be delivered over a significantly longer period of time. A number of recommendations have been made for future progress in this area and we would like to see similar models developed amongst other communities.

Recommendations:

- Provision of ongoing long-term funding to ethnic communities.
- More focus on prevention and early intervention in culturally and linguistically appropriate formats.
- More targeted approach by governments and funding bodies in responding to mental illness.
- More focus of collaborative work between the mainstream and ethno-specific sector. This may include:
 - Professional development for those working in the mental health sector.
 - Community education and the role of ethno-specific media.
 - The mapping of gaps in existing mainstream and culturally specific mental health services.
 - Improvement in the resources available for Multicultural Mental Health Agencies/Teams
- The distribution and dissemination of the findings of this report to key Government and community agencies.

Introduction

It is estimated that one in five Australians will experience mental illness at least once in their lifetime. As Victoria is one of the world's most culturally and linguistically diverse (CALD) societies, where over forty per cent of its citizens have been either born overseas or have at least one parent born outside Australia, the impact of cultural issues and communication barriers should be acknowledged in the mental health discourse (Department for Victorian Communities 2004). Kokanovic, Peterson, Mitchell and Hansen (2001) argue that migration, culture and language have a profound influence on a person's lived experience and mental health, and that these factors influence the manner in which the person utilizes mental health services. The key concern emphasized in the mental health policies and research of recent years is that structural barriers are present in accessing services for people of CALD backgrounds, preventing those in need from obtaining necessary assistance.

Although mental health is an issue for many CALD communities, how these communities respond to mental health issues is quite variable. For example, their understanding of mental health, the services available, and their access to these services varies significantly. Whilst some communities are over-represented in their access to some mental health services (i.e. crisis), many other services are under-represented, with much needed help not being sought. There appears to be a dearth of information and resources for the various CALD communities, and decisions at a governmental/policy level to provide translated resources is based upon which communities have the largest number of people in Victoria/Australia, and/or or which communities are accessing the mental health system in the greatest numbers. Further, access to the service system is often prioritized towards those most recently arrived populations entering the country as refugees or under humanitarian programs.

It is acknowledged that there is a need for newly arriving communities to receive vital mental health support to help them deal with a range of issues, including the traumas of war, migration and resettlement. Notwithstanding these issues, it should also be acknowledged that there is a need for services and education for members of communities that have been in Australia for varying lengths of time, and who also have a range of mental health related issues.

Through this project, it is proposed that the five ethnic communities (Arabic-speaking, Cambodian, Chinese, Macedonian and Polish) work together to:

- raise awareness of the mental health needs of their respective communities;
- promote access to services;
- produce resources to enable communities to gain a greater understanding of how the mental health system works in Victoria; and
- promote strategies addressing preventable mental health conditions, thereby reducing the need to access services.

Aim

The Multicultural Mental Health Project (MMHP) was funded by the philanthropic sector through the William Buckland Foundation and Coles Group Community Fund. The project aimed to provide community education to five ethnic communities in Victoria, namely: Arabic-speaking, Cambodian, Chinese, Macedonian, and Polish. The selected communities were identified with the assistance of the Mental Health Branch of the Department of Human Services (DHS) and the Victorian Transcultural Psychiatry Unit (VTPU) as being under-represented in the non-acute mental health service system in Victoria.

The broad project aims of the MMHP were to:

- raise awareness in the five communities about mental health;
- provide the communities with culturally and linguistically appropriate information on available services, and key information brochures translated into community languages;
- raise awareness about issues faced by the CALD communities; and
- contribute to discussions that can influence the development of mental health services in Victoria.

Methodology

Stage 1: Project Preparation and Consultations

- Organizing Steering Committee with representatives of the selected community agencies and other relevant agencies to discuss project objectives.
- Consultations with VTPU & VicHealth.
- Establishing Project Workers Working Group.
- The Mental Health Working Group met on a regular basis in order to monitor the progress of the project and set up future directions. Seven meetings were conducted; their outcomes were documented.
- Literature Review in preparation for the community consultations.
- Each Project Worker reviewed the available literature on mental illness, in order to better understand the extent of research undertaken in the selected communities. Secondly, it assisted with the initial planning for the community consultations:
 - Prevalence of Mental Illness, and
 - Cultural Beliefs around Mental Illness.

Stage 2: Focus Groups/Community Consultations

Each Project Worker undertook two focus groups with their community members. The groups varied in their profile and size, but were a general reflection of the attitudes surrounding mental illness in their respective communities.

To facilitate the process and assist with eliciting key information, a set of questions was developed by all project workers in the process of consultation.

Consultations were also held with relevant service providers. Each Project Worker focused on relevant organisations in the community that worked in the area of mental health and wellbeing with the selected groups.

Stage 3: Preparation for Community Sessions - Preparation of Resources

- Survey of mental health professionals who spoke their respective community language, utilising database developed by VTPU and other resources.
- Identification of key information and education resources on mental illness and mental health, which have been translated from English into the languages of the selected communities.
- Development of strategies to undertake effective community education campaigns tailored to the needs of different communities.

Example:

General topics covered by the five communities included:

- What is mental health?
- Overview of the most prevalent illnesses in the selected communities, including: depression, anxiety, PTSD etc.
- Prevention: what to do to keep mentally fit?
- Early intervention: where to seek help?

The Cambodian Mental Health Project Worker developed a unique model of practice for the Cambodian community, resulting from the process of consultation with the community members and Foundation House, an organisation that works predominantly with issues faced by refugees and migrants experiencing trauma.

The Community Education Presentations for each Cambodian group were delivered in a package of either three themed separate sessions, or in one longer session with the three themes included. The delivery approach was very much directed by the advice from the Groups' Leaders and the Groups availability of time.

The Cambodian Project Worker developed community education sessions based on three themes identified through the process of community consultation. The topics included:

Session 1: *What is Mental Health/Illness and Where to get help?*

Session 2: *Self Care – Complementary Therapies*

Session 3: *Bad dreams, Problems with Sleeping and Too many worries – Post Traumatic Stress.*

The Polish Mental Health Project Worker organised a series of sessions (three themes repeated in two different locations) dedicated to the needs of carers. Given the Polish community's ageing profile, this was a group identified to be in need of increased awareness about mental and physical wellbeing, the services available, and relaxation techniques.

- Development of brochures about the project in English and the relevant community languages.
- Developing community education sessions through utilising existing resources, including: "Stigma Reduction in Ethnic Communities" by QTPU.

Stage 4: Networking

- Developing links with relevant mental health service providers.
- Active participation in relevant networks.
- Promotion of the project amongst community and mainstream service providers, through mail out to: Primary Care Partnerships (31), rural and metropolitan areas of mental health (over 200 organisations), community based general practitioners and mental health professionals who spoke the relevant community languages, as well as religious representatives.

Stage 5: Community Education Sessions

- Delivery of community education with relevant mental health service providers and registered mental health professionals.
- Delivery of cultural briefings to a range of community service providers working with CALD people with a range of mental health issues.
- Utilising ethnic media to raise community awareness e.g. newspapers, newsletters, radio interviews.
- Distribution and promotion of translated materials.
- Organizing community events, including a theatrical production about mental health.

Stage 6: Evaluation

- The number of community education sessions conducted.
- Collection of verbal feedback and feedback from questionnaires assessing the level of satisfaction.
- The number of enquiries regarding mental health services and information about mental health throughout the duration of the project.

Perceptions of Mental Health in the Selected Communities

Arabic-Speaking Community

Community Profile

The Arabic-speaking population in Victoria is the most diverse community represented in this project in terms of religion, language and age. It is made of over 41,000 people of both Christian and Islamic denominations coming from different countries, which are members of the Arab League of Nations, where the official language is Arabic. The League includes: Lebanon, Egypt, Iraq, Syria and some newly emerging African communities such as Sudan. The Arabic-speaking community in Australia is overall a very young population, with nearly two-thirds of Arabic speakers under the age of 35 years.

Some of the main mental illnesses identified in the Arabic-speaking communities include: post traumatic stress disorder (PTSD), depression, anxiety, self-harming behaviours and schizophrenia. In particular, newly arrived migrants and refugees coming to Australia from war-torn countries are often at increased risk of developing mental health issues as a result of past traumatic experiences. Mental health issues extend across all different age groups in the community, ranging from the young to the elderly.

In this community, mental illness is viewed in negative terms, with the resultant stigma significantly impacting upon the whole family. Similarly to other CALD communities, the Arabic-speaking population has little knowledge about available services, and is not accessing them until the situation reaches a stage of crisis. The Victorian Arabic Social Services (VASS) is often the first resort for assistance for those with complex mental health issues, providing a range of services to the newly arrived and refugees.

Discussions conducted by VASS staff on perceptions of mental health in the Arabic-speaking Community identified mental health issues as a main thread that links its members together. The community is also characterized by its reluctance to seek professional assistance, which can be attributed to a number of reasons, including:

- Stigma surrounding the person with the mental illness and their family members;
- Shame that the individual or family will experience;
- Lack of awareness of mental health illnesses and mental health service providers; and
- 'Traditional and cultural dependency on other sources of help such as family, religious leaders, traditional healers and local Arabic-speaking doctors' (Mackie, 1982; Minas, 1996; Sharon, 1992; Tobin, 2000).

Outcomes of the Focus Groups

The results of focus groups conducted with VASS staff members observed the following perceptions of mental health issues in the community:

HACC Programs Coordinator:

“Mental health is like cancer, people do not easily discuss the diagnosis. They fear the stigmatization not only to themselves but to the other members of their family.”

Family Services Coordinator:

“Mental health is seen as a form of weakness in the community, there needs to be more research undertaken and more funding available for services that can help the individual and the family.”

Family Violence Project Officer:

“Mental health is not really taken seriously in the community. Unless it is affecting them physically they won't seek help. Depression is not seen as a mental health issue, people think that it has no affect on the person physically therefore it must not be that bad.”

Youth to Work/ Education and Employment Coordinator:

“Some young people won't even take their medication as needed because they are afraid of what their peers will think about them. They don't want to be labelled as 'crazy'. I found that in group settings girls find it easier discussing mental health issues than boys.”

Employment and Settlement Officer:

“Everyone seems to know each others' business in the community, people seem to be more sensitive towards mental health and find it difficult to even use certain terminology such as the word “counselling”; people get defensive.”

