REFLECTIONS ON 'CHINTA'

Nepalese Community Consultation on Mental Health Literacy

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Report on Nepalese Community 2021 Consultation on Mental Health Literacy

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Abstract

It is generally agreed that there is a dearth of research in the area of mental health among the Nepalese community in Australia. This report provides findings from a scoping study that consulted with members of the Nepalese community (including international students) regarding their understanding of mental health, the need for further research in this area, and culturally appropriate ways of engaging in that research. Consultations were conducted through basic surveys and focus group discussions in Sydney and Melbourne, providing unique insights into these issues. The levels of understanding about mental health and mental illness was mixed, with some basic knowledge high but other areas based on misconceptions. Community willingness to support friends and family with mental health issues was generally very positive, and yet discussion of mental illness was still contextualised by stigma and taboo. Consultations pointed to a number of issues requiring further consideration such as the intersection between other social problems and mental health issues, community leaders' attitudes, minimal or no access to information, help-seeking behaviours and the insufficient terminology in native language to comprehend the dimensions of mental health issues. For example, the Nepalese word 'Chinta', providing the title of the report, is a catch-all phrase that embraces multiple and diverse meaning associated with mental health and wellbeing. The report concludes with a set of key recommendations and a call for interest in joining a reference group to assist with future research.

Keywords:

Mental health; Mental Health Literacy; Nepalese; Social Determinants of Health; Culturally Appropriate Research

Fields of Research (FOR) codes:

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3 - Good Health and Wellbeing; 10 Reduced Inequalities; 17 Partnerships for the Goals

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A message from the Hon. David Coleman MP

Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention

Thank you for inviting me to be part of your launch today – research like this is critically important, and the partnership between Australia Nepal Public Link and Western Sydney University is to be celebrated. I commend the researchers, the students and members from the Nepalese community here in Australia, and in particular the team of social work students from Western Sydney University.

As the report notes, this is a first. There has been no formal research conducted on mental health issues among the Nepalese community in Australia. The researchers found familiar issues to those in a number of our multicultural communities: the impact of stigma around mental health; the importance of community support and communication; and that a number of people living with mental illness in the Nepalese community are not seeking mental health treatment. This research reaffirms the importance of the Australian Government's policy response on mental health and suicide prevention – a response that includes a strong focus on tackling stigma, on communication, on removing barriers and enablers, and on research itself. It demonstrates our investments are focused on key areas of need – and it underlines the scope of the work we have under way to help ensure Australia's mental health system reflects and responds well to our diverse population. The importance of this work is further underscored by the unrelenting COVID-19 pandemic. This is a formidable virus and it has scant regard for the pressures and challenges that so many of our culturally and linguistically diverse communities – including the Nepalese community – face each and every day.

Mental health and suicide prevention are key priorities for the Australian Government. There is much happening in this space. Our funding support for mental health and suicide prevention is unprecedented. This year's Budget provided $2.3 billion for the National Mental Health and Suicide Prevention Plan – the largest Commonwealth mental health investment in Australia's history. This brings the Government's total estimated mental health spend in 2021–22 to $6.5 billion. This Plan will lead landmark reform in mental health support and treatment for Australians in need – all Australians, including our culturally and linguistically diverse communities.

For these communities specifically, the Government is providing Mental Health Australia with more than $5 million to help ensure the mental health system reflects and responds well to Australia's diverse population, and that quality and culturally responsive care is available when needed most. This includes funding for Embrace Multicultural Australia, an online resource which helps to ensure mental health and suicide prevention resources, services and information are available to a wide range of culturally diverse communities. We are building a world class national network of multidisciplinary mental health treatment centres – through Head to Health and headspace – and are focussing immediate support in COVID-19 outbreak areas, home to numerous CALD communities. In NSW, we established 10 Head-to-Health pop-up mental health support sites in and around Greater Sydney and have extended the operation of 12 similar clinics in Victoria.

The Department of Health is working closely with culturally and linguistically diverse peak organisations in NSW to share information, make translated information and resources easily accessible, and to ensure that CALD communities are getting the information and support they need. Furthermore, the Australian and NSW Governments are jointly funding a $17.35 million mental health support package. This package includes $3 million to support the mental health of vulnerable and culturally and linguistically diverse communities in Greater Sydney, including refugees, through Primary Health Networks and Beyond Blue.

Refugees are a particular focus of the Australian Government. The Program of Assistance for Survivors of Torture and Trauma provides counselling and related support services. Collectively, this is an extensive body of work that aims to ensure our mental health system – and our health system more broadly – reflects and responds to the needs of culturally and linguistically diverse communities. The Australian Government and I look forward to working closely with CALD communities and organisations, including Nepalese people here in Australia, to fulfil that aim.

