A qualitative evaluation of the Questionnaire about the Process of Recovery (QPR) in culturally and linguistically diverse (CALD) populations

Abstract

Purpose: Mental health recovery across cultures lacks understanding and suitable measures. The Questionnaire about the Process of Recovery (QPR) is a self-report instrument measuring personal recovery outcomes for patients of mental health services. However, the extent of its relevance among culturally and linguistically diverse (CALD) communities is unclear. This pilot study aimed to examine the relevance and utility of the QPR among CALD patients of primary mental health services in Australia.

Methodology: Eleven individual, semi-structured interviews were conducted with two general practitioners (GPs) and nine consumers from two clinics, at locations with high Iranian and Burmese refugee or asylum seeker populations. Interviews were transcribed and analysed using a thematic framework approach.

Findings: Although almost all consumers had little or no understanding of the concept of personal recovery, they found the QPR culturally acceptable and understandable. Using the QPR during mental health consultations can help with needs identification and goal setting. Challenges in using the QPR included completion time, cross-cultural differences in concepts and norms for some items, and need for careful translation. Consumers suggested additional items regarding family reputation, sexuality, and spirituality.

Originality: The QPR is potentially a valuable tool to support mental health consultations with CALD consumers, from the perspectives of both GPs and consumers. However, improvements in its usability and usefulness across cultures and evaluation with larger diverse samples are needed.

Keywords: Personal recovery; Mental health; Culturally and Linguistically Diverse; QPR; Migrant; Refugee; (Outcome measurement; Questionnaire; CALD; Migrant; Australia; Asylum seeker)

Article classification: Research paper

1. Introduction

The conceptualisation, experience, and prevalence of mental health concerns varies across cultures. The fields of transcultural psychiatry and global mental health have been dedicated to examining how to provide culturally appropriate mental health services. About 29% of Australian residents are reported to have been born overseas, with the latest figures showing that over 7.6 million migrants currently live in Australia. Migrant arrivals have shifted away from European regions, with a larger number of immigrants arriving from Asian regions in more recently (Australian Bureau of Statistics, 2020). A priority for Australia is to respond to the mental health care needs of its "fast-changing, ever-expanding, culturally diverse nation" (Australian Bureau of Statistics, 2017).

In recent years, the approach to mental health care in countries including the US, UK, Canada, Australia, and New Zealand has shifted towards a recovery-oriented focus. This approach incorporates consumers' desires and preferences in mental health care planning and includes socially and individually valued roles and goals (Slade, 2010; Lloyd *et al.*, 2008; De Vecchi *et al.*, 2015). The Royal Commission into Victoria's Mental Health System in Australia has recommended that Victoria needs a service system that is attuned to promoting inclusion and addressing inequities (State of Victoria, 2021). Numerous frameworks for understanding recovery exist, (Slade, 2009; Lapsley *et al.*, 2002), including the CHIME Framework, comprising: Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment (Leamy *et al.*, 2011). This framework has been applied in conceptualisations of *personal recovery* across community-based mental health teams (Slade *et al.*, 2015) and in culturally and linguistically diverse (CALD) communities in Australia (Brijnath, 2015). Personal recovery has been defined broadly as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Australian Health Ministers' Advisory Council, 2013, p.2). The appreciation of the importance of the personal recovery paradigm has led to the

implementation of service reform and support for recovery oriented practice in mental health policy and training.

An under-researched and poorly understood aspect of mental health is the way mental health recovery is conceptualised and measured across cultures (Slade *et al.*, 2014; 2006; Tesfaye *et al.*, 2010; Kirmayer, 2012). Increases in migration (in Australia and globally) contribute to greater heterogeneity of cultural identities, adding to the challenge of understanding mental health recovery in culturally diverse groups. More specifically they limit the extent to which researchers can draw upon cultural models such as the individualism-collectivism paradigm to theorise how certain groups might conceptualise recovery (Hermans and Kempen, 1998). Even so, some studies have investigated the concept of personal recovery in non-Western cultural groups, revealing that factors such as stigma, family and social support networks, and spirituality/religion (ideas not necessarily mentioned in Western samples) were important in the recovery process (Leamy *et al.*, 2011; Whitley, 2016). Given the cross-cultural variations in ideas of recovery, it is important to expand research to include diverse samples from a range of cultural backgrounds if culturally inclusive ROP is to be achieved.

The value of outcome measures that are generated and completed by consumers has been considered an important aspect of moving to more recovery oriented and person-centred service delivery. A systematic review of existing mental health recovery measures (Shanks *et al.*, 2013) identified 13 measurement tools, among which the Questionnaire About the Process of Recovery (QPR) (Neil *et al.*, 2009) was unique in having all items map onto the CHIME framework. The QPR is a 22-item, self-rated, subjective outcome measure of personal recovery comprising two sub-scales: intrapersonal (17 items) and interpersonal (five items). The QPR has been considered to be a suitable measure for service evaluation in Australian sub-acute services. Although the QPR has been translated successfully into Chinese (Chien and Chan, 2013) and Swedish (Argentzell *et al.*, 2017), the tool has not been applied and tested in culturally diverse settings, nor examined through cultural lenses (Neil *et al.*, 2009).

