B better mental health for all: A multilingual multimedia community awareness campaign promoting the mental health and wellbeing of children, adolescents and young people

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The Transcultural Mental Health Centre (TMHC) of New South Wales (NSW), the New South Wales Health Department’s Centre for Mental Health and the Special Broadcasting Service of Australia (SBS), together developed a mental health community awareness campaign in 15 community languages. The aim of the community awareness campaign was to promote the mental health of children, adolescents and young people from a non-English speaking background (NESB). This aim was achieved through the implementation of the following objectives:

- ensuring that people of a NESB are better informed about mental health issues and mental health services for children, adolescents and young people (this objective included raising parents’ awareness on a variety of mental health issues);
- increasing parents’ mental health literacy by educating on the identification of early warning signs, indicating the onset of a mental health problem; improving the knowledge base of, and access to, mental health services; and encouraging parents and young people to seek assistance at the earliest possible time; and
- reducing stigma surrounding mental illness in families of NESB, by addressing many of the myths and misconceptions parents may have about mental disorders and providing evidence-based information on mental health issues.

A combination of qualitative and quantitative methods were utilised to evaluate the impact of the community awareness campaign. The aim of the evaluation
methodology was to collect data to inform future planning, the development and evaluation of how to carry out large scale, broad based community awareness campaigns for people from NESB. The evaluation methodology was not set up to collect data that could necessarily represent the views of the targeted language based communities.

This chapter outlines the key processes that were followed during the planning, development, implementation and evaluation phases of the community awareness campaign. The partnerships that were essential in achieving these key processes are discussed. The chapter also details practical insights on how to successfully develop multilingual packages for multiple NESB communities, while identifying the barriers and facilitators to developing culturally and linguistically appropriate resources.

**Incidence and Prevalence of Mental Disorders in Children, Adolescents and Young People from NESB**

The results of the child and adolescent component of the National Survey on the Mental Health and Wellbeing of Australians (Sawyer et al., 2000) show that approximately 14 per cent of children and young people (4–17 years) experience mental health problems. Also the main Survey indicated that over 25 per cent of all young adults (18–24 years) suffered from at least one mental disorder over a 12-month period (Commonwealth Department of Health and Aged Care, 2000).

In NSW it has been estimated that at any one time, one in five children and adolescents will experience mental health problems (NSW Health Department, 1999) with only 29 per cent of children and adolescents with a mental health problem contacting a professional service (Commonwealth Department of Health and Aged Care, 2000).

Despite the dearth of accurate statistics on the prevalence of mental health problems experienced by children, adolescents and young people of NESB, recent research suggests that NESB groups underutilise mental health services (McDonald & Steel, 1997, Minas, 1991). Although the prevalence of mental health problems may not be less (McDonald & Steel, 1997) the lower use of services may be an indication that NESB children and adolescents are high-risk groups unlikely to be engaged by the early intervention strategies that target majority populations.

Minas, Lambert, Kostov and Boranga (1996) listed the following reasons for the underutilisation of mental health services by communities of NESB:
- lack of information about available services;
- reduced access to services due to language and cultural barriers;
- greater stigma attached to mental illness and the treatment of mental illness by some communities; and
- the somaticisation of psychological problems in some communities resulting in misdiagnosis and inappropriate treatment outcomes.
Children, adolescents and their families from a NESB may also be at risk for poor mental health outcomes as a result of:
• intergenerational and intercultural conflict;
• lack of English language ability;
• resettlement processes;
• migration or refugee experiences;
• grief and loss relating to the migration experience, as well as separation from family members;
• post-traumatic stress from experiences prior to resettlement, difficulties with acculturation;
• possible experiences of racism and discrimination;
• marginalisation;
• educational disadvantage;
• isolation; and
• lack of knowledge about systems and services (NSW Health Department, 1998; Sozomenou et al., 2000).

The above points highlight the importance of improving mental health literacy among NSW’s culturally diverse population and establishing initiatives to promote the mental health and prevent the onset of mental health problems and disorders. The specific needs of individuals and families from a NESB have often been overlooked in wide scale mental health promotion based education campaigns (Jorm et al., 1997; Mrazek & Haggerty, 1994; Marshall & Watt, 1999, cited in Pope et al., 2000). Makara (1997) argued:

that currently used tools of health promotion and primary prevention can at best only achieve solid results among the middle and upper-middle classes of society. This also means that effective health promotion is likely to contribute to the increase of social inequalities in health. The old health education and prevention dogmas are often useless among the poor, ethnic minorities, the unemployed and immigrants (p. 97).

Therefore, the development and evaluation of well documented evidenced-based strategies for communicating mental health issues to NESB communities is a priority area.

Planning and Policy Context

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000) is underpinned by the US Institute of Medicines mental health intervention spectrum for mental disorders (Mrazek and Haggerty, 1994). The framework (see
Figure 8.1) differentiates between the prevention of mental health problems and disorders and mental health promotion, but notes that:

Although the goals of prevention and promotion differ, there is often considerable overlap. An intervention aimed at increasing wellbeing in a community (promotion) for instance, may also have the effect of decreasing the incidence of mental health problems (prevention). Intervening early for mental health problems (early intervention) may prevent the development of diagnosable disorder (prevention) (Commonwealth Department of Health and Aged Care, 2000, p.7).

**Figure 8.1: The Spectrum of Interventions for Mental Health Problems and Mental Disorders. (Source: Commonwealth Department of Health and Aged Care (2000, p.7).**

The National plan contrasts the goals of prevention with that of mental health promotion in the following way. Prevention is defined as ‘interventions that occur before the initial onset of a disorder’. Mental health promotion is defined as ‘any action taken to maximise mental health and wellbeing among populations and individuals’ (Commonwealth Department of Health and Aged Care, 2000, p.6). For mental health promotion proponents mental health is not viewed as simply the absence of disease, but rather as:

The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice. (Commonwealth Department of Health and Aged Care, 2000, p.5).
The National plan recognises the importance of the level of mental health literacy within a community as underpinning its ability to ‘develop the structures to promote mental health, prevent mental ill health, and recognise and respond early to mental health problems and mental disorders’ (Commonwealth Department of Health and Aged Care, 2000, p.22). The National plan provides the following rationale for carrying out such programs:

There is a high level of misunderstanding about mental health problems and mental disorders in the Australian community which contributes to the stigma and discrimination experienced by people with mental disorders. It also discourages people from seeking early and appropriate help for mental health problems and disorders. Community acceptance, valuing, inclusion and support of all members, regardless of disability, or other perceived differences, and a commitment to enhancing mental health for all, provides a basis for the wellbeing of all Australian communities (Commonwealth Department of Health and Aged Care, 2000, p.22).

