A qualitative evaluation of the questionnaire about the process of recovery (QPR) in culturally and linguistically diverse (CALD) populations

A qualitative evaluation of the Questionnaire about the Process of Recovery (QPR) in culturally and linguistically diverse (CALD) populations~~What is the cross-cultural relevance of The Questionnaire about the Process of Recovery (QPR)?~~

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Use of the term "CALD" will probably help the paper perform better with regards with to SEO.

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Perhaps "mental illness" might be a little more specific; "mental health" is thrown around very liberally these days.

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Abstract

Background: Australia is an increasingly culturally diverse society. While the mental health of migrants is a societal concern to all nations, conceptualisation of mental health recovery across cultures is poorly understood and suitable measures are lacking. The Questionnaire about the Process of Recovery (QPR) is a self-report instrument measuring personal recovery outcomes for patients of mental health services. However, the extent of its relevance among culturally and linguistically diverse (CALD) communities in Australia is unclear.

Objectives: This pilot study aimed to examine the relevance and utility of the QPR among CALD patients of primary mental health services.

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

Results: Almost all patients had little or no knowledge about the concept of personal recovery. Nevertheless, the QPR was generally considered culturally acceptable and understandable. Using the QPR during mental health consultations can help with needs identification and goal-setting. Challenges in using the QPR included completion time, cross-cultural differences in concepts and norms for some items, and the need for careful translation. Patients suggested additional items relating to family reputation, sexuality, and spirituality.

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

1. Introduction

The conceptualisation, experience, and prevalence of mental health and ill-health varies across cultures. T~~and t~~he fields of transcultural psychiatry and global mental health have been dedicated to examining how to provide culturally appropriate mental health services. Australia has welcomed 1.3 million migrants since 2011 from approximately 180 countries, and about 29% of Australian residents are reported to have been born overseas; the majority of whom are from Asia (Australian Bureau of Statistics, 2020). A priority for Australia is to respond to the mental health care needs of its "fast-changing, ever-expanding, culturally diverse nation" (Australian Bureau of Statistics, 2017).

In recent years, the approach to mental health care in countries ~~such as~~including the US, UK, Canada, Australia, and New Zealand~~,~~ has shifted to ~~encompass~~ wards a recovery-oriented focus. This approach considers and respects patients' desires and preferences in their mental health care planning, ~~including the incorporation of~~and incorporates socially and individually valued roles and goals (De Vecchi et al., 2015; Lloyd et al., 2008; Slade, 2010). Numerous frameworks for understanding recovery exist (Lapsley et al., 2002; Slade, 2009), ~~one of which is~~including the CHIME Framework, comprising: Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment (Leamy et al., 2011). This framework has been applied in ~~the~~ conceptualisations of *personal recovery* across community-based mental health teams (Slade et al., 2015) and in culturally and linguistically diverse (CALD) communities in Australia (Brijnath, 2015). Personal recovery has been defined as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Australian Government Department of Health, 2013).

A yet under-researched and poorly understood aspect of mental health is the way in which mental health recovery is conceptualised, defined, and measured across cultures (Kirmayer, 2012; 2006; Slade et al., 2014; Tesfaye et al., 2010). I~~The i~~mpacts of ~~the~~ multiple forms of migration (in Australia

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and globally) adds to the challenge of understanding mental health recovery, and how that they affects the mental health needs, and service response in culturally diverse communities.

A systematic review of all existing mental health recovery measures (Shanks et al., 2013) identified 13 measurement tools, among which the Questionnaire About the Process of Recovery (QPR) (Neil et al., 2009) was the only one tounique in having all its items map onto the CHIME framework. The QPR is a 22-item, patient self-rated, subjective outcome measure of personal recovery consisting ofcomprising two sub-scales:; intrapersonal (17 items) and interpersonal (five items). Although the QPR has been translated successfully into Chinese in Hong Kong (Chien & Chan, 2013) and into Swedish (Argentzell et al., 2017), the tool has not been applied and tested in culturally diverse settings, nor examined through a cultural lenses (Neil et al., 2009).

