BRIDGING THE GAP: EDUCATING FAMILY MEMBERS FROM MIGRANT COMMUNITIES ABOUT SEEKING HELP FOR DEPRESSION, ANXIETY AND SUBSTANCE MISUSE IN YOUNG PEOPLE

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Main messages

The project fills an important gap in the evidence in terms of barriers and facilitators to help-seeking among young African migrants, their family and communities. The findings of this report can be used by a variety of relevant stakeholders, including recently arrived migrant communities and services, health care providers, and policy makers.

Community

- Parents have poor mental health literacy about how to address mental health and alcohol and drug issues in their son or daughter.
- Parents were often unsure how to approach the issues without creating conflict with their son or daughter.
- High levels of stigma related to mental health and alcohol and drug problems were commonly reported, which was a significant obstacle to seeking professional help.
- Differing levels of community connection meant some recently arrived communities lacked the necessary social capital to support young people.

Health care providers

- There was limited awareness of available mental health and alcohol and drug specific services, particularly among parents.
- Parental concerns around the cultural competency of health professionals meant this form of support may not be viewed as a viable or preferred option.
- The financial cost of accessing and receiving professional treatment was identified as a barrier to help-seeking.

Policy makers

- Migrant communities welcomed the opportunity to come together and talk about health-related issues affecting young people and the difficulties their parents may have around having a conversation with young people about mental health and alcohol and drug problems.
- The health promotion resource has the potential to normalise difficulties encountered by parents when parenting their son or daughter in a new cultural context and to discuss topics that carry significant stigma.
- The resource was well received and was considered helpful, relevant and appropriate.
Executive summary

1. Background
Currently, one in every four (26%) Australian residents are born overseas [1]. For many migrants, adjusting to life in a new country presents a range of difficulties and challenges such as learning a new language, negotiating differing cultural and societal norms, as well as financial difficulties and often fewer family and community connections. The period of re-settlement presents unique challenges for young people and parents. Furthermore, the differential rates of acculturation between young migrants and older family members, with young people often adjusting at a faster rate, may place additional pressure on families.

Within Australia, youth mental health is a significant concern, with around one in four people aged 16 to 24 years having experienced at least one mental disorder in the previous 12 months [2]. For young migrants, mental health issues can be compounded by the challenges of acculturation, pressures that are also associated with an increase in alcohol and drug misuse. Many who experience mental health or alcohol and drug problems are reluctant to seek help. Attitudes towards help-seeking have been studied widely in adults, with stigma and poor health literacy commonly identified as key barriers. Cultural-specific help-seeking systems, which rely heavily on family and social networks, are less accessible in Australia as family and community connections are more likely to be fragmented, and this impacts adversely on help-seeking. Along with this, awareness of professional health services varies greatly. Together, these factors create significant challenges for addressing mental health and alcohol and drug use problems among young migrants, with limited health promotion programs available currently for recently established migrant communities to support their young people to seek appropriate help.

2. Aims
The primary aims of the project are:

a) To identify the barriers and facilitators to professional help-seeking for anxiety, depression and alcohol and drug use problems, for young people from recently established migrant communities.

b) To develop and pilot an innovative health promotion resource that encourages parents to support their son or daughter to seek help for anxiety, depression and alcohol and drug use problems.

A secondary aim is to understand the intergenerational issues that arise between parents and young people, in response to their different cultural experiences within Australia, and how these experiences affect their attitudes to help-seeking for anxiety, depression and alcohol and drug use problems.

3. Methods
The project was conducted over three phases. **Phase 1**: Barriers and facilitators to help-seeking were investigated through in-depth qualitative interviews with 28 African born young people who had migrated to Australia and four focus groups with 41 African-born parents. **Phase 2**: A pictorial-based
parenting health promotion resource was developed based on the findings of Phase 1. The development phase involved focus testing the resource with 49 Adult Migrant Education Service (AMES) students to ensure the images accurately conveyed their intended, culturally appropriate, messages. **Phase 3**: The final resource was piloted tested and evaluated in four AMES classes and two community-based sessions with parents of African background. The evaluation involved feedback on the usefulness, relevance and overall experience of the resource.

4. **Key findings**

Based on the qualitative interviews with young people and focus groups with parents, several key themes were identified about help-seeking.

**Help-seeking barriers**

- Poor mental health literacy about early problem recognition and the availability of professional support and treatment, particularly among parents. Among young people, dismissing early signs of alcohol-related problems, and only seeking help when problems became serious, were common. Also, the perceived low level of mental health literacy among parents, according to young people, meant young people may not seek help from parents.

- Parents acknowledged the problems associated with mental health issues and alcohol and drug use, and the impact these had on teenage children; however, parents were often unsure how to approach the issues without creating conflict with their son or daughter.

- Stigma associated with disclosing mental health and alcohol and drug problems was reported frequently. Fears associated with disclosure meant that young people and parents were reluctant to seek help within their particular migrant community. This was particularly an issue for parents as informal community networks were their preferred way of addressing other health issues. Stigma was also identified as an obstacle to seeking help from professional services.

- Differences in help-seeking were compounded by language and cultural differences, with parents favouring family and community support, whereas young people preferred to seek help from friends, and at times, professionals, instead of family. This created challenges for young people in terms of involving their parents if they had accessed professional support.

- Differing levels of community connectedness meant some recently established communities lacked the necessary social capital to support young people. This was perceived as a vulnerability of the community, and a barrier to addressing mental health and alcohol and drug problems.