In the Southern Region of Melbourne, Victoria, Australia, the Principles Unite Local Services Assisting Recovery (PULSAR) project aimed to develop localised, practical, and collaborative approaches to supporting personal recovery in primary and secondary mental health care settings. This involved the provision of an intervention adapted from the UK's REFOCUS trial whereby staff received training in recovery-oriented practice (ROP) with the aim of improving self-reported recovery outcomes in service users under their care (Meadows *et al.*, 2019). The QPR was the primary outcome measure (Shawyer *et al.*, 2017; Enticott *et al.*, 2016; Meadows *et al.*, 2019). Findings showed that delivering the REFOCUS-PULSAR training intervention to staff in ROP had a small but significant effect towards improving consumers' self-rated recovery based on the QPR. This is the first study globally demonstrating the impact of staff training in ROP on consumer-rated recovery outcomes. This research presents a qualitative pilot sub-study of the PULSAR project, exploring the cross-cultural relevance and appropriateness of the QPR for evaluating personal recovery among Iranian and Burmese participants from CALD communities. People who experience mental illness and engage with General Practitioners (GPs) services are generally referred to as "patients" and this convention may not be so stigmatising in the primary care context. However, in line with the recovery-oriented framework for this work and parallel PULSAR Secondary Care projects, the term 'consumer' will be used outside of any direct quotes referring to patient/s.

2. Method

This sub-study included individual face-to-face semi-structured interviews with GPs and CALD consumers, aged 18-75 years, receiving mental health care from primary care clinics.

2.1 Study Participants and Recruitment

The study setting included two primary care clinics in the outer suburbs of Melbourne, both cluster sites in the main PULSAR project. The sites serviced CALD communities that included refugees and asylum seekers and which, due to English proficiency challenges, posed difficulties in recruiting participants for the main PULSAR study (Enticott *et al.*, 2016). This sub-study therefore

sought to examine specific aspects of recovery-oriented practice among CALD groups attending these clinics to better understand diverse consumer groups' needs. Following consultations with the GPs, Iran and Myanmar were identified as the primary source countries for the two clinics. They were among Victoria's fastest-growing 'lower-ranked birth countries', experiencing a 123% and 96% rise between 2011 and 2016, respectively. (State of Victoria, 2016b).

Participants were purposively sampled and recruited as follows:

a) One GP was recruited from each of the two PULSAR cluster sites with high CALD populations. The GPs, who were already participants in the main PULSAR project, were contacted through the PULSAR Team.
b) Consumer participants, aged 18-75 years and receiving mental health care, were recruited through their GPs at the clinics. Eligibility criteria included: being able to provide informed consent; being consumers of participating GPs; being from Iran or Myanmar/Burma (based on birth country, language, or both); having a recent mental health plan, a recent mental health care plan review, having continually received antidepressant medication as treatment for a mental illness, and/or having been diagnosed with a mental disorder(s). GPs provided flyers to eligible consumers to introduce the study. Interested individuals were given more written details pertaining to the study and tasks before consent was requested. All materials, including the QPR, were provided in participants' native languages. A professional translation company was hired to translate (including back-translation procedures) the QPR. Participants were informed that interviews would be conducted in their preferred language.

2.2 Data Collection and Analysis

Data were collected between September and October 2016. GPs participated in 30-minute individual semi-structured interviews (with OUC) at their clinic to explore and record their general views on personal recovery and the QPR tool in key areas: the QPR measure's relevance among CALD consumers; its applicability with their own consumers; and potential cultural and linguistic issues that may arise in using the QPR with CALD communities.

Consumer interviews were conducted by a Burmese general practitioner and an Iranian clinical psychologist who both had clinical and research experience and were fluent in English and their own language. Despite engaging professional translators, the translation quality for the QPR was considered poor by the interviewers for both languages, as evidenced by the literal translation of mental health content. The interviewers were able to identify translation problems and amend the questionnaire before commencing recruitment.

Consumers participated in one-hour, individual, semi-structured interviews conducted in their preferred language by the Persian- or Burmese-speaking interviewer. Interviews were conducted at clinics, with participants first completing the self-administered QPR. Consumers were then asked about: 1) their experience with the QPR questions' clarity and ease of use, and their perspectives about their general knowledge and conceptual understanding of personal recovery; 2) each item on the QPR, including any cultural and linguistic issues encountered in completing them; and 3) their views on possible benefits and application of QPR use. Completed QPRs were not collected by researchers as questionnaire responses were not the present study's focus.

All interviews were audio-recorded. English interviews were transcribed by OUC while non-English interviews were translated into English then transcribed by the interviewers. Framework analysis (Ritchie and Spencer, 1994; Ritchie *et al.*, 2014) was used to analyse qualitative data. A thematic framework developed from literature reviews was refined using transcripts. A coding frame was developed, cross-checked, and refined by team members to ensure quality and integrity. Transcripts were coded using NVivo 11 Pro software (QSR International, 2016) where nodes and sub-nodes were generated. Charting and mapping of themes and cases were also done; thereafter findings were presented and interpreted, using a deductive approach.

The ethnocultural background of the research team included: Australian (n=2), Japanese (n=1), Nigerian (n=1), Burmese (n=1) and Iranian (n=1). The Nigerian, Burmese, and Iranian interviewers had training as a social worker, medical doctor, and clinical psychologist, respectively, and had both clinical and research experience, which informed the interview process.