In the Southern Region of Melbourne, Victoria, Australia, the Principles Unite Local Services Assisting Recovery (PULSAR) project aimed to develop localised, practical, and collaborative approaches to supporting personal recovery in primary and secondary mental health care settings. The QPR was the primary outcome measure (Enticott et al., 2016; Meadows et al., 2019; Shawyer et al., 2017). FThe findings showed that delivering the REFOCUS-PULSAR training intervention to staff in recovery-oriented practice (ROP) had a small but significant effect towards improving consumers' self-rated recovery based on the QPR. This is the only existing study internationally to date to demonstrating the impact of this staff training on consumer-rated recovery outcomes. The current research presents the findings of a qualitative pilot sub-study of the PULSAR project that examined the QPR's cross-cultural relevance and appropriateness of the QPR tool in assessing personal recovery among participants from two CALD communities: Iranian and Burmese.

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2. Method

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

2.1 Study Participants and Recruitment

The study setting included two primary care clinics in the outer suburbs of Melbourne, which were cluster sites in the main PULSAR project. Both sites serviced CALD communities that included refugees and asylum seekers and which, ~~largely~~ due to English proficiency challenges, posed difficulties in recruiting participants for the main PULSAR study (Enticott et al., 2016). This sub-study therefore sought to examine specific aspects of recovery-oriented practice among CALD groups attending these clinics to better understand ~~the needs of~~ diverse patient groups' needs. In consultations with the GPs, Iran and Myanmar were ~~selected~~ identified as being predominant ~~cultures~~ source countries at the two clinics, both of which ~~represent refugee source countries and~~ are among the fastest-growing 'lower-ranked ~~countries of~~ birth countries' in ~~the state of~~ Victoria (Iran - increasing by 68%, Myanmar - increasing by 213%) (State of Victoria, 2013).

Participants were purposively sampled and recruited as follows:

a) One GP was ~~purposively~~ recruited from each of the two PULSAR cluster sites with high CALD populations. The GPs, who were already enrolled as participants in the main PULSAR project, were contacted through the PULSAR Team, and the study proposal ~~for the study~~ was explained to them.

b) Patient participants, aged 18-75 years and receiving mental health care, were recruited through their GPs at the clinics. Eligibility criteria included: being able to provide informed consent; being patients of ~~the~~ participating GPs; being from Iran~~,~~ or Myanmar/Burma (based on ~~country of~~ birth country, language, or both); having a recent mental health plan, ~~or~~ a recent ~~review of a~~ mental health care plan review, ~~and/or~~ having continually received ~~any class of~~ antidepressant medication ~~on a continuing basis~~ as treatment for a mental illness, and/or ~~or people with~~having been ~~a diagnosis of a~~diagnosed with a mental disorder(s). GPs provided ~~a~~ flyers to eligible patients to introduce the study. Interested individuals were given a more detailed information sheet describing the study and tasks before consent was requested. All materials, including the

QPR, were provided in ~~the~~ participants' native language~~s~~. Participants were informed that ~~the~~ interviews would be conducted in their preferred language ~~of preference~~.

2.2 *Data Collection and Analysis*

GPs participated in ~~a~~ 30-minute individual semi-structured interview~~s~~ (by *UO*) at their clinic intended~~,~~ ~~the purpose of which was~~ to explore and record their general views on personal recovery and the QPR tool in ~~the following~~ key areas: the ~~relevance of the~~ QPR measure's relevance among CALD patients; its applicability with their ~~his/her~~ own patients; and potential cultural and linguistic difficulties or issues that may arise in using the QPR with CALD communities.

A professional translation company was hired to translate (including back-translation procedures) the QPR. However, ~~the quality of the~~ translation quality~~s~~ was considered poor by ~~the~~ interviewers for both languages. In their view, ~~the lack of~~lacking topic and content expertise in public health and mental health were~~as a~~ key concern~~s~~. The two interviewers – a Burmese general practitioner and an Iranian clinical psychologist – who were fluent in both English and their own language and had both clinical and research experience, were able to identify translation problems and amend the questionnaire before commencing recruitment and data collection.