- Parental concerns around the cultural competency of health professionals meant this form of support may not be viewed as a viable or preferred option.
• The financial cost of accessing and receiving professional treatment was identified as a barrier to help-seeking.

Help-seeking facilitators
• The trust and familiarity of close friends, and the bond between families facilitated help-seeking through informal sources. For young people, encouragement and emotional support provided by family and friends also facilitated access to professional help.
• Young people and parents recognise the importance of community as a form of support, with well-established community networks and systems that support help-seeking from informal and formal sources. Strong cultural affiliations enable parents and young people to capitalise on existing resources within their own community and as means of providing access to professional support.
• The perceived expertise of health professionals, in dealing with mental health, alcohol and drug or young people’s behaviour, increased some young people’s confidence in seeking help from formal services.

Based on these findings, a health promotion resource addressing problem recognition and the stigma of openly discussing mental health, drug and alcohol problems, was developed. The resource includes pictorial vignettes, and key messages that are communicated through group-based discussion.

Piloting and evaluating the health promotion resource
The health promotion resource was piloted and evaluated in a migrant-specific educational setting and a general community setting. Key outcomes from the resource sessions were:
• The resource was well received and considered helpful, relevant and appropriate. The groups who attended the sessions indicated an increase in awareness of the signs and symptoms of mental health, alcohol and drug problems; an acknowledgement of the stigma associated with seeking help; and an increased willingness to engage in help-seeking for mental health, alcohol and drug problems. However, further evaluation is required to measure the impact of the resources on reducing the stigma and increasing help-seeking behaviours.
• The groups embraced the opportunity to come together and talk about health-related issues affecting young people in their communities, and the difficulties parents have around having conversations with their son or daughter about mental health, alcohol and drug problems.
• The resource, including pictorial vignettes, facilitated open, non-threatening discussion. The vignettes allowed issues to be discussed through an intermediary without the participants having to disclose personal information. They also allowed the difficulties encountered by parents when parenting young people in a new cultural context to be normalised. Normalising these experiences was acknowledged as helping to reduce the stigma of discussing these issues.

• Findings indicate that the resource may be suitable and appropriate for educational and community settings. However, the most appropriate models for delivering this resource, in a sustainable and effective manner, require further investigation.

5. Next steps
The health promotion resource was found to be accessible and appropriate in facilitating discussion about mental health, alcohol and drug problems. The next question is how to disseminate the resource in a way that leads to improved help-seeking amongst newly established migrant communities. Potential options include:

1. Investigate how to further develop the resource so it can be housed on relevant websites, such as beyondblue, to make it accessible to a range of recipients, including community groups, teachers and service providers.

2. Develop and trial models, whereby community members can be trained and supported to deliver the resource within their own communities as a way to increase dissemination and ensure the sustainability of the resource.

3. Develop briefing materials for services and government departments about migrants’ help-seeking practices and preferences. This information could be used to improve the cultural competence of services.

4. Develop and pilot a suite of culturally appropriate images to ensure broader application of the resource to other communities.
1. Background and methods

1.1 Background

It is widely established that adolescence and early adulthood are times of physical, emotional and social transition. These developmental years are also the ‘time when there is the greatest risk of emergence of mental health problems and mental illness’ [3 p. 35]. Furthermore, young people may begin to engage in risk-taking behaviours such as alcohol and drug use during this period, which may lead to adverse outcomes [Chown et al., 2008 cited in 2]. While these health conditions and behaviours invoke concern, low levels of help-seeking for these problems among young people have warranted attention as part of the wide scale reform of the Australian health service sectors [3]. As such, significant investment has been made to identify and intervene early in the life course when young people are most likely to experience the first onset of mental health problems. On a general community level, advances have occurred in expanding youth specific service options [4], yet much is still unknown about the mental health status and service needs of different populations; in particular, migrant and refugee young people.

1.1.1 Cultural diversity in Australia

The majority (58%) of migrants who arrived in Australia between 2000 and 2010, and were still living in Australia in 2010, were born in Asia, North Africa and the Middle East [5]. Population data also indicate that ‘recent immigrants are younger than the general population’, especially within the 20 to 29 year age group [6]. Migration patterns continue to shape the profile of Australia and it is important that health services are resourced to understand and address the needs of culturally and linguistically diverse (CALD) communities [7].

Young migrants and refugees are vulnerable to the risk factors that affect youth in general, as well as marginalisation, racism and stereotyping, and the challenges associated with re-settlement and adjusting to life in a new cultural environment. Subsequently, some young people experience additional pressures that place them at risk of adversity [8, 9].

1.1.2 Mental health and alcohol and drug problems amongst young migrants

Depression and anxiety

The mental health of young Australians is a longstanding national health priority area [3]. In 2003, almost half (49%) the burden of disease among young Australians aged 15 to 24 years was due to mental health problems and disorders, with anxiety and depression the leading specific cause [Begg et al., 2007 cited in 2]. The 2007 National Survey of Mental Health and Wellbeing reported that one in four young people aged 16 to 24 years experienced at least one mental disorder in the previous 12 months, with anxiety disorders (15%), substance use disorders (15%) and affective disorders (6%) the most commonly reported [2]. While the survey provides the best available estimates of the prevalence of mental health disorders among young people in Australia, it did not include a specific focus on recently arrived young migrant [6].