This is a transcript of the Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention's speech, delivered at the launch of the report on 10 October 2021.

A message from the Hon. Bronnie Taylor MLA

NSW Minister for Mental Health, Regional Youth and Women

Congratulations on the publication of the Nepalese Community Mental Health Research Scoping Consultation report.

It goes without saying that it has been a really tough 18 months, especially for the people of South West and Western Sydney who have remained stoic as they endured some of the toughest restrictions in the second wave of the COVID-19 pandemic.

For our young people, it was a particularly difficult time, with each and every individual confronted by disruptions to their schooling and sporting activities as well as being separated from their friends and loved ones.

Throughout the pandemic, as the NSW Government responded to the threat to our physical health, we also ensured mental health services were introduced or scaled up to support early intervention and vulnerable groups, like our young people and our diverse communities.

When the second lockdown arrived, I was pleased to announce a joint package with the Commonwealth Government worth $17.35 million to ensure the people of NSW, particularly those in Greater Sydney, could access urgent mental health support during this difficult time.

In addition to targeted help for young people, parents, people with eating disorders and those in mandatory isolation, there was a specific focus on supporting people in Culturally and Linguistically Diverse (CALD) communities.

This $3 million investment enabled Beyond Blue and Primary Health Networks to ensure multicultural communities had access to services and appropriate language translation services, with targeted help for communities in South West and Western Sydney.

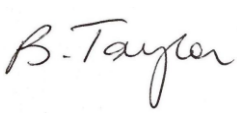
It meant our clinicians could perform outreach into communities and that we could increase access to existing services for people experiencing poor mental health who were born overseas. We focused also on a communications campaign to increase awareness of available mental health services and supports and funded a new CALD phone line as well as boosting existing telephone supports for people from non-English speaking backgrounds.

If this last 18 months has taught us anything, it's that it has never been more important for us to think about our mental health and that of the people around us in our everyday lives.

It has driven home the importance of knowing the signs to look out for that indicate someone might be struggling and trusting your instinct when you notice a change in their behaviour.

I encourage you all to start a conversation about mental health with those around you in your community and importantly, knowing when and how to put your hand up and who to go to for help.

A huge thank you to the Nepalese Community and congratulations on the release of this Scoping Report into Mental Health. I look forward to hearing about the outcomes and working with you to see how the NSW Government can continue to support the community.



The Hon Bronnie Taylor MLC

Minister for Mental Health, Regional Youth and Women

Acknowledgments

We would like to express our immense gratitude to everyone for their contribution in preparing this report. It would not have been possible without the students and community members from Nepalese community in Australia who invested their time and efforts to make their inputs during consultations. We would specifically like to thank the team of social work students from Western Sydney University – Rishika Parathan, Amber Duong, Christina Deng, Amanpreet Bawa, and Si Thu Htet Naing – for their valuable work with the consultations and preparation of the report.

We also gratefully acknowledge the assistance of volunteer members of the Nepalese community – Jyoti Simkhada (President ANPL Victoria), Gaurav Khadka, Dr Sandesh Pantha, Sadhna Sharma, Tara Gaire, Uddhav Khadka, Richa Sharma Aryal, Anil Shrestha and Yashoda Dhakal – who assisted with organising the consultations, and facilitating and scribing for the focus groups. Thanks also to Deep Raj Neupane (an executive member of ANPL), for the cover design of this report.

Thanks also to the Mental Health First Aid team – Prof Anthony Jorm, Kathryn Chalmers and Bharat – who gave permission for us to borrow and adapt questions from their pre/post evaluation questionnaire in developing our survey.

This project has been a real community effort and we look forward to ongoing partnership as we endeavour to use research for positive change for the community.

Neil, Bharat, Dibya and Nirajan

Foreword

Australia Nepal Public Link (ANPL) Inc is a not-for-profit community organisation registered with NSW Department of Fair Trading and Department of Community Services Victoria in 2012 and 2014 respectively. Since its inception, ANPL has been tirelessly working with Nepalese community in Australia raising awareness about mental illnesses and road safety. Western Sydney University (WSU) is situated in one of the most multicultural regions in Australia, and a significant proportion of their international students come from Nepal. They are deeply engaged in research and advocacy around mental health and suicide prevention.

Mental health issues are universal to humankind; Nepalese people are not immune to mental illness. However due to stigma, people are not prepared to speak about it or seek professional help. Nepali language has limited vocabulary to describe mental illness and words that describe different mental illness are used interchangeably which makes it extremely difficult to differentiate if someone is experiencing moderate to severe mental illness or going through rough time.

