OPENING DOORS & CONVERSATIONS

Culture, self-determination & mental health

An evaluation of the VicHealth mental health literacy pilot project

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Cultural rights protect the rights for each person, individually and in community with others, as well as groups of people, to develop and express their humanity, their world view and the meanings they give to their existence and their development through, inter alia, values, beliefs, convictions, languages, knowledge and the arts, institutions and ways of life

(United Nations, 2010)

Together, we can carve our struggles into something beautiful and find strength in our shared experiences by embracing mental health literacy as a pathway to healing and growth-one conversation at a time!

(Next In Colour)

Acknowledgments

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We acknowledge the Traditional Owners of the land on which this work took place, the Wurundjeri Woiwurrung peoples of the Kulin Nation and pay our respect to their Elders, past and present.

We acknowledge that these lands are stolen lands and that Aboriginal sovereignty was never ceded.

Table of Contents

Executive Summary

This mental health literacy (MHL) project supported the trialing of several culturally anchored approaches to MHL for three cultural communities: South Sudanese, Sri Lankan Tamil, and Pasifika. One of the main purposes of the current project was to shift away from Western perspectives on mental illness and to establish foundations that foster creating culturally anchored methods of discussing and addressing mental well-being within non-Western cultural communities. Community consultants were selected by VicHealth to lead each program and ensure culturally specific and community-oriented programs were developed. A key feature of the project was that programs should be self-determined so that the community consultants running each program were able to steward each program in ways that best suited community needs, attitudes, and accessibility.

The evaluation of this MHL project was guided by the concept of cultural rights, which are the rights of people and communities to "develop and express their humanity, their world view and the meanings they give to their existence and their development through, inter alia, values, beliefs, convictions, languages, knowledge and the arts, institutions and ways of life" (United Nations, 2010, para. 3). This also aligns with the concept of epistemic justice which is the (re)locating and empowering of knowledge and knowers within communities (Sonn et al., 2021). MHL for non-Western communities should be fostered from the ground up through the amplification of cultural, ancestral and community wisdom and knowledge.

Given the fundamental role culture plays in MHL, the evaluation focused on two main areas of investigation: Developing culturally anchored MHL resources, and fostering relationships, support and cultural safety.

While the community projects all took a different approach, each of them attained important successes in several areas of MHL for their communities. Those successes were:

- **Building capacities and knowledge** around mental health through both formal training and experiential learning in running the projects.
- **Dissemination of culturally relevant resources** about mental health tailored toward community attitudes, beliefs and worldviews. This included the production of short films, flyers, social media posts, and a spoken word performance.
- **Creation and facilitation of spaces** for social connection and conversations about mental health, and wellbeing. They were also places of cultural safety where conversations could be raised about the impacts of racialization and marginalization could occur. Spaces were both in-person and online.
- **Multiplying networks of support.** Each program collaborated with or connected to other groups and organizations to support their programs, including local councils, cultural community groups, and other government services.

In supporting and overseeing the pilot project, VicHealth staff were found to be flexible, supportive, and understanding. It was also reported by the community consultants that they felt culturally safe in their interactions with the organization. While funding was welcomed by each community consultant, they also all stated it was insufficient to cover the reality of running such programs and noted that MHL is not

short-term and therefore short-term funding is unsatisfactory and creates an ongoing anxiety about the sustainability of such self-determined projects. While the flexibility of VicHealth and its non-directive approach toward fostering self-determined projects was appreciated by all the community consultants, some also stated they felt as though they had been a bit left to fend for themselves. Based on the information collected from this evaluation, the following are recommendations for VicHealth to strengthen its positioning and resourcing for self-determined, culturally anchored, mental health literacy projects.

1. Increased support and resourcing for a community of practice for the community consultants and program facilitators to foster a sharing of knowledge, resources, and to build their conceptual framing of MHL to support their programs. This would also be an opportunity to engage with a range of culturally diverse and creative approaches and strategies to decolonize MHL.
2. Greater awareness of the impact of short-term funding specifically for MHL projects which do not have short-term solutions. This should include ways to economically empower communities through greater consultation and co-design about what is possible with a given amount of funding, so there is less likelihood of communities being exploited and not left vulnerable when funding ceases.
3. More training and support from VicHealth regarding communication and health promotion strategies for the community consultants and their programs. This would also be an opportunity for VicHealth to model the amplification of cultural knowledge from communities.
4. Greater support and resourcing for VicHealth staff to be able to more closely connect with individual MHL programs. Understanding more of the specifics of each program would assist in knowing what resources and support could be offered to cultural communities for their programs and would strengthen those community partnerships.
5. To ensure there is sufficient culturally safe mental health and wellbeing support for consultants and facilitators who may be faced with distressing or traumatic stories in their programs. As they are members of the communities they are working with, their programs are also deeply personal and therefore there is a heightened risk of them being adversely impacted.

The current evaluation shows that the project undoubtedly affected the community consultants and program facilitators in positive ways. The research team believes this evaluation will offer VicHealth useful insights to continue working toward supporting cultural rights and fostering self-determined mental health literacy projects in the future.

Background

In light of the COVID 19 pandemic and the psycho-social repercussions this had on young people within Victoria, VicHealth has committed to "taking a comprehensive approach to address the issue of low social connection and poor mental wellbeing amongst young people in Victoria" (REF). Through their Future Healthy initiative, VicHealth has sought to develop a dialectic collaboration with young people, in aims of listening, collaborating, and understanding what needs to be achieved to make happier, healthier living a reality for as many young people as possible. For this purpose, VicHealth created their pilot program Big Connect, a three-year integrated health program aiming to support the mental health and wellbeing of young people. Within Big Connect, VicHealth created a pilot project that seeks to support the self-determined development and dissemination of culturally relevant frameworks of mental health literacy (MHL) among non-western cultural communities. The aim of this pilot project is to support the de-centring of western conceptualisations of mental illness and provide groundwork for the fabrication of culturally and historically relevant ways for talking and working around mental wellbeing within non-western cultural communities. Therefore, VicHealth has developed a partnership with a steering committee of young people and cultural consultants from three non-western cultural communities (Pasifika, South Sudanese, and Tamil-speaking Sri Lankan). With VicHealth's financial support, each of these communities aimed to improve MHL in young people (0 – 25 years of age) and their carers in the community; through raising awareness of what mental health is and looks like, and the protective factors that enhance mental wellbeing in culturally relevant ways.

The VicHealth Mental Health Literacy Pilot Project

The MHL pilot project is grounded in an understanding that MHL is central to mental wellbeing and that mental health means different things to every cultural community and their unique cosmology and worldview. It centres the importance of culture and its specificity in the processes of knowledge-making and translating. Hence, through this pilot project, VicHealth has endeavoured to develop tailored community-led approaches to MHL with the aim of developing culturally, historically, and contextually relevant knowledge on what mental wellbeing and mental health literacy might look like in non-western cultural communities; how it might be experienced and develop ways to talk about it and reduce the stigma associated with these experiences that might currently exist within their respective communities. In addition, the program has also sought to create opportunities for social connection. For this purpose, VicHealth has engaged in:

- Partnering with culturally specific organisations and communities to codesign products and methods of engagement.
- Connecting with mental health experts who are representative of the target communities.
- Delivering workshops, webinars, and community forums online and (where appropriate) in person and in local community settings.
- Making recordings of webinars and community forums available through VicHealth and community channels.

The MHL pilot project sought to achieve specific outputs. These outcomes included the following:

1. Longform video of MHL information, focusing on what mental wellbeing might mean for each specific cultural community, the importance of developing an understanding about mental health and wellbeing that is grounded in culture, and encouraging people to talk about mental health issues that exist within their community, including tackling stigma. The video was to be easily reusable and shareable in the community, and intended to be created with support from the VicHealth Social Marketing & Communication (SM&C) team.
2. A culturally relevant and guided MHL program, which might take different shapes and forms that are flexible and responsive to the needs of the cultural community. The program was required to be accessible and replicable. Some ideas of what this might look like involved workshops, webinars, community forums, online discussions, toolkits, presentations and/or other contextually relevant methods determined by the participating communities.

   These programs were conceived to be co-designed with young people, mental health professionals, and Elders (if culturally relevant) from the community and directed and advised by a cultural consultant and a steering committee.

3. Participatory research and evaluation piece.
4. Stories for a social media campaign run by VicHealth. These were optional.
5. Final report outlining the experiences of creating this program and reflections around this.

The project also envisioned specific outcomes within a short-, medium- and long-term basis:

Short-term:

1. Participants will develop an understanding of social connection as a protective factor for mental wellbeing.

2. Development of and confidence in understanding MHL from a place that centres cultural and historical specificity. The proposed indicators for this have been:

a. Develop an understanding of what mental health looks like in the community and knowing what mental wellbeing means within the context of their cultural community.

b. Understand how to approach mental ill health with family, friends, and professionals. Confidence in knowing how to support community by helping them access culturally appropriate support.

c. Participants feel socially connected with other participants and with family/friends in understanding each other and any mental wellbeing difficulties they may have or witnessed in others.

d. VicHealth would develop and strengthen connections with new stakeholders and communities with whom VicHealth has had limited engagement with.