3. Results

Eleven participants, including two GPs and nine consumers (five males and four females), were interviewed. With an average duration of about 20 minutes, interviews with GPs were generally considerably shorter than those with consumers (mean duration = 90.5 minutes; range 25 – 200 minutes). GP interviews were conducted in English, as were two consumer interviews. Participant responses are presented in line with the thematic framework used for the coding (Ritchie and Spencer, 1994; Ritchie *et al.*, 2014).

3.1 GP Participants

3.1.1 Demographic characteristics

The GPs were immigrants from England and Iran, each with extensive experience working with CALD communities, including refugee populations. Additional information is withheld to safeguard confidentiality, given the limited sample size.

3.1.2 Perspectives on mental illness prevalence among CALD communities

Both GPs reported very high mental illness prevalence among CALD communities in their respective clinics, possibly related to their migration experience. For example:

> *"… within the refugee groups specifically it's quite high. […] at least sort of half the patients would have some kind of mental health issue […] clinical depression or anxiety; […] and then also on top of that you've got sort of PTSD type stuff as well." [GP-01]*

> *"I reckon it's … very high prevalence, […]. Some of them or probably most of them [have] all of these mental issues from home, and then they migrate to Australia because of the… the distance being away from the family, visa concern, and also, the background that they have, their mental health deteriorate[s] very bad[ly]." [GP-02]*

3.1.3 Differences in mental illness between CALD and non-CALD consumers

The contexts and experiences contributing to mental illness were reported by GPs to vary significantly between CALD and non-CALD communities, and within CALD communities. The stigma and discrimination associated with mental illness was also reported to be an important concern among CALD communities.

> *"Most of the patients I am seeing are Iranian and [another non-Australian culture [...]. If I want to explain about the [other culture] patients' [...] mental issues are something that don't have any meaning […] some of them are ashamed, ashamed of what they're experiencing, The Iranian, ...they know about mental issues. Some of them got treatment before in Iran, and although, still there is a barrier between the GP and them, for expressing all of their emotions and their concerns... On the other hand, Australian patients are completely different. They come in and ask for treatment." [GP-02]*

GPs reported that consumers had a diverse range of distressing experiences relating to circumstances of their country of origin (e.g., war, torture, domestic violence, and rape) and that language and cultural differences posed challenges to gaining trust and responding to individual needs.

Differences between CALD and non-CALD consumers in relation to mental health services reported by GPs included: lower health literacy, poorer medical history, adjustment to new social and cultural environments, language barriers, and potentially distressing issues around immigration status, with most CALD consumers on temporary bridging visas.

> *"I think probably health literacy is a big one […] there is adjustment to [a] new culture, new society, and so talking about mental health can sometimes be a very impractical thing [that] doesn't really help them pay their bills […] other issue is the barriers around language which is using interpreters" [GP-01]*

"If you want to send Iranian and [another non-Australian culture] patients to [a] counsellor or [a] psychiatrist, they reckon that, oh, it has effect on my future; and for immigrants, they reckon that, oh, does it affect my case? […] Yeah, the immigration status, this is really something strange here, but this is something that the Australian Aussies, [don't] have..." [GP-02]

GPs reported that poor health systems in countries of origin often resulted in improper diagnosis and treatment for CALD groups. "I think up till now they have multiple medical problems, and very little medical history….and, it's going through all that process and then on top of that, making sure to remember to look after mental health issues. […] and often it is dealing with their key medical issues, or even chronic issues that have not really been treated." [GP-01]

3.1.4 Available options towards more culturally responsive mental health services

While GPs reported lacking guidelines for engaging with CALD consumers, they also reported some resources available to them: culturally diverse staff background; culturally-specific counselling services; psychological and psychiatric services; interpreters; support groups; case managers; and referral services. GPs also described the need for safe spaces and care continuity.

3.1.5 Conceptualization of personal recovery

One GP discussed recovery as follows:

"I …view it as, as an approach to …working with someone to help them become more functional, in terms of …addressing their mental health issues, and being able to, …more… self-manage… it is… about…achieving goals together, so it's more of collaborative I think approach? […]. It's an important shift … Because I think, curative and clinical approach can be seen as non-ending, and I think it does sort of empower the… patient." [GP-01]

This GP also noted that adapting to recovery-oriented care may be challenging among communities that are more familiar with medicalised treatment models of mental health care, where there is an expectation of a 'fix':

> *"… I think … it's again the issue… of introducing those kinds of concepts. First, you've got language barrier, and already you've got low health literacies…and… maybe there is …. a medicalised kind of model that within this group there has been over-reliance on more curative services, so; and then the expectation often is: you fix my problem. So, I think it could be a challenge now. [GP-01]*

3.1.6 Relevance of QPR among CALD consumers - benefits and barriers for use

Both GPs agreed that the QPR is relevant to CALD consumers, \ helping to identify needs and set goals for recovery; touching on different aspects of recovery; empowering the GP and the consumer to actively manage mental health; assisting in referral; and fostering shared responsibility between GPs and consumers.

> *"…it's probably helpful as a tool, to make it more objective […] and then maybe access after some time to see whether there is any improvement, and may also then help to facilitate, referral because sometimes they're quite […] unwilling." [GP-01]*

Nevertheless, two issues were identified by GP participants as challenges: time, and comprehension difficulties due to cross-cultural conceptual differences and language barriers.