Cambodian Community

Community Profile

The majority of the Cambodian community arrived in Australia as refugees subsequent to the Pol Pot regime in the 1980s. It is estimated that there are 10,000 Cambodians residing in Victoria, predominantly in outer southern (Dandenong, Springvale), northern (Epping, Northcote, Broadmeadows) and western suburbs (Altona, Laverton). Due to past war-time experiences, post traumatic stress disorder (PTSD) remains the most prevalent issue in the Cambodian community.

Many Cambodians believe that great shame is brought upon a family by one of its members becoming mentally ill or emotionally disturbed. Severe emotional disturbance and mental illness is usually attributed to either being possessed by malicious spirits, bad karma from misdeeds in past lives, or to inherited bad luck. Mental illness is usually denied and feared. Families may try to deal with any mental illness “in-house” in order to avoid outsiders becoming aware of any problems. People who talk about their mental health problems risk being ostracised by their family and social networks.

Consequently, many Cambodians are reluctant to use mental health services, or delay seeking care until disturbed family members become unmanageable. In addition, a lack of English proficiency, inadequate knowledge and awareness of existing services, and cultural differences in the assessment and treatment of mental illness, are all additional barriers to utilising the mental health care system.

Outcomes of the Focus Groups

Focus Group Participants:

The Cambodian Elderly Focus Group comprised ten community members (two males and eight females), with ages varying from late 50s to early 70s. This meeting was held at the Cambodian Association of Victoria’s Community Hall, Springvale. The Cambodian Families Focus Group comprised nine community members (two males and seven females), with ages varying from early 30s to early 50s, and all of whom had children. This meeting was held at the Dandenong Citizens Advice Bureau, Dandenong. All of the participants’ first language was Khmer, and they resided in the Southern Metropolitan Region of Melbourne.

Themes:

Limited Understanding about Mental Illness

Most participants had limited understanding of the different types of mental illness.

Comments included:

“Not normal thinking or working of the brain in the person.”

“It is a problem of many thoughts in your head. These many thoughts in your head will cause the lack of sleep, being upset, really sad.”

“They have unusual behaviour, easy to get angry which is unusual for that particular person.”

“Not reasonable what they say or do.”

“Aggressive.”

When it came to explaining the Cambodian community’s meaning of mental illness, the majority of participants believed that mental illness is associated with bad spirits, bad karma, witchcraft or upsetting ancestors. Many comments included:

“Cambodians see that problems of the brain like this have to do with the spirit of the ancestors being upset with someone in the family. The ancestor makes the person upset. That’s why it comes to your family.”

“Many Cambodians believe that the spirit of the land or water has taken over the person because the spirit is upset.”

“It is a bad karma of the person who has got this illness.”

“Someone has used witchcraft on you to make you ill like this....It maybe that the spell went wrong to you or it backfired onto you.”

Many participants agreed that the Cambodian community’s attitudes towards mental illness are not the same as other illnesses such as heart disease, diabetes, asthma etc. Some of the comments included:

“In the community not many people say they have mental illness or any of their family has it. You worry people look down at you. If you say to people you have heart problem or something like this then people say yes I know someone or it happen to me. They not feel shame with this.”

“They are more worried about mental illness. If they go to see the doctor about their illnesses such as heart disease, diabetes, asthma etc., the doctor will prescribe them the medications to take and so on. They then follow the doctor’s orders and their illnesses will be improved and be in control. However, if they go to see the doctor about their mental illness,

the doctor will prescribe them the medication to take to help them to sleep all the time. These tablets make the person worse because they don't do things at all anymore. This is worse."

Most participants said that it is dependent on the level of the mental illness as to whether it is curable or not. Comments included:

"Yes it is curable for the less severe mental illnesses."

"We know someone ill like this and when they get to hospital and see doctors they got better but never the same as before. Like it changed the person, they look not well, not talk to you fully. They are 50% not 100% any more. Hard for the family."

"Like when the mirror is broken you cannot have a good mirror to look at anymore."

Stigma in the Cambodian community

The majority of participants agreed that the Cambodian community generally believe that great shame is brought onto a family by one of its members becoming mentally ill. Comments made included:

"I think people feel shame. I know one family and they not tell us, they not come to our house for a long time for this reason."

"No one wants to say they have this problem. It means that you can't look after yourself properly or you not look after someone properly."

"You feel ashamed to let anyone know your family has this problem. Because you worry not only for that person who has the problem, but it can mean it is not easy for the other siblings or relatives to get married as well. People would think that if you marry to that person or that person's siblings or relatives it is in their breed. So stay away from that breed."

Many of the participants said that if they lived next door to a person with mental illness they would feel sorrow, empathy or offer support. Comments included:

"I would feel sorry."

"We know what it is like to have something in the mind not well. Try to help if only they accept. We know that delicate situation for the family."

When asked if they would continue to be friends with someone that suffers from mental illness, the majority of participants stated that they would continue to do so. Comments included:

"Yes, in fact feel more sorry."

"Yes and help them somehow. Go to visit them."

Where to Get Help when Needed?

Participants identified a range of sources they would possibly access if they were to seek help with a mental illness. Some participants felt they would choose spiritual healing through a local Cambodian Buddhist temple and Cambodian monks, or a Christian church and priest. Other participants felt they would either liaise with their local doctor or seek their family's support, or use both Western medicine and Cambodian traditional methods. Comments included:

"If I had this problem the first thing that would come to my mind is the Cambodian Buddhist Temple and to get help from the monks."

"I have many illnesses and worry very much before. I feel better now because I go to Church and see my friends and I pray. I would say to people who are Christian to go to Church too and this can help them like me."

"Go to your GP."

"Ask family for help with getting help and looking after the person [who is] ill."

"Try Cambodian and Australian ways, nothing to lose for the family."

Barriers to Mental Health Services

The majority of participants lacked knowledge about mental health services, particularly in relation to the types of services, different treatment options, and the location of services. As well, participants did vary in their opinions about mental health services. Some participants had doubts about their usefulness, while others believed that the services were helpful but there needed to be an enhanced understanding about the culture of Cambodians. Comments included:

"Yes, they can help people, the mental health services, but maybe they not know about Cambodians, how hard our lives and our ways. And to help us not just Western ways but traditional ways too. Traditional ways can help too. We know people it help too."

"These mental health services do not understand how to treat us Cambodians. Like they not understand our traditional beliefs."

"I know a family that has a daughter who has had a mental illness. They got for this young woman help through medicine and electric shock to the brain from the mental health services in the Dandenong area. The young woman condition has improved, however she is still not 100% well."

"I know one family, the wife of my nephew. She was not well mentally. She received treatment from mental services here but not help her. So they took her to Cambodia to see if they can find traditional Cambodian healer. She still there and it help her."

“Yes we heard very useful to have the mental health services but we have no idea of where they are and what we can get to help us.”

“The problem I see is that when they give the tablets to the mentally ill people they make them sleep too much. How can this help them? They make them more ill. I seen this with my own eyes with a friend we know.”

Limitations:

It should be acknowledged that whilst valuable feedback was gathered by conducting the focus groups, there were a number of methodological limitations. The gathering of information from the Cambodian community through Focus Groups was largely limited by the amount of time and resources available. Due to these restrictions, it was not possible to conduct consultations with a range of Focus Groups such as young people, groups comprising only women or men etc.

Additionally, the Cambodian Families Focus Group was formed for this consultation only. This made it initially difficult to openly engage and gather information from participants. Many of these participants did not know each other previously and they did not regularly participate in such group oriented activities. Approximately half of the consultation session time was devoted to making the participants feel comfortable in offering their opinions in an open and frank manner. In contrast, by working with an already established group (Cambodian Elderly Focus Group), it did assist in gathering information, as it was attended by those members of the Cambodian community who were comfortable in group oriented activities. With this already established group there were accepted group dynamics and norms already in place.

Another limitation was that there are people in the Cambodian community who are either isolated and cannot attend a group, or who do not like the group format. The real challenge for future consultations of this kind is to gather information from people who are not involved with groups in the Cambodian community.

Through observation and reflection, the Cambodian Project Worker concluded that mental illness is generally a sensitive issue in the Cambodian community. This heightened sensitivity presented itself through people not wanting to participate in the Focus Groups either because they do not have a mental illness, or concern that if they did attend they would be labelled by others as having a mental illness. Those that did attend the group sessions appeared to be hesitant to openly discuss their experiences of mental illness. The reasons for this apparent hesitation appear to be related to the perceived stigma attached, the traditions of the community, as well as sensitivity to criticism from inside and outside the community.

Nevertheless, by holding the Focus Groups as sub-population groups, provided the means of obtaining a ‘snapshot’ of specific sections of the community For

example, obtaining the views of the elderly, as well as families, necessitated adopting a different approach for each.

Finally, it must be acknowledged that the use of translation services to obtain a community's views may compromise the reliability of the data. However, every effort was made to ensure accuracy of understanding when translating the Focus Groups results from Khmer into English.

Conclusion:

The two Cambodian Focus Groups clearly demonstrated the level of stigma surrounding mental illness, and the very limited understanding about the issue in their community. It also highlighted the importance for Cambodians to utilize religious and traditional methods in seeking help with a mental illness. One element of particular concern was the general lack of understanding about mental health services, particularly the types of services, treatment options and service locations. One positive recommendation was made towards mental health services needing to better understand the Cambodian culture.

The findings may also apply to the broader Cambodian community. It would be of great benefit if a particular strategy was adopted to try and understand more about the issues that are of greatest concern to them, particularly stigmatization, while also facilitating opportunities in the community for Cambodians to learn more about mental illness and mental health services.

Chinese Community

Community Profile

According to the 2001 census, there is an estimated 37,000 Chinese-speaking people living in Victoria.

In relation to the perception of mental health in the Chinese community, most people follow a traditional model based on Chinese medicine, which attributes illness to be the result of negative energy and imbalances within the body. Therefore, mental health is not viewed as being an intractable problem. Nevertheless, there is a strong sense of shame attached to the whole issue of mental illness, which often delays the process of seeking professional help until the illness is regarded as "acute" or "very serious".

In general, people in the Chinese community appear to have a limited understanding of what mental health may involve, but acknowledged that they, and the community in which they live, to a large degree, lack knowledge and understanding of the issue. For instance, whilst most people were able to classify a few illnesses as being a mental illness, their responses were limited to the following: fear, mental disorders, mental deterioration, depression and

schizophrenia. As well, the perception of mental illness in the Chinese community appears to be heavily influenced by the media and often associated with violence and harm caused to oneself or others. This perception is further reinforced by peoples' assumptions and stereotypical views of the mentally ill as being violent and causing harm and injury.