In the absence of population level estimates, knowledge about the mental health status of young migrants is based on small-scale studies. For example, McGrath et al. [10] found that migrant status
was associated with a significantly decreased odds of having a psychotic disorder. However, a meta-analysis of 20 studies comparing mental health problems of migrant and non-migrant children was inconclusive, with higher and lower levels of problem behaviour being reported in both groups [11]. In part, these findings may be explained by factors associated with research design and ethnicity indicators used, data collection and reporting methods, as well as differing conceptualisation of mental illness, shame and stigma. They could also be affected by the ‘healthy migrant’ effect, which relates to the rigorous health checks migrants are required to complete before being allowed to enter Australia [12]. There is, however, agreement that young people who enter Australia as refugees are at ‘risk of developing significant psychological and substance use problems as a result of accumulated stress before, during and after migration’ [13 p. 20].

*Alcohol and drug misuse*

In a recent review of the literature focused on mental health and drug and alcohol co-morbidity in young people of refugee backgrounds, Posselt et al. [13] identified a considerable gap in the literature, as no studies were found that reported prevalence estimates of substance use disorders among young people of refugee background living in Australia. Existing studies that investigated alcohol and drug use among young migrant living in Australia focused on refugees, and mainly young male refugees of Sudanese background who were experiencing a range of stresses and had engaged in high-risk behaviours [14-16]. While these studies provide valuable insights into highly marginalised groups of young people, transferability of the findings is limited.

Furthermore, as part of a small study (n=49) focused on the perceptions of drugs and drug use in Victoria’s African communities, alcohol and cannabis were reported as the substances most commonly used among African young people, and young people involved in the study indicated that drug use was ‘quite common in their peer group of African and non-African children’ [17 p. 2].

Overall, research relating to problem drug use amongst young people of refugee and migrant backgrounds is limited and insufficient to draw conclusions about the scale of problems amongst young migrants in general. Where efforts have been made to measure the prevalence of alcohol problems in specific communities, in young and older age groups, the findings have questionable accuracy and validity [18, 19].

*Barriers to service use*

Help-seeking behaviours among migrant groups are affected by many factors, although for mental health and alcohol and drug issues, poor mental health literacy (knowledge and beliefs that aid in the recognition, management and prevention of mental health issues) is particularly important [20]. Different ways of conceptualising mental health and alcohol and drug problems, accompanied by limited knowledge of services and treatment options, are likely to further impact on presentation rates [7, 21]. Indeed, a qualitative study of access to alcohol and drug treatment in eight CALD communities in Victoria [22] identified the following help-seeking barriers: services’ insufficient knowledge of the perceptions, expectations and needs of their clients as well as of the diversity of people utilising their services; language barriers; lack of advocacy by community leaders; community pressures to be discreet about drug use; a desire to be self-sufficient in dealing with alcohol and drug problems; and lack of family inclusion in alcohol and drug programs. Similarly, young refugees living in Australia reported that low priority placed on mental health by refugees, poor mental health and service knowledge, distrust of services, stigma associated with
psychosocial problems and help-seeking, and social and cultural factors affecting how problems are understood were key help-seeking barriers to mental health services [23].

There is also significant stigma associated with reporting mental health and alcohol and drug problems in migrant communities, and the desire to avoid bringing shame on the family and/or community provides a powerful incentive among young migrants not to disclose problems [14, 23-25]. Additionally, studies investigating help-seeking related to health concerns suggests that young migrants are reluctant to approach a service provider within their own community because of shame and concerns about breach of confidentiality [22, 23, 26]. Therefore, many young migrants are caught in a double bind situation as they are often unwilling to go to service providers within their own community and are reluctant to approach mainstream Australia service providers.

**Additional risk factors for young migrant groups**

In addition to the challenge of poor mental health literacy and discordant health beliefs, young migrants are also at increased likelihood of exposure to a range of other risk factors. Potential risk factors lie in the stress of forced or voluntary migration and the process of resettlement. There may be a history of torture and other trauma; low income; lack of meaningful work; school difficulties; desire to gain acceptance through participation in Australian drinking patterns [27, 28]; and lack of knowledge of mental health and alcohol and drug problems. In addition, their family may be absent, or there may be family conflict as a result of resettlement difficulties [8].

While resilience factors or strengths may lie in the maintenance of traditional values and norms, which provide important connectedness for young people [7, 29], there is limited evidence, that these values may be at odds with post-migration youth freedom and changes in gender roles [30]. While people who migrate as adults tend to continue to maintain traditional values and norms from their culture of origin, their children tend to embrace the cultural attitudes and behaviours of the host country, meaning young people are at risk of alienation from both cultures [7]. Current research suggest that differential family acculturation, role reversal and loss of parental control over adolescents by parents pose a threat to the wellbeing of young migrants and family members and thus, increase a young person’s propensity to experience mental health problems [25, 31].

**1.1.3 Improving help-seeking among young migrants**

*Cultural competence*

Health service structures and systems also create significant barriers (e.g., poor cross-cultural communication, inadequate access to interpreters, and stereotyping) for migrant groups seeking equitable access to information and assistance [32, 33]. To counter these barriers services need to be culturally competent: ‘cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services’ [34 p. 7].

It is important to identify and incorporate culture-based positive attitudes and community strengths into health promotion programs targeting recently arrived migrant communities [35, 36]. First, programs need to be tailored for cultural appropriateness and accessibility. This involves developing resources that reflect an understanding of the cultural traditions and practices, such as a strong focus on oral literacy, in addition to imagery and symbolism that is recognised within the communities, and build on protective factors within the culture. Second, programs need to be
grounded in appropriate theory [7, 36, 37]. Evidence-based practice that is supported by a robust theoretical framework has been shown to improve the efficacy of prevention programs within migrant communities [38]. Third, programs need to include a family and community-based component, as knowledge is exchanged and fostered through social and community networks [7, 36]. This is due, in part, to the finding that discussing problems or seeking help outside of the family is an uncommon practice in many migrant communities. Finally, communities should be actively involved in all stages of a health promotion program, from planning through to evaluation, to ensure it is culturally competent [36].