In part, this last statement encapsulates much of what this project has been directed towards achieving.

The project can be conceptualised as part of a larger framework as outlined in Caring for Mental Health in a Multicultural Society: A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds (NSW Health Department, 1998, p.1). The project is one initiative that works in partnership with other key strategies to improve the mental health and wellbeing of children, adolescents and young people from culturally and linguistically diverse communities. Figure 8.2 illustrates the larger framework that utilises a range of strategies to achieve the principle aims of:

- providing an effective mental health system to meet mental health needs in a non-discriminatory and sensitive manner taking into account the social, cultural, linguistic and religious values and practices of all people living in NSW; and
- improving the mental health and wellbeing of all people from culturally and linguistically diverse communities living in New South Wales (NSW Health Department, 1998, p.1).

This project specifically addressed strategies 1 and 4 from Caring for Mental Health in a Multicultural Society (NSW Health Department, 1998). Strategy 1 relates to the provision of information on mental health and mental health services to people of culturally and linguistically diverse backgrounds in a manner which is sensitive to their cultural values, practices and language by following a rigorous process of consultation with the targeted communities. This will ensure that resources are culturally and linguistically relevant and meaningful. Strategy 4 relates to the promotion of positive mental health attitudes within the targeted communities.
Rationale of the Project Strategy

The effectiveness of the use of radio and print materials as tools to present health messages that influence public attitudes and change behaviours in the area of mental health has some support in the literature. The rationale for choosing radio and print over other types of mediums is that:

an effective television production has a very high per-exposure cost and that radio is a more cost-effective way to present health messages. Radio programs also have the advantage of reaching people in their homes or cars or at work. Brief segments may be particularly cost-effective because they can be inserted between programs during prime-time hours. Print media — newspapers, magazines and newsletters — can be cost-effective if magazine or newspaper space is free. . . . One advantage of print is that it can be re-read, clipped out, copied and passed on (Austin & Husted, 1998).

Other lessons learned from more general campaigns indicate that effective campaigns need to be multifaceted in nature and part of a larger strategy that directly or indirectly supports the aims of the campaign.

In 1995 the Community Awareness Program (CAP) was launched with the aim of increasing community awareness about mental illness and reducing stigma and discrimination associated with people experiencing mental illness.
CAP was essentially a multimedia advertising campaign comprising of a number of strategies (TV, posters and brochures). Successful aspects of the campaign included:
• the use of an integrated multilevel approach using a range of media and other strategies;
• the use of radio programs; and
• print media options.

Overall the campaign was considered successful in reaching target audiences, and increasing awareness of the health message promoted. Translation of awareness into behaviour change was less evident, due to the complexity of establishing such an association (The National Mental Health Strategy, 1998. p.14).

While CAP did not specifically target people from culturally and linguistically diverse communities, the Australian Transcultural Mental Health Network (ATMHN) was established in 1995 with funding from the National Mental Health Strategy to contribute to the CAP activities. The result was the publication Reducing stigma about mental illness in transcultural settings: A guide (Bakshi, Rooney, & O’Neil, 1999).

The main objective of the guide was to ‘provide an understanding of the process by which multiple factors interact to produce stigmatisation of those with a mental illness’ (p. 1).

The guide offers two ways to reduce stigma about mental illness:
• increasing community acceptance of mental illness and knowledge of mental illness; and
• reducing stigma at different levels simultaneously (at a service delivery, community and individual level).

The guide emphasises that ‘to reduce stigma surrounding mental illness in NESB communities, strategies need to be multifaceted to provide the maximum chance of accessing all members’ (Bakshi et al., 1999, p.14).

Methodology

Collaborative framework

An integral component of the project was the formation of partnerships with:
• 23 bilingual consultants;
• the NSW Health Department’s Centre for Mental Health;
• SBS Radio and SBS Languages Translation Services;
• community participants involved in the focus groups (and telephone interview questionnaire); and
• TMHC Mental Health Promotion Subcommittee (see Appendix A).
The TMHC Subcommittee oversaw the project. The subcommittee was made up of Area Health Service representatives, multicultural health workers, consumers and community workers. The subcommittee often provided support, advice and direction on many facets of the project.

The partnerships required a coordinated response across a number of organisations; and they provide the foundation upon which future TMHC mental health promotion initiatives, particularly with the communities themselves, can be built.

Partnerships with bilingual workers required the development of protocols and accountability systems that ensured quality outcomes throughout the project. It was also necessary for the project to develop an innovative marketing and distribution strategy for the resources developed, including the development of new partnerships to negotiate for:

- airplay time on regional community radio stations;
- public libraries that held community language sections to stock copies of the multilingual materials developed;
- writing articles for publication;
- writing to key agencies and individuals; and
- writing promotional articles to each of the ethnic media.

A separate report (Spiteri, 2001) documents the dissemination strategy of the project in greater detail.

Aims and Objectives

The campaign focused on building bridges between (i) families from culturally and linguistically diverse backgrounds and (ii) the NSW health system and other related support services. The project focused on providing information to parents about the mental health needs of children, adolescents and young people 24 years of age or under from a NESB.

The overall aim of the community awareness campaign was to promote the mental health of children, adolescents and young people from NESB. The objectives of the project were implemented through a statewide, broad-range, multilevel community awareness campaign targeting 15 community language groups. The objectives were:

- to ensure that people of a NESB are better informed about mental health issues and mental health services for children, adolescents and young people (this objective included raising parents’ awareness on a variety of mental health issues);
- increasing parents’ mental health literacy by educating them on the identification of early warning signs, indicating the onset of a mental health problem;
improving the knowledge base of, and access to, mental health services; and
e励ng parents and young people to seek assistance at the earliest possible
time;
• to reduce stigma surrounding mental illness in families of NESB, by addressing
many of the myths and misconceptions parents may have about mental disorders
and providing evidence-based information on mental health issues.

These objectives were implemented through a range of strategies:
• the dissemination of this new information to families of the 15 language groups
targeted via the production and distribution of a culturally appropriate Family
Help Kit (FHK) dealing with nine mental health issues;
• the dissemination of this new information to mental health professionals, com-

munity health centres, general practitioners, multicultural community welfare
agencies and workers, ethnopspecific community organisations, early childhood
centres, specialist child and adolescent services, youth centres, allied health
workers and other key groups;
• the production and dissemination of audio tapes in fifteen community languages
on a variety of mental health issues; and
• the coordination and evaluation of a statewide radio campaign on nine mental
health issues in fifteen community languages.