> *"I think they […] take a long time to fill in. […] so, I think the 10-15 minutes appointments,[…]doesn't really work. I think fortunately within the refugee health we do, we do have longer time, but then also with interpreter it's sort of makes it more, more, you know…." [GP-01]*

> *"Especially for women, I reckon it is a…bit difficult, because, ...some of the questions for example, ah "I can take charge of my life", for them it is a bit strange. Or, "I am able to access independent support". For them everything is family." [GP-02]*

"It can be relevant, if they can understand the question correctly, and answer properly. […] [For] [s]ome of them […] [t]he concept is different." [GP-02]

3.2 Consumer participants

3.2.1 Demographic and socio-economic characteristics

As presented in Table 1, consumer participants ranged in age from 24 to 51 years, and just over half (55.6%) were male. Five were single, two married, and one each were separated and widowed. Five had lived in Australia for over three years, while others had arrived more recently. Education level was variable and tended to be higher among Clinic One participants.

----- INSERT TABLE 1 HERE ------

3.2.2 General views and understanding of mental illness and personal recovery

Consumer participants generally lacked understanding of mental health and its causes but acknowledged that migration and trauma-related stressors could contribute to mental ill-health.

"I […] used to think that a person with mental health problems is actually mental (crazy)…. Now, I would think that person must have been through a lot […] Migration, leaving her country, etc. could be some examples which might have impacted on her mental wellbeing." [D-03]

Nearly all consumer participants lacked knowledge of the personal recovery concept; either not knowing what it meant or only having a vague understanding of the term. Some described it as a process rather than an outcome.

"It gives me a sense that he [had] before [a] problem with mental health. Now he is recovering. That's what I understand." [R-01]

Some participants had an understanding and views about recovery that align with the personal recovery paradigm:

"For example, here I think about recovery from both physical and mental point of views. I mean financial issues are also included. It's not just mental problems overall so I can have a clear mind to think about social things properly. They are together. But here, it just says "recovering", which isn't clear." [D-02]

3.2.3 Experiences using the QPR

After completing the QPR, consumer participants generally endorsed the instrument as being useful and relevant in helping them reflect and refocus on their mental health situations. For example:

"No it is not very difficult to understand. […]. This questionnaire helps them to think about their mental health situation. And it also helped me to think about myself." [R-01]

The extent to which items' interpretation and relevance was linked to culture versus personal perspectives and experience was still unclear for some participants:

"I think these items depend on individuals more than on cultures. I think these are more like personal questions rather than culturally-related questions." [D-02]

"Those questions, […] people have different feeling, those might be suitable for some people, but might not suitable for some. It […] would be not good to force to use it. There will be no benefit […] From the cultural aspect, this is [a] psychological thing. So, I think for those who have psychological issues, those are very essential questions." [R-03]

3.2.4 Clarity and interpretation of QPR items

Consumer responses about the QPR items' clarity and relevance are consistent with GP participants' observations. Despite the potential relevance of the QPR and the general feeling that it is culturally applicable, some participants reported difficulties understanding specific items, or had different interpretations.

"I had difficulty with the translations. I could not understand them. I did not understand what it means by independent support, does that mean I can do my things independently on my own?" [D-02]

Some concepts posing comprehension challenges included *recovery*, *independent support*, *purposeful life*, how recovery will help challenge people's notions of getting better, and possibly translation accuracy.

For some participants, there also seemed to be problems applying statements to timeframes (i.e., "at the present time, in particular over the last 7 days") and interpreting the response options (*strongly disagree* to *agree strongly*) within given timeframes. Furthermore, understanding and establishing items' relevance to their lives seemed problematic for some e.g., item 17 regarding the recovery process, item 12 regarding taking charge of my life, and item 15 regarding sensitivity towards others.

The idiosyncrasies in some QPR items' interpretations are presented in Table 2, demonstrating the need for careful review of items' face validity, as well as how they translate conceptually across cultures.

----- INSERT TABLE 2 HERE ------

The analysis indicates that some interpretation issues were socio-culturally driven. For instance, with *Q4 (I feel part of society)*, while one participant reported feeling part of society rather than isolated, another person read the item differently. The following comment speaks to how 'society' can be interpreted as a general and global construct or culture-specific, and highlights migration impacts and cultural differences contributing to experience of loneliness.

"I'm a lonely, isolated person if I'd tell you that I'm social I would be lying. This's not my type of society that I can say I belong to it. I'm on a bridging visa; I'm not a part of the society yet. […] I'd still be an isolated individual within the Iranian community..." [D-01]

In relation to explaining their interpretation of *Q6 (I feel my life has a purpose)*, one Burmese participant highlighted close connections with nature among Burmese participants:

> *"Yes, I have a purpose for the future. Purpose, future is something like, if I were a tree, I should be a tree with full of fruit, and should also give a shade for anyone who come and rest under me." [R-03]*

The importance of religion, spirituality and sexuality was also raised by some participants.

> *"I think God would be another item you could add to your list here. Because for me and for so many others like me, when we're in a difficult physical or emotional state, one of the first things we'd think about [is] God. Even our physical bodies would refer to God. I think this might be helpful." [D-01]*

> *"Yeah, it could be (like) about … your sexuality? Yeah, this is not included in here." [R-04].*

There were some indications that completing the QPR together with a GP would yield better information rather than simply giving it to consumers. As noted above, some participants had difficulty understanding several items until they were further explained. One participant highlighted the importance of describing the purpose and benefits of such tools to encourage consumer engagement.