Outcomes of the Focus Groups

The focus groups conducted in the Chinese-speaking community revealed that, overall, the community's understanding of mental illness is very limited and heavily influenced by the media. Whilst many agreed that the Australian Government is generous with general health care, they felt that an insufficient amount of attention has been allocated to mental health patients and community education. Listed below are the key findings obtained from some mental health professionals, as well as participants from the MMHP focus group meetings.

The link between the severity of the condition and harm/violence

The viewpoints of some psychiatrists, as well as the views gained from the majority of participants attending the two focus group discussions, related to the level of severity of a patient's mental illness, with the likelihood of him/her causing harm or injury to others. In other words, the relationship found is as follows:

The higher the severity of mental illness, the more likelihood of the person being harmful/violent.

One of the key reasons attributed to this relationship is the influence of the media, whereby the mentally ill are often portrayed to be violent, extreme and unpredictable. This is an important finding, as it highlights the Chinese community's automatic stereotyping of mental illness with violence. Whilst the community acknowledges that this relationship may not hold for all mental health cases, they have nevertheless automatically made the link between mental illness and harm/violence. These findings highlight the fact that there is a lack of knowledge, understanding and awareness in the community regarding mental health issues and its implications.

People with mental illness are differentiated in the community

Due to the automatic link between mental illness and harm, many people agreed that the community cannot accept mental illness in the same light as other illnesses. Consequently, a person with mental illness is likely to experience discrimination and differentiation in the community, particularly if his/her behaviour suggests that he/she may be harmful to others.

When participants were asked whether they would fear, and be cautious towards a person with a mental illness, most replied “yes”; especially if the person’s behaviour convinces them of violence and harm.

Lack of knowledge, understanding and awareness towards mental health issues

Whilst the Chinese community agreed that the Australian Government has allocated a generous amount of funding to the health care system, they also felt that there was a lack of attention towards educating the community, and the treatment of those with a mental illness. These views were reinforced by the participants’ limited understanding of the different types of mental illnesses, as well as the assumption that all those diagnosed with a mental illness are violent. It was felt that the media’s biased portrayals, together with a lack of education campaigns concerning mental health, as the key reasons for the lack of knowledge and understanding, resulting in the mentally ill being feared and isolated by the community.

In conclusion, the views of some mental health professionals, as well as feedback from the focus group meetings, revealed the biased attitudes of the community towards mental health issues. Increased knowledge, understanding and awareness are urgently required, in order to support those with a mental illness who are impeded in their recovery.

Macedonian Community

Community Profile

The Macedonian community in Victoria is estimated to be around 33,000, with the highest concentration of the population residing in the north-western suburbs of Melbourne.

The Macedonian community is one that faces specific cultural stigmas associated with mental health. In particular, lack of education, knowledge and access to information being the major contributors to this problem. The initial catalyst to this stigma appears to be the Macedonian community’s lack of understanding of the issues involved with mental illness.

The majority of the Macedonian community does not view mental illness as an authentic illness, but more as a burden and a source of shame to the family. There is a belief that the individual, or the individual’s family, are to blame for the mental illness.

Additionally, many people within the Macedonian community are unaware that there are some preventative measures that can be taken to prevent potential mental health problems. As well, the fear of being negatively judged by others in

the community often leads to denial about the illness. This results in those affected by mental illness either hiding away, or hiding their emotions, creating greater problems for their own physical and mental health, as well as creating potential problems for the next generation.

These issues outlined ultimately contribute to those most needing help, not looking for it, and not knowing where to look for it. They need to be aware how and where to access help and treatment, and just as importantly, be reassured that seeking help is not a source of shame.

Outcomes of the Focus Groups

Sessions with the two focus groups were conducted in order to get an insight into what the Macedonian community understood about mental health and the potential stigma attached. The two groups comprised Macedonian-speaking youth, and Macedonian-speaking senior citizens. Each focus group was conducted on different dates and in different locations, with the questions used in the sessions remaining unchanged.

Understanding

Although both groups had an understanding of what mental illness is, it was evident that the youth were more knowledgeable on the matter in comparison to the seniors. The youth often only referred to depression and schizophrenia as mental illnesses, whereas the seniors were only aware of dementia as being a mental illness. This would appear to be due to first-hand experience. One similarity between the groups was that certain participants held extreme views concerning depression. For example, one member of the youth group viewed it as simply a social condition, while some members of the seniors' group believed that the only "real" cure for it was shock treatment therapy. Also, there was a highly spiritual and religious relationship attributed to mental illness by the seniors, whereas there was a more scientific approach attributed to mental illness amongst the youth.

When asked if mental illness was viewed as an illness like any other within the community, both groups responded in the negative, although within the seniors' group, some stated that it was dependent on the particular individual. The youth viewed society and other outside sources as the major reason for mental illness, whereas the seniors believed that the closeness of their community, as well as certain individuals were the cause.

When the participants of both groups were asked whether there was a cure for mental illness, there was a marked difference of opinions. The youth believed that there was only a cure if the illness was detected early, but there was no indication of what they believed that cure to be. The seniors, on the other hand,

indicated that they were aware that medication was the cure, although one of the participants responded by saying that “*death was the only cure*”.

Stigma

Both groups agreed that there is stigma associated with mental illness within the Macedonian community. The youth believed that lack of knowledge and education were the major factors that contributed to this stigma, whereas the seniors believed that there was just not enough support from the community.

Amongst both groups, it was clear that they believed mental illness was a phenomenon not accepted by the Macedonian community, and at times, even by oneself. Mental illness brings shame and embarrassment to the family, and people hide away rather than seek help, for fear of what people will think and say. Amongst the youth, it was felt that if a person was to feel pain in their stomach, for example, then the person would go to the doctor without any hesitation. By contrast, if that person felt there was something mentally or emotionally wrong, then he/she would hesitate asking for help, and more than likely, ignore the problem altogether. They also brought up the issue of religion and superstition, stating that a lot of the time, people believed that going to church and being forgiven for one’s sins would cure the illness. This was not even a topic of discussion with the seniors, possibly because it was an assumed belief.

When asked how they believed their own families would react if someone close to them was to be diagnosed with a mental illness, participants in both groups believed that they would be supportive. One member from the seniors’ group, who had been in that position, confirmed this to be true because she had received much support from her family when faced with the illness.

Treatment and Access

The first question asked of participants in relation to treatment and access was whether they believed that they would be able to identify someone living with a mental illness. Surprisingly, it was the youth who believed that they would not be able to identify it, and that they would simply “brush off” the sadness or distress as just a bad day. The seniors on the other hand, were quite confident that they would be able to spot the symptoms, and would possibly even be able to identify a mental illness just by looking into someone’s eyes.

When asked where they would go for help, the seniors immediate response was that they would go to the Macedonian Community Welfare Association. The youth on the other hand, were not even aware of the existence of the organisation. They commented that they would initially go to a friend or sibling,

but would not go to a parent, because they believed their parents would simply ignore the issue, for fear of what people might think if it turned out to be a serious issue. Both groups also mentioned that they would go to their general practitioner (GP) for assistance.

Overall, the respondents in both focus groups enabled the facilitators to gain a brief overview of the perceptions of two completely different generations of people within the Macedonian community, as well as gaining an understanding of the extent of knowledge and education they possess in relation to mental illness. It was concluded that there is a large stigma associated with mental illness within the community. However, the fact that the people in this community still had a sympathetic approach, and a willingness to understand the illness, was a positive outcome. It was interesting to see the difference in knowledge and opinion between the two groups. The generation gap between the two groups may have played a major role. It appeared that the seniors were highly knowledgeable on the matter, in contrast to the youth group. The overall conclusion drawn from these two focus groups was that education and easier access to information and services are the key issues that need to be addressed, in order to demystify the stigma associated with mental illness.

Polish Community

Community Profile

In 2006, the Australian Bureau of Statistics (ABS) reported that there were 52,253 Polish people living in Australia. There were 18,073 Poles in Victoria alone and 7,062 of them were 65 years and older. The Polish elderly comprise Victoria's fifth largest ethnic elderly population and the second largest non-English speaking population aged 85 and over. In addition, the percentage of members of the Polish community who arrived as refugees to Australia is the highest in comparison to other ethnic groups (Drozd *et al* 2004).

Most of the Polish migration to Australia occurred in two waves. In the early post-World War II (WWII) period, predominantly between the years of 1947 and 1953, an estimated 60,000 Polish persons arrived as refugees under the Displaced Persons Program. During WWII, Poland was occupied by Germany from the west and Russia from the east. Over three million Polish Jews and one million ethnic Polish people died in German concentration camps, and it is estimated that six million Poles died in total during the war years. Furthermore, many Poles had no home to return to due to the changes in Poland's borders following the war (Drozd *et al* 2004).

The second main wave of migration took place in the early 1980s. Close to 16,000 people arrived in Australia seeking escape from martial law and the communist regime of that time. Whereas the former group of immigrants was

comprised of people whose lives were significantly disrupted before arrival as a result of WWII, in terms of family ties, education and employment, a significant percentage of the latter group was comprised of young families and adults who had attained post-secondary education, and who had practiced their professions in Poland. Upon arrival, the level and quality of formal assistance with resettlement and English that was available eased the settlement process, in comparison to the absence of such help in the 1940s and 50s (Kokanovic *et al* 2001).

What do we know about mental illness among members of the Polish Community?

Research conducted by Evert (1996) through the VTPU identified that Polish people were over-represented in admissions to psychiatric facilities, in comparison to other CALD communities. In addition, Polish born women in the over 65 year age range have significantly higher contact per capita with community mental health services, than their Australian born counterparts, as well as Polish born men in the same age range. The older age and accompanied age-related illness (e.g. depression, dementia: Alzheimer's disease or multi-infarct dementia), combined with the refugee status of earlier immigrants, may partially account for this over-representation of the older Polish migrants in mental health services (Drozd *et al* 2004).

In a study conducted by Mackiewicz (1996), exploring the impact of WWII on the lives of post-war Polish migrants, it was suggested that there was a presence of hidden grief and loss among that group. Despite their efforts to forget the past, the participants indicated that they still remember and have dreams about the war, which result in sadness. The study could not measure the extent of clinical PTSD, however, its findings suggested that some of the symptoms were present.

Moreover, cross-cultural studies of suicide rates in Australia indicated that several of the overseas-born groups, including those from Poland, have a higher risk of suicide than their Australian born peers (Drozd *et al* 2004). In 2001, the ABS reported that on average in Victoria, every second month, a person of Polish background would take his/her life.