Medium term:

1. The materials produced through the pilot project are disseminated throughout the specific cultural communities and are used for community training and education.

2. Community and culturally specific research is used to trigger further research on culturally specific MHL programs

3. VicHealth would be able to increase its capacity to implement anti-oppressive models of mental-health literacy that empower communities to self-determine healthy futures.

Long-term:

1. Increased MHL across selected communities, which supports the application of protective factors and help seeking behaviours in ways that work for them.

Cultural Communities' projects: objectives and deliverables

This section details the initial program proposals from the three cultural communities and what the aims and objectives were. Proposed program objectives were the elements community consultants stated as a part of their initial ideas for each program. While each project remained, community led and focused

on mental health and wellbeing, some of the project objectives and the actual deliverables changed due to a range of factors. The difference between proposed objectives and actual deliverables is briefly outlined here.

Pasifika Community

Proposed Program objectives

This MHL pilot program has been led by a leadership and advocacy group that consists of 18 Pasifika young people (ages 17 to 25 years old), under the role of *Pasifika Navigators*. These Pasifika Navigators are based in the northern and western suburbs of Melbourne.

The group sought to focus on two main groups of participants: 1. Young people 12 – 25 years of age and 2. Carers – paying special attention to caregivers who have children under 18 years of age.

The Pasifika group decided to conceptualise their project around two main activities: 1. Talavou Talanoa sessions (youth discussions) and 2. A video project serving as an accompaniment to the Talavou Talanoa sessions.

1. Talavou Talanoa (TT) sessions – were envisioned as a 6 session program where Pasifika Navigators would engage the broader community in a series of forums and discussions around what MHL and mental wellbeing might look like in their community. These conversations were conceived as hybrid in nature (in-person and online) and targeted both Pasifika young people and parents. Topics of these Talavou Talanoa sessions included:

- Mental Health needs/challenges of Pasifika youth
- Talk to someone
- Family engagement opportunities
- How to keep yourself safe
- Healthy minds and well-being

The community group also envisioned upskilling and supporting their Pasifika Navigators through the organising of a training day which aimed to provide Talavou Talanoa facilitators with information and tools that would assist them in facilitating these youth community forums.

2. Video Project - This video project was envisioned as an accompanying resource to the Talavou Talanoa sessions. The video project would be led by one of the 18 Pasifika Navigators and produced by a youth creative director. The video was conceptualised as casting and featuring the Pasifika Navigators. The video intended to address key questions, which included:

- What is mental health?
- What does it mean to talk about mental health?
- What are some protective factors that young people can take on…etc?
- Why mental health matters to Pasifika young people?

Program Partners

The community group envisioned collaborating and being supported by a number of community organisations based on their expertise. These were: 1. Pacific Islands Creative Arts Australia Inc. (PICAA) (creative artists); 2. VASA Consultancy (community engagement consultant); and 3. Pasefika Health Collective (health practitioners)

Actual Program deliverables

After evaluating some of the initial mental health training for the Pasifika Navigators, it was decided by the facilitators of the project that given there were some indications they may not be ready to engage in community work, and there was a need to focus more inwardly on their protection and development. This included deciding not to make a public video sharing community stories of mental health as it too could be a source of pain and distress for the navigators. Despite these challenges and the community consultant having to step away from the project for personal reasons, one of the more experienced navigators was able to step up and continue the work with the Pasifika Navigators.

Through a mentoring model the project was able to expand its existing cohort of navigators (which had been developed prior to this MHL funding) from 7 to 14 Pasifika young people. Funding allowed for three of the navigators to attend mental health first aid training.

In place of a film, a spoken word performance was delivered at the VicHealth showcase by Lyle Makepeace who is a Pasefika Mental Health Advocate and co-led the navigator project. This was created to capture the collective experiences, ideas and feelings of the navigators in the project in a culturally safe way. This was performed at the VicHealth showcase in June 2023 and can be seen here:

https://vimeo.com/showcase/10461256/video/842679529

Southeast Asian Community

Proposed Program objectives

The program sought to engage young people (aged 12-25 years) and carers (particularly carers who had children under the age of 18 years) from the Tamil Sri Lankan community and share youth focused mental health literacy material.. This project has been guided and supported by Shankar Kasynathan as a cultural consultant. The engagement was conceived through four main activities:

1. Community arts-based practice: Carnatic Indian Classical Music and Dance event – with a mental health focus (written, produced and performed by Tamil Sri Lankans) for the purpose of the VicHealth foundation project.

2. Mental Health Literacy Short Film: A short film, in Tamil/English language focusing on the story of a Tamil Sri Lankan artist and young Tamil Sri Lankan dancers who embark on a journey to address mental health awareness in their community. This short film was to be filmed and produced by young Tamil Sri Lankans.

3. Mental Health First Aid training and capacity building: Skill building for a Tamil Sri Lankan mental health professional
MHFA and accompany guidebook for CALD communities: delivery to Tamil School teachers, religious community, families, young people.

4. Online community space (designed by Shakti Mental Health): Using Instagram and Facebook to create online stories for mental health engagement and knowledge building.

Program partners:
The community group envisioned collaborating and being supported by a number of community organisations based on their expertise. These were: 1. Darebin Ethnic Community Council; 2. Darebin Intercultural Centre; 3. Your Community Health; 4. Tamil Refugee Council; 5. Australian Ensemble for Creative Advocacy (Tamil Sri Lankan led art community).

Program deliverables
Although the project initially sought to focus on young people as a result of community consultation it was discovered there was a pressing need to address a number of issues relating specifically to men in the broader Southeast Asian community. As a result of this ongoing consultation, four men's discussion groups were started in various locations throughout Melbourne and were facilitated by community members who had been recruited by the project lead. Facilitators had completed their mental health first aid training as a part of the funding for the project. It was noted that there was an ongoing hope that younger men would still be involved in these groups, and in some instances there were a few who did participate, but several facilitators commented they would have liked a greater involvement by young people in the groups.

Groups met in community spaces that were booked by the facilitators and generally met once a month for 12 months of the evaluation but are continuing beyond this. They covered a range of topics relating to mental health and wellbeing, including, masculinity, racism, identity and substance abuse to name a few. The topics were mostly decided by facilitators, but in some instances, groups were asked for feedback about potential topics. The groups were not designed to be therapeutic, but rather an opportunity for men to come together and share stories and experiences in a safe space. It was also an opportunity for men to hear other men be open and vulnerable.

Group sizes ranged from 3 to 8 participants and ran for approximately 1 hour. Some groups ran during the day on weekends, whilst others were held in the evening during the week. While efforts were made to make these days and times convenient to participants, there was also a need to fit in with facilitators who in most instances were working in other jobs or other projects as well.

In addition to the men's circles, the project also delivered three films relating to mental health in the community. These were shown at the VicHealth showcase in June 2023. Details of these films are as follows:

- Project Arokkiyam / Jagesh Panchal and Shakti Mental Health: brought together a group young people from Tamil, Sri Lankan and South Indian background to discuss challenges, advocacy, experiences and ways to create change in an effort to increase mental health literacy. https://vimeo.com/showcase/10461256/video/835652843
- The Open Exchange: By community, for community / Keith Rhodes, Shankar Kasynathan, Jagesh Panchal and John Sugunanathan: shared interviews with those involved in the project and the rationale and aim for the project. https://vimeo.com/showcase/10461256/video/835652778
- A Helping Hand / Shuvethigah Antony: creatively depicted and narrated some of the cultural expectations, fear of judgment, and limited awareness of mental health issues can contribute to a reluctance to seek help. https://vimeo.com/showcase/10461256/video/835652743

The programs has also maintained a website (https://theopenexchange.org) and various social media accounts to engage, share information, and promote upcoming events and the men's groups.

South Sudanese Community

There were two separate programs conducted with the South Sudanese community. Due to unforeseen personal circumstances, the first iteration of the MHL program was not able to be completed. However, there was a substantial amount of planning and engagement that was undertaken in this first program, which is important to acknowledge here.

First program

Program objectives

The community group conceived the program as pertaining two main activities. These included a MHL community program and a video. The group sought to focus on two main groups of participants: 1. Young people 0 – 25 years of age and 2. Carers – paying special attention to caregivers who have children under 18 years of age. This project was guided and supported by cultural consultant Monica Majok.

1. **Community sessions:** The group envisioned providing monthly s community sessions over a 6 month period (6 sessions in total). Sessions would focus on the six different layers of human psychological triggers. These six layers are: intellectual, emotional, social, physical, spiritual, and environmental mental wellbeing. In addition, the community group conceptualised the use of brochures/flyers which would be distributed across the states by different delivery agents. These delivery agents were community leaders, young people of influence, professional athletes, and professional leaders who would deliver the brochures/flyers to the specific groups of community members they were working with. The aim of these brochures/flyers was to have them accessible and available around South Sudanese homes and other community spaces. This method sought to encourage and support members in the family in becoming comfortable

with a vocabulary to communicate feelings of frustrations, anxiety, trauma and sadness to each other.

2. Video: The group imagined the video to be shared on different social media platforms**;** along with using influential and professional athletes, community leaders and other community organisations to share/post this video.