Patients participated in ~~a~~ one-hour, individual, semi-structured interview~~s~~ conducted in their native language or in English, based on their preference, by a Persian- or Burmese-speaking research assistant. ~~The~~ Iinterviews were conducted at ~~the~~ clinic~~s~~ and commenced with ~~the~~ participant~~s~~ first completing the self-administered QPR. Patients were then asked about: 1) their experience ~~in terms of~~with the QPR question~~'s~~~~''s~~ ~~ease of use and~~ clarity and ease of use ~~of questions~~, and their perspectives about their general knowledge and conceptual understanding ~~of the concept~~ of personal recovery; 2) each item on the QPR, including any cultural and linguistic difficulties or issues encountered in completing them; and 3) their views on possible benefits and application of ~~using the~~ QPR use. C~~The c~~ompleted QPRs were not collected by ~~the~~ researcher~~s~~ as ~~their~~ QPR responses were not the present study's focus ~~of the study~~.

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All interviews were audio-recorded and transcribed in ~~its~~ their original language; ~~and~~ non-English transcripts were subsequently translated into English for analysis. Framework analysis ~~according to Ritchie and Spencer~~ (Ritchie et al., 2014; Ritchie & Spencer, 1994) was used to analyse ~~the~~ qualitative data.

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A thematic framework developed from literature reviews was refined using ~~the~~ transcripts. ~~and a~~A coding frame was developed, ~~which was cross-checked and~~cross-checked, and refined by team members to ensure quality and integrity. Transcripts were coded using NVivo 11 Pro software (QSR International, 2016) where nodes and sub-nodes were generated. ~~Chartings of the themes and the cases, as well as their mappings~~ Charting and mapping of themes and cases were also done; ~~and~~ thereafter ~~the~~ findings were presented and interpreted, using a deductive approach.

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

3. Results

All data ~~for the study~~ were collected between September and October 2016; 11 participants, including two GPs and nine patients (five males and four females), were interviewed. Interviews with GPs were generally shorter in duration (averaging about 20 minutes) whereas those with patients were longer (mean = 90.5 minutes; range 25 – 200 minutes). Both GP interviews were conducted in English, as were two ~~of the nine~~ patient interviews. ~~Responses from the participants~~Participant responses are presented in line with the thematic framework used for the coding (Ritchie et al., 2014; Ritchie & Spencer, 1994).

3.1 GP Participants

3.1.1 Demographic characteristics

The two GPs were immigrants from England and Iran, ~~who have~~each with extensive experience working with CALD communities, including refugee populations~~s~~. No further details are provided to ensure confidentiality in the context of a small sample size.

3.1.2 Perspectives on ~~the prevalence of~~ mental illness prevalence among CALD communities

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

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

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

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

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

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

~~The~~ GPs described their patients as having had a diverse range of distressing experiences depending on ~~the~~ circumstances of their country of origin e.g., ~~impacts of war and~~ experiences of war, torture, domestic violence, and rape. Furthermore, language and cultural differences can present challenges for GPs to gain trust and respond appropriately to individual needs.

Differences between CALD and non-CALD patients in relation to mental health services reported by GPs included: lower health literacy, poorer medical history, needing to adjust to~~ a~~ new social and cultural environment~~s (new culture and society)~~, language and communication barriers, as well as potentially distressing issues around immigration status in that most CALD patients are on temporary~~a~~ bridging visa~~s, which allows people to remain in Australia as an asylum seeker whilst their application for refugee status is being determined~~.

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

"~~I~~If you want to send Iranian and [another non-Australian culture] patients to [a] counsellor or [a] psychiatrist, they reckon that, oh, it has effect on my future; and for immigrants, they reckon that, oh~~…h~~, does it affect my case? […] Yeah, the immigration

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status, this is really something strange here, but this is something that the Australian Aussies, [don't] have..." [GP-02]

Poor health systems in ~~their~~ countries of origin resulting in improper diagnosis and treatments were also reported by ~~the~~ GPs to be specific to service users from CALD communities.