As well, a study conducted by Australian Polish Community Services (APCS) examining the prevalence of depression in the Victorian Polish community noted that depression is highly prevalent, with 32 per cent of respondents identifying as experiencing depression. Moreover, the study noted an evident lack of awareness about available services, with 52 per cent of respondents not being aware of any services that they could access, and 30 per cent indicating that they would seek assistance from their GP.

Outcomes of the Focus Groups

The participants in the first focus group comprised ten Polish-born women aged between 40 to 60 years. They varied as to their length of stay in Australia (on average 20 years, some newly arrived), socio-economic background and family composition.

The second group comprised eight Polish-speaking seniors (three males, five females) aged between 70 to 80 years. They varied as to their socio-economic status, level of education, and family composition (mostly married, de-facto or widowers).

The two focus group sessions were conducted on different dates and at different locations.

Focus Group 1

Schizophrenia, mental deviance and mental retardation were listed as the most prevalent mental illnesses within their community. According to the participants, mental illness often results in “dumbness”, distrustfulness, and dissociation from the wider environment. The person affected by the mental illness does not reach developmental milestones, and is often characterized by nervousness, uncoordinated moves and thinking patterns.

Participants varied in their opinions of people affected by serious mental illnesses:

“People suffering from schizophrenia are sometimes quiet and isolated from the people. The person thinks that he/she is not liked by the others and is shutting down from the outside world. Slowly one can turn into a violent psychotic person e.g. rapist. However, sometimes a person suffering from mental illness can be very intelligent and has strong preference towards living in one’s own world.”

Participants held the belief that depression does not classify as a mental illness. They appeared to be very familiar with the illness and its symptoms due to their own personal struggles or stories of family members or friends. Depression was described as “dullness and isolation”. Participants also emphasized feelings of loneliness associated with the illness:

“One wants to go through it on their own but it may take long and not everyone has enough persistence to fight it. Some will win and recover from it but others lose. This explains high rate of suicides.”

It was noted that in today’s society, when critical situations arise, people have to rely mostly on themselves, and only occasionally on their close family members

or friends. The general impression conveyed was that if one is in trouble, people are not very willing to help because in today's world people are very busy and do not have the time or energy to look after others. If someone falls into depression (or as described by the participants, lower mood), he/she may not be detected in time to prevent the development of serious mental illness.

Additionally, a lack of personal relationships and supports were also attributed to a more consumer-oriented and secular way of living in Australia, which, in turn, contributed to the onset of mental illness. According to participants, the more conservative and pro-family oriented Polish society, where church and family networks play an important role, served as important protective factors against developing mental illness:

“Here in Australia Polish people are isolated because of the long distance from their country of origin. Also the Australian multicultural society does not support/encourage strong interpersonal bonds because there is a lack of support for the cultivation of tradition and culture and strong family links. As a result of it the interpersonal links are much weaker e.g. children do not visit their parents. In the participants’ view, in Poland family links were much stronger and people did not suffer from depression. This provides an explanation as to why the profession of psychology remains unrecognized by the community.”

According to the participants, people are slipping through the networks of society, unless they have dedicated family members or friends who are able to prevent the deterioration. The participants felt that the dedication of friends, and their persistence and willingness to be around a person with depression as being the most valuable sources of help:

“Friends rather than (mental) health specialists are more effective combating problems such as depression. However, good friends are people very rare to find (“wsrod serdecznych przyjaciol psy zajaca zjadly”). When people are doing well in life they are not interested in helping “those who are losers”. They do not want to stick around someone who is a failure and therefore in critical situations, such as a diagnosis of mental illness, people affected by it and their carers rely mostly on themselves.”

Participants also identified divorced people as being at increased risk of being affected, primarily because of exclusion from their community. As was noted:

“Divorce still remains a sort of taboo in the Polish community and people often do not know how to behave in its aftermath.”

People financially disadvantaged as a result of different life situations were also identified as being at increased risk of social isolation, as *“they do not have money to go out or to invite people”*. Furthermore, it was noted that women (including those divorced) are even further disadvantaged financially. Residents

of aged care facilities were also identified as directly affected by the issues of social isolation and subsequent depression.

According to the participants, the environment may have a negative impact on the individual, causing stigma and creating negative connotations attached to the illness (*"ja jestem psycholem a ty jestes rabnieta"* meaning *"I am psychotic and you are loopy"*). This belief seems to, in part, derive from their country of origin (Poland), where as noted: *"people seeing a person suffering from a mental illness made him/her look more retarded than he/she really was"*. Mental illness, as with any other form of disability, has been traditionally been viewed in Poland as a personal weakness and failure.

It was also felt that a friendly approach and support from others as being important aspects in helping to break the barrier of stigmatisation, and stopping the person from being further marginalized. As well, the perceptions of others were viewed as significant factors in the progression of the illness.

Barriers to Services

The participants felt that support in combating mental illness is generally expected from peers, close relatives and friends.

Although GPs were identified as the first resort to seek help, there were divided opinions as to the level of effectiveness of treatment provided by GPs. Additionally, although several participants admitted to utilising professional mental health services, it was noted that there is still an element of stigma attached to seeking assistance from this profession. People appeared to be mistrustful towards utilising counselling services. Some expressed the belief that *"psychologists have power to permanently affect one's way of thinking, which subsequently leads to losing control over one's life"*. Other sources of support mentioned included, religious representatives, followed by community organisations (including APCS).

However, it was noted that those with a mental illness may find it difficult to access available services, with language being the main obstacle. Language barriers inhibited interaction between people – for example, *"if you are Polish and do not speak English well, your interaction with your neighbour who is, for example, of Chinese background is limited"*. The language barrier was noted to be of particular significance amongst the elderly.

Attendance at church and the role of religious representatives were recognised as a strong protective factor, not purely for spiritual reasons, but also because it facilitated social networks. In the view of participants, church provides an important role to those in need of social support through creating social networks, its welfare role, organising tours and meetings:

“This, even more than the belief system, helps people to get by and find a point of reference in their life. It also provides them with motivation to get involved and be a part of the community.”

Participation in meetings held by Senior Citizens Clubs was also noted to play an important role in supporting people with their dilemmas, as they provided a platform for discussion.

Furthermore, finding a hobby was identified as an important factor in redirecting one’s mind onto more optimistic pursuits, and becoming involved with a group of people with the same interests.

Finally, education, environment and social networks were also listed as important protective factors in preventing the development of mental illness.

Focus Group 2

The participants of the second focus group belonged to a group of WWII survivors. They viewed their weekly attendance at the Senior Citizens Club meetings as the main source of social interaction. The club was also described as a hub of information (information sessions organised by service providers and ethno-specific agencies) and entertainment (bingo, social dances, festivals etc.).

According to participants, their generation is specifically affected by mental illness because of the war-time experiences most of them endured during their youth. They experienced torture, displacement, placement into slave labour, and separation from family and friends. These experiences not only had a permanent impact on their perception of the world, but also influenced their coping abilities. As a result, many believed that their personal aspirations, education or career choices were significantly compromised.

The participants believed that their life would be much happier and better had they not have gone through those traumatic experiences, which have left them disillusioned about their future choices. *“A person remains silent and angry; constantly seeks someone that would provide one with answers, provide some support.”*

In some cases the experiences of the past have left permanent scars. Many of them have stopped going out and socializing (*“dziczeja” “the people are becoming loners”*), and spend much of their lives re-living their sadness and sorrows.

Generally, the participants understood the concept of mental health, and were aware of the prevalence rates of mental illness. It was evident that mental illness was viewed as a sign of personal weakness and inability to cope with life. It was

noted that: “one should be strong to combat mental illness or any other misfortunes”. However, it was also noted that: “it is something different and much easier talking about overcoming difficulties rather than struggling with them on one’s own”.

Participants listed different factors contributing to the development of mental illness, including: alcohol, drugs, problems at work, and divorce. Furthermore, the older participants felt that the death of close relatives or friends (husband, wife or a child) were important factors contributing to mental illness.

The group listed a number of measures one could take in order to remain active in society. For example, continuing physical activities, and keeping up social involvements, e.g. through social clubs, were mentioned as being of great importance:

“This prevents people from spending time at home on their own and wasting time thinking about the things that they sometimes have no influence over.”

General practitioners were reported to be the main source of information when in need of services.

Conclusion

Both focus groups demonstrated varied levels of understanding in relation to mental health, its contributing risks and protective factors, as well as knowledge about the available services.

It was evident that participants from both focus groups were reluctant to share their views on paper. This may have been due to several factors, including: limited level of literacy, limited insight into the problems associated with mental health, and issues surrounding confidentiality.

In both groups, verbal discussion of the issues proved to be of great benefit, providing participants with the platform for discussion and free exchange of their opinions. It was noted that participants in the second focus group (the generation of the WWII survivors) were more unanimous in their views, than participants in the first focus group, which was more varied in its profile. The participants in the first focus group also demonstrated a very different level of insight into the topic of mental health; some being more liberal in their views, others holding more traditional opinions.

Because both groups were familiar with the facilitator, it was relatively easy to engage them in discussion, establish rapport, and build a level of trust. Some participants related to the stories of people from their direct environment, who had experienced a mental illness, which subsequently led to suicide.

Furthermore, some participants appeared to have a strong emotional involvement in others' stories, or while talking about their own experiences.

The participants were offered support and practical assistance should they require it at any time. They were advised also that in case of emergency, help can be sought directly through Polish-speaking workers at the APCS office. As well, strong confidentiality rules were kept at all times.

In conclusion, the participants of both focus groups demonstrated a fairly sound understanding of the factors contributing towards good mental health. In both groups, there was a strong focus on social connectedness as an important protective factor. This entailed cultivating close links with relatives or friends, participation in social clubs and gatherings, or belonging to church groups. There was varied understanding of the available support services. General Practitioners and religious representatives were listed as the main sources of support when in need of help. Finally, there was a level of mistrust towards mental health professionals, with the majority of participants being rather sceptical about their services.