Many African communities migrating to Australia are founded on collectivist cultural practices, where by the community and family are accorded greater precedence than the individual. Within these communities, there are few precedents for openly acknowledging and discussing mental health and/or alcohol and drug problems [37]. For example, Reid et al. [39] suggest that many community members will typically try to hide a family member’s alcohol or drug misuse and deal with it on their own for as long as possible. Treatment is only sought when the situation appears hopeless, or following a medical or legal crisis. Empowering families with education about anxiety, depression and substance misuse, how to recognise problems and where to go for help is reportedly well received by migrant communities [38]. More importantly, however, it recognises that inter-generational acculturation issues needs to be addressed in order for young people to successfully access appropriate help within many newly arrived communities [7].

Addressing a key gap
Despite the high prevalence of mental health and alcohol and drug problems among young people, low rates of mental health literacy and help-seeking among migrant communities and concerns about acculturation stress, few resources have been developed specifically to improve help-seeking among at-risk migrant youth. This is not surprising as most studies examining barriers to service use have been conducted in adult populations, with limited research specifically exploring what young migrants and their parents identify as barriers and facilitators to help-seeking for anxiety, depression and substance use problems. In addition, while research by Browne and Renzaho [7] highlights that effective programs need to be culturally competent, include a family-based component, and be theory-driven, limited research has been conducted to explore how these components can be included in a broad-based health promotion program targeting help-seeking for migrant youth from CALD communities.

1.2 Research aims
The primary aims of the Bridging the Gap project are:

a) To identify the barriers and facilitators to professional help-seeking for anxiety, depression and alcohol and drug use problems, for young people from recently established migrant communities.

b) To develop and pilot an innovative health promotion resource that encourages parents to support their son or daughter to seek help for anxiety, depression and alcohol and drug use problems.
A secondary aim is to understand the intergenerational issues that arise between parents and young people, in response to their different cultural experiences within Australia, and how these experiences affect their attitudes to help-seeking for anxiety, depression and alcohol and drug use problems.

1.3 Research team

The team consisted of researchers from three institutions: Turning Point/Monash University (Professor Dan Lubman – study lead, Anne Kyle and Janette Mugavin – project officers), Victoria University (Professor Terence McCann – senior investigator) and Monash University (Professor Andre Renzaho – senior investigator). The team met regularly every 2-3 months throughout the project. The lead and senior investigators provided expertise advice and ensured the cultural appropriateness of the data collection activities and the pilot education program as well as clinical expertise in terms of addressing mental health and alcohol and drug problems.

1.4 Study design

The project was conducted in three phases:

Phase 1 – identify the barriers and facilitators to professional help-seeking for anxiety, depression and alcohol and drug use problems, for young migrants.

Phase 2 – develop and pilot a health promotion resource in the AMEP resettlement program.

Phase 3 – evaluate the resource and its dissemination.

A summary of each phase is provided below.

Ethics approval was granted by the Eastern Health Human Ethics Committee (E46/1213).

1.4.1 Phase 1 – Interviews with young people and community members

*Interviews with young people*

28 semi-structured, individual interviews were conducted with young people of African background. Throughout the report, the term ‘young people’ is used to reference data from these participants. Interviews were conducted by two bilingual research assistants who recruited participants through community networks. A small number of young people were recruited through two youth specific mental health and alcohol and drug services. Purposive sampling (Patton, 2002) informed participant recruitment. Inclusion criteria were (i) newly-arrived African migrants or refugees living in metropolitan Melbourne (for the purpose of this project, ‘newly-arrived’ is defined as living in Australia for five years or less. The duration of time in Australia criterion was not applied for young people recruited from specialist services as young people in contact with the two services had typically been in Australia for more than 5 years); (ii) aged between 16 and 25 years; and (iii) some knowledge of mental health and/or substance use problems among young people within their community.

Interviews were conducted in English as participants were reasonably proficient in conversational English, and took place in the participant’s home or a mutually convenient location (e.g., café or youth service). Consent for the interview to be audio-recorded was obtained from participants.
Interviews lasted between 20 and 90 minutes and each participant received a $25 supermarket voucher as reimbursement for their time and any associated travel costs.

Open-ended questions were used to explore seven overarching topics: young people’s experience of being a new migrant in Australia; young people’s understanding of mental health and alcohol and drug problems within their community; help-seeking options and awareness of services; what would assist or encourage a young person to seek help; and what would prevent or get in the way of a young person seeking help.

Focus group

Four focus groups were held with 41 participants recruited by three bilingual research assistants. The participants were African born parents and adults who were not parents, but had a leadership role within the community. As the majority of the focus group participants were parents, the term ‘parents’ is used to reference data from these sources.

The focus groups were held in community centres and a public park. Focus group discussions were facilitated by senior investigators, with the support of the bilingual research assistant who recruited participants. Three of the four focus groups were conducted in English, and one discussion was conducted in Kirundi, and translated into English.

Discussion themes included: experiences of being a parent in Australia, including mental health and alcohol and drug problems among young people in their community, sources of help and help-seeking practices and preferred mode of receiving health-related information. Focus group discussions lasted between 90 and 120 minutes and each participant received a $25 supermarket voucher as reimbursement for their time and any associated travel costs.