Selection of Fifteen Language Groups to be Targeted

Approximately 15.7 per cent of the population of NSW were born in a non-English
speaking country. This figure increases to over 30 per cent when the
children, adolescents and young people of immigrant parents are included. There
are over 100 languages spoken in NSW, with one in six people aged five years and
over speaking a language other than English at home.

The 15 language groups were chosen according to three criteria:
1. the largest NESB communities in NSW;
2. the fastest growing NESB communities in NSW; and
3. NESB communities with the largest number of children, adolescents and young
people aged 24 years and under.

The breakdown of the largest 15 groups in NSW who spoke a language other
than English (LOTE) are represented in Graph 8.1, which shows that the Arabic,
Cantonese, Italian and Greek speaking populations are the largest NESB communi-
ties in NSW.
Graph 8.1: Largest 15 communities speaking a language other than English, aged five years and over in NSW (ABS, 1996, Census)

The fastest growing communities, highlighted by Graph 8.2, are the Cantonese, Mandarin and Vietnamese speaking communities.

Graph 8.2: Fastest growing language groups in NSW, speaking a language other than English (ABS 1996 Census)
Graphs 8.1 and 8.2 indicate that there are eight language groups that are both the largest NESB communities in NSW and also the fastest growing groups in NSW. These language groups are: Arabic, Cantonese, Mandarin, Vietnamese, Tagalog (Filipino), Macedonian, Hindi and Korean.

Seven additional languages (see Graph 8.3) were chosen due to the large number of children, adolescents and young people, 24 years of age or under, in the language group. These languages are: Italian, Greek, Spanish, Turkish, Croatian, Tongan and Serbian. The ability of bilingual workers to become actively involved in the project also influenced the decision of the final 15 NESB communities selected to be a part of the community awareness campaign. The 15 final language groups chosen were: Arabic, Cantonese, Croatian, Greek, Hindi, Italian, Korean, Macedonian, Mandarin, Serbian, Spanish, Tagalog (Filipino), Tongan, Turkish, Vietnamese.

![Language spoken]

**Graph 8.3:** Number of people aged under 24 years of age for the selected fifteen language groups (ABS 1996, Census)

**The Eight-stage Process of Implementing the Program**

Figure 8.5 depicts sequentially the eight stages in which the program was implemented, while the processes involved are outlined in greater detail in the following section.
Stage 1: Modification of the English Version of the Family Help Kit (FHK)
Partnerships were formed with bilingual/bicultural health professionals, community workers, multicultural community welfare agencies, ethnic community organisations and key community members, including parents and young people, who were consulted to ensure the information and issues covered in the Kit were sensitive to the cultures, values and practices of their targeted language groups.

Figure 8.5: Major stages and processes of the community awareness campaign.

The Kit provides information on nine topics:
i. child and adolescent mental health problems;
ii. prevention of suicide;
iii. challenging behaviours;
iv. grief and loss;
v. psychosis;
vi. body image and eating disorders;
vii. post-traumatic stress;
viii. depression; and
ix. fears and anxiety.

Modification of the English version of the FHK was considered crucial if the resources to be developed from this Kit were to be meaningful to the 15 targeted communities. To ascertain which issues needed to be included or revised in the multilingual version of the FHK, a series of interviews were conducted with parents and young people of NESB, and with key stakeholders in the transcultural mental health field.

The Kit, therefore, differs from the original FHK in a number of ways. The Kit outlines mental health problems in a way that allows the social, cultural and linguistic values and practices of the 15 targeted language groups to be taken into consideration. The Kit also discusses issues that may impact on families who have
migrated to Australia. As a result, it promotes the importance of cultural diversity and offers families the framework for support within the wider community. While parents from NESB may have their own cultural perspective on mental health issues they may need support in understanding child and adolescent mental health issues within an Australian framework. The Kit also discusses the additional mental health issues that children and adolescents of NESB may face, such as racism, intergenerational and intercultural conflict and language barriers.

In addition, an extensive literature review on the mental health needs of children, adolescents and young people was undertaken to further inform the process. The main areas of the English FHK that required revision were in the topic areas of child and mental health issues, grief and loss, and post-traumatic stress disorder.

The additional material included in the multilingual FHK included:
- financial hardship (sometimes due to the inability to find employment);
- inability to speak English or to communicate with others;
- difficulties at school and the impact on academic performance;
- the lack of social networks and religious activities, and the absence of support from family and relatives;
- exclusion from health and other services, particularly for refugees;
- difficulties accessing health and other social services in a timely manner;
- the impact of migration on children, adolescents or young people;
- the impact of trauma or prolonged stress in one’s home country, especially on children, adolescents and young people who are survivors of war or torture;
- parental concerns relating to their own migration and resettlement process and experiences of torture and trauma, that may affect their son or daughter (vicarious traumatisation); and
- challenges in attempting to balance the Australian way of life with the need to preserve traditional cultures and values.

Stage 2: Translation of the FHK into 15 Languages
All the modifications were finalised into an English master copy of the FHK. SBS Language Services translated this master version into the 15 targeted languages. Once in draft form these translations were then back translated, initially by bilingual consultants, and were read by the various communities themselves in a focus group process where they were asked to comment on a range of questions about the translated material. The aim was to ensure that the material had been translated appropriately, was user friendly, simple to understand, and was culturally and linguistically appropriate.

Stage 3: Launch of the Radio Campaign
Once the translations had been appropriately modified and approved, the translations were used as the basis for the radio broadcasts. The bilingual consultants were involved in extensive training in the medium (radio broadcasts), as the ‘on air’
presentation of the translated material required considerable skill on behalf of the bilingual consultants, most of whom were not conversant with this type of medium. The result was the recording of the FHK into fifteen community languages using an interview style, question-and-answer format, with all nine mental health topics covered on a single tape for each language.

*Stage 4: Production of Audio Tapes and Booklets*
To enable the mass production of the audio tapes SBS provided master videotapes for all of the fifteen languages. The tapes could then be distributed either as part of the FHK or on their own. Printed Booklets were developed, based on the modified translations in the fifteen community languages. The Multilingual FHK can also be viewed and downloaded in the fifteen community languages, from the NSW TMHC’s web site (www.tmhc.nsw.gov.au).

