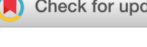

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ORIGINAL ARTICLE

Perspectives of culturally and linguistically diverse (CALD) community members regarding mental health services: A qualitative analysis

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Abstract

What Is Known about the Subject?

- Immigrant, refugee and asylum seeker populations worldwide are at high risk of mental health issues
- National mental health policies call for recognising Australian society's multicultural characteristics to ensure adequate mental health services to CALD communities
- Several barriers exist for people from CALD communities in Victoria to access and utilise mental health services
- Improving mental health professionals' knowledge of mental health service provision and cultural responsiveness can enhance CALD community access to services.

What Does this Paper Add to Existing Knowledge?

- We analysed the perspectives of people from CALD communities in Victoria regarding their needs and experiences with mental health services. Participants reported diverse perceptions and understanding of mental health issues and services
- Various challenges were identified regarding health service utilisation for the CALD community in Victoria, including language barriers, stigma towards mental health issues, mental health illiteracy, distrust and lack of familiarity with mainstream mental health services. These challenges were acknowledged by community members even after a long residence in Australia
- The data generated on the beliefs about mental health issues and consequent help-seeking behaviours highlight the importance of culturally sensitive targeted prevention and early intervention strategies and ongoing commitment to building mental health literacy in the wider community

What Are the Implications for Practice?

- The information from the study can be adapted for quality improvement and culturally responsive practices
- The strategies for effective service delivery drawn by this paper can be a comprehensive resource tool for mental health professionals, organisations and policymakers

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- The findings imply that CALD mental health service users and their families will likely benefit from improved service assessment and quality of mental health care and equity when MHNs undertake cultural competence training and bring that into their practice.

Abstract

Introduction: Victoria is one of the most multicultural states in Australia. Many CALD communities in Victoria may have encountered complicated migration journeys and complex life stressors during their initial settlement, leading to adverse mental health concerns. This diversity necessitates public policy settings to ensure equity and access in health services planning and delivery. While the MH policies and services take cultural diversity into account, there needs to be more implementation of those components of MH policies that relate to the particular needs of various CALD communities in Victoria. Even though mental health services prevent and address mental health issues, many barriers can impair CALD community access and utilisation of mental health services. Furthermore, the recent Royal Commission inquiry into the Victorian Mental Health system drives a renewed policy imperative to ensure meaningful engagement and cultural safety of all people accessing and utilising mental health services (Department of Health, 2023).

Aim: This study focused on the perspectives of people from CALD communities in Victoria regarding their mental health service needs, understandings of and experiences with mental health services to prepare an education package for mental health nurses as part of a larger multi-method research project.

Method: A qualitative descriptive design was used to collect and analyse the perspectives of 21 participants in Victoria, using telephone interviews, followed by thematic analysis.

Results: The themes and sub-themes identified were: Settling issues; Perceptions of understanding of mental health issues *(help-seeking attitudes toward mental health issues; the need for CALD community education)*; perceived barriers to accessing and utilising mental health services in Victoria (*socio-cultural and language barriers; stigma, labelling and discrimination; knowledge and experience of accessing health facilities*); experience with mental health services and professionals.

Discussion: Community participation, mental health professional education and robust research regarding the mental health needs of CALD people are some of the recommended strategies to improve access and utilisation of mental health services in Victoria.

Implications for practice: The current study can contribute to the existing knowledge, understanding, practice and quality improvement as it vividly portrays the issues of various CALD communities in Victoria. The findings of this study imply that CALD MH service users and their families are likely to benefit in terms of improved service assessment and quality of MH care and equity when MHNs undertake CC training and bring that into their practice.

KEYWORDS
CALD community in Victoria, cultural diversity, mental health issues, understanding and experiences of mental health services

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1 | INTRODUCTION

Australia is a vibrant multicultural country often portrayed as 'a nation of immigrants' (Phillips & Klapdor, 2010). However, rapid growth in migration, changes in demographic patterns, increased numbers of multi-racial and multi-ethnic individuals, and advanced technology have contributed to Australia's cultural evolution. Therefore, it is vital to recognise Australian society's multicultural characteristics to provide adequate mental health (MH) services to culturally and linguistically diverse (CALD) communities.

The acronym 'CALD' is often synonymously used with ethnic communities. It is the preferred term for many governments and community agencies. The Parliament of Victoria (2018) identifies CALD communities as people living in Australia who were born overseas or who have parents or grandparent (s) born overseas and are principally from non-English speaking or non-western countries (Fung & Macreadie, 2018, p. 7). Even though the term 'Culturally and Linguistically Diverse' background includes people from indigenous and immigrant backgrounds, this project did not include the indigenous population.

The state of Victoria in Australia is one of the most culturally diverse societies globally. One in two Victorians was born overseas, or at least one parent was born overseas (The State of Victoria Department of Premier and Cabinet, 2018; Victorian Multicultural Commission, 2020). The Australian Bureau of Statistics (2017) Census shows that Victorians are from more than 200 countries, speak over 250 languages and dialects and follow 130 religions. The proportion of those born overseas from non-English-speaking countries is 77.7%, the peak for all Australian states and territories. Moreover, Victoria has the second-highest proportion (26%) of persons speaking a language other than English compared to other states in Australia (The State of Victoria Department of Premier and Cabinet, 2017). In 2019, over 7.5 million migrants lived in Australia and 29.7% of the population was born overseas (Australian Bureau of Statistics, 2019).