Intended partnerships
Formation of collaborations and partnerships with other relevant stakeholders like HASA, Woodlea Soccer Academy, Melbourne United Basketball Club, Victoria Police, Department of Health, to tackle specific challenges through a new framework.

Program deliverables
Due to personal circumstances this project was not able to be completed and thus no deliverables resulted from the project. That said, initial conversations were had between the community consultant, their community and potential partners about the program. Discussions were also had about mental health and how best to engage community (i.e. flyers, video, social media).

Second program

Program objectives
Given the relatively short turnaround time, the second project was only able to focus on producing a short film to be distributed to the community. Prior to the creation of the film a group of people from the community came together to collaborate on ideas around mental health in their communities and what the film could look like.

The project was led by Next In Colour (NiC). NiC functions as a creative entity with the purpose of addressing diverse manifestations of structural inequality. Their focus lies in establishing alternative environments and fostering impactful partnerships to counteract these issues. The project was described (via an information pamphlet produced by NiC) in this way:

> *For this project Next In Colour partnered with Popular By Default, Say Less Music Group and individual creative practitioners to produce a short film that reflects the communities we come from, and that we can proudly call our own. We wanted to speak to untapped ancestral knowledge by exploring the meaning of mental wellbeing through cultural ways of being, knowing and doing. However, our commitment extends beyond the creation of remarkable and transformative art. This project was designed to support*

and nurture the work of emerging and established African artists working across a range of disciplines. We want to continue to build bridges, break boundaries, and create a more inclusive and vibrant community that truly reflects the diversity and richness of our society, and to explore issues affecting social cohesion, mental wellbeing and gender equality from African perspectives.

Program deliverables

Through this collaborative endeavour, a short film titled '*It's Crooked Wood That Shows The Best Sculptor'* was produced and shown at the VicHealth showcase along with the other creative outputs from each community. The film is described by NiC as a:

> *captivating short film that speaks directly to the South Sudanese community's unique Journey, tackling the Importance of culturally specific mental health literacy and the transformative power of communication. The title itself draws upon the universal wisdom found within the African proverb of the same name. This powerful proverb speaks to the nature of our struggles as human beings and how they shape us into something beautiful.*

The film was shown at the VicHealth showcase in June 2023.

Evaluation Approach and Design

Guiding concepts and critical questions

This evaluation is informed by critical community and cultural psychology which understands people and communities as being inseparable from and in constant dialogue with their various cultural locations. This means that even when people and communities have been displaced or have relocated away from their 'home' culture, they are still in dialogue with it, and it therefore informs important psychosocial aspects of identity and wellbeing (Sonn et al., 2021). Given the centrality of culture, the project is also guided by the concept of cultural rights, which are the rights of people and communities to "develop and express their humanity, their world view and the meanings they give to their existence and their development through, inter alia, values, beliefs, convictions, languages, knowledge and the arts, institutions and ways of life" (United Nations, 2010, para. 3). This implies that epistemic justice (Sonn et al., 2021) is also an important part of cultural rights in that it aims to (re)locate and empower knowledge and knowers within communities.

Given the fundamental role culture plays in MHL, two main areas of investigation were outlined for the evaluation: Developing culturally anchored MHL resources, and Fostering relationships, support and cultural safety. These and their related evaluation questions are listed below.

Developing culturally anchored Mental Health Literacy resources

Progress and production

- What have been the challenges in the programs/production process, and how have these been overcome?
- What have been the strengths of the programs in terms of producing the MHL resources?
- What are the unique ways each cultural community has produced MHL resources?
- How has each program defined MHL and how has that shaped the structure and format?

Outcomes, MHL resources and impacts

- What are the ways the project/programs have influenced understandings of MHL and of social connection as a protective factor?
- What have people learnt or experienced from participating in the programs?
- What are the ways programs/outputs have sought to reach different audiences?

Fostering relationships, support and cultural safety

Partnerships and support

- What are the processes for establishing and maintaining partnerships?
- How are issues relating to the projects being addressed?
- How do the community consultants perceive the level of support and cultural safety from VicHealth and other partners?

Funding and resourcing

- How have community consultants perceived the level of funding?
- What costs have been incurred outside the funding for the projects?
- What areas of resourcing or support did consultants report needed attention?

Evaluation design

The MHL project was a pilot, therefore it was appropriate that this evaluation was framed as a process evaluation. This kind of evaluation seeks to determine whether program activities have been implemented as intended and is concerned with evidence of activity, and the quality of implementation. Process evaluation draws on multiple sources of evidence and is focused on:

1. Evidence of activity that shows what has taken place. Data for evidence of activity comes from a number of sources such as: program data, program artefacts, observations and field notes.
2. Evidence of process quality. Data for evidence of activity comes from a number of sources such as: interviews, questionnaire, observations and field notes.

Data sources

Data was collected via several sources and will be referred to throughout this report in the following ways:

- Interviews – conducted by the researchers with community consultants, program facilitators and VicHealth staff.
- Observations – weekly sessions were attended by researchers and detailed notes were taken.
- Field notes – detailing informal conversations, settings/context, and sessions/program details, as well as meeting between VicHealth and community consultants.
- Program data – reports, program documents and materials and data collected by VicHealth and each program.
- Program showcase – conversations, films and observations from the VicHealth showcase of all the films

Data collection occurred both in-person and online from August 2022 to July 2023.

To establish credibility of the findings, all data collected was regularly discussed by the research team which ensured findings and themes were triangulated and corroborated by multiple researchers and sources.

Research team

The research team consisted of one chief investigator (CI) who is a registered psychologist with research expertise in community psychology and program evaluation; one psychology PhD student, and two research assistants (RA). Where possible the CI visited the MHL programs over several months along with the PhD student. The CI and RA conducted the individual interviews with program participants, facilitators and VicHealth staff. All members of the research team were based at Victoria University.

Data analysis

Interviews and other audio available were transcribed and coded by individual researchers. These codes were then used by the research team to collaboratively develop the main themes. This form of thematic analysis (Braun & Clarke, 2021) is a systematic approach to analysing qualitative data and has been utilised extensively in psychology and allied health to establish robust findings from various forms of qualitative data. The main objective of thematic analysis is to ensure that themes arrived at are clearly supported by the data and that themes are meaningful to the data.

Findings

Five main themes emerged from the interviews conducted with community consultants, a participant of one of the community programs, and a member of VicHealth who was involved in managing the project. These themes have been labelled as: **Connecting with community, Strengthening capacities, MHL in cultural communities, Fostering cultural safety, Support and resourcing**. Within each theme several sub-themes have also been identified. Main themes and the relationship to sub-themes can be found in Figure 1.

Figure 1. Map of main themes and related sub-themes from findings

Connecting with community

This theme covered the ways in which community consultants spoke of their approaches and strategies required to reach, connect, and maintain engagement with community and program participants during their projects. This included using social media and a range of other communication strategies to let communities know about their MHL programs and in some cases to encourage people to attend ongoing

meetings (as in the case of the SE Asian group). Due to the different nature of each community project, the engagement strategies and approaches were varied as were the challenges faced.

Reaching and supporting community

Overall, it was observed that all community consultants and program facilitators needed to be resourceful in how they sought to reach and connect with community and that they drew on a range of strategies to do this.

> *So if they come to one discussion, we've got their email address and ways to contact them...where we can kind of even send them like a newsletter or email out on ongoing resources. So we don't want that support just to stop after they've come to our discussion…we want to ensure that they've got that support when they need (S)*

A common factor that arose throughout the interviews was the creative use of social media to both reach and engage with people.

> *so it started off with Instagram lives where we would go live, and then for our youth to just like, you know, messengers, yeah, jump online, interactive, fast. I mean, we'd like we'd hold or have a conversation, but we'd also group on live, and they could see, yeah, just so they'll be to host. And then there'll be some others who are helping film, and keeping an eye on the comments and stuff. And like letting us know, so we can interact with them, but also still holding this conversation. So we did that. And that was like, really fun (E)*

> *But social media has definitely played a big part on our reach our target audience and how we sort of expressed the stories on Instagram, like, it's very, very easy to like, pull up a perspective, read it, and be like, Oh, I relate to this. I know someone that is probably struggling with this. Let me just quickly hit share and send it to them. Like, like that. Like that, like straight away…So Instagram has definitely been like a big catalyst for us. Absolutely. And we're really happy with sort of the organic growth and how it's come across to people. (D)*

Some consultants also expressed a need to continue to evolve in terms of reaching their communities and the need to be more diverse in terms of who they attracted to their programs.

> *I think the only thing I really want to improve upon is outreach and engagement. Bringing in like a wider audience, greater ages, life experiences, even willingness to talk and like levels (V)*

It was noted that this kind of outreach/engagement for many of the consultants was a large part of the 'work' involved in getting their programs up and running and that it required continued effort and resources to maintain such engagement.

> *Yeah, so [facilitator] like single handedly runs the marketing, creates the content, you know, looks at like posting and the schedules for posting all the emails. It's a fair a bit of work, especially because this isn't the only initiative [they] run (V)*

Community consultants often had to use their personal connections to their communities to gain attention for their projects, and they also spoke of drawing on their love and concern for their community as being important drivers for the work.