*Stage 5: Launch of the Audio Tapes and Booklets*
The launch of the multilingual FHK and audio tapes by the Minister for Health provided a prominent opportunity to inform families and professionals about the importance of the mental health issues contained within the FHK.

*Stage 6: Distribution and Marketing of Resources*
The distribution and marketing strategy for the project primarily involved a pre-launch and post-launch strategy targeting the print media and public libraries. The NSW Health Department’s Better Health Distribution Centre and the TMHC web site were also involved in marketing and distribution. The products were distributed across New South Wales to mental health professionals, community health centres, mental health services, general practitioners, multicultural health and community services, ethnonspecific community organisations, early childhood centres, specialist child and adolescent services, youth centres, allied health workers and other key groups.

*Stage 7: Ethnic Media Strategy*
An ethnic media strategy was also developed that specifically targeted the ethnic press and radio stations. Radio stations broadcasting programs in the fifteen community languages were sent a copy of the tape, plus printed material relevant to the language group, and were requested to play the tape over a nine-week period corresponding to the nine mental health issues covered on each tape.

*Stage 8: Evaluation*
The TMHC and the Centre for Mental Health investigated whether the radio broadcasts and multilingual FHKS:
1. raised the awareness of the mental health issues impacting on children, adoles-
cents and young people from the fifteen selected NESB communities and the services available to assist them of the parents and carers’ interviewed and surveyed;
2. conveyed a positive portrayal of children, adolescents and young people experiencing a mental health problem or disorder and, as a result, reduced the stigma associated with mental illness among people from a NESB; and
3. provided useful and practical information that was culturally sensitive and linguistically appropriate to parents and carers interviewed and surveyed.

Details of the Evaluation

The broad-based multilevel community awareness campaign aimed to ensure that parents and carers had a better understanding of the mental health problems that children, adolescents and young people could experience. It also aimed to provide information for the early recognition and identification of mental health problems in the targeted groups.

A combination of qualitative (focus groups) and quantitative (usage rates and telephone questionnaire data) methodologies were utilised to evaluate the impact of the community awareness campaign on parents and carers.

The evaluation methods included:
- an analysis of the TMHC Clinical Services intake data base (quantitative data);
- focus groups conducted prior to the intervention (qualitative data); and
- a post-telephone questionnaire (quantitative data).

The 23 bilingual consultants with an understanding of mental health issues were selected from the 15 communities. They were used extensively throughout the evaluation of the multilingual FHK and conducted the pre-campaign focus groups as well as post-campaign telephone questionnaire.

Utilisation of the TMHC clinical services

The TMHC Clinical Services intake database provided a baseline of rate of referral for the fifteen communities for children, adolescents and young people (24 years of age or below). By comparing four years of referral data for the months of November and December with the referral data for the same months in 1999 when the radio broadcasts were aired, a measure of campaign impact could be expected.

Focus groups

The focus groups were primarily used up to ensure that:
- the translations had been carried out correctly;
• the translations were easy to understand and appropriate terminology was used throughout; and
• the translations were culturally appropriate, relevant and meaningful for their particular community.

The secondary purpose of the focus groups was also to explore the general level of awareness that participants in the focus groups had about the nine mental health issues contained in the FHK.

Focus groups were selected as the most timely and efficient method of obtaining a perspective on the range of opinions among the different communities. Due to time constraints, the bilingual consultants specifically selected many of the participants from their respective communities.

One month was assigned for the recruitment of participants. The recruitment included the acquisition of bilingual consultants to act as facilitators who would then organise their own scribe to record focus group findings. The bilingual consultants were also to recruit participants from the 15 specific language groups.

In all, 88 participants — parents (male and female) over 24 years and young people (males and females) 24 years and under — were involved in focus groups. Copies of the translations were sent to the participants to read before the focus group was conducted. Generally, it was left to the bilingual consultants to organise times, dates and venues for the sessions.

A package was prepared and sent to each of the participating bilingual consultants to assist them in conducting the focus group. The package outlined the following:
• setting the scene and introduction;
• presenting the objectives of the focus group;
• providing a brief overview of the Mental Health Promotion Program;
• discussing issues of confidentiality;
• conducting the focus group; and
• closing comments.

The project officer attended several of the focus groups to ensure the protocol was adhered to. The bilingual consultants were crucial in not only accessing their respective communities prior to the launch of the radio broadcasts, but were also important in carrying out the telephone interviews post-intervention.

The consultants had the necessary language skills, were often from a mental health background, and had ready access to their particular community.

The questions put to the group participants covered the following issues and points:
• Is the information provided on the different topic areas clear — are the concepts understood?
• Is the language used in the translated version simple to understand?
· Is the size of the font used in writing the words adequate?
· What colours, graphics or pictures do you believe would be appropriate to be used on the sheets of the different topics and on a Kit generally?
· Is there anything else you would like to add concerning the individual topic areas or concerning the FHK generally?
· Who in particular might this type of information be useful to? Anyone else?
· Is any of the information contained in the topic areas new to you? What?
· Have you read or heard about any of the issues before? When? Where?

After receiving each of the reports from the bilingual consultants the data were transferred into a grid, according to the question answered. While these notes were not in the form of a full transcript, every effort was made to keep them as verbatim as possible. The grid was then analysed for both content of theme and number of occurrences of themes.

**Telephone interview questionnaire**

Prior to the introduction of the FHK to their respective communities a focus group method was employed to ensure that the appropriate terminology was used in the translations, that the translations had been carried out correctly and that they were culturally appropriate and meaningful. After the FHK intervention was complete, a telephone interview questionnaire was used to gauge an understanding of whether the campaign had increased the knowledge of those people selected that had listened to the radio broadcasts or had read the FHK booklet in their language.

A telephone interview questionnaire was selected as the most timely and effective method of obtaining a perspective on the range of opinions among those people from the fifteen communities targeted post-intervention who had listened to the radio broadcasts and had read the FHK booklets. One month was assigned for the recruitment of participants for the collection of data from the telephone questionnaire. The recruitment included the acquisition of bilingual consultants to phone participants from their respective communities. The bilingual consultants recruited interviewees on the basis that they ideally had:
· listened to all or part of the nine topics of the Family Help Kit that was aired on SBS Radio between November and December 1999; and
· received and read a copy of the FHK in their language.

There are, however, limitations to the method as the data collected cannot be considered to be representative of any individual community. While 181 participants were involved in the telephone interviews with an average of 12 interviews per individual community, the data provided from the telephone interviews is not the same as what a fully representative sample would have produced. The selection bias of the sample, due in part to limited resources is an issue that future campaigns
will have to overcome with the development of innovative methodologies. Nevertheless, the data provides useful information for the planning, developing, implementing and evaluation of large scale, broad based community awareness campaigns directed to people from a NESB.