Research from Australia and overseas reveals that the immigrant and refugee population worldwide are at high risk of mental health issues (Adhikari et al., 2021; Australian Institute of Health and Welfare, 2018; Bhugra et al., 2011; Brijnath et al., 2020; Chen et al., 2017; Cross & Singh, 2012; Idemudia & Boehnke, 2020; Minas, 2018; van der Boor & White, 2020). As pointed out by numerous researchers, social issues like intergenerational conflicts, acculturation and society's negative attitudes to a particular religion or faith can be stressful to the CALD community (Chao, 2012; Chao et al., 2020; Fozdar & Salter, 2019; Purnell, 2018; Torres Stone et al., 2020; van der Boor & White, 2020; World Health Organization, 2018). These factors can also hinder engaging with the broader community and forming social connections. It has been shown that CALD people in Australia have more involuntary admissions to hospitals for mental health needs (Idemudia & Boehnke, 2020; Kisely et al., 2017, 2021; Moss et al., 2019; Segal et al., 2018; Zhang et al., 2011). Similarly, refugees and asylum seekers have lower access to hospital and community MH services than the rest of the population (Adhikari et al., 2021; Lee, 2019; Minas, 2018; Schweitzer et al., 2011).

Furthermore, CALD communities receive mental health support more likely at an acute and crisis stage rather than early intervention services (Kirmayer et al., 2014; Moss et al., 2019). Several researchers have recommended more research about the barriers and service access for the diverse communities in Australia, especially in Victoria (Bastos et al., 2018; Colucci et al., 2015; Fauk et al., 2021; Federation of Ethnic Communities' Councils of Australia, 2015; Fozdar & Salter, 2019; Khatri & Assefa, 2022; Parajuli & Horey, 2019; Valibhoy et al., 2017; Wohler & Dantas, 2017; Yava et al., 2021). Minas (2018) argues that there is little implementation of the cultural diversity components of MH policies that relate to the particular needs of various CALD communities. Consequently, a lack of data reporting may have led to persistent disparities in the availability and access to MH services, quality of care and mental health care outcomes for people from CALD backgrounds. Furthermore, previous research on the CALD population in Victoria is mainly epidemiologic research. Also, there is a dearth of research inquiring about mental health service access and utilisation of CALD communities in Victoria. This study is part of a more extensive study to explore the experiences and views of people from CALD communities about mental health services. The findings have informed the development of an educational intervention for mental health nurses to improve their cultural competence.

2 | STUDY DESIGN

A qualitative descriptive design was used. Ethics approval was obtained from Federation University, Australia Human Research Ethics Committee. Due to COVID-19 restrictions, the research was amended to conduct telephone interviews instead of focus groups.

2.1 | Recruitment

Participants were recruited from various regions in the state of Victoria with the assistance of the Victorian Multicultural Commission and several community agencies, using purposive convenience sampling facilitated through social media (Facebook and LinkedIn) and flyers. The sample was taken from a group of people easy to contact or reach. Samples were selected based on participant availability. Purposive and convenience sampling are non-probability sampling techniques commonly used when randomisation is impossible due to the vast population or when the researcher has limited resources, time and workforce (Etikan, 2016; Taherdoost, 2016).

As advocated by Creswell and Plano Clark (2011), purposive sampling involves identifying and selecting individuals or groups with the knowledge and experience of the phenomenon being studied. Moreover, the availability and motivation to participate and the ability to share experiences and opinions in a coherent, expressive and reflective fashion is also essential (Palinkas et al., 2015). Current residents of

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Victoria, 18 years or older from a CALD background, who could speak and understand English were invited to participate in the study. These criteria and the sampling process may limit diversity in the data.

2.2 | Data collection and analysis

A written informed consent was collected from all participants. The first author conducted all interviews. The interview questions were derived from a project commissioned by the Department of Health, Gippsland Region (Poropat et al., 2014). The questionnaire contained two parts. Part A provided basic information questions to collect sociodemographic data. The questions included in Part B related to accessing mental health services. The questions were a mix of open and closed-ended (Trier-Bieniek, 2012). Finally, the interview questionnaire was used as a guide rather than a structured script. Even though all participants spoke English, a few still had difficulty understanding the interview. Therefore, the researcher spoke slowly during the interview, was patient with them and explained when they required assistance. Interviews were audio-recorded for verbatim transcription by the first author. Twenty-one interviews were conducted; interviews ranged from 15–40 min. Interviews took place between November 2020 to March 2021. Data collection ended when data saturation was achieved (Doyle et al., 2020).

First, recordings were transcribed using NVivo software (NVivo, 2022; Zamawe, 2015). The first author then analysed the data using the thematic analysis framework by Braun and Clarke (2006), with the support and guidance of the other authors. The thematic analysis provided insight into the participant's responses using an inductive approach (Braun & Clarke, 2014). Braun et al. (2017) state that thematic analysis is a method for identifying, analysing and interpreting patterned themes in qualitative data. It is a vigorous, systematic framework for coding qualitative data and then using that coding to identify patterns across the dataset concerning the research question (Braun & Clarke, 2014). As Kolb (2012) advises, thematic analysis patterns within the text were tracked. A continuous comparative method was used to develop ideas from the data by coding and analysing each verbatim response.