> *"I think so, it is fine to use for patients. Will be OK but you need to explain to get their interest and to be acceptable. It will be not OK, if we say so bluntly..." [R-03]*

3.3 Comparing Consumer vs GP Responses

Both GP and consumer responses reflected similar issues, including the QPR's relevance among CALD consumers, implications for future use, and barriers toward using it.

Participants communicated that the QPR could benefit both consumers and GPs. While expressing optimism on its future use, acceptability and cultural context, participants also suggested useful changes to increase relevance, including accurate translation to consumers' language.

> *"I think it's a good way forward. I think, …having material in different languages will be very helpful… I think time will be the main issue I don't know whether it's, it's possible to simplify some of the… tools? abbreviate them, …. if they can be simpler, just… bearing in mind, low health literacy and also, the additional time needed to using interpreter. I think, if that, that can be taken into consideration, I think it will be more, the tools will be probably, more readily accepted." [GP-01]*

4. Discussion

Issues related to the QPR's cross-cultural relevance explored in this study included: understanding and knowledge of mental health concepts and personal recovery; item content and expression; the QPR's relevance among CALD communities; barriers to its use; implications; and recommendations for future use.

Though a small sample, GPs' views were congruent in reporting high mental illness prevalence among their CALD communities and consistent with existing evidence among refugees/asylum seekers (Khavarpour and Rissel, 1997). Findings are also consistent with the expected impact of environmental changes (i.e., new settlement) on mental health typically experienced by immigrants and refugees (George *et al.*, 2015; Schweitzer *et al.*, 2011). These disruptions in mental health are partially due to stress-related factors, including crisis and post-crisis situations from home countries, acculturation, economic uncertainty, perceived social isolation and discrimination in Australia, immigration uncertainty and separation from family and familiar surroundings (State of Victoria, 2016a). Therefore, changes in environment, society and culture may contribute to CALD consumers' current mental health concerns. Reported differences between CALD and non-CALD consumers by GPs including poorer medical history information, the impact of weaker health systems within countries-of-origin, and poorer health-seeking behaviours, concur with earlier

findings from a similar study (Alegria *et al.*, 2010). CALD consumers were reported to be less likely to seek medical help for their mental illness compared to their non-CALD peers. Consumers from countries with poor health systems, diagnostic and treatment procedures, low health literacy, and high stigma towards mental illnesses, are less likely to seek mental health assistance when needed (Flaherty and Donato-Hunt, 2012), largely due to lacking awareness and services, among other factors (Dow, 2011).

An observed challenge in operationalising personal recovery-oriented approaches among CALD consumers was adaptation to the new concept. This finding aligns with Hungerford and Fox's (2014) study which found that uncertainties among service providers, and especially service users, constitute challenges in operationalising recovery-oriented approaches. These authors suggested more targeted practice-focused education around the concept for both service providers and users. Tension between personal and clinical definitions of personal recovery from consumers' perspectives was revealed in the study, as previously observed by Davies and Gray (2015), with some participants having divergent views on the fundamental definition of personal recovery concepts (Anthony, 1993; Leamy *et al.*, 2016). There seemed to be difficulties in distinguishing between personal and clinical recovery - a common problem in trying to operationalise the recovery paradigm. Moreover, we observed difficulties in translating the term 'recovery' due to the absence of a direct equivalent in Iranian and Burmese languages, highlighting cultural differences and the potential for varying perceptions of the concept, particularly in cultures where English is not the primary language. GPs mentioned that guidelines were lacking on how to better provide services to the CALD and refugee community presenting with mental illness. Having mental health-specific guidelines is consistent with some recommendations from other related studies (Henderson *et al.*, 2011; Wohler and Dantas, 2017). Over the last decade, comprehensive policies and guidelines have been developed in Australia that increasingly emphasise the needs of people from diverse populations such as the Framework for Mental Health in Multicultural Australia (Mental Health in Multicultural Australia, 2014). The National framework for Recovery-oriented Mental Health Services (Australian Health Ministers' Advisory Council, 2013) includes practitioner

capabilities and practices that support the mental health recovery of people from diverse backgrounds.

Consumer participants generally found the QPR useful, but GP participants were concerned about the time taken to complete it. While a brief (15-item) QPR has been proposed (Law *et al.*, 2014; Williams *et al.*, 2015b), its psychometric performance across cultures is not confirmed. Language barriers were another emergent theme, especially explanations and interpretations of the instrument's concepts and items. Using interpreters may help but is expensive and time-consuming. Instrument translation into relevant languages is another possible solution to language and communication barriers (Chien and Chan, 2013). Examples of similar instruments' translations resulting in high validity and reliability include the K6 and K10 (Tesfaye *et al.*, 2010) and the General Health Questionnaire (Montazeri *et al.*, 2003). In this study, the QPR and other relevant documents were translated to participants' local languages, and research interviewers fluent in these languages conducted interviews. Although there is evidence of the QPR's high validity and reliability (Williams *et al.*, 2015a; Law *et al.*, 2014), there was misinterpretation of some items, requiring further examination.

The study found that life goals, important for self-determination, vary across cultures and social-standing. Some cultures place significant importance on family reputation. The QPR, as it stands, takes an individualistic approach to health and wellbeing that is common across most Western societies but may be inconsistent with non-Western societies' socio-cultural nature.