Specifically, the objectives of the telephone interview questionnaires were to:

- explore the interviewees’ level of awareness of the mental health issues covered in the series of SBS radio broadcasts, based on the multilingual FHK, The Mental Health and Wellbeing of Children, Adolescents and Young People of NESB aired from 1 November 1999 over nine weeks;
- explore the interviewees’ level of awareness of the mental health issues contained within the printed multilingual FHK;
- gauge if the campaign had assisted in changing attitudes towards people experiencing mental illness, with the aim of reducing stigma; and
- gauge future mental health needs of the targeted communities.

The questions put to the interviewees covered the following points:

- Have you, read or heard anything about either mental health issues or about family mental health issues in your specific language in the last six months regarding children, adolescents or young people?
- During November–December 1999, have you heard a campaign on SBS radio that talks about mental health issues in your specific language regarding children, adolescents or young people?
- What are the main things you remembered from the radio program?
- Did the radio programs make you think about your own attitudes towards people with a mental illness?
- Do you believe there are ways in which parents/carers can promote their families’ mental health, that is, prevent mental health problems from occurring in the first place?
- Over the last five months have you read a booklet in your language, which discusses family mental health issues regarding children, adolescents or young people?
- Can you recall any messages about any family mental health problems for children, adolescents and young people in the booklet?
- Do you feel you have enough mental health information in your specific language at present?
- If either one of your children, adolescents, or young person (under 24 years of age) that you care for developed mental health problems and you decided they needed help who would you go to?
- Which radio station do you listen to most?
- What time of the day do you listen to the radio?
Findings from Clinical Referral Data, Focus Groups and Telephone Questionnaire Interviews

The following summary provides an overview of results and findings from the clinical referral data of the TMHC, focus groups and telephone questionnaire. A more detailed report is available from the TMHC.

Results from the referral data measures: pre- and post-intervention measures

Preceding the intervention a baseline of current referrals to the TMHC was sought for children, adolescents and young people for each of the fifteen communities targeted. This was accomplished by examining the TMHC Access database. The same examination was made after the campaign was completed (i.e. post-intervention). Graph 8.4 summarises the total referrals for all community languages for all children, adolescents and young people 24 years of age and under, over a five-year period for the months of November–December (from 1996 to 2000).

Graph 8.4: Comparison of referrals for children, adolescents and young people aged 24 years and under, for the fifteen targeted language groups compared to non-targeted communities for the months of November–December from 1996–2000
Graph 8.4 indicates that referrals to the TMHC, for children, adolescent and young people increased by 120 per cent during the SBS Radio Broadcasts compared to the same period the previous year (1998). The increase in referrals for the targeted communities was sustained the following year, with minimal changes in the non-targeted communities.

Of the fifteen communities targeted eleven communities had registered referrals either immediately (eight weeks) prior to the broadcasts or during the radio broadcasts. Of the communities targeted during the campaign an increase in referrals was most prominent in the Arabic-speaking and Mandarin-speaking communities.

**Focus group findings: Awareness of mental health topics versus awareness of mental health issues**

Except for the introductory information sheet on *Child and Adolescent Mental Health* the majority of participants noted that they were familiar with the nine overall topic headings contained within the FHK. The information contained within the individual topics areas, however, was described as ‘new’ information that participants were not familiar with. Examples of such ‘new’ information were tantrums and attention deficit hyperactivity disorder (in *Challenging Behaviours*), anorexia nervosa and bulimia (in *Body Image and Eating Disorder*), and post-traumatic stress disorder.

The quotes that follow illustrate the diversity of opinions provided by participants in reference to their current awareness of mental health topics (that is, FHK headings) as distinct from issues (that is, ‘new’ details subsumed under the topic heading):

> During the past years of education many of these topics were covered, but as the years drag on and a person gets caught up with daily life, many of them are forgotten [Extract from the Arabic bilingual consultant’s report].

> We heard about some topics but this FHK contains more information about various topics, that now our knowledge about various mental health is broadened [Serbian participants].

> For at least one community (Tongan) the information contained in one topic area (body image and eating disorder) clashed with their generally held cultural perception of the particular issue, as highlighted in this extract.

> There is a contradiction in what parents view as ideal. Polynesians’ ideal body image is a voluptuous figure whereas young people who have become Westernized prefer to be very slim. This contradiction in itself can cause eating disorders in young people, eating more in front of their parents then may cause vomiting in the end [Extract from the Tongan Bilingual Consultant’s Report].
Participants across the 15 language groups noted that the relatively ‘new’ topics areas (challenging behaviours, body image and eating disorder and post-traumatic stress disorder) were less well known to them than the topic areas that have had a greater exposure in the media (depression, psychosis, grief and loss, and suicide).

These findings indicate that translations into specific languages would need to take into greater consideration ‘emerging’ communities, which were found to be less aware of mental health issues than more established communities and therefore would be less likely to seek appropriate assistance.

It was difficult to ascertain the current knowledge base of the communities targeted on the mental health issues contained within the translated FHK, or mental health issues generally. A greater number of questions may need to be asked to successfully achieve this aim completely. However, the post-intervention telephone questionnaire may be used to gain a better understanding of the boundaries of this knowledge base.

Although all of the participants had knowledge of some of the issues contained within the kit, it was not possible to determine the level of understanding the participants had of the issues. Two participants stated:

I am only familiar with the terms such as suicide, but I do not know if this relates to the mental health problems [Cantonese speaking participant].

My friend has this condition. Through Taiwanese newspapers and magazines, I have acquired information about mental health problems [Mandarin speaking participant].

Although many focus group participants had familiarity with the language of topic headings in the FHK, the actual details of issues described under those headings were often less familiar. A majority of participants within the focus groups had read or heard about at least some of the issues in the FHK. A minority of participants within the group had not heard about any of the issues discussed in the FHK or had only heard about a very few issues at a superficial level (conversations with friends). Two communities in particular (Tongan and Spanish) noted that limited English proficiency made it difficult to obtain information on those issues in their own language and therefore this had impacted on their knowledge base.

Depression was the most common issue that participants had read or heard about. Participants were also asked to identify when they had read or heard about the issue. Participants indicated that they had read or heard about these issues when they were in school. Usually obtaining the information from print medium (magazine, newspaper, book), very few participants mentioned electronic forms of media (TV or internet).