Then the data were charted, and items relevant to the research questions were labelled and classified to develop the initial codes. Next, codes were generated from the labelled transcripts. Later, the participants' responses were classified into positive and negative categories. The next step was the formulation of themes and subthemes. The themes were then reviewed and analysed for coherence, consistency and distinctiveness. Finally, four key themes and five sub-themes were formed. Participants' experiences are quoted verbatim in this report.

3 | FINDINGS

Twenty-one CALD participants from different regions in Victoria, Australia, were recruited. In order to protect the confidentiality, no participant identifiers are included. Table 1 provides participant characteristics. The analysis of the data generated *four* themes and *five* subthemes. The first theme was Settling Issues. The second theme, Perceptions and understanding of mental health issues, had two sub-themes – help-seeking attitudes toward mental health issues and the need for CALD community education. The third theme was Perceived barriers to accessing and utilising mental health services, with sub-themes of socio-cultural and language barriers; stigma, labelling and discrimination; knowledge and experience of accessing health facilities. The last theme identified was the experience with mental health services and professionals. The themes are now presented in more detail below:

3.1 | Settling issues

Many participants indicated that they had initial settling issues in Australia that affected their mental health directly or indirectly during the later stages of their life in Australia. Issues included finances and finding employment, speaking English, feeling detached from the rest of the community and adjusting to new social norms. In addition, feelings of anxiety and stress for themselves or a family member during the initial settling phase were reported by many participants, especially if they had arrived in Australia as war refugees and were experiencing the after-effects, including post-traumatic stress disorder (PTSD).

> *I left my country Lebanon, but due to war, my sister been injured, and the whole building collapsed, and we had to leave, being forced to leave our country Lebanon. And we moved to Kuwait first, and then I got married to America and then had a daughter. I have only one daughter and then moved to Australia here and come to Australia to start my life and make journey in Australia. Those experiences were definitely stressful because those memory doesn't go away easily, so it is, you know, like every time you think about it, it is still in my mind.*
>
> (*Participant 14*)

> The settlement was very difficult, it was not very easy to settle and then to find a career, it was quite hard. Because I had my education in Afghanistan and then I came to study here, I, with the job, I find a job very quickly. But really, it was hard.
>
> (Participant 19)

> I was all alone, and I did not know anyone in the beginning and the neighbours, you know, they were like, well, you know, nobody came to place, and I did not go anywhere either.
>
> (Participant 12)

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TABLE 1 Participant Demographics.

Participant no:	Age of participants (years)	Gender	Ethnic background	Languages other than English spoken at home	Length of time lived in Australia (years)	Immigration status
1	*37*	*F*	*Nigerian*	*Igbo*	*6*	*migrant*
2	*30*	*F*	*Indian*	*Kannada*	*4.8*	*migrant*
3	*40*	*M*	*Indian*	*Malayalam*	*15*	*migrant*
4	*39*	*M*	*Indian*	*Tamil*	*10.5*	*migrant*
5	*35*	*F*	*Chinese- Australian*	*Mandarin*	*15*	*migrant*
6	*39*	*F*	*Australian-Maltese*	*Nil*	*38*	*Born in Australia*
7	*53*	*M*	*Indian*	*Malayalam*	*17*	*migrant*
8	*18*	*F*	*Pakistani*	*Pashto*	*11*	*migrant*
9	*18*	*F*	*Pakistani*	*Pashto*	*11*	*migrant*
10	*48*	*M*	*French Mauritian*	*French*	*15*	*migrant*
11	*73*	*M*	*Greek*	*Greek*	*56*	*migrant*
12	*35*	*F*	*Pakistani*	*Urdu & Sindhi*	*34*	*migrant*
13	*37*	*F*	*Iraqi*	*Arabic*	*6*	*war refugee*
14	*57*	*F*	*Lebanese*	*Arabic*	*36*	*war refugee*
15	*73*	*M*	*Greek*	*Greek*	*48*	*migrant*
16	*69*	*F*	*Turkish*	*Turkish*	*34*	*migrant*
17	*76*	*F*	*Caucasian*	*Swedish*	*76*	*Born in Australia*
18	*56*	*F*	*Australian-Greek*	*Greek*	*56*	*Born in Australia*
19	*35*	*F*	*Afghanistani*	*Dari*	*8*	*migrant*
20	*53*	*F*	*Malaysian- Indian*	*Tamil*	*16*	*migrant*
21	*18*	*F*	*Vietnamese*	*Vietnamese*	*18*	*Born in Australia*

One of the participants voiced their experiences living in the refugee camps like Bonegilla during their first arrival in Australia. Some participants revealed discriminatory experiences for themselves, friends or colleagues. However, they did not want to call it racism. Some participants also mentioned the mental health effects of these experiences as frustration, anxiety, or depression.