This study was the first to translate and pilot the QPR to compare each item's cross-cultural relevance and appropriateness in an Australian context. Some study limitations contribute to the need for caution in interpreting findings. For instance, the translation quality of the professional translators was considered poor by the interviewers highlights the importance of having translators with sufficient content familiarity to ensure high-quality translations. Fortunately, interviewers were able to correct the questionnaire before recruitment and data collection.

Furthermore, the issues with interpretation were not only about language differences. Table 2 shows the many of the items that consumer participants tended to struggle with were ones that had been identified previously as lacking sufficient face validity or having ambiguous wording, highlighting the importance of having sound psychometric properties (Law *et al.*, 2014; Argentzell *et al.*, 2017).

The time constraints in this pilot study precluded in-depth consultations to ensure QPR items' translation and articulation appropriateness and restricted our ability to supervise interviewers. Therefore, our capacity to foresee issues that may arise during interviews was limited. Time constraints also prevented us from continuing recruitment until we reached data saturation (Ritchie *et al.*, 2014). Consequently, two issues emerged as potentially affecting data quality. First, it is possible that not all participants fully understood the purpose of some questions. This was highlighted by some participants' comments about the QPR's appropriateness as part of 'service delivery', instead of as a recovery assessment tool. Moreover, some discussions were focused more on the meaning of "recovery" to consumers, rather than the tool's appropriateness in assessing it. This is a substantial limitation, and future research could examine how to better conceptualise or translate "recovery" within the QPR, and whether doing so would improve the measure's cultural appropriateness.

Second, due to time constraints and difficulties in recruiting adequate numbers of respondents from the Burmese community, the inclusion criteria were relaxed to include participants who spoke Falam (Chin community) rather than Burmese, which the interviewer spoke. Consequently, the Burmese group was not as homogenous as planned. Our consumer participants ranged between 24 to 51 years in age, which also adds further heterogeneity to our small participant sample and may also have impacted their interpretations of QPR questions.

This pilot study has a limited sample size and concentrates on two refugee communities with distinct migration and settlement pathways compared to other groups, such as economic migrants (Douglas *et al.*, 2019). Therefore, the study cannot definitively determine the relevance and

appropriateness of the QPR across other CALD groups. Rather, findings demonstrate that while overall, use of recovery-based assessment tools would likely be useful and welcomed by consumers across cultures, more work is needed to ensure clarity and cultural appropriateness of QPR items and response options. In addition, findings suggest that cultural appropriateness of the QPR could be improved through added questions pertaining to family reputation, religion or spirituality, and sexuality. This study was able to expose diverse ways mental health and recovery are conceptualised, how the QPR items can be (mis)interpreted, and how interpretations can be influenced by socio-cultural norms. As such, recommended directions for future research on mental health management and QPR use among CALD groups are clearly relayed.

5. Conclusion

This pilot study highlights how socio-cultural norms and constructs can influence interpretations of well-developed instruments like the QPR. While the findings support the QPR's potential utility toward more culturally responsive mental health care, careful review and adaptations of the QPR tool are necessary for CALD groups. The findings have important implications in the context of ongoing, local and international, support for recovery oriented practice and ensuring a focus on assessing whether those from CALD groups are sharing in the positive impact of recovery oriented practice.

6. References

Alegria, M., Atkins, M., Farmer, E., Slaton, E. & Stelk, W. (2010), “One size does not fit all: taking diversity, culture and context seriously”, *Administration and Policy in Mental Health and Mental Health Services Research,* Vol.37 No.1-2, pp.48-60, doi:10.1007/s10488-010-0283-2

Anthony, W. A. (1993), “Recovery from mental illness: the guiding vision of the mental health service system in the 1990s”, *Psychosocial Rehabilitation Journal,* Vol.16 No.4, pp.11-24, doi:10.1037/h0095655

Argentzell, E., Hultqvist, J., Neil, S. & Eklund, M. (2017), “Measuring personal recovery - psychometric properties of the Swedish questionnaire about the process of recovery (QPR-Swe)”, *Nordic Journal of Psychiatry,* Vol.71 No.7, pp.529-535, doi:10.1080/08039488.2017.1346144

Australian Bureau of Statistics. (2017), “Media release - census reveals: we're a fast changing nation”, available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/mediareleasesbyReleaseDate/6E48F1297C95696BCA258148000DBE59?OpenDocument?OpenDocument&ref=story (accessed 8 March 2023)

Australian Bureau of Statistics. (2020), “Australia's population: over 7.5 million born overseas”, available at: https://www.abs.gov.au/ausstats/abs@.nsf/lookup/3412.0Media%20Release12018-19#:~:text=ABS%20Director%20of%20Migration%20Statistics,resident%20population%20were%20born%20overseas. (accessed 8 March 2023)

Australian Health Ministers' Advisory Council. (2013), “A national framework for recovery-oriented mental health services: guide for practitioners and providers”, available at:

https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers (accessed 8 March 2023)

Brijnath, B. (2015), "Applying the CHIME recovery framework in two culturally diverse Australian communities: qualitative results", *International Journal of Social Psychiatry,* Vol.61 No.7, pp.660-667, doi:10.1177/0020764015573084

Chien, W. T. & Chan, Z. C. Y. (2013), "Chinese translation and validation of the questionnaire on the process of recovery in schizophrenia and other psychotic disorders", *Research in Nursing & Health,* Vol.36 No.4, pp.400-411, doi:10.1002/nur.21549