This collaboration between WSU School of Social Sciences and ANPL Inc is a significant milestone for the Nepalese community in Australia. There is a significant gap in research of mental health in Nepalese community globally. This scoping consultation is the first of its kind and has great potential to bring the Nepalese community and academics and researchers together and undertake culturally appropriate research about mental health issues experienced by Nepalese community in Australia.

We would like to extend our sincere thanks to all facilitators, community leaders and participants for their valuable time and providing input that enabled us to bring this report. We look forward to receiving more support and collaboration in the coming days.

- Nirajan Gauli, President of ANPL Inc

The following is a link to the Nepali transcript of a SBS radio interview about the consultation
https://www.sbs.com.au/language/nepali/mental-health-condition-of-nepalis-in-australia

Introduction

This project is a partnership between Australia Nepal Public Link and Western Sydney University. We undertook a consultation during 2021 with community members and international students from Nepal residing in Australia to understand the mental health literacy among residents from Nepal living in Sydney and Melbourne, with a view to designing a broader research project to explore the knowledge and experience of mental health in the Nepalese community in Australia.

Mental illness is common globally. Despite being a common condition, public perception about mental illness mixed, which could be attributed to poor mental health literacy (MHL). People experiencing mental illness delay seeking professional help. Especially, it is more prevalent in culturally and linguistically diverse (CALD) communities. This could be due to denial/stigma and lack of ability to perceive that mental illness can be treated (Rai, et al 2020). Moreover, people from "non-English speaking backgrounds have reduced mental health services relative to their English speaking counterparts" (Pirkis et. al, p. 175).

The Nepalese community is one of the fastest growing communities in Australia. Understanding and perceptions of the mind and the body relationship is viewed distinctively by the Nepalese community (Jha et al 2018). This view regulates the attitude towards mental and physical illness in the community. Nepalese speaking community members are experiencing mental illness (Rai at al 2020) however its prevalence has not yet been systematically studied. There is an urgent need to understand mental health beliefs and help-seeking behaviours in this community. MHL plays important role in improving the skills and resilience of individuals, carers and family members. It contributes to a reduction in prevalence of mental disorders by improving awareness and by accepting early intervention and treatment related to it.

The findings of this scoping consultation will inform future mental health research with Nepalese community in Australia by exploring and developing culturally appropriate and sensitive ways of conducting future research. This process is to have deep rooted co-design and co-development of community itself that is being studied. Instead of external experts investigating its issues, community participation and direction is at the heart of this process.

Background

Mental health outcome is cumulative result of interaction between numerous biopsychosocial factors at different context and levels which is often beyond individual's control. Poor mental health literacy has been found to be contributing to multiple negative health, mental health and social outcomes (Kutcher, et al. 2016). Some of the few factors impacting mental health of individuals are socioeconomic conditions,

educational attainment, health and spiritual beliefs, tolerance and attitude to self and others, employment, and housing (Silva, Loureiro & Cardoso 2016).

Findings of national level mental health studies of Nepalese population do not exist however a pilot study has been undertaken, which found that 20-30% of population are at risk of suffering from one or more mental illness. This prevalence is comparable to developed countries such as Australia and USA (AIHW 2021 & NAMI 2020), and also found that a significant proportion of people living with mental illness are not seeking mental health treatment. Nationally representative systematic study of mental health help seeking behaviours of Nepalese speaking community has low utilisation of mental health services (Jha 2018).

Simkhada et al (2020) found that mental health service was poorly utilized by UK Nepalese population. Moreover, it was found that UK based Nepalese speaking community had poor mental health literacy. Mental illness is believed to be a spiritual dysfunction or a weak mind and is attributed to spiritual possession, black magic, divine wraths, bad karma and misdeeds in previous lives. As a result, traditional healing is the first point of contact as most people seek help from traditional healers and religious healers in Nepal (Rai, et al 2020). There are strong similarities in between Nepalese speaking people living in United Kingdom and those living in Australia. Nepalese speaking community is one of the rapidly growing communities in Australia. Mental wellbeing of an individual and community is affected by multitude of factors, complex in nature and requires whole of government, public private partnership along with active participation of mental health consumers in service planning, implementation, and evaluation.

Stigma and discrimination among people with mental health conditions is consistently prevalent across the world. However, the magnitude of stigmatising behaviour experienced by people with mental health conditions varies from country to country (Maharjan & Panthee 2019). Self-stigma among people with mental health condition is associated with poor quality of life, low educational attainment, low treatment adherence, poor self-esteem, increase in severity of symptoms, low level of self-efficacy and poor recovery problems. Suicidality is found to be significantly higher in severe self-stigmatising attitude (Maharjan & Panthee 2019). Major problems experienced by Nepalese speaking people with mental illness are stigma and discrimination (Rai et al 2020). Stigma and discrimination could be attributed to a lower MHL in Nepalese speaking community which is manifested by hiding mental health problems, avoiding treatments and/ or seeking alternative care options such as traditional or faith healers (Rai et al 2020).