Results

Highlights of the Arabic Project

- Two focus groups conducted with Arabic-speaking community workers, women, young people, and community leaders, to ascertain their perceptions and knowledge of mental health issues.
- Liaison with a number of key organisations in the community including: beyondblue, Moreland Community Health, Banyule Community Health Centre, ADEC and MRC.
- Promotion of the project through participation at different community events, including: Mental Health Day on 10/10/07 at the Darebin City Hall distributing promotional resources to fifty people.
- Community education sessions for Arabic and Christian women (with beyondblue), as well as an Islamic youth group.
- Engaging community through: meeting with community senior leaders (two general meetings were conducted where fifty brochures about mental health were distributed), a young leader in the Assyrian community (to discuss depression in young men and women, and by also using art therapy), and church leaders (100 brochures about mental health were distributed).
- Promotional mail-out to 44 community leaders in the Arabic and Assyrian Community (220 brochures distributed).
- Total number of brochures and flyers distributed in Arabic and Assyrian from beyondblue to community and service providers totalled 257.
- Total number of brochures and flyers distributed in Arabic and Assyrian from Multicultural Mental Health Australia to community and service providers totalled 244.
- Distributed Multicultural Mental Health Project brochures to 44 Arabic community leaders.

Highlights of the Cambodian Project

- Conducting two Focus Groups with nine to ten participants in each group: one group targeted was families, and the other was older persons.
- Liaison with over forty key professionals, including a Cambodian-speaking Pharmacist, a Cambodian-speaking Private Counsellor, a private Research Consultant, Cambodian Christian Pastors and their churches' respective Religious Leaders, Cambodian Buddhist Monks and their Temples' Religious Leaders, GPs working with Cambodian patients, and an overseas Cambodian Psychiatrist/GP.
- In addition, liaised with key staff from a range of services, including the Greater Dandenong Community Health Service, Gambler's Help Southern, South Eastern Drug & Alcohol Service, Monash Division of General Practice, Inner East Primary Care Partnership, Foundation House, Cambodian Association of Victoria, Cambodian Community Welfare Centre and La Trobe University - "Caring for older survivors of genocide and mass trauma" Project.
- Media promotion through advertising of the Cambodian Programs on Radio Stations SBS and 3ZZZ, submission of articles about the Cambodian Mental Health Project and it's community education resources in the Cambodian Community's National Newspaper.
- Project promotion at different community forums including: Kind2Mind information display at the City of Kingston's Community Mental Health Expo.
- Partnerships built with several key specialist and community organisations, including:
 - the Victorian Foundation for Survivors of Torture (Foundation House) run in collaboration with the Cambodian Project Worker responsible for the Community Education Presentations.
 - Gambler's Help Southern had assisted the Cambodian Mental Health Project through allowing their Cambodian Women's Group to participate in the Community Education Presentations.
 - the Cambodian Association of Victoria Inc had assisted the Cambodian Mental Health Project through allowing their Seniors Group's members to participate in one of the Focus Groups and the Community Education Presentations.
- Thirteen Community Education Presentation sessions were conducted, targeting over 500 Cambodian community members. Some of the groups included:

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- Cambodian Senior's Group (Worked collaboratively with the Cambodian Association of Victoria).
 - Cambodian Women's Group (Worked collaboratively with Gamblers Help Southern).
 - Family's Group (The Project Worker in consultation with the Supervisor from the Cambodian Community Welfare Centre).
 - Cambodian community's two Buddhist Temples in Southern Metropolitan Region of Melbourne.
 - Cambodian community's two Christian Churches, in Southern and Eastern Region of Melbourne.
- Approximately 500 of the Mental Health Information related fact sheets/brochures in Cambodian (produced by various organisations such as Multicultural Mental Health Australia, beyondblue, Transcultural Mental Health Centre, and NSW Health Department) were handed out to participants at the above-mentioned Community Education Presentations, and also distributed to key organisations including: Greater Dandenong Community Health Service, Cambodian Community Welfare Centre and Cambodian Association of Victoria Inc., for display at their respective workplaces.
 - Approximately 1,000 Multicultural Mental Health Project Cambodian brochures were given out to participants at the above-mentioned Community Education Presentations and also distributed to key organisations including: Greater Dandenong Community Health Service, Cambodian Community Welfare Centre, Cambodian Association Of Victoria Inc., two Cambodian Buddhist Temples, two Cambodian Christian Churches, and a Cambodian-Speaking Pharmacy in Springvale, for display at their respective workplaces.

Highlights of the Chinese Project

- Two Focus Groups conducted with a total number of 14 participants, to assess Chinese attitudes towards mental illness.
- Recruitment of Mental Health Professionals to be involved in the Mental Health Project:
 - 12 professionals including 6 psychiatrists, 2 social workers, 1 pastor and 3 psychiatric nurses.

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- Project Seminars and information sessions conducted:
 - Nine Seminars on Mental Health issues:

Chinese attitudes towards mental health in the Chinese community - Dementia, Depression, Community's perception regarding mental health issues.

Number of Participants: 520 Seminar participants plus the audience of SBS radio, and readers of Chinese newspapers.

Speakers: Dr. Michael Wong, Dr. Joseph Lee, Ming Hui (PhD), Carmen Kong, Marion Lau and Mei Yu.

Participating Groups: Boroondara Seniors Club, Box Hill Seniors Club, Caulfield Medical Centre, two Groups of Spectrum Migrant Resource Centre, Lutheran Chinese School, and Self-Help group of CHFA.
 - Participation in information sessions and community events, including:
 - Kingston Mental Health Festival – Kind 2 Mind Event.
 - Multicultural Day at the Aged Care Psychiatry Centre in Caulfield, where a presentation on Chinese perceptions of mental health was delivered by the President of the Chinese Mental Health Foundation, Marion Lau.
 - Project Promotions:
 - Interview report in Chinese Newspapers:

Topic: The Chinese community's perception regarding mental health issues.

The Interview report by Dr. Michael Wong issued in the common Chinese newspapers: Asian Media, The Same Way Chinese Newspaper.
 - Radio interviews on SBS and 3CA:

Topic: Chinese community's perception regarding mental health issues.

Speaker: Dr. Michael Wong.
 - Working relationship developed with other agencies:

Boroondara Chinese Seniors Club, Extend Family, Lutheran Chinese School, Spectrum Migrant Resource Centre, Box Hill Seniors Club, Louise Multicultural Centre and SBS Radio.

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- Resources produced and Project brochures:
 - Two Project brochures in Chinese and English distributed to many Chinese groups and displayed at Mental Health Forums. Also, the CHFA had sent Project brochures to a Chinese GP and mental health professionals.
 - Seminar flyers and handouts.
 - Power Point presentation for seminars.

Highlights of the Macedonian Project

- Information and Resources:
 - Two focus groups conducted: one consisting of Macedonian-speaking youth (7 participants), and one comprising Macedonian-speaking seniors (19 participants). A greater understanding was gained of what the Macedonian-speaking community knows about mental health and the services available. As a result, key problem areas were identified.
 - A multitude of informative resources, in Macedonian, have been gathered from the Multicultural Mental Health Foundation and beyondblue, in order to ensure that MCWA always has information available on mental health. Prior to the Mental Health Project, MCWA had limited resources available in Macedonian that could be accessed by the community.
- Networking:
 - Established relationships with Macedonian-speaking doctors and psychologists. A list has been created consisting of all Macedonian-speaking service providers (12), that will be available post-project and be accessible by all staff, in order to link people with health professionals, as required. The list is also available on the MCWA website.
- Project Promotion:
 - Three brochures have been created. The first is a brochure for service providers, containing information about the project, its aims and purpose. The second brochure is a generic brochure in English, and the third is a translation of this brochure into Macedonian. These brochures were printed in bulk, and sent out to mental health service providers, Macedonian Orthodox churches, local councils, etc., to be made available to the wider Macedonian community. Over 6,000 brochures have been distributed amongst the community.

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- Eight articles were published in the Australian Macedonian Weekly promoting the project, as well as informative articles about a range of mental health illnesses and issues. Many phone enquiries were received from both service providers and the community, not only in Victoria, but also from New South Wales and South Australia. 8,000 copies of this newspaper are delivered weekly, which means a significant amount of people had the opportunity to read information relating to mental health.
 - An article published in Golden Years magazine (publication of the Ethnic Communities Council of Victoria) about the mental health project. Number of people reached unknown. No follow-up phone calls or emails received.
 - Two radio interviews were conducted, the first based on the project aims and progress up to that point, and the second, a general informative interview about mental health and wellbeing. Many phone calls were received after the interview, with enquiries about service providers, and requests for information to be sent. The Macedonian program on SBS radio has approximately 20,000 dedicated listeners weekly, which means that a significant audience would have listened to the interviews.
 - Presentations delivered to service providers:
 - Bundoora Extended Care - four people were at the meeting, positive feedback, networking opportunities, invitation to participate in a forum at Banyule Community Health.
 - Mental Health Foundation Australia – six people at the meeting, some positive feedback, created a lot of discussion on the issues faced by CALD communities.
 - Insight – three people, extremely interested, positive feedback, very informative and raised new ideas for the organisation concerning the issues that CALD communities have to deal with.
 - Community Presentations:
 - Planned Activity Group, Hoppers Crossing - 24 people attended, some questions asked. The feedback was positive from most, with a lot of enquiries and interest on the issue.
 - Planned Activity Group, St Albans – 20 people attended, very enthusiastic to learn about mental health and wellbeing. Positive feedback, with attendees approaching project worker after the presentation.

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- Victorian School of Languages – Macedonian classes, years 9 to 11. Students were attentive, and interested. Feedback was positive, from both students and teachers, with teachers advising that they would also introduce the topic in class. Show-bags with information were handed out on the day, and there were requests for more.

Highlights of the Polish Project

- Two focus groups were conducted in the Polish community: one group of ten women (aged 40 to 60 years), and one group comprising eight Polish seniors (three males, five females).
- Community education:
 - Thirteen presentations were delivered for community members in Senior Citizens Clubs around metropolitan and regional Victoria, including: Western suburbs of Melbourne (Footscray (50 participants), Sunshine (105), St. Albans (40), also: St. Kilda (60), Reservoir (60), Rowville (150), and regional centres: Morwell (35), Ballarat (12), Geelong (40).
 - Two blocks of sessions (consisting of three themes) were delivered to Polish carers living in the South and East regions and the North and West regions of Melbourne (total of 13 carers targeted).
 - Two sessions conducted in Footscray and Rowville for Polish-speaking volunteers, providing social support to isolated elderly people living in their homes and aged care facilities across Victoria.
 - Two sessions conducted for the Polish Planned Activity Group in Sunshine (25).
 - A session was conducted for ten Polish-speaking residents at an Office of Housing property in Prahran.

Over 650 people were directly engaged by the project.

- Estimated 2,000 people targeted indirectly through the media campaign:
 - A series of five radio interviews broadcast through the Polish SBS radio, dedicated to different topics including: the overview of the project, what is mental wellbeing, risk and protective factors across the lifespan, most prevalent mental illnesses, including depression and anxiety, where to seek help, and how to keep mentally fit.