> *I know in the future, through that connection, where they're going to build more connections through the people that I love and care for, because like, that's just how I involve community. I'm like, I love sharing my community with anybody and everybody. And as long as it says, as long as it's safe to do so…we're starting that journey, we're still building a relationship with community and still figuring out like how we can show up (E)*

Because the work was personal, support also meant supporting those community members who were facilitating the programs.

> I *would say that a big part of my role has been mentoring and building and trying to keep people going through the course of this project. And then responding quickly, when someone actually falls off the rails. For me, it's been a massive learning curve, and perhaps some insights for the project is that, you know, continue to keep listening, listening and listening to what the community needs are (R)*

A key message that was present throughout the interviews and field observations was that while these mental health literacy programs were designed to support communities, there was also a need for the program facilitators and community consultants themselves to be supported through the challenges they faced doing this work. Promoting and connecting with community was at times not easy for the community consultants. These difficulties were partly due to the barriers which are known to exist around mental health literacy.

Barriers and challenges

***"The ways you communicate mental well-being in Punjabi might be different to what it might be to Tamil people"* (Open Exchange)**

All programs reported facing a range of barriers and challenges often based around overcoming the stigma attached to mental health in their communities. Many of the consultants spoke about shame or judgement as things they believed prevented people from engaging with their programs.

> *you know, there are those that are those challenges that are that are coming up so that the perceived opinion around these groups, is what I need to the presumptive judgments that people make around these groups is what I think the biggest challenges, I think, if we can overcome that in some shape, or form or, or help people to be open about coming along, then that would, that would have a lot of inroads into, you know, inroads for expanding this in the community bit more (Y)*

The consultants described stigma or perceived value of the programs as being one of the barriers to connecting or attending. In some instances, consultants considered that the programs might require a certain level of preexisting mental health literacy for potential attendees to see their value.

But that is like a struggle we've seen...since the inception of these events, it's hard to get the older people to come in…like, inherently, mental health is just not as spoken about within those older demographics. And I guess in saying that, to put aside, your time to attend one of these events, is sort of, like hard to do, if you don't, like, believe in it…it makes sense that people that come here already hold some level of mental health literacy, and are willing to talk about things (V)

"Using the word mental health or psychiatrists, that part of that word translated into Arabic is, is crazy. So, there's a lot of things that need to be decolonizing" (Community consultant)

However, mental health literacy does not occur in a cultural vacuum and several consultants motioned that concepts and approaches from a western framing were not only inadequate, but potentially harmful.

whilst I was working as a case manager and youth worker, a lot of people didn't understand what mental health was. Or there'd be language barriers, such as you know, using the word mental health or psychiatrists, that part of that word translate into Arabic is, is crazy. So there's a lot of things that need to be decolonizing, the way that they engage with ethnic communities. And also the way that they psycho analyzing over clinicals things, or sometimes the language that they use is very offensive, and derogatory (I)

Consultants also reported a range of logistical challenges running regular programs and trying to find days, times and locations that best catered for their intended participants. It was also reported and overserved that trying to develop topics of relevance and interest to communities was a major challenge and often consultants reported difficulty finding the right way to present topics that would attract people.

we've started these like, trailing monthly topics, because we want to see if we can get more guys interested in our discussions that way as well. So, they can kind of see the topics and be like, Oh, I kind of like affiliate with this one. I've had some issues with this. Maybe I'll come in June, that maybe not so much July, because I haven't had that…those challenges (S)

And it was a struggle to get people in the door, we had food, we have other things we had community champions bringing people on. So, we've had to keep experimenting with the way in which we wrap up content (R)

In summary, this is an overview of just some of the challenges facing community consultants and program facilitators in trying to reach and engage communities. Although the ideas presented are gathered into neat themes and sub-theme it would be erroneous to conclude that these challenges and barriers are homogenous across all the cultural communities. Even concepts such as stigma need to be considered in culturally specific ways so as not to flatten the reality of them for each community.

Strengthening capacities

This theme details the ways in which community consultants and program facilitators spoke about their own personal growth, but also the ways in which they shared knowledge through collaboration to foster cultural strengthening. Capacities were also described in terms of navigating their own relationship to their culture the d their perceived sense of duty or obligation that can be inferred by undertaking this community work.

Learning and personal development

"I'm not the face of my community, I'm not the face of it. And I don't think one person should ever have to be the face of a whole community. And I feel like that's quite often put on to people of colour… there's somebody who gets often put a lot of pressure on them to be the face of face of a whole community, which is not fair and not representative enough"
(Community consultant)

Although community consultants came to the project with their own knowledge and expertise, many of them also indicated different kinds of learning that had occurred as a result of being a part of their mental health literacy programs. Some of this was around formal learning such as mental health first aid courses which were part of their funding while other learning was more organic and experiential.

> *Mental Health First Aid training, because I feel like that was super good going into these projects, having that training. Because we also have, like, I would say, the academic westernized understanding of mental health, but also our own cultural understanding. So having the ability to compare for me, at least, and the others, because we have our own practices of how to take care of our mental wellbeing (E)*

Also, several consultants spoke of the impact of their projects on their own development in their relationship to culture, and the ways in which they thought about mental health.

> *I think the biggest thing was like, I think it's definitely learning that mental health is definitely, it can't just be an individual journey, like I thought, a long time ago that it was just me and my own sort of trauma that I had to go through it (D)*

> *Coming from and counseling spaces, is a good opportunity for me to just feel safe and, and reflect as a man, I think I'm very, very conscious about the fact that I don't want anyone to fix my problems. I want someone to just listen to what it is that I'm saying (Y)*

> *The biggest thing for me as well, it was just learning about struggles that older generations have been through also, and having the sort of advice like passed down to me as well (D)*

> I've definitely learned how to be more patient and also, like, valuing others time, as well as my own, respecting others time in my own time. And I feel like that's super important, (E)

Collaborations and networks

Being able to develop connections to other organisations that built capacity and fostered knowledge exchange, was a key avenue of support of many of the community consultants and facilitators. For some, connecting with organisations also offered a way of validating and strengthening their projects.

> *I can leverage these, you know, these organizations and these connections and say that, look, I'm part of a bigger network, that gives me more credibility, and I guess more, more confidence to be able to reach out and, and talk to people about what it is that I do, and what it is that I want to do. So even though even though at the moment, it's in its early stages, it I can, I can have a vision of what I wanted to be able to provide for the community (Y)*

The nature of these programs meant that community consultants were not working *on* communities but working *with* and *within* them. The people leading the programs all stated how important it was to try and connect to a diverse range of collaborators within their cultural communities, but that also this was not an easy task, and it took time.

> *So, in summary, there's been a huge amount of trial and error, this work, and, and part of that trialing has been engaging people and collaborators (R)*
>
> *We had a, like an event where different people, like different people from community had come in to, we introduced ourselves and what our passions are and what we hope to achieve. And like, it was good, because then we got to meet more people who can provide support as well, who are considered like leaders within our community (E)*
>
> *it has to be organic, you know, really, because, you know, we started talking in August, and then the group kicked off in January. And it took at least three months of, you know, me kind of trying to figure out what it is that, who it is that I wanted to connect with. And this place only happened because I'd known them from a year before, because of another project that I was working with (Y)*

It was also reported by interviewees that bringing community consultants and program facilitators together would have been a useful way to find commonalities in their work, to share ideas and resources and offer support in culturally safe ways.

> *collaborating with these other cultural communities to understand how we can tackle the situation together, you know, because at the same time, we're all a minority in this country here, right? At no fault of our own, like, for sure. But how can we also collaborate with those other communities, and identify issues that affect us, and those people as well sort of come together and work towards like that common goal of how we can support just multicultural mental health in general? Yeah. So I would love to, like do like a big discussion between like us (D)*
>
> *Do you think there's a way that all different cultural backgrounds could come together to create something that goes through what everyone's experience is? And is there something that a shared experience that you all kind of have reflected on? (S)*

From the reflections offered by the community consultants and program facilitators, it is too easy to assume that community members come with pre-existing connections and that these are what underpin successful MHL projects. Rather, what was found here was that extensive work was required to develop and sustain those connections and supports among community members.

MHL in cultural communities

This theme captures the ways in which MHL was defined and used to frame each community project, but also some of the issues that can arise if Eurocentric conceptions of mental health seep into the approaches or ideas around mental health and wellbeing. Most community consultants and facilitators were acutely aware of the tenuous nature of conceiving mental health in limited ways, but also reported the utility of having something to frame the work and were able to add their own culturally anchored elements.

Value and purpose of MHL

All interviewees spoke positively about the value of mental health literacy for their communities.

"Because you're also asking us to really reflect on our community's trauma. That and part of that community's trauma is through colonization, which this condition is built on" (community consultant)

However, the real value stated by most community consultants in opening up conversations for people about their mental health was to connect these to the underlying issues that manifest as psychological distress. All community consultants pointed to the ways in which mental health is inseparable from much bigger issues such as coloniality, and modernity.