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

3.1.4 Available options towards ~~a~~ more culturally responsive mental health services

While ~~The~~ GPs reported ~~the~~ lack~~ing~~ ~~of a~~ guideline~~s~~ or protocol~~s~~ ~~on~~ for service provision ~~for~~ to CALD patients~~,~~ ~~but~~ they also reported some resources available to them~~, such as~~: culturally diverse staff background ~~of staff~~; culturally-specific counselling services; psychological and psychiatric services; interpreters; support groups; case managers; and referral services. GP~~s~~~~S~~ also described the need for ~~a~~ safe space~~s~~ and care continuity ~~of care~~.

3.1.5 Conceptualization of personal recovery

One GP talked about recovery as follows:

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

This~~e same~~ GP also pointed out that adapting to recovery-oriented care may be a challenge among communities that are more familiar with ~~the~~ medicalised treatment models of mental health care, where there is an expectation of a 'fix':

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

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

Both GPs generally agreed that the QPR is relevant to CALD patients with benefits including: helps identify needs and set goals for recovery; touches on different aspects of recovery; empowers both the GP and the patient to actively manage ~~their~~ mental health; assists in referral; and can ~~enable~~ foster ~~the sharing of~~shared responsibility between ~~the~~ GPs and ~~the~~ patients.

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

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

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

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

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

3.2 Patient participants

3.2.1 Demographic and socio-economic characteristics

As presented in Table 1, the patient participants ranged in age from 24 to 51 years, and a littlejust over half (55.6%) were male. Five were single, two married, and one each were separated and widowed. Five had lived in Australia for over three years, while the restothers were relatively new arrivalshad arrived more recently. Education lLevel of education was variable and tended to be higher among Clinic One participants.

----- insert Table 1 here ------

3.2.2 General views and knowledge/understanding of mental illness and personal recovery

Patient participants generally expressed low levels of knowledge and understanding of mental health problems and their potential causes. Nevertheless, many acknowledged that stressors, such asincluding those associated with migration and trauma, can potentially contribute to mental ill-health.

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

Almost all patient participants had very little or no knowledge about the concept of personal recovery. When asked, they either responded that they had no idea, or had heard about it but did not know what it meant, or. However, some referred to it as a process rather than an outcome.

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

Nevertheless, some participants had an understanding and views about recovery that align with the personal recovery paradigm:

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

3.2.3 Experiences using the QPR

After completing the QPR, ~~the~~ patient participants ~~were generally of the view~~position was generally that the instrument was useful and relevant in helping them reflect and refocus on their mental health situations. For example:

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

However, the extent to which the item~~'~~s' interpretation and relevance ~~of the items is~~ are linked to culture versus personal perspectives and experience was still unclear for some participants:

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

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

3.2.4 Clarity and interpretation of QPR items

The Ppatient responses about the QPR item's' clarity and relevance of the QPR items are consistent with the observations of the GP participant's' observationss. Despite the potential relevance of the QPR and the general feeling that it is culturally acceptable and understandable, some patient participants reported difficulties understanding specific items, of the instrument or had different interpretations.

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

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

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

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

----- insert Table 2 here ------

The analysis indicates that some of the interpretation issues were socio-culturally driven. For instance, with *Q4 (I feel part of society)*, while one participant reported feeling part of society rather

than isolated, another person read the item differently. The following comment was also made, which speaks to how 'society' can be interpreted as a general and global construct or culture-specific, and highlights ~~the impact of~~ migration impacts and cultural differences contributing to ~~a sense~~experience of loneliness.

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

In relation to explaining ~~his/her~~their interpretation of *Q6 (I feel my life has a purpose)*, one Burmese participant explained in this way, highlighting ~~the~~ consistently close connections with nature among Burmese participants:

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

The importance of religion and spirituality was also raised by some participants - as ~~was~~ were other aspects of life, ~~such as~~ like sexuality.

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

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

There were also some indications that completing the QPR together with a GP would yield better information rather than simply giving it to ~~the~~ patients. To illustrate, as noted above, some participants found several ~~of the~~ items difficult to understand until they were further explained ~~to~~

them. One participant also highlighted the importance of describing the purpose and benefits of such a tools to encourage the patients' engagement in the process.