Participants requested that information be provided on a number of topics not included in the Kit, such as:

- parenting issues;
- the adolescent developmental stages (physiological and psychological changes);
• intergenerational conflict;
• school related issues; and
• the impact of discrimination.

The majority of groups also provided valuable information on the FHK generally. Participants provided thoughtful suggestions to make the FHK as user-friendly as possible. Many of the ideas identified throughout this process were acted upon during the development of the FHK. Some of the suggestions that were incorporated in the FHK were:
• the inclusion of telephone numbers for services; and
• the inclusion of the English name of the mental health problem next to the translated name.

Many of the beneficial aspects of the FHK were also mentioned by a number of the participants in the groups. A selection of comments from the Bilingual Consultants’ Reports and individual participants were:

The FHK translated into Tongan will become a stepping stone into families becoming aware that a lot of behavioural problems in children can be helped and that these families are not alone [Extract from the Tongan bilingual consultant’s report].

Parents found the topic on depression and suicide really useful and the young people in the group appreciated the relevance of the topic on body image and eating disorder [Extract from the Filipino bilingual consultant’s report].

It is good that each topic has an introduction to it which tells you what that particular mental health problem is all about. The symptoms or the signs of those are there as well, so whoever reads this can easily recognise the health problem. Also the best part of each topic is the one how each parent can help their children [Macedonian participant].

Advice on each topic is good because there are quite a number of people in the Arabic-speaking community who are shy to go and ask their doctor as to advice to help themselves [Extract from the Arabic bilingual consultant’s report].

Participants made the comment that the information provided in this Kit is useful and needed in their community. They commented on the lack of information in the Spanish community about mental health issues and the services available to them [Extract from the Spanish bilingual consultant’s report].

Overall, the participants found the translations to be clear and understandable. A minority of the groups, however, raised several concerns regarding the translations. These were:
some of the terms and concepts used were not clearly articulated;
• there were no specific words that could explain certain terms or concepts in certain languages;
• the words used were often confusing or had lost their meaning;
• one translation was found to be too literal a translation from English to the specific language;
• one translation was found to be too technical and containing jargon;
• certain languages were translated in a specific dialect, manner, font or style (formal/informal style) that was not considered to be the ‘primary’ language — for example, Lebanese Arabic as opposed to a Jordanian Arabic dialect; Spanish language from Spain was favoured, not the Spanish used in South America;
• the language used in the translation was not suited to the lay person who would prefer the use of popular terms;
• the style and prose of certain translations were too long; for example, sentences in the Vietnamese translation were found to be too long, making the concepts difficult to understand; the Cantonese translation was considered to be too literal a translation which hampered its style and prose; the Arabic translation was found to be too directive and specific; and
• the use of ‘non-specific’ terms of another related language; for example, Chinese-Vietnamese terms in the Vietnamese translation.

It would appear that while a generic translation of the FHK may be appropriate for dissemination to all communities, there needs to be a process in place that ensures the modifications made by each language group are suitable to the diverse needs of each of the communities targeted. To provide advice and assistance in particular areas of the conceptual translation, and to discuss the style and prose of the translation, it would be advantageous to establish working groups made up of a wide range of language-based community representatives. This process would assist in making translations more appropriate to a range of individuals within one language-based community group.

Font and colours/graphics used within the FHK

The majority of the participants within the groups found that the font used in the translation (12 point Times New Roman) was adequate. However, there were concerns in the Macedonian-speaking and Serbian-speaking groups over the use of Roman fonts when the Cyrillic font was preferred in their respective communities. The Mandarin-speaking participants stressed that the traditional simplified Chinese font should be used for the Chinese translation. A working group of community members from NESB and bilingual workers could ensure that these important
requirements are not overlooked. Another relevant issue to be acknowledged is
differential language font layout and printing costs. Languages with non-roman
fonts, such as Cyrillic, Chinese and Arabic language fonts, require additional costs
to be allocated for layout and printing.

The majority of group participants stated that the colour/graphics used in
the original FHK were inappropriate for their community. Many of the groups
suggested alternative traditional colours and graphics that could be used for their
communities. The reasons for specific communities feeling that the colours/
graphics used were inappropriate were as follows:
• colours used in the original FHK were found to be too strong and bright. For
these participants the use of too many colours made the passage appear very
disorganised. Other participants thought that too many colours were used in the
original FHK and recommended the use of light colours;
• for the Cantonese speaking community certain colours and graphics (red/black,
the use of fluorescent colours and the sign ‘X’) were considered undesirable.

Most language groups provided examples which they considered to be more
appropriate for their culture than the colours used in the original Kit:

In the Tongan community a particular design called the ‘Kapasi’ was suggested as it
is well known in the Tongan community as well as the Pacific Islanders. This design
is used on the TAPA which was used by Polynesians as their traditional means of
clothing [Extract from the Tongan bilingual consultant’s report].

The majority of participants felt that the addition of cartoons/pictures/images
that reflected the content of the Kit would:
• assist in explaining the concepts and messages portrayed in the topic areas dis-
cussed in the Kit, particularly if the image was used to illustrate the different
emotional states of the particular issue;
• enhance the Kit; and
• make the Kit more interesting.

In general, participants raised the following issues with regards to the Kit:
• a booklet format was preferred over the existing loose-leaf format in the
original FHK;
• a colour-coding system should be devised to classify each topic to make it more
user friendly;
• the use of ‘real life cases’ as examples within the text would make the content
more appealing to the reader; and
• it would also be helpful to provide statistical information and demographical
information on the different age groups most vulnerable to the particular issue
being discussed.
While a number of the above issues were incorporated in the multilingual FHK, others were more expensive and time consuming to implement but could be incorporated in any future campaigns.

The majority of groups felt that the original English version of the FHK was, in some parts, inappropriate for their respective communities. This highlights the need to have a rigorous process in place that involves the relevant communities from the very beginning in translating both the words and the content from English to other languages. Most of the communities had specific colour requirements. While there was a general consensus regarding the use of graphics (cartoons, images or pictures) within the FHK, the participants emphasised that these need to be culturally appropriate.

With some language groups, the decision about the appropriateness and inappropriateness of certain colours and graphics could be considered in a working group of community members who could provide valuable knowledge and advice with material being translated.

**Potential users of the FHK**

Participants identified the three groups most likely to find the FHK and the information it provides useful:
1. parents (or guardians of children);
2. teachers (including the school environment generally); and
3. whole of community (especially health professionals).

Given that the Kit has been specifically designed for parents of the target group, the majority of participants agreed that the FHK would benefit this group.