> … because after coming here to Australia, I feel so lonely that, one day I don't know I was so depressed. At home, we had fights, and we had a lot of misunderstandings. So, I became too low. And then I was holding a knife one day, and I was sitting, thinking want to do, I just wanted to cut myself and being done.
>
> (Participant 2)

> Well, of course, for the first time, coming to Australia was not easier. I cannot lie about that. Living in Bonegilla, living in the little hut, I am not used to live like this before, I found it very, very hard to adjust to that. And often got depressed, and I had to go on a que to get some food. I felt like I was living in a concentration camp in Germany. Afterwards, when we came down to Melbourne and then got a job. So, we were one of the lucky ones to survive in a short time. But even so, being alone sometimes makes me very depressed and I start crying for no reason.
>
> (Participant 16)

3.2 | Perceptions and understanding of mental health issues

Many participants knew about mental health and the signs or symptoms of mental health issues and listed mental health issues such as schizophrenia, depression and post-traumatic stress disorder. They stated that depression might be a common mental health issue among community members. Others had minimal knowledge of mental health issues. Participants acknowledged stress and frustration, isolation, losing a loved one, unemployment, head injury, chemical imbalances in the brain, issues stemming from the subconscious mind and trauma from the war as causes of mental illness.

> I had no clue what depression or anxiety is because we have never named it. Might be we do go through this in India as well, but we have never, you know, addressed it or ignore it. But after coming here, I got to know that there is something called anxiety or like depression, something like, may be like becoming too

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aggressive. I had no idea about it. I know I have seen these expressions but never a name

(Participant 2)

3.3 | Help-seeking attitudes toward mental health issues

Mental illness was perceived as a crisis by most participants. They believed that mental illness is a Western concept used by health professionals. Yet, seeking help was considered complicated due to the factors like a lack of knowledge about the illness, whom and where to approach for help. Most participants wanted to talk to a friend, family or a reliable person if they had a crisis. They relied on word-of-mouth information or searching the Internet. Many participants suggested counselling. However, seeking help from a psychiatrist was not considered an early step for many reasons, including stigma.

… there would be like no one wants to discuss with people, you know, certain things like go visit a doctor in a psychiatrist or, mental health person, as opposed to, you know, someone who happens to be, you know, a professional. But again, this thing about, you know, feeling inadequate when, maybe it is a bad thing that this person is, you know, having mental health problems, for a child, a younger person, a teenager in the crisis; if we are there to accept that this what the person has but it's almost like accepting defeat.

(*Participant 1*)

Many participants were unaware that General Practitioners (GPs) could be the first step to accessing help for mental health issues, although this is not a unique issue in CALD communities. Some participants stated their awareness about GPs developing a care plan for physical health concerns but not mental health issues. Some expressed that getting a mental health care plan from the GP and filling in many forms was challenging. Moreover, the option of getting a second opinion once diagnosed with a mental health issue was unknown to many participants (when the researcher asked about this). Some stated that other community members might not recognise the signs and symptoms of mental health issues.

…I think the majority of them don't even know that they have this condition because they simply think it's shyness or they are off mood or something like that…I didn't know what was going on the first time because I had depression. I just felt like crying all the time.

(*Participant 3*)

Even though many participants agreed about the importance of seeking help for mental health issues, some thought that depression is self-centred or would cure itself if people had tried harder. For example, some of the participants expressed their thoughts as:

My understanding is that, you know, the mental illnesses may or may not be the result of, things that, you know, the cause will be sometimes known, but the cause, most of the times is unknown, and it could be coming from your subconscious or whatever; the end result is also, you know, behaviours and, socially unacceptable, sort of, expressing behaviours in a socially unacceptable manner and you know having problem at home and at work.

(*Participant 3*)

I do not believe there is a stigma, but I think, like a lot of things, because depression in particular, it is such a self-centred illness that after a while, people get bored with hearing about it.

(Participant 17)

Some of the strategies for mental health issues suggested by participants were praying to God, faith leaders, talking to a family member or a friend, meditation or yoga, complementary medications, psychologists and counselling services.

I did meditation while in Mauritius, and still, I do it because it helps me when I am in stress. You see, with meditation, I see it will connect me directly to the Supreme God. Which makes me feel happy and everything and successful in life.

(Participant 10)

Many participants said they would help a family member or a friend who approached them for help. Nevertheless, they seemed anxious about how to help rather than talking to them, as they were unsure how to get involved. Some participants were aware of people's preferences and rights but were uncertain about moving forward. Yet, they all stated that community members might be reluctant to seek help. This aspect includes the need for privacy and confidentiality about mental health issues among community members. Some were even reluctant to talk about their issues in their husbands' presence.

Especially if they are man like he is the head of their men then, he has to show all the time strong not weakness, but for the women, she is scared, like if she told her husband, the husband will marry someone else.

(Participant 14)

Participants noted the importance of using language cautiously when assisting people with mental health issues from some

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communities. For example, while using terms like mental illness, some community members hesitated to seek help.

> … they say, you know, I'm going to the social worker, but it's actually she is helping them with mental health.
>
> (Participant 14)

3.3.1 | Need for CALD community education

All the participants felt the need for community education about mental health issues and available support. However, many of the participants were unaware of support organisations. Some participants mentioned the names of organisations, such as Beyond Blue and Headspace. In addition, some participants were unsure if any cultural organisations supported their community members with mental health issues. One or two participants mentioned clubs and certain groups in their community for socialising and other activities and sometimes having education sessions about mental health issues.

> All the time education about, like information sessions, there are so many events happening on like the International Women's Day or our cultural events. It's always good to talk about this one…educating the community that it is ok to talk, it's ok to talk. All of us learning different…tips and tricks, you know how to ask about it and be mindful about it. But all the time, educate the community about it, non–stop.
>
> (Participant 14)

3.4 | Perceived barriers to accessing and using mental health services

Barriers such as socio-cultural, language, stigma, labelling and discrimination issues perceived were described by the participants. Their knowledge and experience of accessing and utilising health facilities were also highlighted.