Analysis

An interpretative phenomenological analysis (IPA) approach guided data collection and analysis, in terms of understanding the socio-cultural influences of mental health problems, alcohol and drug use and help-seeking. IPA provides a suitable framework to understand the attitudes and perceptions of participants and how these impact on behaviours of interest (Smith, 2007).

Audio-recordings were transcribed and NVivo10, a qualitative software package, was used to help organise the interview data into a set of codes with common experiences grouped under the same code. Codes were grouped into provisional themes and sub-themes. Provisional themes were then clustered into groups of themes, and those insufficiently grounded in the data were omitted. A more focused analytical ordering of themes was then undertaken. Finally, exemplars were identified to illustrate the different themes and sub-themes and the source of the exemplar provided in terms of the data collection activity (i.e. interview with young person or focus group with parents).

Characteristics of the interview and focus group participants

The majority of young people were male (66%) and slightly more than half (52%) were aged between 16 and 19 years. The cultural background of participants was diverse, with eight (28%) born in Tanzania, six (21%) in Zambia, four (14%) in Sudan, three (10%) in Zimbabwe, and three (10%) in Burundi. The majority (86%) of young people had lived in Australia for five years or less.
Among the parents who participated in one of the four focus groups, the majority were female and most (78%) were aged between 30 and 49 years. The focus group participants were purposively sampled by country of origin as way to understand cultural norms and beliefs within and across different African communities in terms of migration experiences, substance use and mental health problems and help-seeking. A profile of each group is described below.

Focus group 1: 10 participants (6 females; 4 males) and the majority were aged between 49 and 49 years, and had lived in Australia for 6 or more years. The cultural background of participants was diverse and included parents born in Zimbabwe (30%), Zambia (30%), Kenya (20%), Ghana (10%) and Malawi (10%).

Focus group 2: 9 participants (5 females; 4 males) and the majority were aged between 30 and 39 years, and had lived in Australia for 5 or less years. Six participants were born in Burundi and four in Rwanda.

Focus group 3: 11 participants (6 females; 5 males) and the majority were aged between 30 and 39 years, and had lived in Australia for 5 or less years. All participants were born in Zimbabwe.

Focus group 4: 11 male participants and the majority were aged between 40 and 99 years, and had lived in Australia for between 6 to 10 years. 10 participants were born in South Sudan and two in Sudan.

1.4.2 Phase 2 – Developing and piloting the health promotion resource

Development

Key findings from Phase 1 were used to develop a discussion based health promotion resource. The resource comprised two pictorial vignettes; one presenting an alcohol and drug problem, and the other a mental health problem. The characters, context and key messages were written by the project team and translated into pictorial vignettes by BeInSync Pty Ltd\(^1\) an independent agency specialising in communications and marketing for CALD communities. The vignettes were designed to encourage discussion about key communication and conflict resolution parenting strategies.

Initial testing

Initial testing of the health promotion resource was conducted with a convenience sample of students enrolled at Adult Migrant Education Service (AMES) centres in three metropolitan suburbs in Melbourne (Footscray, Williamstown and Werribee). AMES is the provider of Adult Migrant Education Program (AMEP) classes in Victoria. AMES Centre coordinators were approached about the project and possibility of running focus testing in their classes. The Centre coordinators then discussed the project with the teaching staff to determine what classes would be appropriate and able to participate in the focus groups. Students were invited by their teachers to participate in the focus groups on a voluntary basis. Four classes, comprising a total of 49 students (29 females; 20 males), participated in the health promotion resource testing.

\(^1\) BeInSync has had notable success with their CALD Com storyboards format for a range of issues and services. (http://www.beinsync.com.au/).
Table 1.1 Characteristics of the participants recruited for initial testing

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Pilot and evaluation

The health promotion resource was piloted in an AMES education setting and a community setting with a total of 30 adults.

Educational setting

The educational setting sample included 18 AMES students (4 classes across three sites: Yarraville, Footscray and Williamstown). Students were recruited using the same method described for the initial testing. A member of the research team facilitated each 60 minute session. At the end of each session, students were offered seedlings as an expression of thanks for their participation.
### Table 1.2 Characteristics of the Education Setting pilot participants

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### Table 1.3 Characteristics of the Community Setting pilot participants

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* 1 not stated
**Community setting**

African born parents were invited to participate in the pilot of the resource by bilingual research assistants who recruited them through community networks. Two resource pilot sessions were held in community centres and were facilitated by members of the project team, with the support of the bilingual research assistants. One session was conducted in English, and one session was conducted in Kirundi/Kinyarwanda, and translated into English. Each community pilot session lasted between 90 and 120 minutes. Participants were offered a $25 supermarket voucher as reimbursement for their time and any associated travel costs.

The resource sessions were conducted following the same format as the education settings described above.

**1.4.3 Phase 3 – Evaluation of the health promotion resource**

Participants (i.e. AMES students and parents) were invited to complete a feedback form at the end of each session, about the resource. AMES students in the low English literacy classes were assisted by their teachers to complete the form. The form included basic demographic questions and a series of questions about the content and delivery of the resource.
2. Interviews and focus group findings

The findings from the interviews and focus groups cover three main themes: migration experiences; mental health literacy (including alcohol and drug use) and help-seeking; and barriers and enablers to help-seeking. We refer to two main help sources in the report: informal and formal sources. Informal help sources include friends, family members, including parents, sibling and other relatives, community members, elders and religious leaders. Formal help sources include general practitioners (GPs), counsellors, psychologists, specialist helplines (e.g., Lifeline, Kidsline), mental health services, alcohol and other drug (alcohol and drug) services and professionals working in an educational setting (e.g., teachers, lecturers).