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- Three articles in English about the project in APCS newsletter, “Golden Years” by ECCV and newsletter published by Multicultural Mental Health Australia.
 - Two articles about the project in APCS Polish newsletter and the Polish national newspaper, “Express Wieczorny” (Evening Express).
 - Project promotion:
 - Mail out to:
 - 31 Primary Care Partnerships
 - 20 mental health professionals speaking community languages
 - 20 Polish speaking GPs.
 - Sessions delivered to service providers about the project, including:
 - Five presentations to Primary Care Partnerships (Bendigo, Inner South (Glen Eira and Port Philip), Bundoora Extended Care, Inner East Primary Care).
 - Presentations to mental health service providers including: Orygen Youth Mental Health Services, and Southern Health CATT Dandenong.
 - Presentations about the project and the needs of CALD communities in the context of mental health were delivered at relevant network meetings including: Ethnic Community Council of Victoria Health Committee, Mental Health Foundation Australia Advisory Committee for Mental Health Week, ISEPICH Mental Health Working Group, meetings with Dandenong and Maribyrnong local city council representatives, VTPU Workers and Carers Support Group.
 - Throughout the duration of the project there has been a noted increase in the uptake of mental health services, observed by way of an increase in the number of phone enquiries about available services (on average one per week).
 - There was a number of partnerships with mainstream organisations established as a result of the project, including: beyondblue, Prahran Mission, ADEC, Multicultural Mental Health Australia, ISEPICH, Mental Health Foundation Australia, and Carers Victoria.
 - Resources:
 - A multitude of informative resources, in Polish, have been gathered from the Multicultural Mental Health Foundation and beyondblue.

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- New resources developed: brochure in Polish about depression, general brochure about the project for service providers, and generic brochure about mental wellbeing for community members.
 - Presentations developed:
 - “Multicultural Mental Health Project description”
 - “Mental Health in CALD communities”
 - “Dementia in the Polish community” (enhanced version)
 - “Wellbeing for carers”.
 - Poster illustrating outcomes of the project “Collaborative Approaches to Mental Health Promotion”.
 - Polish Worker represented MMHP at:
 - Regional Forum organised by Multicultural Centre in Ballarat (April 2008).
 - On a discussion panel at the Kind2Mind Forum organised by the City of Kingston (May 2008).
 - Multicultural Day organised by the Aged Care Services in Caulfield (July 2008); Polish Project Worker delivered a presentation on “Dementia in the Polish Community”, which was attended by over 100 people and commented on as one of the most informative presentations at the forum.
 - A poster “Collaborative Approaches to Mental Health Promotion” was developed, illustrating the model of collaboration between ethno-specific and mainstream services applied throughout the duration of the MMHP. The poster was exhibited and presented as an oral presentation during the World 5th Conference on Prevention of Mental and Behavioural Disorders (September 2008).

Discussion

Qualitative Overview

Arabic-Speaking Community

As a result of the mental health project, VASS was able to reach approximately one-thousand people from Arabic-speaking backgrounds, including Egyptian, Assyrian, Chaldean, Iraqi and Lebanese communities. By conducting information sessions and focus groups, VASS “opened the door” for people who experience a mental illness, or those who know of someone who experiences a mental illness that need support. Through the focus groups conducted, it was found that women and young people appeared to be the most vulnerable populations to experience some form of mental illness. The most prevalent illnesses found amongst young people and women were depression, anxiety and PTSD.

In particular, it was found that depression was the most common form of mental illness among Arabic women. After attending the information sessions, some women felt comfortable enough to approach VASS and ask for a list of Arabic-speaking psychologists and counsellors. The project also identified that many Assyrian and Iraqi women were diagnosed with PTSD by their doctors. These women were brave enough to share their stories with other women on the hardships they faced as a result of the Iraq war, and the atrocities committed against their families and friends.

In terms of young people, the most prevalent forms of mental illness were depression and anxiety. Many felt that the stresses of school and home life were much to endure. The majority of the young people VASS had spoken to and met with made it clear that intergenerational conflict was a major factor in their depression and anxiety. The fact that they cannot relate to their parents and families, who have the attitudes and expectations of a different generation, makes them feel isolated and stressed. For many, migrating to Australia was a burden in terms of their identity, and was viewed as a barrier to their academic performance and general mental wellbeing.

Overall, the project was very successful in terms of its aims, and certainly raised awareness of mental health issues among Arabic-speaking communities in Victoria. As previously noted, mental illness is generally not spoken of in Arabic-speaking communities, and is seen as shameful, embarrassing and very personal. However, there are individuals within these communities who are not reticent to voice their opinions. It would be beneficial to explore further, different and creative ways of engaging these communities.

Cambodian Community

The work conducted as part of the Cambodian project demonstrated strongly the level of stigma regarding mental illness, and the very limited understanding that this community has about the issue. It also highlighted the importance for Cambodians to seek help for a mental illness through religious and traditional pathways. One concerning finding was the lack of understanding about mental health services, particularly the types of services, treatments available, and where they were located. One positive recommendation made is that mental health services need to better understand the culture of Cambodians. Services generally were viewed as not particularly responsive to the needs of the Cambodian community in terms of culturally and linguistically appropriate care.

Whilst many participants agreed that the Australian Government is generous with general health care, they also felt that an insufficient amount of attention has been allocated to mental health patients and community education.

The evaluation of the Cambodian Community Education Presentations was undertaken by the Cambodian Project Worker both prior to commencing and at the end of the sessions, through verbal dialogue with those who attended. The verbal evaluations were recorded and then transcribed in full, from Cambodian to English, with a summary of the key findings.

It is believed that the main findings may be generalized to the broader Cambodian community. In particular, it is important to recognise the stigma that surrounds mental illness, and the need to explore opportunities to engage this community further in understanding the issues surrounding mental illness and the services available. Listed below is a summary of the evaluation findings arising from the Education Presentations.

Session 1: “What is Mental Illness? and Where to get Help?”

Before the session:

Most participants had limited understanding about mental illness and the majority believed that mental illness is associated with bad spirits, bad karma, witchcraft or upsetting ancestors. Comments included:

“It’s when the person is mad and not normal behaving.”

“They get very easy to be angry.”

“Not reasonable what they say or do.”

“It is a bad Karma of the person who has mental illness.”

“Sins this person commit in a previous life.”

“They come from a family when someone in it commit very bad things.”

“Offend ancestors and spirits.”

The majority of participants generally agreed that they believe there is great shame brought onto a family by having one of its members experiencing a mental illness. Comments included:

“People like to keep secret when this problem happens in a family.”

“They are scared what other people think of them, maybe a bad family.”

“Lose face not just for ill but whole family.”

The majority of participants would try to deal with mental illness themselves, firstly through seeking spiritual healing and/or Cambodian traditional medicines, and secondly, if it gets too much for them to handle, to then go to a local public hospital. Comments included:

“I would first go to the Cambodian Monk to see advice to do and pray.”

“I go to Church and see the Pastor and I pray.”

“Try Cambodian ways of going to Cambodian and Chinese Medicine to take.”

“Go to Monash Hospital like when we get ill really bad.”

After the session:

Most participants had a better understanding about what mental illness is. Comments included:

“It’s not just when people hear voices (psychiatric illness) or speak not like normal.”

“It’s when you feel depressed, really continue to be worried.”

“It can happen to anyone these illnesses. Not just because of karma.”

“This problem is common for us Cambodians because we escape as refugees from evil Pol Pot.”

“Too hard for our lives there in Cambodia, in Refugee Camps and to live here too are hard but different hard. That’s why we can easily get these types of illnesses and bad dreams in the mind.”

The majority of participants were able to identify a greater range of possible sources to contact for help when dealing with a mental illness. Some believed they would still seek spiritual healing. However, most participants believed they would also liaise with their local doctor and Foundation House, and utilise both Western and Cambodian traditional medicine and methods. Comments included:

“If I had this problem I still go to the Temple but I see my doctor for help too.”

“I would go to Church and see my Pastor and to pray to God for help and healing.”

“Go to your GP first.”

“Try Cambodian herbs and do the coining and Australian medicine too.”

“Go to specialized place like Foundation House that can help refugees like us.”

Session 2: “Self Care – Complementary Therapies”

Before the session:

Most participants stated that they were not aware of undertaking anything in particular to maintain positive mental health and general wellbeing. Comments included:

“Not sure I do anything.”

“Don’t really do anything. Just live my life day to day.”

“Keep busy.”

After the session:

The majority of participants were able to identify that they did in fact take steps to maintain positive mental health and general wellbeing. Most participants were also able to identify additional strategies that they could attempt. Comments included:

“I do mediation.”

“I pray.”

“I meet with friends.”

“It’s good to come to groups like these as I learn something good for me and the family.”

“Go for walk.”

“Massage I like to try and maybe help with my sleeping problem.”

“Try Western Herb Medicine to help me. May be good like Cambodian.”

“Smoke and drink less. I need to do.”

“Talk to my Doctor.”

Session 3: “Bad Dreams, Problems with Sleeping and Too Many Worries – Post Traumatic Stress”

Before the session:

The majority of participants said that they have had, or are still having, recurring bad dreams, flashbacks, anxiety attacks, regular headaches, body aches,

forgetfulness, social withdrawal, intense fear, and problems with sleeping. Comments included:

"Not sure why I still have these bad dreams."

"Anything on the news about Cambodia or when they show fighting I have awful dreams for days about the horrible things I have to do when Pol Pot."

"Now that I am not working I have bad thoughts come back to me. Before I was too busy with the farm work for many years and I am too tired now my body worn out."

"I get worried too easily now and I mean very, very worried."

"I am worried and not that I am not happy but I am worried. This is strange for me. I get upset with this. Why can't I be happy like other people?"

"I get scared sometimes that my child becomes like me with this worry."

"I forget too easily. Maybe to stop thinking of bad things that happened to me and my family in the Camps and back home."

"Sometimes I go somewhere like to shops and cross the road and get scared that car hit me. But the car is too far away. I can be scared for no real reason."

After the session:

The majority of participants were able to better understand that post traumatic stress affects many Cambodians because of the impact of their experiences as refugees in Thai Camps, and survivor experiences from the Killing Fields of Pol Pot and other regimes in Cambodia. Some of the comments included:

"It makes sense what you say about this, I know so many Cambodians like this."

"I couldn't believe this that it all catches up on me now as it is a long time ago and I am not in the situation. But it is the truth this Post Stress."

"I can see I need to do something to help."