3.4.1 | Socio-cultural and language barriers

Language barriers were significant hurdles to accessing and utilising mental health services. Many participants suggested interpreter assistance or seeking help from a family member to overcome language barriers. However, even though people could speak English, they were unsure if healthcare professionals understood them fully and vice versa.

> *Because if we say to them call the ambulance again, they need to speak to them in English. So, it is always stuck, in my time, it is hard. You know, if they are on their own, you know, we always have to rely on the family member for supporting them for their language barrier.*
>
> (*Participant 14*)

Nevertheless, some participants thought not speaking to health professionals in English might reflect poorly on them.

> I did go with my brother to the psychiatrist; I heard my brother because I told my brother to explain his problems because he is a bit reserved, so does not wordily reveal what he feels and thinks, like that. My brother couldn't speak English particularly well. I am a bit surprised that the psychiatrist did not offer more sort of counselling and psychological help rather than medical help.
>
> (Participant 21)

Some participants thought having more health professionals who could speak their language would benefit them. Participants also expressed that people in Australia are more open to discussing their mental health issues than people from other countries.

3.4.2 | Stigma, labelling and discrimination

Most participants conceded stigma as a feeling of shame, fear and failure. They believed that stigma about mental illness existed in their communities, more in the country of origin than in Australia. Participants reported that stigma was often attached to the label of mental illness. Hence, culturally appropriate language was required to discuss the management of such issues. Participants believed that younger generations in Australia are more open to discussing mental health issues than older generations. Many considered mental health issues as part of their life stressors and wanted to move on and deal with them.

> Look, I have depression. I have mild depression. All right. I am not sure if I have it now or not. But I was diagnosed with it. But as I said, nobody talked about it. Even I have not talked about it with anyone as such. No one really, no one talked about it. So, you wouldn't know.
>
> (Participant 12)

> And the thing that you know you having to go and see a psychiatrist or psychologist is like that is going to be like bad on this person. And people are going to definitely look down upon you when you do that. So certainly, there is a stigma.
>
> (Participant 3)

Participants acknowledged that many community members in the broader community are stigmatised, leading to experiences of

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social segregation and discrimination. For example, many community members are worried about being labelled 'mad or crazy'. They also feared some ramifications of revealing their mental health issues, such as losing a job, losing status in their ethnic community and legal issues related to mental health, such as police and social justice department involvement. In addition, community members suffering from stigma cloaked the issues from family and other support networks, prolonging their isolation and worsening their mental illness.

> No, it is not about labelling, other people labelling them, it's about they are labelling themselves. They might get insecure that if they turn towards some treatment, they might feel low about themselves, and people might start pointing that out as well. I'm sure there are barriers, first thing is that they start to feel inferior to themselves.
>
> (Participant 2)

> "…it is not easy for the community members to accept that they have any kind of mental health diseases, and most of the time they think like a taboo, and they are not shared with other community members",
>
> (Participant 19)

> Yeah, I think, the moment you say that I do, I got this issue, then really people might think that you are crazy.
>
> (Participant 20)

3.4.3 | Knowledge and experience of accessing health facilities

Participants were satisfied that general health services were affordable and mentioned that it was easy to access services from a GP for medical issues. Most participants compared Australia's medical system to their own countries and stated it was very advanced. Participants indicated their own and their community members' knowledge regarding access to medical services available in Victoria. For emergencies, most people know to telephone 000. However, if it is not an emergency, many prefer to present to a hospital or GP for their medical issues. One participant mentioned that they believed the ambulance service was unavailable to specific places in Victoria. In addition, many participants were frustrated about the long waiting periods in the emergency department, for surgical procedures or seeing a medical specialist.

> Yeah, 000 I will but I know who is right near my house, and she is a good friend of mine. I think I will first approach her because that is way too faster than dialling a 000. By the time I gave all information, it will take time and I think the other way is faster.
>
> (Participant 2)

Some participants believed that going to the emergency department at the nearest hospital is faster because it does not require an ambulance. Instead, they would prefer to use their own transport or be driven by their husbands, family members, friends or relatives. Some stated that they drive their parents or family members to appointments due to language issues and the use of interpreters. Nevertheless, some were not completely satisfied with the interpreter service due to fears around privacy. Some participants responded:

> 'People like my parents, for example, have found it hard with the language…So, they always ask for help from us their children. If I cannot make it to the appointment, I have to book an interpreter'.
>
> (Participant 18)

> 'But when there is someone interpreter, they feel scared, may be if I talk something, and the interpreter, because she knows you from the community, I mean, even the interpreter, she is not supposed to say any word, because of the privacy, but they seem to be scared of the interpreter'.
>
> (Participant 14)

3.5 | Experiences and views on mental health services and professionals

Many participants did not have much experience with mental health services for their own care, even though a few stated that they had mental health issues but were undiagnosed. There were not any mentions of admission to a mental health service. Some stated that they knew a family member, a friend or a community member who was admitted to a mental health ward. One participant described the experience of symptoms of PTSD and taking treatment secretly for the same.