2.1 Migrant experience

The migration experience presented opportunities and challenges for young people and parents. In many instances however, the same experience (e.g., employment opportunities) had both positive and negative connotations.

2.1.1 Opportunities

According to the young people, the benefits of living in Australia, compared with Africa, were largely attributed to a better quality of life, and access to education and employment opportunities. Others embraced the cultural diversity of Australia, the opportunity to develop new friends and learn a new language. Furthermore, parents and young people indicated that the migration experience was perceived as a chance to improve one’s own life and that of one’s family, either by supporting family members in Australia and/or enabling them to provide financial support to relatives living in Africa.

2.1.2 Difficulties and consequences

2.1.3 Language and communication

A significant challenge raised by parents and young people was the strain that differing language competencies between parents and children placed on families. Parents talked of feeling disconnected from, and poorly informed about, their children’s lives when their children adopted English as their dominant language. They felt disempowered as their ability to communicate with their children about everyday issues was compromised. Communication challenges and family conflict were also seen as a significant barrier to parents addressing concerns about their adolescent’s mental well-being and alcohol and drug use.

Sometimes they [teenage children] can conspire [in English] and we [parents] can feel ashamed because we can’t understand what they are doing. (Focus group 2 participant)

Language difficulties further complicated roles and power dynamics within families. When asked to comment on the way young people communicated with parents in Australia in comparison with Africa, one participant explained:

It is like ‘day and night.’ Back home, authority and respect is by default.... When we migrated here, that did not cross our mind that we would actually have difficulties with the kids. We
thought they would carry the same respect for authority here. But once [they] mingled with their peers...that goes out the window. (Focus group 1 participant)

2.1.4 Parenting challenges

For many parents, parenting in Australia was extremely stressful. Australia’s parenting style, seen as overly permissive and as promoting the individual, self-determination and independence, is a stark contrast with the traditional African authoritarian parenting style that promotes, respect for elders, corporal punishment and interdependence. These, coupled with parents reporting their family and extended support networks are still developing, affected how they conducted themselves as parents.

The saying, ‘it takes a village to raise a child,’ means that the parental role is not left to one couple or two people to look after that child. That is why it is allowed in Africa for a total stranger to say, ‘don’t do that’. People will listen because it’s everybody’s responsibility.... But in Australia, if parents try and adopt the same approach they are verbally abused. They will use all the ‘f-words.’ You dare not even intervene. (Focus group 1 participant)

Parents also perceived that the Australian legal system afforded protection and rights to children, over parents. This was a concern raised frequently during focus group discussions. Many parents were uncertain about their rights and responsibility as parents in Australia, particularly in relation to discipline, and, as a result, felt powerless to act when conflict arose.

The system is designed so that everyone is free; the children are free and now you don’t have the right, as parents, to control your children; so that is the problem. (Focus group 4 participant)

2.1.5 Intergenerational gap

Parents and young people acknowledged that young migrants readily adopted an ‘Australian way of life’ (Focus group 4 participant), whereas parents were more inclined to maintain the cultural values and practices of their country of origin. This, in part, created tension between young people and parents. Parents also talked about the link between culture, language and parenting, and the difficulty of communicating ‘African culture using English’ (Focus group 1 participant).

There is a gap, a very big gap between parents and the kids .... So this gap is affecting our kids, but access to alcohol and drugs is not the problem, but how kids reach that stage is our role. If the [Australian] system allows us to put culture into practice, just a little bit, to teach our kids from early age up to 24 years, [this] would solve [the problem] a little bit. (Focus group 4 participant)

2.1.6 Employment and education

Other commonly reported challenges associated with resettlement were securing employment, financial stress, and adjusting to an educational system that allocates children to year levels based on age as opposed to language ability and numeracy skills. These difficulties and challenges were thought to contribute to an increased risk of young migrants misusing alcohol and other drugs or experiencing poor mental health. As one young female explains:
Also, Australian society, they only look at the age, but they don't look at the brain. You come here, you are 15, and they're like, ‘oh yeah, here we go, you’re in Year 9’, just like that. Back home, you didn't even go to primary; you haven't even finished primary school; they just jumped you from Year 2 to Year 9. So they get depressed, and then they have depression; it grows and grows and grows. (Interviewee 9)

2.2 Mental health literacy and help seeking

Health literacy is acknowledged widely as a key determinant of help-seeking for health problems. In this section, we discuss two main themes: knowledge and beliefs about mental health problems and alcohol and drug use; and knowledge about professional help availability and help-seeking intentions. Help-seeking barriers and facilitators associated with these themes are also discussed.

2.2.1 Knowledge and beliefs about mental health and alcohol and drug problems

This theme includes three sub-themes associated with mental health and alcohol and drug problems: risk factors; adverse effects and problem severity.

2.2.2 Risk factors

Young and older migrants’ experiences of mental health and alcohol and drug use problems were typically attributed to social and environmental stressors associated with cultural transition and resettlement. Commonly reported stressors were: difficulties obtaining employment; financial hardship; difficulty completing education and training requirements; language barriers; peer pressure, social isolation as well as challenges associated with intergenerational conflict. A number of participants also reported that, in the case of refugees, mental health or alcohol and drug problems may be related to pre-migration trauma, such as having lived in multiple countries of asylum on route to Australia, having endured long periods of uncertainty regarding the outcome of their humanitarian visa applications, and deaths of family and community members in their country of origin.