Davies, K. & Gray, M. (2015), "Mental health service users' aspirations for recovery: examining the gaps between what policy promises and practice delivers", *British Journal of Social Work,* Vol.45 No.supplement 1, pp.45-61, doi:10.1093/bjsw/bcv089

De Vecchi, N., Kenny, A. & Kidd, S. (2015), "Stakeholder views on a recovery-oriented psychiatric rehabilitation art therapy program in a rural Australian mental health service: a qualitative description", *International Journal of Mental Health Systems,* Vol.9 No.1, pp.1-11, doi:10.1186/s13033-015-0005-y

Douglas, P., Cetron, M. & Spiegel, P. (2019), "Definitions matter: migrants, immigrants, asylum seekers and refugees", *Journal of Travel Medicine,* Vol.26 No.2, 10.1093/jtm/taz005

Dow, H. D. (2011), "Migrants' mental health perceptions and barriers to receiving mental health services", *Home Health Care Management & Practice,* Vol.23 No.3, pp.176-185, doi:10.1177/1084822310390876

Enticott, J. C., Shawyer, F., Brophy, L., Russell, G., Fossey, E., Inder, B., Mazza, D., Vasi, S., Weller, P. J., Wilson-Evered, E., Edan, V. & Meadows, G. (2016), "The PULSAR primary care protocol: a stepped-wedge cluster randomized controlled trial to test a training intervention for general practitioners in recovery-oriented practice to optimize personal recovery in adult patients", *BMC Psychiatry,* Vol.16 No.1, pp.451, doi:10.1186/s12888-016-1153-6

Flaherty, I. & Donato-Hunt, C. (2012), "Cultural and family contexts for help seeking among clients with cannabis, other drug and mental health issues", *Mental Health and Substance Use,* Vol.5 No.4, pp.328-341, doi:10.1080/17523281.2012.711768

George, U., Thomson, M. S., Chaze, F. & Guruge, S. (2015), “Immigrant mental health, a public health issue: looking back and moving forward”, *International Journal of Environmental Research and Public Health,* Vol.12 No.10, pp.13624-13648, doi:10.3390/ijerph121013624

Henderson, S., Kendall, E. & See, L. (2011), “The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review”, *Health & Social Care in the Community,* Vol.19 No.3, pp.225-249, doi:10.1111/j.1365-2524.2010.00972.x

Hermans, H. J. M. & Kempen, H. J. G. (1998), “Moving cultures: the perilous problems of cultural dichotomies in a globalizing society”, *American Psychologist,* Vol.53 No.10, pp.1111-1120, doi:10.1037/0003-066X.53.10.1111

Hungerford, C. & Fox, C. (2014), “Consumer's perceptions of recovery-oriented mental health services: an Australian case-study analysis”, *Nursing & Health Sciences,* Vol.16 No.2, pp.209-215, doi:10.1111/nhs.12088

Khavarpour, F. & Rissel, C. (1997), “Mental health status of Iranian migrants in Sydney”, *Australian and New Zealand Journal of Psychiatry,* Vol.31 No.6, pp.828-834, doi:10.3109/00048679709065508

Kirmayer, L. J. (2012), “Rethinking cultural competence”, *Transcultural Psychiatry,* Vol.49 No.2, pp.149-64, doi:10.1177/1363461512444673

Kleinman, A. & Benson, P. (2006), “Anthropology in the clinic: the problem of cultural competency and how to fix it”, *PLOS Medicine,* Vol.3 No.10, pp.1673-1676, doi:10.1371/journal.pmed.0030294

Lapsley, H., Nikora, L. W. & Black, R. (2002), “"Kia mauri tau!" narratives of recovery from disabling mental health problems”, available at: https://researchcommons.waikato.ac.nz/bitstream/handle/10289/1666/2002KiaMauriTaureport.pdf?sequence=1&isAllowed=y (accessed 8 March 2023)

Law, H., Neil, S. T., Dunn, G. & Morrison, A. P. (2014), “Psychometric properties of the questionnaire about the process of recovery (QPR)”, *Schizophrenia Research,* Vol.156 No.2-3, pp.184-189, doi:10.1016/j.schres.2014.04.011

Leamy, M., Bird, V., Boutillier, C. L., Williams, J. & Slade, M. (2011), "Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis", *The British Journal of Psychiatry,* Vol.199 No.6, pp.445-452, doi:10.1192/bjp.bp.110.083733

Leamy, M., Clarke, E., Le Boutillier, C., Bird, V., Choudhury, R., Macpherson, R., Pesola, F., Sabas, K., Williams, J., Williams, P. & Slade, M. (2016), "Recovery practice in community mental health teams: national survey", *The British Journal of Psychiatry,* Vol.209 No.4, pp.340-346, doi:10.1192/bjp.bp.114.160739

Lloyd, C., Waghorn, G. & Williams, P. L. (2008), "Conceptualising recovery in mental health rehabilitation", *British Journal of Occupational Therapy,* Vol.71 No.8, pp.321-328, doi:10.1177/030802260807100804

Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., Weller, P. J., Wilson-Evered, E., Edan, V. & Slade, M. (2019), "REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial", *The Lancet Psychiatry,* Vol.6 No.2, pp.103-114, doi:10.1016/S2215-0366(18)30429-2