> 'Yeah, I had a car accident. It was not our fault, not in the driving side, the other side. So, and then it took me like six months to recovery from the accident. Yeah, yes. I was told that all of that was trauma from previous experience. Because I can feel my sister when shot injured, you know all the blood, that rushes into like you know from the wound, and the blood come to my face. I fainted, and I fainted you know, because I can feel my sister in front of me. I did take some treatment, only I did it secretly because of the Arabic and

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> Lebanese culture, I did not tell anyone about it. It is just I could not stop crying'.
>
> (Participant 14)

Many were aware of the culturally appropriate services available in the hospital, like food choices and male or female caregivers. However, they were not fully aware of other culturally appropriate services available.

> 'She said she was let to do her prayers and do like everything she wanted to like they provided her cultural food, and she was happy'.
>
> (Participant 13)

Nonetheless, some participants who sought help from GPs were concerned regarding the less-than-optimal time with GPs for medical or mental health issues. Some indicated that the outcome was not helpful when they approached the GP for mental health services. GPs did not have time to listen to their concerns, prescribed some medications and did not discuss options about seeing a counsellor or psychologist.

> 'But the doctor (GP) was not very willing to refer her to a specialist and if you were to listen to that doctor you would have wasted your valuable time. So, then we decide to go to another doctor and finally we got her referral and she got assessed'.
>
> (Participant 3)

> 'Sometimes we go to the GP, and we don't know, like, if the GP is going to refer me to the right service or … So, we just guessing during this whole system thing, you know'.
>
> (Participant 5)

> 'Some of the GPs that I have found, or I heard, I that they are just writing prescriptions. They are not really even caring, what is happening'.
>
> (Participant16)

Additionally, many were concerned about the cost of seeing a private psychiatrist as the referral to the public system took longer. Some participants were pleased about having a multicultural workforce in hospitals. However, a few were worried about their confidentiality, especially from a small CALD community where people knew each other. Most participants believed that mental health nurses do their work professionally, acknowledging that caring for people with mental health issues can be challenging. Nevertheless, many had no direct experience with mental health nurses. Some of them indicated the experiences of their friends, family, or community member with MHNs. Many had assisted their friends, family, or community members in accessing mental health services or had heard about their experiences.

Moreover, they acknowledged the importance of the care provided by mental health nurses. Some thought MHNs were like ordinary nurses and did not know what the MHNs were supposed to do. However, participants also mentioned that mental health nurses understood and treated their clients with respect and dignity.

> 'I feel like they were very similar to the hospital, the normal hospital nurses. Like I said, I do not know if that is supposed to be what they are doing, like their job. OK, I think I would like the nurses to be more for sort of, because we are dealing with mentally ill patients. I think it is that they have more sympathetic, more conversational nurses rather than the nurses that are in the hospital sort of tend to. And the nurses to be empathetic and friendly as well'.
>
> (Participant 21)

4 | DISCUSSION

This study explored the experiences and views of the CALD community members with the prospect of preparing an education package for mental health nurses. However, the findings were similar to other studies in Australia and globally. The project included first, second and third-generation CALD people in Australia who identified themselves as migrants, refugees and asylum seekers. Even though the experiences of these groups may be unique, the level of acculturation that happened over the years may have influenced their life circumstances.

There are various barriers to the CALD community's understanding and perceptions of mental health and their ability to access mental health services (Au et al., 2019; Department of Health, 2021; Harrison et al., 2020; van der Boor & White, 2020; Wohler & Dantas, 2017). Resettlement issues such as securing employment and accommodation, and acculturation were evident in the experiences of the research participants. The World Health Organization (2018) indicated that acculturation difficulties could be associated with integrating into a new country. These difficulties can also be risk factors for mental health issues for CALD groups. In addition, more extended wait periods for receiving health care; lack of quality time with GPs and other healthcare professionals have constantly challenged the Australian health system's core principle of equitable treatment (Johar et al., 2013; Ward et al., 2017). These might hinder the CALD community from accessing mental health services (Adhikari et al., 2021; Mulraney et al., 2021). Of note, many CALD community members preferred to drive to the emergency departments at the hospital and not call a 000 for any type of emergency, and some were unaware of emergency ambulance services. Another important finding was the lack of knowledge of mental health services provided by GPs and the perceived lack of quality information regarding mental health from GPs (Wohler & Dantas, 2017).CALD community members have different English proficiency levels, which may not increase

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with their time in Australia (Federation of Ethnic Communities' Councils of Australia, 2019; Gunasekara et al., 2019). Many senior CALD community members are expected to have lower English proficiency rates. At the same time, second-generation migrants are more likely to retain their parent's language. CALD communities may be anxious that mental health service access may impact their income from Centrelink, NDIS, aged care, or disability pensions (Australian Institute of Health and Welfare, 2019; Zhou, 2016). Mental health illiteracy has also been identified as a barrier due to a lack of exposure and knowledge of mental health services (Fozdar & Salter, 2019). Research suggests that educating the CALD community has been a key to raising awareness, positive attitudes and behavioural changes, thereby encouraging the utilisation of mental health services in the target community (Blignault et al., 2009; Prasad-Ildes & Ramirez, 2014).