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

3.3 Comparing Patient vs GP Responses

When comparing the GP and patient responses, consistencies were evident on issues such asincluding the relevance of the QPR's relevance among CALD patients, implications for future use, as well as barriers toward using it - albeit for different reasons in some cases.

PThe participants were of the viewcommunicated that the QPR could be helpful for patients and the GPs. While expressing optimism on its future use, acceptability and cultural context, participants also suggested useful changes for making theto optimise instrument more relevantrelevance, such asincluding accurate translation to the relevant language of the patients' relevant language.

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

4. Discussion

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

Though a small sample, GPs' views were congruent in reporting high mental illness prevalence ~~of mental illness~~ among their CALD communities and consistent with existing evidence among refugees/asylum seekers (Khavarpour & Rissel, 1997). F~~The f~~indings ~~is~~ are also in line with the expected impact of environmental changes (i.e., new settlement) on mental health ~~of a change in environment or new settlement as is typical among~~typically experienced by immigrants and refugees (George et al., 2015). These disruptions in mental health are in part due to stress~~-~~-related factors, ~~such as~~including crisis and post-crisis situations from home countries, acculturation, economic uncertainty, perceived social isolation and discrimination in Australia, immigration uncertainty and separation from family and familiar surroundings (State of Victoria, 2016). Therefore, ~~the~~ changes in environment, society and culture may ~~be contributing~~ contribute to ~~the~~ CALD patient~~-~~s' current mental health ~~situation~~concerns ~~of the CALD patients~~.

Reported differences between CALD and non-CALD patients by GPs~~, such as~~ include poorer medical history information, the impact of weaker health systems within ~~CALD~~ countries-of-origin, and poorer health~~-~~-seeking behaviours, concur with earlier findings from a similar study (Alegria et al., 2010). CALD patients were reported to be less likely to seek medical help for their mental illness compared to their non-CALD peers. Patients from countries with poor health systems, diagnostic and treatment procedures, low health literacy, and high stigma towards mental illnesses, are less likely to seek mental health assistance when needed (Flaherty & Donato-Hunt, 2012). These influences are largely due to lack~~-~~ing ~~of~~ awareness and ~~non-availability of~~ service~~s~~s, among other factors (Dow, 2011).

An~~One of the~~ observed challenge~~s~~ in operationalising personal recovery-oriented approaches among CALD patients was adaptation to the new concept, as noted by one ~~of the~~ GP~~s~~. This finding aligns with Hungerford and Fox's (2014) study (Hungerford & Fox, 2014), which found that uncertainties among service providers, and especially service users, constitute ~~a~~ challenge~~s~~ in operationalising recovery-oriented approaches. Hence, these authors suggested ~~a~~ more targeted practice-focused education around the concept for both ~~the~~ service providers and ~~the service~~ users. Tension between personal and clinical definitions of personal recovery from patients' perspectives,

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as previously observed by Davies and Gray (2015) (Davies & Gray, 2015), was revealed in the study, with some participants having divergent views on the fundamental definition of personal recovery concepts (Anthony, 1993; Leamy et al., 2016). There seemed to be difficulties in distinguishing between personal and clinical recovery ~~and this is~~ a common problem in trying to operationalise the recovery paradigm.

~~The~~ GPs mentioned ~~the absence of~~~~lacking clear~~ guidelines lacking on how to provide services effectively and efficiently to the CALD and refugee community presenting with mental illness. The Australian National Human and Medical Research Council's cultural competency guide (2006) focuses on general health services and does not specifically address mental health issues as they relate to CALD groups. Having mental health~~ –~~specific guidelines is consistent with some recommendations from other related studies (Henderson et al., 2011; Wohler & Dantas, 2017).