Peer pressure …. Teenagers do it because they want to be cool. Sometimes they do it because they want to fit in. Then they have their friends telling them to do it or they see people doing it and they end up doing it. But then when they drink, when you get tipsy, you want to keep drinking more and more. (Interviewee 7)

Many that I know are stressed about work, stressed about finding jobs, stressed about problems in Africa right now, so their family over there, stressed about income and some of them are stressed about how they’re doing at school. (Interviewee 26)

2.2.3 Adverse effects

Many young people and parents appeared to have a general awareness of the adverse effects of mental health and alcohol and drug problems; however, others had little or no knowledge. Among those with some understanding of mental health literacy (within Australian or western contexts), commonly reported adverse effects included: impaired decision-making ability, violent or aggressive behaviour, conflict with family members, and disengaging from studies or employment. As for
mental health problems, young people associated these with feeling stressed, intense sadness, depression, feeling overwhelmed or anxious. Social withdrawal, inability to concentrate, lack of motivation and self-harm were also identified as adverse effects of poor mental health. Young people also talked about alcohol and drugs being used as a way of coping with the ongoing challenges of resettlement.

When they use drugs or alcohol, it could be because they are trying to run away from their problems or they are running away from responsibilities, or they’re just running away because they don’t know how to live in this country. (Interviewee 19)

### 2.2.4 Problem severity

The likelihood of help-seeking for alcohol problems was influenced by problem recognition; hence, problem recognition was viewed as a help-seeking facilitator. Some young people suggested their peers would seek help if they thought the problem was serious; however, this step would require the person to identify, and admit, they had a problem. Others indicated that young migrants would not identify drinking, even heavy drinking, an issue worthy of concern. According to one young person, normalisation of alcohol use within Australia could be a barrier to help-seeking. For others, however, it was unclear if problem recognition was due to a young person’s lack of awareness about the harms associated with alcohol or attitudinal factors.

[What of negative community beliefs about alcohol and drug use, could that also prevent them from seeking help?] With alcohol, ‘no;’ with drug abuse, ‘maybe.’ I think alcohol is too ingrained into the Australian society for it to be viewed as negative. (Interviewee 26)

In terms of mental health problems, participants often referred to the ‘non-physical’ nature of mental illness; therefore, within African cultures, mental health was not perceived as priority, or a condition, that required formal treatment. This belief was perpetuated through lack of discussion about mental health issues within families and the general community. Furthermore, young people often cited the tendency of fellow Africans to dismiss mental health concerns as a barrier to seeking help from informal, and to a lesser extent, formal help sources. However, young people and parents acknowledged that the higher level of public discourse around mental health issues in Australia, and its prominence as a health issue, encouraged discussion and this, in turn, enabled help-seeking.

We don’t mainly seek help for something that’s not physical. So, things like mental health we tend to just brush them off as something not that important. (Interviewee 23)

### 2.2.5 Knowledge about professional help availability and help-seeking intentions

### 2.2.6 Awareness of professional help options

The majority of young people were able to identify at least one formal help source, with some naming specific services (e.g., Kids Helpline, beyondblue, Youth Stop (YStop) and headspace). Awareness of services was typically gained from speaking with friends, educational settings, public promotion campaigns (e.g., television or posters), or personal experience. Some young people,
however, had little or no knowledge of formal sources of help and this was considered a key barrier to help-seeking.

The level of service awareness also varied among parents; however, on the whole, they had a lot less knowledge of formal services than young peoples. This finding was not unexpected due to young migrants’ quicker English acquisition and acculturation to Australian society. According to some parents, the only help source they were aware of was the police. Furthermore, they avoided accessing formal services for help because of concerns about perceived adverse consequences of help-seeking, such as removal of their children, ongoing surveillance, or having their visa revoked. These concerns were related to their previous experiences of government authorities in the countries of origin and highlighted their mistrust of regulatory systems and government intervention.

Going to the family doctor, like if it’s at an early stage of mental health, we are scared to put somebody in the system. Because everything here is documented and if you are on the system, it will be very hard to get rid of it. (Focus group 4 participant)

2.2.7 Help-seeking intentions

The extent to which different help-seeking sources were considered to be acceptable was explored during the interviews with young people and focus groups with parents.

Informal sources of help

Among young people, informal help sources, such as friends, particularly close friends, and to a lesser extent, family members (e.g., parent, sibling), were typically the source young people would turn to first if they were experiencing mental health or alcohol and drug problems. Informal sources were overwhelmingly the preferred avenue of support reported by parents; however, clear and carefully considered hierarchical decision-making processes were applied that involved approaching those closest to them in the first instance and widening the support circle, only if necessary. In this case, the informal source may provide advice or speak to the child directly.

At first, it will be within your family. You try and deal with the problem in the house. If it [the problem] escalates then you go and seek a friend’s help; one that you trust. The friend comes and speaks to whichever child is misbehaving. If it goes on, then the circle widens. You seek more help from more friends or even more families. (Focus group 1 participant)

Formal sources of help

While young people and parents considered informal supports as their main source of help, some differences emerged in respect to seeking help from formal sources, with young people reporting this as a viable and, at times, preferred avenue of support. Formal help sources, however, were considered the last option, if an option at all among parents. This difference in help-seeking intentions was attributed mainly to young Africans being more acculturated to the concept of seeking professional help. While parents were less familiar and comfortable with formal support channels, some suggested they would seek professional help for their children.