There is a significant gap in knowledge about treatment and management of mental health conditions amongst public. Nepalese speaking community has very different belief about mental illness and is reluctant to seek professional help and treatment. This belief about mental ill health needs to be explored and

understood to improve mental wellbeing as well as enabling early intervention and professional help seeking. Current understanding is extremely limited. Na, Ryder, & Kirmayer (2016) identify that modifications in mental health service delivery are needed to develop culturally responsive framework for mental health.

Research Focus

This consultation was a scoping exercise with community members (including international students) to:

- ascertain the need for research in the area of mental health among the Nepalese community,
- explore the potential focus areas for such research, and
- seek advice on culturally appropriate strategies to be considered while conducting research on mental health issues in this community.

Some specific questions related to people's mental health literacy (i.e. knowledge and attitudes), community members' understanding of physical and mental health issues, if mental health issues exist within Nepalese community in Australia, and whether community members can access mental health services as needed. It was also seen as important to seek input on what are the barriers and enablers in seeking help, and what are culturally appropriate strategies for conducting research on mental health issues in this community.

Consultation Technique

An invitation to the consultation was sent via email, utilising project partners' networks. Purposive sampling method was used to invite the participants to be a part of the consultation. Purposive sampling 'involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest' (Cresswell & Plano Clark, 2011 cited in Palinkas et. al, 2015, p. 2). This was deemed the most useful method considering the unique needs of migrant communities and known dynamics of the Nepalese community, where stigma is attached to anything to do with mental health.

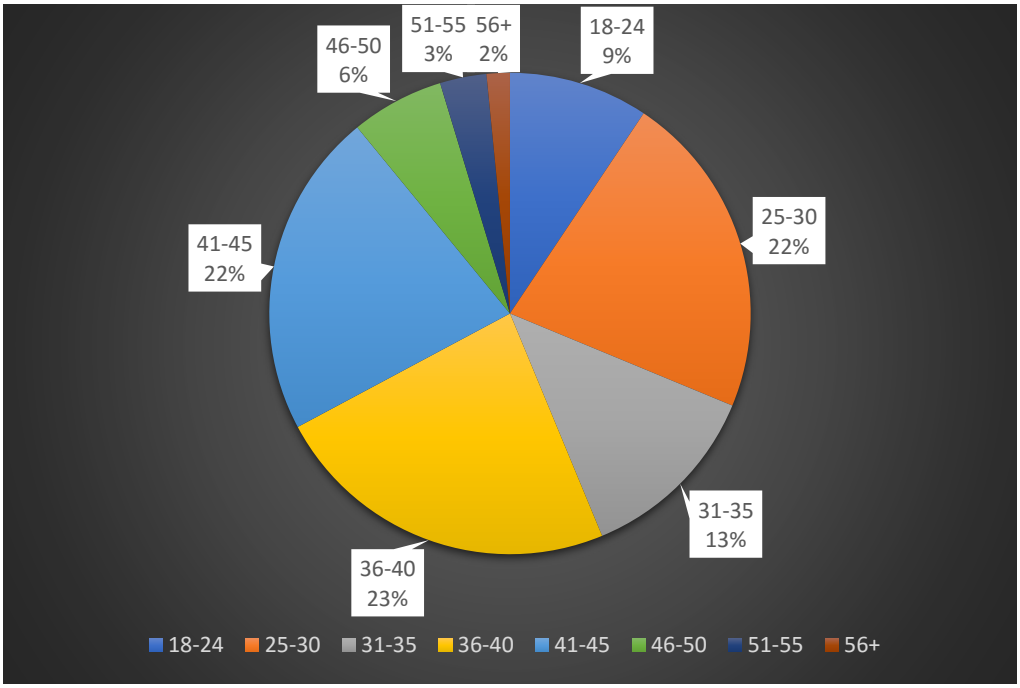
This project adopted an online survey and face-to-face focus group discussions (FGDs) as a multi-method technique. Qualtrics software was used for data collection and analysis. The survey link was shared with the participants during consultations. The focus groups were conducted with 2 facilitators and 5-6 community members. Responses were written down and a subsequent thematic analysis was applied to the notes.