A number of participants felt that a Kit repackage and redesigned for children, adolescents and young people would be beneficial as they could directly take a role in improving their own mental health.

Some of the participants suggested Internet users and Medical Centres as possible environments where this type of information may be useful. These findings have implications for the distribution and marketing of the FHK. The Kit could be used for educational purposes, forming the basis for a community education package.

**Findings from the Telephone Questionnaire**

*Overall awareness of mental health issues – telephone questionnaire*

In general, participants were found to be aware of mental health issues, with 60 per cent of participants able to correctly identify one or more of the topics or issues contained within the FHK.
The SBS broadcasts of the FHK

Of the total number of respondents 56 per cent had obtained their information on mental health issues, in their language, from the radio broadcasts on SBS. Of these respondents 93 per cent indicated they had listened to two or more topics from the SBS broadcasts. The main topics/issues that participants could recall from the radio broadcasts were issues surrounding:

- depression;
- suicide prevention; and
- psychosis.

Attitudes towards people with a mental illness

Almost half (49 per cent) of the total number of participants in the survey indicated that the radio programs made them think about their own attitudes towards people with a mental illness. Of these participants 54 per cent indicated that they now had a better ‘understanding of the issues’ as they relate to people with a mental illness.

Promoting mental health in the family

The multilingual FHK was designed to promote the mental health and wellbeing of children, adolescents and young people by providing positive mental health advice that enhanced wellbeing in families. Throughout the Kit there is information such as the importance of providing genuinely caring relationships with their children, adolescents and young people; and listening to children. Of the total respondents 56 per cent answered ‘Yes’ when asked if they believed there were ways in which parents/carers could promote their families’ mental health. The three most frequently recorded responses were (i) importance of providing consistent parenting; (ii) importance of seeking help early; and (iii) teaching coping skills to their children.

Consistent parenting has been found to be an important factor in promoting the mental health and wellbeing of children. Seeking help early, while regarded as being a part of the early intervention end of the mental health promotion/prevention continuum, provides children, adolescents or young people a better opportunity of potentially breaking the trajectory of mental illness (from becoming serious in the first place). These messages were frequently mentioned in the radio broadcasts, FHK booklet and audio tapes.

Interviewees also picked up on the importance of teaching of coping skills to children, adolescents and young people. While this message was intertwined within a number of the multilingual FHK topics it was not covered in any great detail in the FHK or radio broadcasts. Coping skills have been highlighted in the resilience/protective literature as important in modifying, ameliorating or altering a person’s response to some environment hazard that predisposes to a maladaptive outcome (Rutter, 1985).
The multilingual FHK booklet

When participants of the survey were asked if they had read the booklet in their language in the last five months, 100 participants (55 per cent of the total participants in the survey) responded 'no'. Of the 81 remaining participants 6 did not know if they had read a booklet in their specific language, 30 interviewees provided no response to this question and 45 interviewees (25 per cent of the total participants surveyed) had answered 'yes' to this question. Just over half (57 per cent) who answered 'yes' to this question were able to correctly name the title of the booklet, The Family Help Kit. The ability to name the booklet correctly was considered a positive result, given that the FHK contains many different titles within it.

When participants were asked to recall any messages contained within the booklet, the three most frequent responses that participants were able to recall were:

- importance of intervening early;
- where to seek help; and
- recognising the problem in the first place.

All of the above responses relate to the early intervention end of the mental health promotion/prevention continuum. Participants in the survey appear to have become aware of these very important and practical messages that were central to the Kit and the project.

The mental health information needs of those who participated in the telephone survey

Of the total number of participants surveyed, 38 per cent indicated that their information needs were currently being met. However, 50 per cent of the total participants indicated that they did not have enough mental health information in their specific language at present. These figures indicate a need for continued efforts in developing resources that increase the level of mental health literacy within NESB communities.

When asked about their specific information needs the three most frequently identified areas parents wanted more information on were:

- the area of drug and alcohol (particularly as it relates to young people);
- effects of the migration experience and mental health; and
- increased information on general mental health issues as they relate to adolescents.

The first point of call for parents and carers

Seventy per cent of parents indicated they would go to their local doctor if their child, adolescent or young person developed a mental health problem.
Demographics of the radio listeners

The most listened to radio station was SBS Radio and the most popular time of the day the respondents listened to the radio was in the morning. This was also the most popular time of day for SBS Radio listeners. Using only one radio broadcaster, however, has its limitations, as there are a number of commercial and community radio stations that also have tremendous reach and appeal to specific NESB communities.

During the course of this project numerous commercial and community radio stations with a community language program were contacted and invited to obtain a copy of the taped broadcasts for their use at no cost. The aim of this initiative was to link the education campaign to other potential audiences, market the new resources available, and get the maximum benefit possible from the overall campaign. The following community radio stations broadcasted the information on the tapes in a variety of languages. 2933 2AAA FM 107; 2936 2 BLU; 2935 2BBB; 2954 2WKT (Highland FM); 2948 2TLC; 2YOU 88.9; 2959 VOX FM. Unfortunately, due to a lack of resources, there was no evaluation mechanism in place to monitor the effectiveness of the broadcasts for those people who may have listened to the broadcast and who may have phoned the TMHC Clinical Services Unit for assistance.

Conclusion and Future Directions

This project has added to current knowledge of effective strategies to promote mental health literacy within culturally diverse populations. There is limited literature on processes undertaken in promoting mental health literacy across a range of culturally diverse populations. To date, the majority of mental health literacy campaigns in Australia have focused on mainstream populations. This project provided the opportunity to explore effective processes that contribute to raising the awareness of positive mental health strategies for culturally diverse populations. The results subsequent to the intervention indicate the success of the strategy in the short term.

It is difficult at this stage, however, to establish just how effective this campaign was in reaching its initial objectives. Information provided by the pre-intervention focus groups and post-intervention telephone survey would seem to indicate that an increase in awareness of mental health issues contained within the FHK was accomplished within groups exposed to the information within the targeted communities (at least in the short term). Behaviour change that promotes access to services at an earlier stage of the mental health problem has been more difficult to measure and verify, despite the encouraging results from the TMHC Clinical Service Referral database.
The aim of reducing stigma attached to mental illness and discrimination against people with a mental illness would require long-term strategies — an aim which, in some respects, is beyond the scope of this time-limited project. The issue regarding stigma is perhaps best encapsulated by a recent Glasgow study that concluded:

There is a stigma associated with mental illness which is reflected in our language, our attitude and our society ... However successful the project, without widespread commitment from all members of society the problem will remain. It is our language, our culture and our responsibility (Kaminski & Harty, 1999, p. 40).