Mental Health in Multicultural Australia. (2014), "Framework for mental health in multicultural Australia: towards culturally inclusive service delivery", available at: https://www.mentalhealthcommission.gov.au/getmedia/59a020c5-ac1e-43d5-b46e-027c44b94654/Framework-for-Mental-Health-in-Multicultural-Australia (accessed 8 March 2023)

Montazeri, A., Harirchi, A. M., Shariati, M., Garmaroudi, G., Ebadi, M. & Fateh, A. (2003), "The 12-item General Health Questionnaire (GHQ-12): translation and validation study of the Iranian version", *Health and Quality of Life Outcomes,* Vol.1 No.1, pp.171-5, doi:10.1186/1477-7525-1-66

Neil, S. T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W. & Morrison, A. P. (2009), "The questionnaire about the process of recovery (QPR): a measurement tool developed in collaboration with service users", *Psychosis,* Vol.1 No.2, pp.145-155, doi:10.1080/17522430902913450

Ritchie, J., Lewis, J., Mcnaughton Nicholls, C. & Ormston, R. (2014), *Qualitative Research Practice: A Guide for Social Science Students and Researchers,* Sage Publishing, London, UK.

Ritchie, J. & Spencer, L. 1994. “Qualitative data analysis for applied policy research”, Bryman, A. & Burgess, R. G. (Eds.) *Analysing Qualitative Data*, Routledge, London, UK, pp. 173-194

Schweitzer, R. D., Brough, M., Vromans, L. & Asic-Kobe, M. (2011), “Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience”, *Australian & New Zealand Journal of Psychiatry,* Vol.45 No.4, pp.299-307, 10.3109/00048674.2010.543412

Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C. & Slade, M. (2013), “Measures of personal recovery: a systematic review”, *Psychiatric Services,* Vol.64 No.10, pp.974-80, doi:10.1176/appi.ps.005012012

Shawyer, F., Enticott, J. C., Brophy, L., Bruxner, A., Fossey, E., Inder, B., Julian, J., Kakuma, R., Weller, P., Wilson-Evered, E., Edan, V., Slade, M. & Meadows, G. N. (2017), “The PULSAR specialist care protocol: a stepped-wedge cluster randomized control trial of a training intervention for community mental health teams in recovery-oriented practice”, *BMC Psychiatry,* Vol.17 No.172, pp.1-19, doi:10.1186/s12888-017-1321-3

Slade, M. (2009), *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals,* Cambridge University Press, Cambridge, UK.

Slade, M. (2010), “Measuring recovery in mental health services”, *The Israel Journal Of Psychiatry And Related Sciences,* Vol.47 No.3, pp.206-212. ,

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. & Whitley, R. (2014), “Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems”, *World Psychiatry,* Vol.13 No.1, pp.12-20, doi:10.1002/wps.20084

Slade, M., Bird, V., Le Boutillier, C., Farkas, M., Grey, B., Larsen, J., Leamy, M., Oades, L. & Williams, J. (2015), “Development of the REFOCUS intervention to increase mental health team support for personal recovery”, *British Journal of Psychiatry,* Vol.207 No.6, pp.544-550, doi:10.1192/bjp.bp.114.155978

State of Victoria. (2016a), “Delivering for diversity: cultural diversity plan 2016-2019”, available at: https://www.health.vic.gov.au/publications/delivering-for-diversity-cultural-diversity-plan-2016-2019 (accessed 8 March 2023)

State of Victoria. (2016b), “Table 1 Victoria: overseas country of birth, 2016, 2011 census”, available at: https://www.vic.gov.au/sites/default/files/2019-08/Table1VictoriaCountryofbirth2016Censusandchange5July17.PDF (accessed 8 March 2023)

Tesfaye, M., Hanlon, C., Wondimagegn, D. & Alem, A. (2010), “Detecting postnatal common mental disorders in Addis Ababa, Ethiopia: validation of the Edinburgh postnatal depression scale and kessler scales”, *Journal of Affective Disorders,* Vol.122 No.1-2, pp.102-108, doi:10.1016/j.jad.2009.06.020

Whitley, R. (2016), “Ethno-racial variation in recovery from severe mental illness: a qualitative comparison”, *The Canadian Journal of Psychiatry,* Vol.61 No.6, pp.340-347, doi:10.1177/0706743716643740

Williams, J., Leamy, M., Bird, V., Boutillier, C., Norton, S., Pesola, F. & Slade, M. (2015a), “Development and evaluation of the INSPIRE measure of staff support for personal recovery”, *Social Psychiatry and Psychiatric Epidemiology,* Vol.50 No.5, pp.777-786, doi:10.1007/s00127-014-0983-0

Williams, J., Leamy, M., Pesola, F., Bird, V., Le Boutillier, C. & Slade, M. (2015b), “Psychometric evaluation of the questionnaire about the process of recovery (QPR)”, *The British Journal of Psychiatry,* Vol.207 No.6, pp.551-555, doi:10.1192/bjp.bp.114.161695

Wohler, Y. & Dantas, J. A. (2017), “Barriers accessing mental health services among culturally and linguistically diverse (CALD) immigrant women in Australia: policy implications”, *Journal of Immigrant and Minority Health,* Vol.19 No.3, pp.697-701, doi:10.1007/s10903-016-0402-6