Survey Findings

Participants

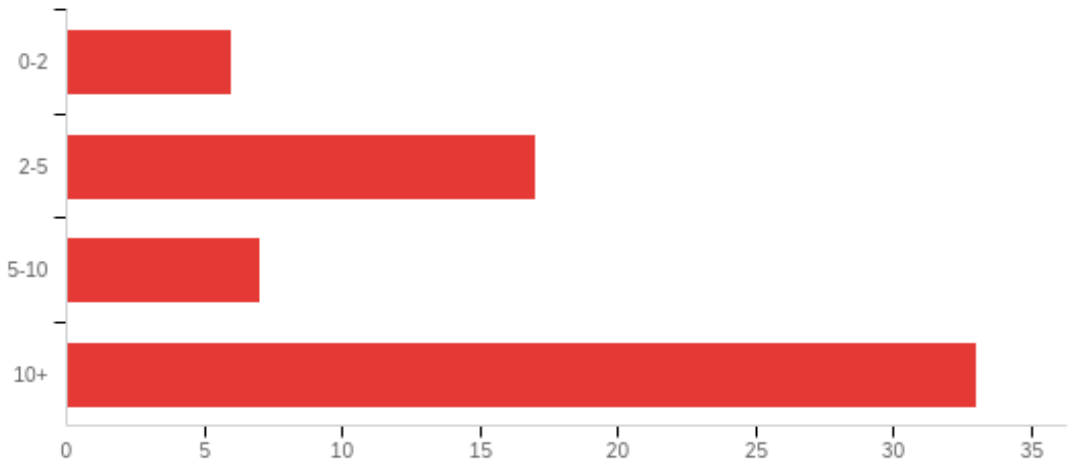
All participants were from the Nepalese community either based in Sydney or Melbourne. There were 63 respondents who completed an online survey - 42 males and 21 females. It is important to note that there were significantly more popele in attendance at the consultations, particularly in Melbourne, but only 63 completed the survey. None of the participants identified themselves as belonging to other gender identities (LGBTIQA+). Participants belonged to different age groups ranging from 18 to 56+, as shown below in Figure 1.

Figure 1: Age of participants



48 participants responded that they were living with a partner and 16 people as living single. When asked the number of years they lived in Australia, the answers varied from 0-10+. As seen below in figure 2, the number of respondents having lived in Australia for less than 2 years is primarily an indication of the students who participated in the consultations. However, it is remarkable that 69% of respondents answered as living in Australia for more than 10 years. This can be an indication that most of them had familiarity with Australia's health/mental health system.

Figure 2: Number of years living in Australia



Mental health literacy

- When asked if half of all people who experience mental illness have their first episode by age 18, 49 of them agreed and 11 disagreed. The other statement on depressive order stated it as the most prevalent mental illness in Australian population to which 54 participants agreed and 5 disagreed.
- 27 respondents agreed that it is important for them to force (if they can) a person who is depressed to and does not want to seek professional help however, 32 participants disagreed. 54 people mandated that exercise could help relieve depression while 4 denied.
- 42 respondents agreed on the role of antidepressant medication as an effective treatment for most anxiety disorders but 18 disagreed. On the claim that a good relationship with family means someone with a mental illness is likely to relapse, 52 respondents agreed and 7 disagreed.
- There was a statement indirectly linking drug and alcohol problem with mental health that stated – 'A good way to help a person with a drug or alcohol problem is to let them know that you strongly disapprove of their substance use'. While 27 respondents agreed to this, 32 disagreed.
- When stated if it was not a good idea to ask someone if they were feeling suicidal that actually would give them the idea, 19 respondents approved while 39 disapproved. 42 respondents agreed that it is best to make people talk about any traumatic experience they had as soon as possible but 15 disagreed.

Likert scales were used to ascertain respondents' understanding of, and perceptions towards, people having mental illness, as well as their willingness to support family/friends with mental illnesses. Figures 3 and 4 (following) summarise the outcomes obtained from responses received via survey. These figures correspond to Tables 1 and 2 (respectively) of raw data found in Appendix A.

Initially, it was evident that participants' understanding of mental illness was mixed. For example, 27.59 % percentage of participants strongly agreed that people with mental illness could get over it they wanted while 20.69 % of them strongly disagreed. Rest of them chose the one or the other options in middle. This indicates that the community members have general understanding of mental illnesses however, it is important to consider that myths about mental illnesses highly exist from total number of respondents who either strongly disagreed, disagreed or neither agree nor disagree that makes 46.55%.

68.5% of respondents either strongly agree, agree or neither agree nor disagree that a mental illness is a sign of personal weakness. This manifests the low level of mental health literacy among Nepalese community members. However, interestingly 66.04% respondents either strongly disagreed or disagreed that a mental illness is not a real medical illness. If these two responses are compared, it demonstrates that most people in the community understand mental illness as a medical illness however, they also have a strong belief that it can be healed with the support from community and family members. This indicates the collective attitude of the community.