Patient participants generally found the QPR relevant and useful, but GP participants were concerned about the time taken to complete the tool. While a brief (15-item) QPR has been proposed (Law et al., 2014; Williams, Leamy, Pesola, et al., 2015), its psychometric performance and robustness across cultures have yet to be confirmed. Language and communication barriers ~~was~~were another emergent theme, especially in relation to ~~the~~ explanations and interpretations of ~~some of~~ the instrument's concepts and items ~~used in the instrument~~. Use of interpreters may ~~be a solution to~~solve these issues, but is likely to be expensive and time~~ –~~consuming. Instrument t~~T~~ranslation ~~of the instrument~~ into ~~the~~ relevant languages is also another possible solution to ~~the~~ language and communication barriers (Chien & Chan, 2013). Examples of similar instrument~~-~~s' translations resulting in high validity, reliability, and acceptability include the K6 and K10 (Tesfaye et al., 2010) and the General Health Questionnaire (Montazeri et al., 2003). ~~There are other examples of translations of similar instruments resulting in high validity, reliability and acceptability of the instruments such as the K6 and K10 (Tesfaye et al., 2010) and the General Health Questionnaire (Montazeri et al., 2003).~~ In this study, the QPR and other relevant documents were translated to ~~the~~ participant~~-~~s' local languages ~~of the participants~~, and research assistants fluent in these languages conducted ~~the~~ interviews. Again, although there is documented evidence on the QPR's high validity

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and reliability ~~of the QPR~~ (Law et al., 2014; Williams, Leamy, Bird, et al., 2015), there was misinterpretation of some ~~of the~~ items, ~~that requires~~requiring further examination.

From ~~a~~ cultural relevance perspectives, the study found that life goals, which are important for self-determination, vary across cultures and social-standing. Family reputation was also found to play ~~a~~ significant roles in some cultures. The QPR, in its current form, takes an individualistic approach to health and wellbeing that is common across most Western societies but may be inconsistent with non-Western societies' ~~the~~ socio-cultural nature ~~of non-Western societies~~.

This study was the first to translate and pilot test the QPR ~~with a view~~ to compare ~~and contrast~~ ~~the~~each item's cross-cultural relevance and appropriateness ~~of each item~~ in an~~the~~ Australian ~~country~~ context. Nevertheless, some study limitations contribute to the need for caution in interpreting ~~the~~ findings. For instance, although~~while~~ a professional translation company was hired to translate ~~(including back-translation procedures)~~ the QPR, ~~the~~ translation quality ~~of the translations~~ was considered poor by ~~the~~ interviewers. Fortunately, ~~the~~ interviewers ~~for both languages. In their view, the lack of topic and content expertise in public health and mental health was a key concern. However, the two interviewers – a Burmese general practitioner and an Iranian clinical psychologist – who were fluent in both English and their own language and had both clinical and research experience,~~ were able to ~~identify translation problems and~~ correct~~amend~~ the questionnaire before commencing recruitment and data collection ~~. This process~~ highlight~~inged~~ the importance of having translators with sufficient content familiarity to ensure high~~-~~quality translations.

Furthermore, this study also found that ~~the~~ issues with translation and interpretation ~~was~~ were not only about sociocultural differences. The items that patient participants tended to struggle with were ones that have been identified previously as lacking sufficient face validity or having ambiguous wording (Argentzell et al., 2017; Law et al., 2014). QPR items found to be redundant are also shown in Table 2, highlighting the importance of having high psychometric properties.

This pilot study was a student project for a Master of Public Health degree which consequently posed ~~some~~ time constraints that 1) ~~precluded in-depth consultations to ensure appropriateness of the~~

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translations and articulations of the QPR itemsprecluded in-depth consultations to ensure QPR item's' translation and articulation appropriateness; 2) limited the extent to which the interviewers could be supervised at the start to identify or foresee issues that may arise during the interview process; and 3) prevented us from continuing recruitment until we reached data saturation (Ritchie et al., 2014). Consequently, two particular issues emerged as potentially affecting the quality of the data quality. First, it is possible that not all of the participants fully understood the purpose of the purpose of some of the question's purpose. This potential was highlighted by observations such as a tendency for one or twosome participant's' commentss to respond about the QPR's appropriateness of using the QPR as part of 'service delivery', instead of as a recovery assessment tool to assess recovery. We observed that the term 'recovery' was not straightforward to translate, as there is no direct translation into Iranian and Burmese. Moreover, the concept of recovery - and as such some of the interview discussions – were focused more on its the meaning of "recovery" to the patients, rather than the tool's appropriateness and relevance of the tool toin assessing it. This is a substantial limitation, and future research could examine how to better to conceptualise or translate "recovery" within the text of the QPR, and whether doing so would improve the measure's cultural appropriateness.