"I don't know if this talking to someone (counsellor) can really help me. To talk about my hardships again how can it help me? But I am willing to try."

Testimonies:

The majority of participants provided extremely positive feedback about the Community Education Presentations. Comments included:

"Very good."

"Informative."

"We should have had this type of things for our community before. It can save families lives."

"I feel I can go to get help. It's nothing to be ashamed about."

“It’s necessary to do something about it before things getting worse. Now I know what to do and I can tell family and friends.”

“This thing should continue for us Cambodians and there should be some group for us to meet and talk and also have people to come to speak to us on special and useful information like this.”

“Good merit for you to arrange this to help us. You have good merit for this present and your future life.”

“Now I know I am not crazy. Other people have these problems like me too.”

In conclusion, these findings from the evaluation clearly demonstrated that the Community Education Presentations created opportunities in the Cambodian community to learn more about mental illness and wellbeing, related support services, and complementary therapies, while at the same time, reducing the stigma associated with mental illness.

Model of Practice

As is evidenced throughout this Report, mental health and illness within the Cambodian community is best addressed through a culturally appropriate community development approach, including group work and community education. This model is best achieved through a partnership between the Cambodian Community Welfare Centre and the Victorian Foundation for Survivors of Torture - a specialist service working with torture and trauma survivors, which encapsulates the majority of Cambodians in Victoria.

The partnership between Foundation House and the Cambodian Community Welfare Centre has resulted in a unique model of practice, and direct outcomes for the Cambodian community, including:

- Increased understanding of and better access to the specialized Torture and Trauma Support Services of Foundation House; and
- Increased awareness about mental illness and wellbeing, related support services, and complementary therapies, and at the same time reducing the stigma surrounding mental illness.

Chinese Community

Some changes observed after implementing the projects:

- Telephone calls: more telephone enquiries were received by CHFA relating to mental health issues, resulting in information being provided by CHFA to enquirers.
- Walk in enquiries: More walk-in enquiries concerning mental health advice.
- Mental Health Seminars request: Further mental health sessions were requested by the Chinese community and also the general public.

Feedback from the Seminars:

- More people are interested and concerned with mental health issues and would like to attend more seminars, and obtain additional information on the subject. Most participants found the project interesting and requested that more topics on mental health issues be made available to the community.
- Evaluations from the Seminars:
 - Total numbers of participants: 520 (60% female, 40% male).
 - Satisfactory Ratio for the project: 95% very satisfied and understand the seminars.
 - Age group of the Seminars: 30-50 years: 35%
50-60 years: 45%
60-80+ years: 20%
 - Suggested topics for future seminars: Depression, eating disorders, the mental health system of Victoria, and mental health issues for the elderly.

Conclusion:

The MMHP has revealed that more assistance is required in addressing the increasing demand for mental health services. It is recommended that there is an increase in government funding, in order to extend services to more metropolitan areas. Therefore, prevention strategies and promotion of mental health issues are essential components to addressing these challenges. Consequently, ongoing government funding will assist in strategies to reduce the chances of those with mental health issues displaying physical violence in public, and/or preventing such individuals from self-harm.

Extension of the project:

Manningham Mental Health Network:

The CHFA participates as a new member of the Manningham Mental Health Network, and is part of the Panel on the Round Table Forum on Mental Health issues in the Chinese Community of Manningham. The target group will be extended to the broader population of Manningham Chinese residents next year.

Mental Health Funding from the Whitehorse Council (New Project)

The CHFA successfully received a minor grant from the City of Whitehorse for 2008-2009. The project's main requirements are to run seminars on mental health in the City of Whitehorse, and produce some brochures addressing mental health issues.

Macedonian Community

Some of the identified benefits of the MMHP included:

- Great introductory model to address issues that have not been previously introduced to the community.
- Covers the community as a whole, and not in sections, (such as north, west, etc).
- Information sessions were beneficial in that they facilitated more personal distribution of information, making the community feel more comfortable and open to the issues.
- Radio interviews and newspaper articles were a great way to educate the community.
- Establishing relationships with service providers was an integral part of the project, as it educated them about the issues faced by CALD communities, and influenced change within their organisations. It also linked project workers with other service providers previously unknown to them.

Reflections:

- The MMHP highlighted the need for greater education about mental health within the Macedonian community, as well as the lack of knowledge of services and help available. It also highlighted the fact that much stigma surrounding mental illness still exists within the community, and it will take much effort to get them to think differently. Unfortunately, this stigma and fear is being passed down to the next generation, and further steps need to be taken in order to prevent this.
- While the brochures produced were useful in relation to the content, they were not particularly appropriate visually for the Macedonian community. Because the photos do not appear to focus on Macedonian people, it may have deterred many from reading the information, or even picking up the brochures.

Main issues encountered throughout the duration of the MMHP included:

- Lack of funding. Twelve hours per week was insufficient time to reach an optimal number of community members and service providers. One year is

also insufficient time to make a significant difference in relation to mental health for the Macedonian-speaking community. It took some time to get the community talking about the issue, and now that the project is completed, it is feared that the learnings will dissipate, with only those people searching for assistance in critical situations, accessing services.

- Limited information available in Macedonian. Although there was some information accessible from Multicultural Mental Health and beyondblue, it was not altogether suitable for the Macedonian community, as this community writes in both Cyrillic and Latin styles, with most understanding one and not the other style. Therefore, a considerable amount of time and money was spent in creating resources.
- Timeframe of the project. The stigma associated with mental illness, is a major issue in the Macedonian community. Twelve months was clearly insufficient time to facilitate community discussion, as well as trying to educate the community about the issues surrounding mental illness.

Recommendations and Observations:

- The need for an ongoing project about mental health for the Macedonian, and other CALD communities, who currently do not have much information available.
- Creating more culturally specific, informative material, instead of having to use the current material available which is too generic.
- Support groups for people who experience a mental illness.
- More culturally appropriate in-home care. Many people that experience mental illness and receive care, do so from non-Macedonian speaking workers.
- More education about mental health targeted specifically for younger people and their needs, either delivered within the school system or through more community information sessions.
- Increased enquiries about mental illness, health generally, and available, services were received. Prior to the project, no calls or enquiries were received in relation to these issues, but as soon as the first article was published in the paper, phone calls and enquiries began. Most of these enquiries started once promotional material was received, or interviews were read or heard.
- The HACC (Home & Community Care) calendar for 2009, does not appear to have any training specifically related to mental health. There should certainly be more training available, which may act as the catalyst to promote further discussion, and the commencement of further mental health related projects.

Sustainability:

- The sustainability of the project appears ensured, with an ample amount of brochures being printed, and kept at MCWA premises, for easy access. This information is also available on the MCWA website.
- The contact details of available service providers have also been placed on the website, and to ensure ease of access and confidentiality.
- As a result of the MMHP, further projects and initiatives have commenced. The first is the play 'Fear and Shame', to be held in early 2009. This is a play, created by a Sydney theatre company, focusing on mental health in the Macedonian community. The success of the MMHP has prompted much effort into bringing the play to Melbourne.
- Another initiative resulting from the project is a Multicultural Mental Health Expo, to be conducted in the City of Whittlesea, in an attempt to educate its residents about available services for a range of CALD communities.

Other:

- In an attempt to gain a greater knowledge of the issues surrounding mental health, many training sessions were attended. For example, Stigma Reduction in Multicultural Communities conducted by ADEC, as well as Introduction to Mental Health for Non-Mental Health Workers, delivered through the HACC Training Calendar.
- Presence on the Mental Health Week Advisory Committee facilitated further promotion of the project, and the need for a greater multicultural focus on mental health. Participating in this committee also fostered collaborative working relationships with other organisations, as well as recognition of multicultural issues at the launch of Mental Health Week 2008.
- Macedonian and Polish Mental Health Project Workers participated in the Kind2Mind Expo on mental health held in the City of Kingston, by way of an information stall. This facilitated the project being promoted outside of normal target areas, as well as establishing links with other service providers.

Polish Community

The MMHP directly targeted predominantly elderly Polish residents in Victoria. The sessions were promoted through the Polish media, mainly through SBS radio.

In general, the sessions evoked interest by participants, who felt comfortable enough to share their experiences and thoughts on the topic of mental health. The topic was generally viewed as something that one does not often discuss in

public, for fear of the negative connotations attached: (*“what would you do if you have noticed that someone around you suffered from a mental illness?”* Answer: *“run away”*; *“what is mental health associated with?”* Answer: *“mental health institutions (mental hospitals; flight over the cuckoo nest)”*).

In addition, the feedback received by participants was very positive, with many expressing great interest in the topic, which was described as *“of relevance to all of us”*. Mental health was described in terms: *“everything”* and *“nothing”*, which highlights the disparities that exist amongst participants in terms of their knowledge and understanding of the issues. While some had sound knowledge of the topic and were actively participating in the discussions, others remained silent or dismissive of the topic. For some participants, the topic of mental health was related specifically to dementia (*“everything is dementia related”*), indicating a rather narrow view of the subject matter.

It was noted by many participants that it was important to talk about mental illness candidly, as it is a topic often ignored. The fact that a few participants spoke of their own experiences was a positive sign that perhaps community attitudes towards mental illness are changing. The sessions provided people with an opportunity to be more active and talk to others, without fear of embarrassment. (*“More talks like this one, less people will be embarrassed to talk about problems that are of concern to them”*). One of the reasons given for the general reticence in the Polish community to be candid about the illness, was the national characteristic of being *“very secretive”* (*“nasi ludzie sa bardzo skryci”*) and *“full of honour”* (*“honorowi”*), which in practice means that many will not seek help when in need. Therefore, the sessions were extremely useful in facilitating the process of frank and open discussion and disclosure, without fear of guilt or shame.

Main Issues:

Some of the main issues highlighted as being most prevalent in the community included: concerns related to ageing and deteriorating health status, as well as worrying about the impact of environmental issues, including pollution, and the increasing price of petrol.

Due to the Polish community’s ageing profile, issues relating to family carers were frequently discussed. Participants discussed the difficulties they have looking after their loved ones, which many found to be very challenging and confronting at times. Support was offered for those in need and many were very pleased to have the opportunity to be linked with a Polish-speaking psychologist. The majority of carers looked after his/her spouse, however, parents of children with mental health problems such as eating disorders or post-natal depression were also represented.

Those caring for their spouse with dementia, spoke of the burden of their role, particularly when caring for someone who is completely unable to perform daily living activities, and is rapidly losing his/her cognitive skills (*“they turn into evil”*; *“no-one can change them”*; *“no-one can see solution”*; *“complete desperation”*). Those carers in particular were affected significantly by the stress of their role, which in turn, appeared to prevent them from seeing a solution to the situation and seeking help*.