Figure 3: Respondents' perceptions of mental illnesses

Respondents' understanding of mental illness as a medical illness is also manifested in their responses to fourth, fifth and sixth statement where 58.82% people either disagreed or strongly disagreed to the statement that people with mental illnesses are dangerous. Similarly, 75.93% of participants disagreed that they might get mental illness if they are in contact with someone with mental illnesses. 80.77% disapproved or strongly disapproved that they would not tell anyone if they had mental illness. Participants' responses to final three statements that summarised the help-seeking behaviour demonstrate that people in the community are inclining to seek help from professionals to address their mental health issues if needed. 79.25% respondents either strongly disagreed or disagreed that visiting mental health professional deem them as not being strong enough to manage their difficulties. Only 8.33% of people either agreed or strongly agreed or neither agreed nor disagreed on not seeking help from mental health professional if they had one. 86 % of the participants expressed their beliefs on the effectiveness of treatment for mental illness provided by a mental health professional. However, it is also important to note that respondents openly shared myriad of barriers in accessing help from professionals significantly in focus group discussions.

Figure 4: Willingness to offer support to family/friends with mental illness

As can be seen in Figure 4 above, there is a general expression of good will towards people with a mental illness. 87% of respondents broadly agreed to a willingness to move next door to someone with a mental illness. Similarly, 90% broadly showed willingness to spend an evening socialising with someone having mental illness. While 24 participants expressed their willingness to befriend someone with mental illness (49%), 31 respondents were willing to have someone with mental illness start working closely with them on a job (62%). Almost 65% of the respondents broadly expressed willingness to have someone with a mental illness marry into their families.

These figures demonstrate that the community members are keen to enhance their knowledge and understanding of mental health issues with more accuracy and wider perspectives. Overall, the percentage of respondents willing or strongly willing to support family and friends with mental illnesses in different ways as shown in the above figure is certainly higher than other who are less willing or not willing to support them. This could be the reflection of participants' awareness about mental health issues gained through their participation in mental health first aid training workshops.

Focus Group Discussions

Focus Group Discussions (FGDs) were held in conjunction with online survey to gather rich and reliable information to assess mental health literacy of people and explore the need of research on mental health issues in Nepalese community. Focus groups were held separately for international students and community members in Sydney however, they were combined in Melbourne.

Each focus group had 4-5 participants and one facilitator. The session started by asking participants to reflect on 'chinta', the most popular term used in the community to denote anxiety. The questions were asked in two sessions (with lunch break in between). The first session aimed to gather general information, and the second focused on obtaining more information about mental health literacy.

Focus group questions: First Session

- To what extent do you think mental illness exists in your community?
- What are examples of mental health and mental illness in your community?

Focus group questions: Second Session

- What are barriers to help-seeking?
- What are aids to help-seeking?
- Are there any differences between physical and mental health in relation to help-seeking?
- What would be culturally appropriate ways to conduct further research on this topic?
- Any other written/verbal comments in Nepalese?

'Chinta'

Reflections on *'chinta'* were insightful. The session exposed that the word *'chinta'* is a term profoundly used by community people and encompasses different mental health conditions such as anxiety, stress, depression etc. One of the respondents shared:

> *If people do or act anything different than others (crazy) that is not normal then, they are labelled as mad. Family and friends wouldn't have a clue that the person might be in need of mental health support.*

The other participant shared that people are unaware of differences between the severity of different mental health conditions and eventually use the most common word for all of them since most of them go undiagnosed.

Another respondent shared:

> *It is very common for people in Nepal to utilise traditional and alternative treatments for mental health conditions such as religious healing, organising religious functions with family, and visiting religious gurus, astrologers, dhamis, jhankris etc. This is because it is understood as an impact of people's bad actions of their previous lives. Someway this trend influences people's attitude towards mental health despite their relocation.*

Six different themes emerged from focus group discussions, which largely aligned with the results from the online survey and aimed to identify several dynamics of the Nepalese community's understanding of mental health issues.

Research in mental health space is non-existent.

There is a paucity of research on mental health literacy in migrant communities in Western countries globally. In Australia, very little research has been done in this space, and no formal research conducted on mental health issues among the Nepalese community in Australia. Participants shared that they have come across research on mental health conducted in other migrant communities funded by NSW government however there is none in the Nepalese community. Some TV channels and newspapers run by community members highlight mental health as one of the significant issues among Nepalese people in Australia. However, most of them are not research-based and considered by the community as unreliable.

Intersection between other social problems and mental health issues is unexplored.