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

As a pilot study with a small sample size, this study is unable to make conclusive statements about the QPR's relevance and appropriateness of the QPR across CALD groups. Rather, the findings demonstrate that while overall, use of a recovery-based assessment tools would likely be useful and welcomed by patients across cultures, more work is needed to ensure clarity and the cultural appropriateness of the QPR items and the response options. In addition, the findings suggest that

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~~the~~ cultural appropriateness of the QPR could be improved ~~by~~ through ~~the addition of~~added questions pertaining to family reputation. This study was able to expose ~~some of the~~ diverse ways in which constructs ~~such as~~like mental health and recovery are conceptualised, how the QPR items can be (mis)interpreted, and how ~~the~~ interpretations can be influenced by socio-cultural norms and expectations. As such, recommended ~~the~~ directions for future research on mental health management and QPR use ~~of the QPR~~ among CALD groups are clearly ~~laid out~~relayed.

5. Conclusion

This pilot study highlights how socio-cultural norms and constructs can influence ~~the~~ interpretations of well-developed and evaluated instruments ~~such as~~like the QPR. While ~~a~~ careful reviews and adaptations of the QPR tool across CALD groups ~~is~~ are necessary, ~~the~~ findings support the QPR's potential utility ~~of the QPR~~ toward more culturally responsive mental health care.

6. Declarations

6.1 Ethics approval and consent to participate

Ethics approval for the study was obtained through the Monash Health Human Research Ethics Committee (Reference Number: 16325A) and site authorisations ~~was~~ were received from the two clinics. All participants provided written consent to participate in the study.

6.2 Consent for publication

No individual's data is presented in the manuscript to necessitate consent for publication.

6.3 Availability of data and material

Data generated and analysed during this study are not publicly available due to risk of compromising participant confidentiality but are available from ~~the~~ corresponding authors on reasonable request.

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Commented [DB21]: This paper has essential discussion around the use of the QPR in CALD, including strengths and limitations. However, it would have been nice to explicitly outline which items should be further reviewed in these populations (e.g. item 4 and 6 should be re-worked/re-translated/analysed for face validity in a larger and more homogenous CALD population). I know this is flagged in the appendix but it would give people more reason to check the appendix.

And then go on to explicitly state what should be potentially added to the QPR; in the end there's only a recommendation for family reputation although a lot more was discussed.

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6.4 *Competing interests*

The Aauthors declare that they have no competing interests.

6.5 *Funding*

This study was conducted as part of a thesis project for a MSc in Public Health for author OUC.

6.6 *Authors' contributions*

OUC, LB, FS and RK led the study development, and implementation, of this study as well as theand preparation of this manuscript preparation. GM, VE and EWE contributed to the interpretation and manuscript finalisation of the manuscript. All authors contributed to the development, implementation, analysis and write up.

6.7 *Acknowledgements*

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684 Table 1. Sociodemographic characteristics of patient participants

	Clinic One (n=5)	Clinic Two (n=4)	Total (n=9)
Gender			
Male	3 (60%)	3 (75%)	6 (67%)
Female	2 (40%)	1 (25%)	3 (33%)
Age			
20-29 years	--	2 (40%)	2 (22%)
30-39 years	3 (60%)	--	3 (33%)
40-49 years	1 (20%)	2 (40%)	3 (33%)
>=50 years	1 (20%)	--	1 (11%)
Marital status			
Single	2 (40%)	3 (75%)	5 (56%)
Married	2 (40%)	--	2 (22%)
Separated	--	1 (25%)	1 (11%)
Widowed	1 (20%)	--	1 (11%)
Country of Birth			
Iran	5 (100%)	0 (0%)	5 (56%)
Myanmar	0 (0%)	4 (100%)	4 (44%)
Years lived in Australia			
<1	1 (20%)	1 (25%)	2 (22%)
1	--	2 (50%)	2 (22%)
3	3 (60%)	--	3 (33%)
5	--	1 (25%)	1 (11%)
6	1 (20%)	--	1 (11%)
Current Living situation			
Living with family*	3 (60%)	2 (50%)	5 (56%)
Living with friends	1 (20%)	1 (25%)	2 (22%)
Living in shared accommodation	1 (20%)	1 (25%)	2 (22%)
Highest Level of Education			
Senior Secondary / High school	1 (20%)	1 (25%)	2 (22%)
<Year 10	--	1 (25%)	1 (11%)