> *Because you're also asking us to really reflect on our community's trauma. That and part of that community's trauma is through colonization, which this condition is built on. Yeah. And although we, we, and we always try to acknowledge that we are settlers on this land, but also our lands have been colonized… our people have had to move other places to look for more opportunities and stuff like that, or to find ways because the lands that we have, like lived on have also been deprived and like of its nourishment and its natural resources* (E)

Similarly, mental health and mental health literacy were described by consultants as belonging to structural problems such as discrimination, displacement and racism.

> *Within the African community, the struggle to translate the concept of mental health and to access vital information as well as treatment can be particularly daunting. For the South Sudanese Community particularly, this struggle is layered with, but not limited to, the impacts of intergenerational trauma, displacement, and discrimination. But we believe that together, we can overcome these challenges and build a courageous community that values mental wellbeing (Next In Colour)*

> *For me this kind of work that really resonates strongly, because, you know, when we talk about why are people struggling with mental health challenges, it is a combination of forced*

displacement, it is racism, it is discrimination, it is all these things, contribute directly to people feeling isolated, cut out, lonely…Yes, I think I think that it's been the inability or the limitations in some of the spaces that I have seen with government funding, where you don't see those sort of intersectionalities (R)

Given this, it would be erroneous to conclude that communities are lacking mental health literacy, when in fact it was presented by several consultants that their cultural ways of knowing and coping have been disrupted or erased by the violence of coloniality.

I think a lot of what we're finding is a lot of the community know what mental wellbeing and mental health is, which is great. But it's now about finding the support for it, and understanding what you can do for yourself, to better support your mental health (S)

And I learned a lot that my mother advised me that, you know, culturally, we had a lot of cultural engagements, you know, and gatherings for men and women and children. And that's been disrupted you know, colonially. And as they come here, as well, nobody's practicing, those things are passing on to next generation, and there's a lack of skills development, but being forced to assimilate is also part of the structural violence we experience (I)

Therefore, a 'lack' of literacy may be more correctly identified as the interruption of cultural, ancestral knowledge that is not captured by western ways of framing mental health and wellbeing.

And so I understand…when my mom said, Oh, what do you mean mental health? And then I was like, oh, so they already had things culturally that they were doing that have been disrupted. So sometimes, you know, it's also good to come back to culture and understand what those practices look like for us, because they're not over clinicalised. Sometimes it might be spiritual, might be music, it might be food, and the way that we practice those things are very different (I)

What emerges from these findings is that MHL in racialized and marginalized communities can serve as an important way to locate the systemic and social issues that can cause psychological distress and re-affirm and strengthen some of the existing practices and approaches to wellbeing within their communities.

Identifying issues and attitudes

"You're seeing a society where these things are talked about, and you're living in a home where, yeah, it's not. And sometimes it may be shunned. Silenced almost, yeah" (program facilitator)

Community consultants and facilitators all identified issues specific to their cultural communities, and some of the perceptions and attitudes regarding mental health. As already mentioned in previous sections, these were often connected to bigger issues such as (un)employment, racism and generational and cultural differences.

And looking at the core of what are some of the biggest challenges facing communities. So, talking about family violence, talked about employment barriers, people's frustration, when they

feel that they come here, they can't get to work. And that being an incentive to talk about issues. And the other one, which is going to be really critical is racism. How people experience racism at work, on the street at school, and being able to create the resources and the language of understanding the problem and understanding allies, and then understanding the pathways to act on it (R)

And, you know, men haven't at least men in this generation haven't seen their, their fathers, their brothers, you know, their uncles asked for help early on, when they needed the support. So they don't, you know, they don't realize that they can do that either. And so, you know, how are men meant to, you know, ask for help, and they feel frustrated (Y)

For sure, just because growing up, the younger people are a lot more exposed to it. I guess from a society perspective, we can see that mental health is a lot more talked about today. And I guess, growing up around it will, like the exposure will help 100% But again, like the cultural factors are still at play, you know, you're growing up, and a lot of South Asians will live at home for like, longer than other people might be. So, there's exposure, you know, what's the word I'm looking for, conflicting factors, right? You're seeing a society where these things are talked about, and you're living in a home where, yeah, it's not. And sometimes it may be shunned. Silenced almost, yeah (V)

Many consultants expressed how their own personal journeys through mental health challenges gave them insight into the ways in which certain attitudes or beliefs among their cultural communities intersected with mental health literacy.

I have had mental health problems for since I was very young, and my family lacked understanding and then how to support me. And so instead of receiving support, I actually got pushed away from it (E)

They also expressed the cultural incompatibility of Western approaches to thinking about mental health and the intergenerational impacts of migration on beliefs around help-seeking.

Whether it be like, you know, things like meant, like depression, mental health. We don't have words for them. Right. Inherently, they are Western findings. So, you know, discourse around it just doesn't exist in these cultures. And like, another point was, you know, we're like, immigrants. We come here with, like, nearly nothing, right? I like my dad was working like, hard. And I think when hard times came upon him, it wasn't, like, I feel bad. I need to, like, you know, go get therapy, you want to talk about it. It's like, I need to make sure I can keep a roof over my family (V)

"And, you know, men haven't at least men in this generation haven't seen their, their fathers, their brothers, you know, their uncles asked for help early on, when they needed the support. So they don't, you know, they don't realize that they can do that either. And so, you know, how are men meant to, you know, ask for help, and they feel frustrated" (Y)

These excerpts are representative of the ways in which community consultants were able to draw on their knowledge of community issues and the barriers to help-seeking such as stigma, shame, lack of

understanding, and sense of incompatibility with western approaches. This knowledge meant the consultants were able to shape their individual programs to more clearly meet the community needs around MHL.

Tailoring MHL with communities

As previously suggested, one of the main challenges interwoven throughout all the MHL programs was translating western centric models and approaches to mental health and shaping them to be more culturally anchored to each community. All the consultants and facilitators mentioned the variety of ways in which they made adjustments to programs and approaches in line with their specific cultural considerations. These ranged from understanding how to frame the programs to engage people to offering resources in other languages.

> *Tamil people are very proud, and private people, where it concerns matters of mental health and well being, or intimate challenges or anything like that. We come from a culture of just how to sleep on it, have a rest and get back to work tomorrow morning. So we've had to be really clever with how even look at how we describe the resources that we're putting in front of people (R)*
>
> *we made videos recordings of us talking about of, you know, Tamil people, which is, you know, like, representation, relevance, talking about these issues in, in a tongue that is familiar. Right. And I think, I think that is infinitely more relevant than seeing, you know, say, like a white person saying these things" (V)*

Tailoring their programs also meant tapping into the importance of personal histories, cultural identities, and understanding some of the generational differences in how mental health is understood in communities.

> *So it was just like educational about the histories about some of the islands and some of the terminologies used like Micronesian Melanesian Polynesian, where they came from, like their impacts on how we view or how we view ourselves as a community and how that and like whether or not it separates us or brings us together or how that adds to identity or take away these conversations" (E)*
>
> *Because at the same time, it's the fact that like, South Asian men specifically have never been asked, How do you feel about anxiety? How do you feel about traumas? Has anyone ever come up to you, and spoken to you about this sort of perspective? And like, we know, in our culture, like, our parents are never going to come up to us. Unfortunately, in this generation, they're never going to come up to us and sit us down and be like… How are you feeling? (D)*

Consultants and facilitators were acutely aware of the complexity of the social and cultural factors that influenced the perceived purpose and value of programs trying to tackle mental health literacy. They were able to draw on cultural knowledge to adapt and create programs to try and address some of the factors.

Fostering cultural safety

While not all programs where therapeutic in nature, there was still a need across all projects to ensure culturally safe spaces were fostered. In some instances, this was through the curation of settings in order to enable participants to feel comfortable sharing stories, and in other instances it was to ensure the safety of program facilitators.

Self-awareness and care

Mental health literacy was demonstrated to be bidirectional in that most of the community consultants and facilitators were also building their own knowledge and recognition about mental health and wellbeing.

> *We had addressed our own self-awareness about how we feel like our understanding of mental health, our experience, and then how do we self soothe? How do we take care of ourselves?...And even though we're stepping into roles, where we're taking care of community, a lot of the things that we realized that we had in common was, we have forgotten to take care of ourselves along the way. So we didn't know what that look like. So then we discussed different ways we can take care of ourselves and the different parts of our lives that we need to take care of…our physical, emotional wellbeing, the different type of wellbeing that we had to acknowledge in those spaces (E)*

Creating safe spaces

"I wanted to create a space where, where men can come and not necessarily be diagnosed…to drink or you know… a place to just talk about life" (Program facilitator)

The importance of being able to create safe spaces conducive to talking and sharing was a feature of most of the MHL programs. In some instances, there was a realization that the space that needed to be created was for facilitators of the program to be able focus on their own safety and mental health needs.

> *there was some hard questions asked about mental health. And there was tears, there was discomfort in the room. And so after that experience, that's when I decided that I don't think already for us to facilitate a space for the wider community, if there's still discomfort in this room and not in like, challenge, like mental health is a challenge to speak about. So I decided that I wanted us to really focus on our group. And like, because as people who are part of community, we are still doing our job by taking care of ourselves, and creating those conversations within our group. So I had decided I was just going to be for us" (E)*

The creation of safe spaces also involved thinking about what would make them more open and accessible for specific groups being targeted by the program.