Based on their experiences, participants shared that there are open/direct discussions on some social problems such as Domestic Violence (DV), Family Domestic Violence (FDV), gambling, financial infidelity, relationships breakdowns, disability etc, however the impacts of these problems on individuals' and families' mental health are not addressed. One of them said:

> *All of these social problems make remarkable impacts on people's mental health. However, they are addressed in isolation disregarding the mental health problems. I think, this can be one of those areas to identify mental health issues.*

The other participant opined:

> *Based on my experiences of working with women in the community who have been in DV, I can say, that there is absence of much required conversations about their mental health. As most of the DV cases are negotiated within the family and friends, no one talks about the mental health aspects of both perpetrators and survivors. Moreover, even when professionals are involved, neither party show willingness to address their mental health concerns.*

Community leaders'/members' dismissal/attitude/ignorance towards mental health issues.

Participants widely discussed that there is minimal initiation from community leaders and members to organise relevant programs and workshops to raise awareness about mental health issues. Even though awareness programs on different other issues are frequently organised, those on mental health issues almost do not exist. One of the community leaders in the focus group shared:

> *I have been a part of meetings and programs on different issues over the years of my stay in different states in Australia however, I have never (actively) involved in the programs related to mental health.*

Respondents openly mentioned that mental health illnesses are understood as an individual's deficit that stops people from sharing about their problems with family, friends and even health professionals.

Another interesting aspect discussed in the focus groups was the impact of socio-cultural-spiritual understanding of mental health issues in Nepal that get transferred in people's lives even when they migrate to Australia. On this note, one participant said:

> *Nevertheless, people migrate to Australia, their understanding of mental illness still remains the same. In Nepalese society, mental illness is a huge stigma and not accepted as medical illness.*

Moreover, large number of people do not even know that mental illness can be diagnosed and treated. Ignorance plays crucial role as well. These influences mental health literacy of Nepalese community anywhere across the world, similar is the case in Australia.

Minimal or no access to information about several aspects of mental health.

One of the major topics raised in all focus groups across the board was the lack of access or less access or no access to information about mental health. Respondents highlighted that the language barrier prevents people from obtaining accurate information about the mental health issues as English is second language for people from CALD communities, in this case for Nepalese people residing in Australia.

One of the participants shared the view:

I think that it is important to utilise culturally appropriate strategies while conveying the message about issues like mental health. People won't get across the message if their cultural understanding of any issue is completely different from what is being conveyed to them.

Another respondent threw spotlight on the dismissal of mental illness and shared:

People openly send their good wishes when someone is physically sick and make time to meet them helping them in their recovery journey. However, when someone is mentally ill, the response is completely different. It is ignored. There is a wide misunderstanding about the correlation between physical and mental health. They are understood as two different entities rather than a totality. This is because people in community do not have accurate information about the symptoms and impacts of mental health problems in individual's overall health.

Respondents also drew attention to the fact that while some people in their own family and friendship circles **can't** navigate the information about mental health, others **don't**. There is minimal access to the information on causes, treatment, and medical facilities/services for mental health problems.

Insufficient terminology in native language to comprehend dimensions of mental health issues

Respondents shared 'Pagal' (Lunatic/mad) and 'chinta' (anxiety) as the most common words used in general to refer to anyone having mental health illnesses/problems in the community. One participant opined that the word 'depression' is becoming a buzz word nowadays and is widely used in general conversation mostly among the young generation in the community. It was discussed that people are not familiar with using language adequately to refer to different mental health conditions that have varied impacts on people's health. Moreover, mental health terminology is not accurately understood in the community. As shared in

FGDs, terms related to mental health in Nepalese language are thought to be more stigmatised than the ones in English. This prevents people from having conversations about any sort of mental health problems let alone about the illnesses.

Help seeking behaviours

This theme was most widely discussed and explored in all focus groups. Respondents highlighted different factors that influence people's help-seeking behaviours to address their mental health problems. One of the international students shared her experience:

> *I was unable to identify my mental illness for many months even though I had conversations with the GP about different physical symptoms I had because of my mental illness. It took me a while to dare to visit a mental health professional. Moreover, I couldn't get the treatment and support as expected from my counsellor and had to find another. I have not been able to talk about this with my family members and my acquaintances. My family expects me to be strong and successful, earn money and help them pay the debt, buy property, and live a better life. There is lack of social support and deeply entrenched stigma attached with mental illness. A person with mental illness brings huge shame and embarrassment not only to own self but also to the family.*

Another international student added:

> *I have been making hard efforts to find a professional who can understand the challenges I am facing because of my mental illness. I have been diagnosed with one, but I must say that it is a nightmare to find mental health professional who can support us that fits in our context. Moreover, getting a diagnosis itself is a hassle. I think, more culturally competent practices are required to help people identify their mental health issues and get relevant support/treatment once they are diagnosed.*

One of the respondents opined:

> *I think it is important to have a role model in the community. If community leaders/people share their stories of having mental illnesses and their struggles of recovery journey, it inspires others to share their mental health concerns. It also eases the avenues to have discussions about these issues in the community. Now, this is missing out. No one dares to share their stories.*

Interestingly, one of the factors discussed was the fear that an individual's mental health illness will be known by people in the community. One of the respondents opined:

Nepalese community is relatively small in Sydney, and we have a culture/tendency of asking about every other people we know in the community. Perhaps, it is our collective culture that sometimes make us intervene other's privacy and ask information. It might be also because what is private and what is not is different in communities like ours than in European and Western communities. This increases the chances that someone's consultation with mental health professional might not remain a confidential information. Thus, people are discouraged to visit a mental health professional (psychologist /psychiatrist/ counsellor).