During the sessions, some participants shared their own experiences of mental health problems, or described situations in which they tried to help others. Some situations ended in tragedy, resulting in feelings of guilt and helplessness due to the apparent inability to provide instrumental help (*“I saw him before he committed suicide but I could not help...because I did not know what to do”*). For some, these feelings remained for a considerable length of time.

Participant Experiences:

One participant shared her experience of experiencing a mental health. She was a client well known to the agency, due to her frequent requests for services. She was also known to the agency as someone “with mental health problems” who was avoided by many in the community. She was often viewed as being aggressive and unapproachable. Betty** shared her experience of mental illness, which she described as a slow deterioration which led to several suicide attempts, and eventually, admission to hospital, where she was severely “medicalised”, with no visible improvement at the end of her stay. Her daughter was the strongest link in her environment, whose continued persistence helped her mother get through difficult times. As explained by Betty, those suffering from mental health problems need to be “pushed hard” in order to be helped. Had she been “pushed hard” at the time when it was needed, her illness may not have progressed to the level it did. As a result, Betty’s life deteriorated to a point where she lost her job, source of income, and people started avoiding her. Betty’s testimony was a very candid and realistic illustration of the journey many people with mental illness often go through.

There were also a significant number of participants who reported being depressed at some point in their life. Some felt the depression was due to past traumatic experiences, some attributed it mainly to the burden of caring for a loved one. Amongst the WWII migrants, many felt that the experience of war had *“deprived them of valuable life chances”*, which impacted significantly on their quality of life.

Furthermore, language barriers and lack of knowledge about the service system significantly deterred many participants from seeking help. When participants were asked where they seek help, most participants indicated priests and psychologists; one person said that *“he/she would go to a swimming pool”*. As noted by a Polish-speaking counsellor, participating in one of the sessions, there

is much stigma attached to the mental health profession in the Polish community. There is a strongly held belief that psychologists manipulate people's brains and leave them changed for life, to the degree that they are not able to make their own decisions, and are almost transformed into involuntary patients. Therefore, psychologists are not viewed as practitioners promoting wellbeing, but rather as charlatans that people should be wary of.

Many participants also associated mental health with loneliness: many of them were widowers, with limited social networks or sources of support. In this context, weekly meetings at a senior citizens' club was seen as a beneficial practice. Seniors' Clubs were generally viewed as community hubs, where people have an opportunity to socialize on a regular basis, and make new friendships. Additionally, the importance of having someone to share problems with, as well as happy moments, was also highlighted. It was noted that *"often people suffer in silence, while one of the purposes of the club is to bring people in need closer together"*.

As well, participants spoke freely of their own methods for keeping mentally fit. One explained that her coping skills strongly rely on four factors: faith (*wiara*), contact kept with friends, hobbies, and nature. (*"These four things helped me to get through difficult moments in my life despite many adversities."*).

In conclusion, over 75 per cent of the participants expressed interest in participating in future sessions on mental health, and considered the topic worthy of discussion at a wider forum. As well, the success of the sessions, and strong interest by the Polish community, were viewed as worthy reasons to justify the continuation of a health promotion campaign. It was felt that other related topics could be included, such as general medicine: how to take medications, where to go if in need of assistance, etc.

* Two sessions were conducted specifically addressing the needs of carers. The sessions were three hours long and focused on: overview of carers, impact of caring (physical and mental implications), mental health wellbeing, what constitutes wellbeing, most prevalent illnesses including depression and anxiety, where to seek help, and relaxation techniques.

** The name of the person was changed due to confidentiality reasons.

Feedback on Sessions:

At the end of each session feedback forms were collected. Overall, carers felt the sessions were useful, and were very positive in their comments. They felt that the most important knowledge gained from the sessions was in relation to:

- accessing services, e.g. counselling services;
- the importance of relaxation, and having time for oneself;
- gaining an understanding of the relationship between depression and dementia, and mental illness generally;
- how to deal with stress; and
- how to best help the people they were caring for (i.e. to look after their loved one, as well as themselves).

When participants were asked what other information they would be interested in finding out about in the future, the main feedback included:

- more information on this topic;
- more information from beyondblue;
- continuation of the same topic plus more information on where to seek help;
- more about diabetes, high blood pressure, arthritis (some indicated that they seek this type of information from their GPs); as well as
- more about stress, and more about communication.

All participants noted that the sessions changed their understanding of the topic and found it very interesting. Furthermore, there was a view that the information be translated into community languages.

Conclusion

The MMHP project provided an ideal opportunity to pilot a potential model of service delivery and community education for multiple communities. The project recognised the similarities of need in the five communities involved and respected the need for each community to identify and respond to their community in a culturally and linguistically appropriate and responsive way. It also provided the workers from each community with the opportunity to share skills and learn from each other, spread the workload in resource development and prevent the reinvention of the wheel which may have occurred had each organisation tackled such a project on their own.

There were a number of issues identified as a result of the MMHP, including two key areas:

- reluctance to identify mental health issues, which often results in denial about the illness; and
- reluctance to seek assistance by both consumers and carers, which only exacerbated the situation, leading to increased isolation and lack of awareness about available services.

There are a number of potential positive outcomes that may well result from the MMHP, but because of the limited timeframe, it is difficult to make any definitive statements. These include:

- increased access to the service system prior to crisis intervention;
- increased usage of funded counselling services in an attempt to reduce the risk of the conditions deteriorating;
- increased support and understanding of mental health issues within communities, thereby reducing isolation and stress related problems;
- increased prevention of the onset of serious mental health issues, through increased awareness of risk factors and more timely approaches to addressing the issues.

Overall, the project demonstrated that there is an ongoing need for educational campaigns in appropriate formats for CALD communities. Also, there needs to be better collaboration between consumers, and ethno-specific and mainstream service providers, in order to improve prevention strategies, and the provision of good quality mental health care for CALD communities.

Living with mental illness is often a silenced phenomenon for the person affected by it, as well as his/her carer(s). Ideally, it requires the implementation of ongoing campaigns, challenging the stereotypical views surrounding mental illness, together with health promotion strategies / programs specifically targeting

members of the identified communities in relation to looking after their mental health, and assistance available.

Recommendations

The findings from this project are important because they indicate significant and serious unmet mental health service needs for Culturally and Linguistically Diverse communities. As a corollary to this, there are suggestions for the effective means of responding to these needs and issues.

Recommendation 1

Provision of ongoing long-term funding to ethnic communities.

- Funding which targeted mental health promotion combined with more generic health promotion would be a strategic approach and would result in better outcomes for the health of the community. For example, health conditions such as diabetes, arthritis and chronic pain can result in social isolation, depression, anxiety and increased dependence on a range of health services, including mental health services.
- Provision of resources to undertake promotional work from a culturally and linguistically appropriate format would enable, amongst other things, prevention and early intervention and longer term reduction of preventable conditions,
- Adequately resourcing ethnic organisations would also result in ongoing de-stigmatisation of mental illness and some health conditions, increased community awareness about the available service system, development of ongoing mental health and related support groups and better provision of services.
- Collaborative approaches, such as the model undertaken in this project, should be included in funding models to enable communities with experience in mental health and health promotion to mentor and support organisations undertaking such activities for the first time.

Recommendation 2

More focus on prevention and early intervention in culturally and linguistically appropriate formats.

- This may include, for example, developing a Community Resource Guide for different communities that includes a description of mental health / counselling / community support services and complementary therapies, contact persons, their details, directions, hours of operation and costs for services.

Recommendation 3

More targeted approach by governments and funding bodies in responding to mental illness.

- This includes consideration of the needs of populations at greatest risk, such as migrants (encapsulating the needs longer term migrants and refugees along side the needs of more recent arrival groups). Broad population-based approaches to mental health must also include strategies targeted at specific segments of the population that are most at risk or have the greatest need.

Recommendation 4

More focus of collaborative work between the mainstream and ethno-specific sector. This may include:

- Improving the referral systems between services to ensure the individuals in need of assistance are responded to appropriately.
- Consultation between the sectors to support culturally and linguistically appropriate care and service provision.

Recommendation 5

Professional development for those working in the mental health sector.

- Mental health professionals need to develop a better understanding of cultural issues that influence how different communities respond to mental health issues and explore culturally and linguistically appropriate responses / approaches to treatment.
- In particular, mental health professionals need to become familiar with the stigma and specific cultural factors / belief systems associated with mental illness in most CALD communities.

Recommendation 6

Community education and the role of ethno-specific media.

- This needs to be part of any reform strategy that attempts to address CALD community attitudes to mental health and preventable health issues and needs to be undertaken in consultation with community organisations with experience in responding to the needs of their community.

Recommendation 7

The mapping of gaps in existing mainstream and culturally specific mental health services

The study identified a number of gaps for CALD groups in existing services i.e. insufficient brochures, inadequate mental health services. These gaps need to be identified and addressed. To support this process APCS will explore the feasibility of developing a *Knowledge and Dissemination Focus Group* from the mental health professionals contacted as a part of this study.

The function of this group will be to:

- Support the creation and execution of tool-kits, flyers, and information sessions to ensure evidence based and culturally appropriate knowledge is disseminated to the often silent portion of Victoria's CALD community with mental health issues.
- Survey health and multicultural services across the State to methodically map gaps in current mental health service delivery to CALD communities. This information will give an indication of areas of highest concern and can then provide the basis for a priority list of items to be addressed.

APCS will remain a catalyst in advocating for (better) mental health services in CALD communities. APCS will approach funding sources to address the next

stage of this project by advocating for a mental health professional to build on the work undertaken in this project. Some of the issues to be addressed are:

- The under representation of people from non-English speaking backgrounds in mental health services.
- Inadequate or culturally inappropriate services
- Lack of information about access to services
- Language barriers including lack of brochures, interpreters and bilingual staff
- The inordinate and serious incidence of mental illness in those people who have suffered torture or trauma or dislocation from country of origin (either long term settled refugees or more recent arrivals)

Recommendation 8

Multicultural Mental Health Agencies/Teams

There is a clear need for specialised multidisciplinary teams or services that bring together cultural knowledge with clinical expertise and language skills.

Recommendation 9

The distribution and dissemination of the findings of this report to key Government and community agencies. This report can add to the body of information about mental illness in CALD communities and may be used to raise awareness and encourage other services to build on these learnings.

Literature

References:

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