CALD participants expressed the practice of approaching a family member, friend, faith leader or priest for their mental health issues and the implications of self-stigmatisation. A considerable amount of shame around mental health issues may result in these practices (Onyigbuo et al., 2016; Poropat et al., 2014). The impediment of mental illness is often perceived among CALD communities as a lack of effort or willpower to 'fix' the issues (Choudhry et al., 2016). In many male-dominated CALD communities, men often tend to hide their mental health issues as they can be identified as a weakness. As a result, they usually do not disclose mental health issues while their husbands or wives are present (Amri & Bemak, 2013; Kiselev et al., 2020). Some participants expressed that community members fear isolation from the community, have low self-esteem and perceive themselves as a burden to the family due to the stigma of mental illness. Consequently, individuals experiencing mental health issues may downplay their illness's intensity (Abdullah & Brown, 2011; Corrigan & Rao, 2012). CALD communities have many cultural and religious beliefs around mental health issues such as demonic possessions, lack of appropriate faith and environmental causes such as childhood trauma, drug, alcohol addiction, etc. (Henderson et al., 2018). These beliefs may lead to individuals not interpreting their mental health issues as a treatable condition. Instead, they seek to improve the aspects of their lives they believe to be the cause. Lack of knowledge about mental health conditions may cause the experience to be normalised by the individual/community as ordinary suffering rather than a mental health condition.

Some participants had difficulty distinguishing mental health concerns from physical health. Psychosomatic mental health presentations are more likely among refugees and asylum seekers (Bhugra et al., 2011; Cross & Singh, 2012). These presentations may hinder the recognition of mental health issues and deter self-admission or access to appropriate services (Bredstrom, 2019; Jongedijk et al., 2020; Pedersen, 2015). In addition, research has shown that there can be misdiagnosed or under-diagnosed mental health conditions in CALD individuals by non-CALD clinicians (Butler et al., 2016; Kirmayer & Jarvis, 2019). A lack of understanding of different presentations of mental ill-health can cause this. Therefore, timely and appropriate mental health assistance will be affected, especially during a crisis.

Many participants expressed uneasiness around mental health treatments for themselves or their families. Mental health treatment is seen as restrictive and severe, causing uneasiness around mental health treatment and often constraining therapy (Weissbecker et al., 2019). CALD communities may have ingrained perceptions and experiences with their home countries that may disseminate the restrictive nature of mental health support. These perceptions can be another barrier to accessing mental health services (Brijnath et al., 2020; Parajuli & Horey, 2019). According to Gopalkrishnan (2018) and Dubus and LeBoeuf (2019), in general, the mistrust of Australian institutions was due to the perceived power imbalances, threats and unjust treatments in the home countries may have led to CALD communities accessing support for mental health issues as a last resort. Similarly, as demonstrated in this study, the use of second opinions in psychiatry is not well-known by people from CALD communities. Nevertheless, as recommended by Heuss et al. (2018), implementation of second opinions is a feasible means of improving the quality of mental health care as it potentially reduces overdiagnosis and cuts down the overall costs both for individuals and society, such as disability pensions and loss of productivity in the workplace.

Confidentiality concerns when accessing mental health services were expressed during the interview by the CALD participants. Many CALD communities are closely knit; they fear social ostracisation if health professionals share their information with the community. Similarly, the CALD communities perceive interpreters as threatening their confidentiality as they speak the same language and share cultural backgrounds (Idemudia & Boehnke, 2020; Sturman et al., 2018). Additionally, cultural brokers or interpreters from the same ethnic communities as clients may risk confidentiality due to the intimate nature of these conversations (Salami et al., 2019). The CALD individual may fear that the interpreter may express some judgement, relay the details to the community, or even be acquaintances (Harrison et al., 2020). In addition, low literacy, lack of education and employment and financial hardships can be substantial stressors for refugees and asylum seekers.

During the interview, some CALD members shared mental health nursing care aspects with the researcher and acknowledged the nurse's role in providing dignity, respect, reassurance and care. However, some participants stated that they experienced mental health issues but did not have a diagnosis or did not have mental health service experience. Most participants had cared for their friends or family members with mental health issues. Many were anxious about how to seek help for mental health issues and instead listened to or spoke to them. As stated earlier, the experience of mental health issues causes much discomfort. Due to stigma, many people will be hesitant to self-disclose mental health issues (Bowden et al., 2019; Cross & Singh, 2012; Gorman et al., 2018; Uribe Guajardo et al., 2019). These issues may influence the clarity or ambiguity of disclosure of mental illness (Rossetto et al., 2016).

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Furthermore, participation in the project was voluntary; many may not have disclosed their mental health issues and what treatment they might have received. Studies by Rousseau and Frounfelker (2019) and Kirmayer et al. (2015) have evidenced that CALD community members may seek alternative treatment for their mental health issues. However, these strategies may not be disclosed to healthcare professionals until a robust therapeutic alliance is established. Several participants discussed the importance of religion and spirituality to their mental health and feelings about mental health issues. However, most were unwilling or unable to speak for themselves regarding their mental health needs. There was a lack of culture-specific descriptions of the mental health issues by the participants. It was evident that there was mistrust, lack of experience with the Australian mental health system and stigma associated with mental health services among most participants; some had no lived experience. All these factors made it challenging for the participants to describe mental health nursing care that would meet their cultural needs.

4.1 | What does the study add to the existing evidence?