This project, therefore, must be seen in the context of other strategies and policies that in combination aim to improve the state of mental health and well-being of people from culturally and linguistically diverse communities.

There was a rigorous process that was followed during the modification, translation and piloting of the resources to ensure a quality product. Given the demand for the booklets and tapes and from comments received from both service providers and consumers, the process followed seems to be positive and useful. While the mechanisms that were put in place appeared necessary, there were some parts of the process that in hindsight could have been handled differently to streamline the process even further. One example would have been to involve the communities earlier and for a longer period to assist and to provide advice on each step of the process in relation to the translation of the material, and in designing colours and graphics, the style, prose and fonts used in the material.

Lessons learnt

Future large-scale campaigns need to consider the following points if they are to build on this campaign:
• collaborative partnerships take time;
• skill building and training needs to be an integral part of the process for mental health workers;
• tools are needed to assist in development of plain language material;
• costing needs to reflect the needs of the particular group; and
• evaluation needs more resources if it is to produce meaningful information.

Future directions

The following recommendations had support from all the communities consulted and should be considered where appropriate when developing multilingual resources. The following priorities for future action have some support from all the communities consulted and should be considered as appropriate when conducting community awareness campaigns:
Recommendations for future community awareness campaigns

1. To ensure that community representatives of the specified community are established at an early stage of the translation process to assist and to provide advice on each step of the process including the use of language, terminology that is linguistically appropriate and culturally relevant, style, prose and fonts used in the translation as well as assisting with the design and colours of any translated material.

2. That budgets include the costs of culturally appropriate colours/graphics to be included in translated materials, not only so as to attract the attention of potential readers from the specified target group but to also enhance the readability and understanding of the material.

3. To develop a community education package based on the FHK to further increase the level of awareness and understanding of mental health issues within targeted culturally and linguistically diverse communities, mental health workers and agencies.

4. To approach SBS and other appropriate radio stations to repeat the radio broadcasts on ‘The Mental Health and Wellbeing of Children, Adolescents and Young People’ on a regular basis.

The following priorities for possible future action also had support from all of the communities consulted and should be considered as appropriate.

- To provide culturally appropriate information on the following: parenting skills; providing specific information in the area of drug and alcohol (particularly as it relates to young people); the effects of the migration experience on mental health; and increased information on mental health issues as they specifically relate to adolescents. Also, to consider:

- developing a community education package, in partnership with communities, that addresses not only mental illness issues but introduces and emphasises the positive aspects of mental health.

Further work in the area of educating parents on how to encourage the development of a positive ethnocultural identity, along with high self-esteem, needs to be undertaken. Parents may also need information on strategies which may assist them to retain styles of parenting from the culture of origin, while developing effective parenting styles which suit the individual family’s needs in the Australian context. Such strategies would be positive steps towards further addressing the needs of children, adolescents and young people living within a diverse range of cultures.
Appendix A

The mental health and wellbeing community awareness campaign could not have been possible without the support from the following people and organisations. Special thanks are owed to those individuals who were involved in making the campaign effective in reaching out to the various communities.

_Transcultural Mental Health Promotion Subcommittee_
Ms Alison Sneddon (Convenor), Deputy Director of Health Promotion, South Western Sydney Area Health Service; Mr John Spiteri (Chair) Senior Mental Health Promotion Officer; Transcultural Mental Health Centre (TMHC) Ms Maria Cassaniti, Team Leader, TMHC; Ms Suzanne Pope, Policy Analyst, Centre for Mental Health, NSW Health Department; Ms Alice Jiang, Research Officer, Blacktown City Mental Health Service, Blacktown Hospital; Ms Sam Milhailovich, Mental Health Nurse, Western Sydney Area Adolescent Team, Mt Druitt; Ms Michelle Azizi, Health Promotion Officer, Blacktown Health Promotion Unit, Blacktown Hospital; Mr Graeme Whatmough, Director of Community Mental Health Services, Greater Parramatta Mental Health Services; Mr Erdal Vurel, Manager Early Intervention, Young People’s Program, Cumberland Hospital; Dr Ajeet Sidhu, Ethnic Health Promotion Officer, Campbelltown Community Health Centre; Ms Yvonne Fung, St George Migrant Resource Centre; Ms Trish Nove, Manager, Health Promotion Professional Services Unit; Ms Jan Kang, Policy Officer, TMHC; Mr Abd Malak, Director, TMHC.

_SBS Radio Station_
Ms Kate Hannaford, Marketing Manager; Ms Seong-Soon Kim, Marketing Traffic Coordinator; Mr Robert Gale, Marketing Producer Radio.

_SBS Language Services_
Ms Tina Koutsogiannis, Manager SBS Language Services; Mr David Djuric

_Bilingual consultants_
Ms Montana Luani (Tongan); Mr Joe Choung (Vietnamese); Mr Erdal Vurel (Turkish); Ms Beste Tungadame (Turkish); Ms Soon Yong (Korean); Mr Dushan Ristevski (Macedonian); Ms Lidiija Sestakova (Macedonian); Ms Daniza Koevska (Macedonian); Ms Kalpana Sriram (Hindi); Dr Suman Tyagi (Hindi); Ms Hend Saab (Arabic); Ms Nahid Khalil (Arabic); Ms Ranya Yacou (Arabic); Mr Biagio Sirgiavnani (Italian); Dr Vito Zepinic (Serbian); Ms Ljubica Vracar (Serbian); Ms Fabiola Bedon (Spanish); Ms Chrissie Pappasavva (Greek); Mr Andrew Sozomenou (Greek); Mr Gerald Cheung (Cantonese); Ms Tinny Fernandes (Mandarin); Ms Alice Jiang (Mandarin); and Ms Jane Pindea (Tagalog).
Staff from the Transcultural Mental Health Centre and the Western Sydney Area Multicultural Health Unit

Ms Jan Heslep, Senior Mental Health Promotion Officer; Mr Andrew Sozomenou, Research Officer, TMHC; Ms Teresa Petric, Project Officer, TMHC; Ms Anna Piperides Lee, Clinical Co-ordinator, TMHC; Ms Myong De Conceicaco, Carer Project Officer; Ms Vicki Katsiffs, Consumer Project Officer, TMHC; Ms Bonnie Chung, Project Officer, Multicultural Health Unit, Cumberland Hospital.

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References