> *I wanted to create a space where, where men can come and not necessarily be diagnosed…to drink or you know… a place to just talk about life. Because, you know, there are a number of things that are that are making our life more complicated and, making my life complicated. I thought there would be similar, you know, similar stories around this neighborhood, especially after COVID. (Y)*

Other considerations were how spaces might be used to connect to other community services or supports.

> *Because I really wanted to work in the community, I didn't want to have it in my, in my backyard, as much as I could. I wanted to work with another agency. So I reached out to a local community center. And, and, and ask them if I could use that space. So that's where, you know, that's where I, you know, so I could, so I could actually get people to notice that there is another community center, which is providing support for them… (Y)*

Ultimately, for many of the community consultants, it was a question of creating safe spaces that could encourage people to overcome the various barriers to help-seeking and affording them an opportunity to have an experience of safety in sharing stories, of social connection, and at times having a place to share difficult conversations that were not had elsewhere in their lives. What can probably be discerned from the findings thus far is that there is an incredible amount of work that community consultants and program facilitators are undertaking as a part of each program, and therefore a crucial underpinning of this work is the support and resourcing.

Support and resourcing

This theme describes the various ways in which program facilitators and community consultants discussed the support received from VicHealth and the overall resourcing required for their programs. Resourcing in this instance refers to all of the ways in which interviewees discussed both funding and other financial aspects but also the various other forms of labour (e.g. emotional labour) that was required of them to ensure to programs progressed.

Agency support

At an individual level, the MHL project leaders at VicHealth were unanimously applauded by consultants for their attention to cultural safety, willingness to provide increased assistance when required, and ability to offer additional funding to support important capacity building activities or to develop resources. The remainder of section relates more to the perceptions of VicHealth as an organisation and the support consultants felt it offered.

Community consultants and program facilitators discussed the double-edged sword of having extensive freedom to develop self-determined and community led programs. While nearly all the interviewees articulated a great appreciation for the amount of flexibility offered, they also expressed a desire for a framework to help guide their projects and some expressed at times it was difficult to know VicHealth's position

> *Yeah, I mean, I don't I don't really know what VicHealth's stance is, in what mental health literacy is. Or it would have been good to know, what is it that they might have done previously, in other projects, to, you know, to promote mental health literacy, you know, I feel like I need to go onto the website and have a look (Y)*

Several interviewees mentioned specific kinds of support they wished VicHealth could have offered and that considered as being within VicHealth's remit. This was particularly the case when it came to interviewees discussing VicHealth's capacity for health promotion and the possibility that they could have done more for the programs in this area.

> *Because obviously, they've done it countless number of times. Right, and they've targeted niche communities before as well. So even if it were this just, you know them taking it into their own hands, marketing through their own avenues, promoting our ventures through themselves… Because at the end of the day, it's not just about us promoting our own work. It's, it's for the community (V)*

> *But I think we would love to see more sort of promotional value from Vic health and same time, just in regards to marketing, and just like putting it out there that these spaces are actually happening. Because as far as I understand, it's really just on us to put it out there. And correct me if I'm wrong, but we don't see a lot of sort of direct marketing from Vic health reaching out to the organizations at the same time to. And I'm sure like, it's something that's happening maybe in the background, but sort of a bit more sort of collaboration between us and the sort of change makers or people that really get to make those decisions would be better (D)*

It was also evident that several community consultants and program facilitators saw VicHealth as somewhere that offered training. This perhaps speaks to a misunderstanding of the role and identity of VicHealth for them.

> *Yeah, so it would have been, it would have been nice for them to you know, because I'm sure VicHealth has different sorts of training. And for us to attend that would, you know, would have given would have been would continue to give us more confidence, I guess. Because at the moment, I'm just seeking out my own training (Y)*

Funding and labour

So yeah…because of all the work that's involved…and a lot of that is, is not covered by the funding (community consultant)

Because community consultants and program facilitators are located within the communities they are working with, they all indicated that they were often going above and beyond what the project funding supported.

> *we haven't like had any other official trainings. Just because money wise, like we are not funded at all really, it's kind of like [community consultant] paying out of [their] pocket for us like to have food at our meetings and stuff. I think even possibly to be hiring the rooms or booking them, stuff like that. And like we don't get paid for our time either to hold these meetings and do things because this is all like we're doing it out of like the need for community (E)*

Most consultants spoke of the short-term nature of the funding and how it seeped into their thinking about the future of their programs. They all hoped their work would go on beyond the funding in some way, but obviously wished there could be more ongoing financial support.

> *And like, you know, they do go above and beyond for it. So, um, to be honest, I'm not too sure what the picture is like, for funding. But I know that it is something we keep in mind. And that we know it is only a finite amount (V)*

All community consultants and program facilitators had other jobs, careers, and study commitments I which they were engaged. Therefore, they had to try and fit their MHL programs around these continued commitments. Several described how taxing this was and given some were precariously employed, there was a danger of them being torn between needed to earn a living and wanting to help their communities.

> *getting the word out, connecting with people takes about a week in advance. And then you know, and then I'm regularly posting on social media as well to see if there's, you know, some interesting articles, and then obviously, I'm doing research around, you know, what, what's out there, and men's mental health and, and attending forums and groups and, and zoom sessions and whatnot, and I'm building my own skill set around what's available and what other people*

are doing. So it does take, you know, behind that two hours of a session a week, I'm at least putting in anywhere between 10 to 15 hours of my own time, just kind of, you know, putting along looking at information and you know, just organically collecting data, and then resources to be able to, to be able to support the men's group (Y)

This is a particularly important as any calculations for future funding should consider the potential for exploitation of community members time and labour due to their inherent commitment to their communities.

VicHealth reflections

It was evident from conversations and interviews with VicHealth staff that they were acutely aware of the how complicated their role was in overseeing a project which sought to empower communities toward self-determined MHL programs, and that they were not always successful in the levels of support they were able to offer.

> *we gave them our support in the sense of like, if there's anything that you need from us if you need us to connect you up with other people. We did a lot of support from our production team. So especially for the film part... And then we also created a steering committee. Which had two young people from each of the communities. And we met I think, three times over the course of about six-seven months (VicHealth Staff)*

> *we didn't really go out and visit we kind of left them to themselves, which potentially they appreciate it but also maybe it would have been great if we could have gone and seen it and worked with them.. And I think maybe that would have been really good in getting the three communities together (VicHealth Staff)*

The level of involvement of VicHealth around conceptual frameworks or definitions of mental health was also raised and the complexity of trying to foster self-determined, community led programs whilst not leaving cultural communities adrift.

> *I actually feel kind of bad by how little parameters we gave them...but at the same time we can't really identify for you what the mental health issues in your own community are and mental health literacy (looks like) (VicHealth Staff)*

Ultimately, from the perspective of VicHealth staff, the project was seen to be as much about social connectedness and empowering community-knowledges as it was about mental health and wellbeing

> *one thing that they really all had in common that coming together and speaking about it was one of the fundamental parts of each of the programs that they rolled out. Let's get together and let's talk..and share your experiences but like it was a common thread through all three of them being so effective (VicHealth Staff)*

However, building on the idea of a connecting the programs and the knowledge of community consultants in a community of practice was seen as somewhat of a missed opportunity.

> *It would have been a really great opportunity to get the three consultants and other working groups together to speak and to share and have that kind of cross cultural learnings (VicHealth Staff)*

It was also observed that collective meetings tended to more of a check-in for community consultants to update VicHealth on progress and issues arising in each program, rather than a space for knowledge production and exchange.

Maintaining flexibility and supporting communities regardless of the outcomes of the project was seen to be a central objective of VicHealth. In their commitment to standing with cultural communities, being able to accommodate changes to programs and to assist with re-direction of funding was integral to the ethos of the project.

> *you're working with communities who do have like who do have high rates of mental health issues and do have, like, I guess, are more vulnerable or have barriers. I don't really like that*

terminology, but you know that maybe you do have to be a bit more like accommodating…but it's like working with the communities who they're struggling…and you can't be like well, I don't really care that the person in your project…and there were there were heaps of times where people had to drop out because of mental health issues. There are heaps of times where, you know, people just dropped out because they no longer had time, they had other commitments like I think you'd have to be like really accommodating about that. Otherwise, like, what's the point of trying to help? (VicHealth Staff)

Yeah, and the other thing that I think we did in terms of support, which I guess is an extra support system, but we were really conscious to be like as flexible as possible with everything. So you know, we had some, I guess, I don't know what you would call it like cushion funding that we had that we were going to use to like do like launch events and that kind of stuff that like the sort of ad money sort of money and we ended up using like a lot of that money to support extra things that went in their budget that came up as we went

Rather than the value of the project being defined by how rigidly each community adhered to the proposed outcomes, the building of trusting, culturally safe, relationships were seen as strengths of the overall project by VicHealth.