The perspectives of the CALD community in Victoria regarding their needs and experiences with mental health services were analysed in this study. Of note is that the participants included first, second and third-plus-generation migrants, asylum seekers, refugees and others who identify with a multicultural background. We recruited from the general community rather than focusing exclusively on service users. Furthermore, this study did not target new arrivals and included participants who had lived in Australia for years and decades. Nevertheless, perceived barriers to mental health services persisted, including language barriers, stigma towards mental health issues, mental health illiteracy, distrust and lack of familiarity with mainstream mental health services. Community members acknowledged these challenges even after a long residence in Australia. The data generated on the beliefs about mental health issues and consequent help-seeking behaviours highlight the importance of culturally sensitive targeted prevention and early intervention strategies and ongoing commitment to building mental health literacy in the wider community. These findings may concede that mental health care disparities still exist among Victorian CALD communities and warrant the research on the inclusion of broader communities in Victoria.

5 | STRENGTHS AND LIMITATIONS OF THE STUDY

The main focus of our research project was the experiences of CALD community members in Victoria, Australia, on mental health services. Though the sample size was small, the sample recruited was a cross-section of community members from many suburbs of Victoria. This aspect is considered the main strength of the study. In addition, this study's scope enabled the participation of CALD community members with diverse immigration histories and experiences. Consistent findings were noted for those with a recent history of immigration and those with more extensive experiences over time. Some findings were similar to other CALD research in Australia and internationally. The participants in the research project had extensive age ranges, educational backgrounds and experiences. These characteristics may have contributed to the rigour of the study (O'Brien 2020). However, the convenience sampling used in the study might have introduced some self-selection of CALD members with solid and polarised civil views on delivering mainstream mental health services.

Conversely, the small sample size and limited representation of CALD communities may affect the transferability of our findings. In addition, the researchers only recruited participants who could speak and understand English. These criteria might have excluded many participants with significant language barriers and extensive mental health experiences. The project has involved a mix of CALD community participants with migrants, refugees and Australian-born experiences. Hence, we cannot generalise the findings as the mental health experiences are likely unique for each CALD community. Again this experience can vary with unique cultural or religious backgrounds as well as levels of acculturation. Purnell (2018) argues that the CALD population adheres to traditional individualistic and collectivistic cultural values, beliefs and practices. The degree of adherence is often characterised by the degree of acculturation, integration and the distinct characteristics of a culture. In addition, most participants did not reveal a lived experience. Therefore, they could not account for their personal experience with mental health services. Moreover, no information on mental health service access and utilisation was collected on actual service delivery or organisational provisions to demonstrate the experiences of the CALD community. However, the views of the cross-section of the CALD community in Victoria provide valuable information on general perceptions of mental health services.

6 | RECOMMENDATIONS TO IMPROVE MENTAL HEALTH SERVICE ACCESS AND UTILISATION

Our study makes the following recommendations. First, efficient settlement services for CALD immigrants are required. Second, there is a critical need to implement policies to eradicate barriers to newly arrived immigrants' economic and community integration. These policies need to open avenues to employment, and social integration, build trust and reduce marginalisation, reducing vulnerabilities to mental health (Wohler & Dantas, 2017). Investing in CALD community education to minimise the self-stigma of mental health issues and improve mental health knowledge among communities is fundamentally essential. National health policies recommend improving CALD communities' awareness of mental health issues to counter stigma and discrimination.

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Nevertheless, significant barriers exist to engaging with mental health services (Fauk et al., 2021; Fozdar & Salter, 2019; Khatri & Assefa, 2022; Todor, 2013; Yava et al., 2021). Third, experiences for the CALD community can be improved within health facilities and through the empowerment of health professionals (Aguiar et al., 2012; Berie et al., 2021; Cross & Singh, 2012; Minas et al., 2013; Wohler & Dantas, 2017). Person-centred approaches, community-based services, primary health care, prevention and early intervention are recommended to improve health care in CALD communities (Fozdar & Salter, 2019). In addition, researchers have suggested that building mental health professionals' capacity through training can improve their cultural competence, awareness and sensitivity (Lin & Hsu, 2020; Radhamony et al., 2021).

Finally, ongoing research with CALD groups and comparing data to capture trends and identify patterns should be advocated. Policies that support longitudinal, comparative and co-designed research with CALD communities should be implemented. Collaboration of governmental and non-governmental agencies exploring the mental health issues of CALD communities are some of the suggested interventions (Wohler & Dantas, 2017).

7 | CONCLUSION

This study identifies diverse perceptions and understandings of mental health issues and mental health services among CALD communities. Challenges include language barriers, the stigma of mental health issues, mistrust of health care and lack of knowledge and familiarity with mainstream mental health services. However, extensive research and innovations on flexible, affordable and CALD-appropriate mental health service delivery models, successful implementations of National mental health plans and the partnership between immigrant services and mainstream mental health services can improve the challenges faced by CALD communities. The practical strategies proposed by many researchers include implementing a three-tiered process of professionals-service-policy level strategies, improving service delivery by developing culturally sensitive practices and partnering and sharing expertise with services with a CALD emphasis. These strategies are warranted to enhance mental health service access and to provide holistic support to people from CALD communities. The worldwide issues of the CALD population should be considered a critical issue, and adequate measures to be implemented to promote and sustain CALD-appropriate mental health services for this community.

AUTHOR CONTRIBUTIONS

RR conducted the interviews and wrote and developed the manuscript. WC, LT and BB critically reviewed the manuscript. All authors approved the final manuscript, confirmed they met the authorship criteria and agreed with its content. The authors report no conflict of interest.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Human Research Ethics Committee at Federation University, Australia (Project Number - A20-024, Date of Approval: 30 September 2020).

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