Certificate I	--	1 (25%)	1 (11%)
Bachelor's (uncompleted)	2 (40%)	1 (25%)	3 (33%)
Bachelor's degree	1 (20%)	--	1 (11%)
Associate degree	1 (20%)	--	1 (11%)

* includes living with partner/children (2), with children (1), siblings (2)

Table 2. Differences in interpretation of ~~some of the~~ QPR items

Item	Differences in Interpretation
Q1. I feel better about myself	Emphasis on level of activity e.g., financial security or physical health which can be indicators of feeling better about oneself
Q3. I am able to develop positive relationships with other people	Focus on 'view' of others (as a contributing factor) as opposed to the 'nature of the relationship' itself.
Q4. I feel part of society rather than isolated	Highlights the different ways the term 'society' can be interpreted and that there can be many societies. Responses to this may depend on 'with which' society (or societies) they identify and feel is important to be part of as well as 'legal' entitlements to be part of a particular society.
Q5. I am able to assert myself	Some respondents associated asserting oneself with being confident, independent, or being able to prove oneself, which are related but may not capture all ~~of the~~ intentions of this statement.
Q6. I feel that my life has a purpose	Many ~~of the~~ Burmese responses had in common a strong reference to nature and being part of the environment.
Q7. My experiences have changed me for the better	Emphasis on being 'different' or 'disconnected' from the past self instead of 'integrating' the experiences (learning opportunity)
Q8. I have been able to come to terms with things that have happened to me in the past and move on with my life	Response option "disagree" was not considered to be the same as "not yet". A "not applicable" option was recommended. For some ~~people~~, the two parts of this item may not necessarily be linked with each other.

Commented [DB23]: I've limited this table to around one example per item. Could get rid of these examples entirely if the word limit won't come down enough.

Formatted Table

Commented [DB24]: Could this be a translational issue? In English, the use of the term "society" differs by context in the sentence. However, in other languages there may be many different words for the term "society" and this then becomes more of a translational issue.

Q10. I can recognise the positive things I have done	What is considered 'positive things' was not clear to all respondents. "In the past 7 days" resulted in one participant to focus on whether or not he/she did something positive in the past 7 days. "R~~r~~ecognise" was interpreted by some as "telling others" that they did positive things.
Q11. I am able to understand myself better	Important link to spirituality / religion
Q12. I can take charge of my life	Participants reported this item as not being clear.
Q13. I am able to access independent support*	The term "independent" seems to be confusing to many, particularly among the Iranian respondents. E.g., one participant interpreted this as 'being' independent rather than being able to access support when necessary. One respondent focused on the term 'access' and saw this as being a 'taker'
Q14. I can weigh up the pros and cons of psychiatric treatment*	Focus seems to be on the ~~quality of the~~ physician quality or treatment received rather than ~~a~~ generally understanding ~~of the~~ benefits and possible risks of psychiatric treatment.
Q15. I feel my experiences have made me more sensitive towards others*	Many interpreted this as being sensitive or fragile rather than their ability to be understanding towards other people facing difficulties.
Q16. Meeting people who have had similar experiences makes me feel better*	How the respondents interpreted 'similar experience' seemed to be broader than those experiencing similar mental health issues.

Q17. My recovery has helped challenge other people's views about getting better*	Some respondents did not understand how their own personal recovery was related to other people's views and therefore did not understand the question (or its objective)
Q19. I can actively engage with life	Focus seems to be on the term 'active' and it needing to be 'constant' over time.

* Items found to have insufficient face validity or ambiguous working (Law et al., 2014)