I think at the moment we're building some really strong connections across different cultures and different diasporas but I also think that like we have so much more work to do and that's not only building those relationships further, but also showing that we can be trusted and worked with

Conceptualizing Mental Health Literacy

Here, an overview of some of the literature is offered to provide a resource as to how MHL has been conceptualised and to indicate any similarities and differences between the evaluation findings and previous research.

Mental health literacy (MHL) was introduced by Australian psychology researchers Jorm and colleagues (1997) and is defined as the "knowledge and beliefs about mental disorders which aid recognition, management or prevention" (p. 182). The concept is centred around the ability to recognise specific mental health disorders, knowledge about the causes and risk factors, and knowledge of the help available (Furnham & Hamid, 2014). Many of the components making up MHL are focussed on the accumulation of knowledge as stated by Jorm (2012):

> (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis. (p. 231)

Central to the concept of MHL is that the accumulation of such knowledge will lead to more appropriate help-seeking behaviours. Bourget and Chenier (2007) propose a broader definition, "mental health literacy is the knowledge and skills that enable people to access, understand and apply information for mental health" (p. 4). MHL involves more than providing information; it includes empowerment so people can make informed decisions and take effective action to support positive mental health and wellbeing for themselves and their community.

Research in Australia has been predominantly focussed on MHL initiatives for adolescents and adults, while research focussing on childhood mental health problems has been largely overlooked (Tully et al., 2019). Although there are number of reasons proposed for this limited attention (such as concerns about stigmatising children and the potential for unnecessarily raising parental concerns resulting in unwarranted help-seeking), the overarching message is that it has resulted in "community ignorance regarding child mental health disorders, which has resulted in the absence of a common language to describe child mental health disorders, unnecessary stigma towards children and parents, and low levels of appropriate help-seeking by parents" (Tully et al., 2019, p. 287).

It is important to acknowledge that while there is a substantial amount of research around mental health literacy (MHL) and its benefits, conceptually it has its origins in Western psychological understandings of mental health, and thus may not capture the ways in which other cultural community conceive, approach, and manage mental health and wellbeing (Na et al., 2016).

Identifying mental health and wellbeing

Research suggests that there are a number of benefits in being able to correctly identify mental health issues and psychological distress such as increased likelihood of help seeking behaviours (i.e. seeking

professional help or taking medication) (Wright et al., 2007). Mental health literacy also leads to a decrease in more harmful self-help strategies such as minimising problems and believing that coping alone is best (Jorm et al., 2006). While much of the psychological discourse around identifying mental health issues suggests they are universally applicable categories, evidence shows that there a number of cultural factors that need to be considered (Furnham & Hamid, 2014; Na et al., 2016). Different cultural communities may have understandings that are not be grounded in the same biomedical, diagnostic criteria that often underpin Western conceptions of mental health and wellbeing (Headspace, 2022). For example, in interviews with South Sudanese women recently settled in Australia, participants emphasised that the concept of depression was foreign and that problems relating to emotional distress, grief or sadness were not necessarily understood as abnormal (Savic et al., 2016). Conceiving distress as being a natural part of everyday life also meant that community, non-professional responses were seen as most appropriate for the South Sudanese community (Savic, et al., 2016).

The challenge for MHL programs working with non-Western cultural communities is to ensure the community knowledge is not being dominated by Western psychological frameworks which can fail to address cultural, spiritual, and holistic ways of knowing and being and perpetuate forms of cultural violence (Na,et al., 2016). To foster a more culturally anchored MHL it needs to move away from promoting "correct labelling" to a more "inclusive, contextual understanding of illness experience and explanation that considers the social embedding of cultural knowledge and practice" (Na et al., 2016, p. 219).

Community perceptions and stigma

Although non-Western cultural communities are heterogeneous, some common themes arise as barriers to fostering improved MHL and help-seeking behaviours. Such barriers commonly centre on negative community perceptions and stigma. In "Talanoa sessions" with members of the Pacific community where they discussed the help-seeking behaviour of Pacific peoples, judgement and stigma were cited as common barriers to accessing mental health services, "Everyone's always scared to talk about [mental illness] because you always think I'm going to end up in a mental health institution" (Ravulo et al., 2021, p. 28). For common descriptors of depressive symptoms (e.g. Do you find it difficult to enjoy your daily activities? Have you lost interest in things?) participants described that community advice often centred on stoicism and "the need to be strong and press on in spite of life's difficulties" (Ravulo et al., 2021, p. 26). It was also found that shame and stigma can be a common experience for people when discussing issues to a mental health professional as the community perception is that this kind of internal struggles of self-worth should be dealt with via one's faith and the care of family and friends "Why are you going to talk [to a counsellor]? You can talk to us? … Why are you going to counsellors? You've got your friends to talk to or you can pray to God" (Ravulo, 2021, p. 28). For some, mental health and the presence of depressive symptoms are framed as spiritual or religious transgressions and as such "mental health is seen as a concept that arises from the Pala(n)gi/Pakeha (White European) world" (Ravulo et al., 2021, p. 26). Spirituality and religiosity were strong determinants of help-seeking across a number the findings in this report which provides an important insight into how culturally anchored developing MHL needs to be.

Negative community perceptions and stigma around mental health is not unique to Pacific communities and local research conducted with Sri Lankan Tamil communities in Melbourne also found a "significant disconnect between the mental distress voiced and the willingness to seek help" (Samuel et al., 2018, p. 93). The reluctance to access formal mental health services is in part a result of the community perceptions of their proximity to 'madness' and 'mad people' (Samuel, et al., 2018).

Multicultural youth and MHL

Often literature investigating mental health and wellbeing are focussed on communities from refugee backgrounds or those who have recently arrived in a new permanent home or host country. While this certainly informs the histories and development of those cultural communities, it is important to note that for young people who may be first or second generation who have multiple or hyphenated cultural identities (Sonn et al., 2021), understanding the cultural elements of MHL is more complex. Part of this complexity is in the fact that multicultural communities are heterogeneous and are comprised of diverse cultural norms, practices and traditions, languages, religions, family structures and life experiences (Shepherd et al., 2021).

Shepherd et al., (2021) looked at differences in mental health problems and social factors between CALD and non-CALD young people presenting at a community based mental health services in metropolitan regions across the Australian states of Victoria and New South Wales. Tentative findings from this suggest that the CALD group was less likely to report a mental illness diagnosis during childhood and less likely to report a family history of mental illness or suicide Some of this was attributed to stigma around mental illness within CALD communities and also that MHL may be low or that families mistrust and/or are unfamiliar with formal mental health services.

There are also intersecting structural and systemic elements such as racism, acculturative processes, and socioeconomic factors at play in the lives of multicultural youth that can influence both their mental health and MHL (Headspace, 2022; Mansouri et al., 2009; Wyn et al., 2018).

Help seeking and service use

Although there are a range of services seeking to provide more tailored approaches to mental health for the needs of different cultural communities, and specifically those from refugee backgrounds, very little is known about the uptake services or the interaction between specific mental health knowledge, beliefs and practices and participation in such services (May et al., 2014). International research has also identified significant disparities in mental health service utilization among many ethnocultural minority groups (Na et al., 2016). This is echoed in Australian research which consistently shows certain migrant and refugee communities use mental health services at significantly lower rates than do Australian-born (Minas et al., 2013) and are under-served by mental health services (Blignault et al., 2022). However, there is a lack of substantive research on the influence of family, carer, and community perspectives and beliefs on help seeking, and on help-seeking and service access pathways among these communities (Minas et al., 2013). This context of disparities and barriers to services is an important consideration

when approaching MHL, as it suggests the approach cannot be one of simply addressing a lack of knowledge at an individual level.

Culturally responsive MHL

Research with East-Asian immigrants in Canada has sought to develop a culturally responsive model of MHL with the purpose of "integrating knowledge of ethnocultural variations in symptom attribution, coping and help-seeking into MHL programs" thus improving their uptake and effectiveness. (Na et al., 2016, p. 224). Na and colleagues (2016) culturally responsive model of MHL connects the key components of MHL to the necessary cultural considerations and implications for MHL, a summary of this can be seen in Table 1. While the sociocultural considerations of this model provide an important addition to conceptualising MHL, overall, their concept is still somewhat centred in Western-centric ideas (e.g., mental illness) and tends toward individualised responses to mental health. This is one of the key issues for western forms of psychology and mental health, is that it tends to turn what should be seen as social problems into problems of the individual. For cultural communities who are racialised and marginalised, this can become a form of victim-blaming, which has a long history in public health (Crawford, 1977)

Table 1 Culturally responsive framework for mental health literacy (adapted from Na et al., 2016)