In a nutshell, the following are significant barriers to accessing mental health services and supports for people in the community:

- Lack of family and peer support
- General cultural beliefs about mental health problems/issues (a taboo topic – challenging conversations)
- Lack of social support
- Visa conditions
- Judgmental attitude of family, friends, and community
- Chances of losing jobs
- Fear of negative outcomes
- Peer pressure (social media --- everything is fine --- life abroad is a luxury)
- Societal expectations (be a happy individual)
- Fear of being labelled as different/abnormal

Respondents also discussed about the enablers that aid or might support community people to seek mental health support when required. Most of the international students openly discussed that their exposure to the information disseminated via media enables them to understand the gravity of mental health problems in Australia. This allows them to use a wider lens to understand about this issue. Respondents from the community highlighted that despite the lack of information in Nepalese language, for some of them it was convenient to obtain the information if needed.

Recommendations to integrate culturally appropriate strategies for future research

1. Utilize broader contextual approach to define and navigate mental health issues existing in the community (use of ecological model)
2. Refer to the similar research in mental health sector in other communities
3. Use of appropriate translation services to comprehend the extent of the issues (accurate translations of words from English)
4. Strategize sustainable approach to meet the research aims for e.g., form a reference group for long-term mental health research in Nepalese community
5. Include voices from other groups (female, people with disability, LGBTQIA+ etc) within the communities in the research to achieve the most valid outcomes
6. Build a research framework that facilitates to get the most reliable sample and genuine responses --- sample sizes and sampling methods must meet the research aims (different factors will influence the sample size and participants)
7. Use of more appropriate research methods (interpersonal) rather than online surveys to capture the real picture of the issue – One of the options discussed was to use stories to get responses from people (Story telling as research method)
8. Use different wordings to communicate about mental health as it is heavily stigmatized. Inviting people from community to have a conversation about mental health issue is big challenge.
9. Navigating pathways to open dialogues about mental health issues with communities at grass root level (down to top approach)

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Appendix A: Raw data

Table 1: Respondents' perceptions towards/understanding of mental illnesses

#	Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
1	People with a mental illness could get over it if they wanted	20.69%	13.79%	12.07%	25.86%	27.59%	58
2	A mental illness is a sign of personal weakness	33.33%	27.78%	9.26%	14.81%	14.81%	54
3	A mental illness is not a real medical illness	24.53%	41.51%	1.89%	15.09%	16.98%	53
4	People with mental illness are dangerous	33.33%	25.49%	13.73%	17.65%	9.80%	51
5	It is best to avoid people with a mental illness so that you don't develop the same problem	48.15%	27.78%	7.41%	12.96%	3.70%	54
6	If I had a mental illness, I would not tell anyone	38.46%	42.31%	3.85%	13.46%	1.92%	52
7	Seeing a mental health professional means you are not strong enough to manage your own difficulties	49.06%	30.19%	1.89%	13.21%	5.66%	53
8	If I had a mental illness, I would not seek help from a mental health professional	47.92%	43.75%	2.08%	2.08%	4.17%	48
9	I believe treatment for a mental illness, provided by a mental health professional would not be effective	38.00%	48.00%	4.00%	4.00%	6.00%	50

Table 2: Willingness to offer support to family/friends with mental illness

#	Question	Very willing	Willing	Not really willing	Never willing	Total
1	How willing would you be to move next door to someone with a mental illness?	33.93% 19	53.57% 30	10.71% 6	1.79% 1	56
2	How willing would you be to spend an evening socialising with someone with a mental illness?	41.51% 22	49.06% 26	7.55% 4	1.89% 1	53
3	How willing would you be able to make friends with someone with a mental illness?	42.86% 21	48.98% 24	8.16% 4	0.00% 0	49
4	How willing would you be to have someone with a mental illness start working closely with you on a job?	28.00% 14	62.00% 31	8.00% 4	2.00% 1	50
5	How willing would you be to have someone with a mental illness marry into your family?	17.31% 9	48.08% 25	32.69% 17	1.92% 1	52