Components of MHL	**Cultural values and migration issues**	**Implications for MHL**
Knowledge and recognition of mental illness (Symptoms, signs, modes of expression, thresholds of tolerance)	Use of culturally specific terms to describe mental health problems Symptoms and modes of expressing distress that differ from Western models	Move from conveying "correct" knowledge to a more inclusive view of mental illness that allows for diverse cultural models Tailoring assessment of knowledge and recognition of mental illness to capture culturally relevant actions
Beliefs about risk factors and causes of mental illness (Causal attributions and explanatory models)	Explanatory models of illness identify causal factors that differ from those included in biopsychosocial models Migrant-specific risk factors affect mental health (e.g., stress due to migration, acculturation, discrimination)	Include culturally salient explanatory models of illness, and risk and protective factors specific to migrants Identify knowledge, attitudes, and practices that influence diverse forms of help-seeking
Knowledge about and attitudes toward help-seeking options	Culturally specific values, and concerns confer stigma and influence help-seeking Preference for forms of help that are congruent with cultural beliefs about the causes of illness	Attitudes toward health care professionals may reflect their perceived ability to provide culturally appropriate interventions Help-seeking pathways must include alternative treatments valued by the community
Self-help strategies and social support	Use of alternative self-help strategies based on cultural practices Loss of social networks and access to self-help strategies as a result of migration	Self-help strategies and their effectiveness may differ from those found in the general population Pathways to care may differ from the general population due to lack of culturally sensitive services or heightened stigma in some migrant communities Consideration of accessibility of self-help strategies among migrant groups

Evaluation summary & recommendations

This evaluation found that while community consultants where unanimously in favour of the levels of autonomy afforded to them to develop community-oriented mental health literacy programs, at times there was a sense of uncertainty about the overarching direction of the collective project being run by VicHealth. This was also expressed as a lack of clarity as to how mental health literacy was being framed. Although all the programs did in fact find ways to pursue elements of mental health literacy in each of their communities, there was some trial-and-error in terms of approaches across all the programs. In several instances this meant funding things that ultimately would become redundant to the programs.

However, several positive outcomes arose from this trial-and-error approach including all community consultants stating they had learned things about themselves and mental literacy health in their communities. They all reported they had gained important insights into what worked and what did not in terms of program delivery and had developed useful skills and capacities. They overwhelmingly reported that the Mental Health First aid training offered as a part of the funding was useful even though they were aware of the Western centric nature of its framing. In some cases, this led to the start of decolonizing mental health approaches.

Within most programs community consultants discovered there are many underlying complexities to MHL in their communities and that trying to address them all is an impossible task. There were times where community consultants and facilitators were faced with difficult conversations, and potentially distressing situations. While there were no reports of anything that could be construed as unsafe, there are risks worth considering. For instance, what does it mean to ask people from a community to open the door to MHL in their community and what personal impact might that have for them? Some consultants spoke of the potential for re-traumatising by asking them and communities to be public about their psychological distresses.

That said, it was observed that all the programs were able to create safe spaces that enabled social connections and productive conversations. Sometimes these spaces were not about mental health at all, but rather encouraged conversations about identity, gender, wellbeing, family, work, friendships, parenting, and being vulnerable to name a few. The spaces were all curated in ways that community consultants perceived would be most conducive to the groups they were trying to encourage to attend. While attendance at some of the programs fluctuated, it is acknowledged that it is difficult to establish sustained attendance over the short time frame of the project.

While all the community consultants were appreciative of the funding, they all reported it being insufficient in terms of what they ended up designing and delivering. In part this seems to have been due to a lack of ongoing collaboration with VicHealth regarding what was realistically possible to deliver.

Returning to the main concepts of the evaluation, Figure 3 encapsulates the key agency positionings and resourcing required to support self-determined, culturally anchored mental health literacy programs.

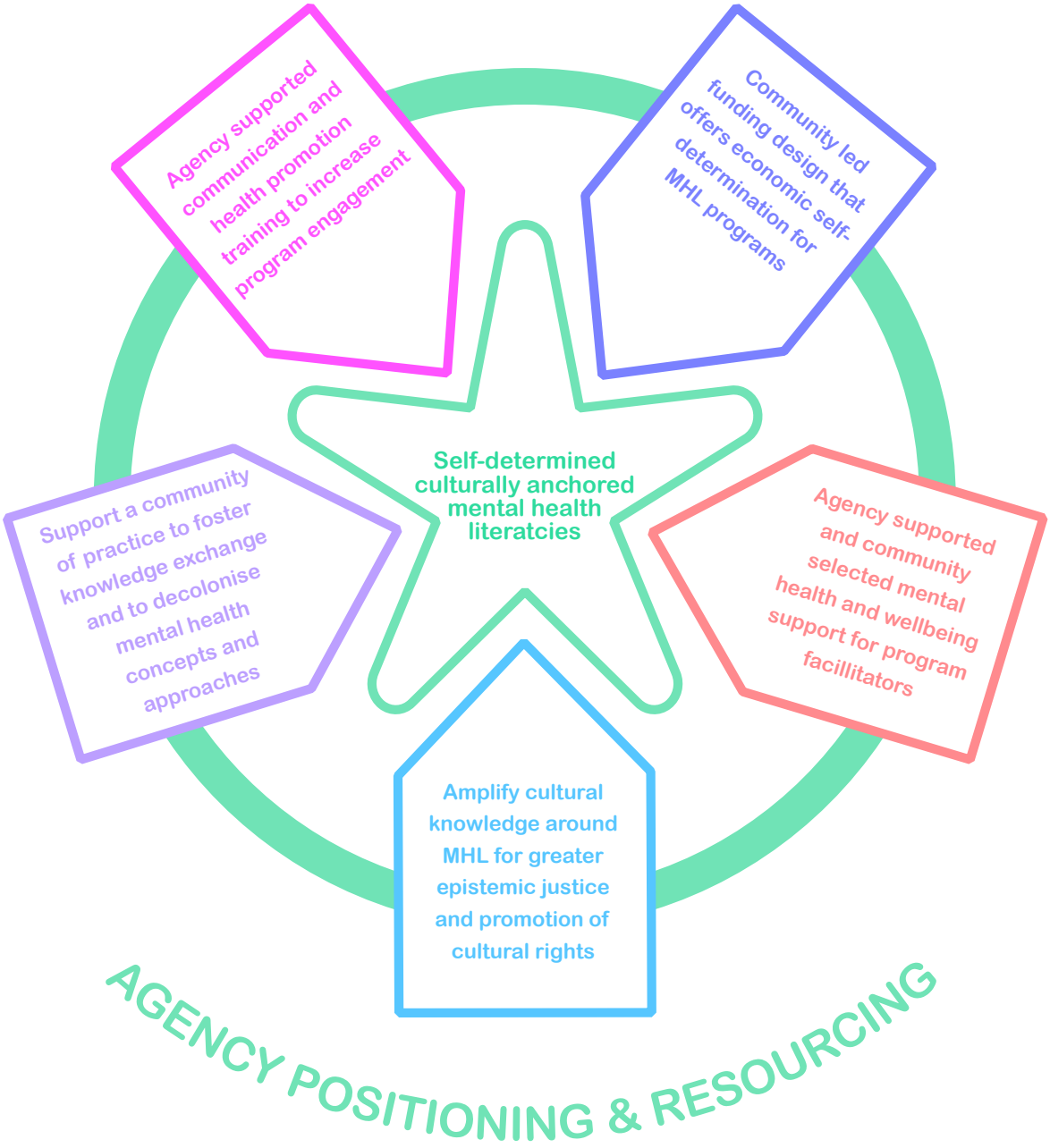

Figure 3 Agency positioning for culturally anchored MHL program delivery

This positioning and resourcing underpin the following recommendations for VicHealth regarding the delivery of mental health literacy projects.

1. Increased support and resourcing for a community of practice for the community consultants and program facilitators to foster a sharing of knowledge, and resources, and to build their conceptual framing of MHL to support their programs. This would also be an opportunity to engage with a culturally diverse and creative range of approaches and strategies that would offer programs more ways to tackle MHL.
2. Greater awareness of the impact of short-term funding specifically for MHL projects which do not have short term solutions. This should include ways to economically empower communities through greater consultation and co-design about what is possible with a given amount of funding, so there is less likelihood of communities being exploited and they are not left vulnerable when funding ceases.
3. More training and support from VicHealth regarding communication and health promotion strategies for the community consultants and their programs. This would also be an opportunity for VicHealth to model the amplification of cultural knowledge from communities.
4. Greater support and resourcing for VicHealth project leads to be able to more closely connect with individual MHL programs. Understanding more of the specifics of each program would assist in knowing what resources and support could be offered to cultural communities for their programs and would strengthen those community partnerships.
5. To ensure there is sufficient culturally safe, mental health support for community consultants and facilitators who may be faced with distressing or traumatic stories in their programs. As they are members of the communities they are working with, their programs are also deeply personal and therefore there is a heightened risk of them being impacted.

Concluding statement

This MHL project did indeed open doors and start conversations around mental health with three cultural communities. Given it was a pilot project, the evaluation was less focused on quantifying the impact of the three programs on the wider community, and more concerned with investigating what happens when communities are funded to develop self-determined approaches to MHL. Thus, the approach taken in this evaluation has been to build a rich, qualitative picture of the projects, the knowledge attained and shared, the challenges faced, connections made and desires for the future.

"The project in general, it's a pilot project...how many people directly has this affected? Probably not that many, but I think it's affected the people involved" (VicHealth staff)

As the evaluation has shown, the project has undoubtedly affected the community consultants and facilitators in positive ways, and the research team believes this evaluation will offer VicHealth important insights to continue working toward cultural rights and self-determined mental health literacy in any future projects.

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