I think if you are asking whether we would take ourselves to professionals as grown-ups, we wouldn’t. But for our kids, I think we would, as a last resort. If you look carefully, our kids are
able to express themselves [in English] much better than we do. But for them having mastered the culture here, I think they are closer to bridging that gap. I think the kids can really open up to them [formal help sources], as opposed to us. So what is probably stopping us from seeing the professionals or taking the kids to professionals is us, as parents. (Focus group 1 participant)

2.3 Help-seeking barriers and facilitators

2.3.1 Barriers

Three help-seeking barriers for mental health and alcohol and drug problems were identified: stigma, cultural competency of formal help sources, and financial costs.

**Stigma**

Three types of stigma were identified by young people and parents: self-stigma, perceived stigma and personal stigma.

**Self-stigma**

Internal or self-stigma, as in turning stigmatising attitudes against one’s self, was a common help-seeking barrier. While young people and parents expressed a need for support, the act of obtaining support from informal or formal sources was often perceived as a sign of personal weakness or failure. Furthermore, feeling ashamed of one’s own mental health or alcohol and drug problem may deter young people from seeking help.

> The shame. The shame in this community again; being labelled a drunkard. It’s like I failed myself; I had to go and seek extra help. So it’s the shame; the disappointment would stop me; the embarrassment. (Interviewee 20)

**Perceived stigma**

Young people and parents frequently reported concerns about what their community members might do if they became aware that a younger or older member sought help for mental health or alcohol and drug problems. Many concerns related to fear of being judged, rejected or shunned by the community. Fear that family members, namely parents, would attribute blame to the young person for their problem, particularly if the problem was related to alcohol and drug use, was another stigma-related barrier. For this reason, young people may seek help from a formal source, instead of family members. Furthermore, the traditional belief that mental health or alcohol and drug problems were contagious, that they could be passed from one person to another, was discussed by a small number of participants, mostly parents. While some acknowledged this belief was based on a misconception, the perceived transferability of these problems contributed to this form of stigma. As one parent explained:

> So the fear is that you don’t take your burden to another friend, because by bringing that burden, it makes them sick .... so [it is] better to keep [it] to yourself. (Focus group 1 participant)
Personal stigma
The perceived fear of being labelled a ‘lunatic’, and the associated stigma, often meant young people or their parents would avoid seeking help from informal and formal sources. Negative labels also extended to mental health professional; for example, the negative connotations of seeing ‘a shrink’ deterred help-seeking from this group of professionals.

I don’t know about other cultures but my understanding in my culture is, well as an individual, I might recognise these [mental health specialists] are qualified professionals in their field, but I grew up knowing them as ‘shrinks.’ So I wouldn’t want to be seen outside the door of one; that’s my belief. (Focus group 1 participant)

Cultural competency of formal help sources
Among parents in particular, a shortage of same-culture health professionals was perceived a barrier to help-seeking. They commented that, unless the health professional was born in Africa, or had an extensive understanding of African cultures, there would be little value in seeking formal help as the cultural context of the issue would be lost or ignored. Treating the issue within a culturally appropriate framework was also viewed as an essential part of the healing process. Across the focus groups, few parents were aware of mental health or alcohol and drug services that employed an African health professional. However, a small number of parents were confident they could find a same-culture health professional, if required.

I would so much appreciate access to information of culturally sensitive psychologists or professionals. Sometimes we think twice about going to see a professional because by the time you get through the cultural understanding it will be seven months down the line and my child will have done whatever they wanted to do. (Focus group 1 participant)

Financial costs
The financial cost of seeking formal help was viewed as a barrier by parents and young people; with the latter suggesting the perceived costs of seeing a specialist would deter parents from seeking formal help for their son or daughter. Within the African context, accessing a specialist was a sign of financial wealth, as specialist services were only available through private health systems, which were unaffordable to most people. There was also a perception by participants that Australian mental health and alcohol and drug specialist services were only accessible to individuals with permanent resident status.

2.3.2 Facilitators
Five help-seeking facilitators were identified in the data: being open with friends and family; strong community systems; trustworthiness and confidentiality; relevant expertise; and education and awareness.

Being open with friends and family
‘Being open,’ ‘feeling comfortable,’ sharing personal information with friends or family, because they were accessible, ‘they are always around’, were the main reasons why young people sought help from these informal sources. Furthermore, the personal knowledge and insights of friends and family meant they were well placed to recognise the problem and offer support or advice.
Encouragement and positive attitudes of family and friends facilitate access to formal sources, and formal help sources may encourage dialogue between young people and their parents.

Actually, if it’s a friend, a friend means a lot. If you’re best friends, you talk a lot and you know a lot about each other. So if I go to my friend, I know they will understand how I feel and they will understand what is best for me. (Interviewee 8)

Strong community systems
Existing support systems within migrant communities were viewed as a protective factor against young people developing mental health and alcohol and drug problems as well as an avenue through which emotional and practical help and advice could be sought and obtained. The positive impact of cultural support systems and structures was thought to increase over time as communities become more established and members balance the values and practices of their country of origin with those in Australia.

As a community, we have tried, since the time we arrived here, to be available for each other, to be a support group for each other, because no one understands us better than our own. (Focus group 3, participant)

Trustworthiness and confidentiality
Within the context of mental health and alcohol and drug problems being highly stigmatised in the general community, the trustworthiness of help sources, and assurance that information disclosed would remain confidential, was a critical aspect of the help-seeking process. For the most part, trustworthiness was discussed in reference to seeking help from informal sources.

At first, you look at people you know ... how close are you to them, how credible are they? If they have similar issues, okay. You also hope to be discrete ‘in the shadow’ (seeking help without others knowing). So it’s not like it’s a ‘free-for-all’ and you just put it on the ‘notice board’. (Focus group 1, participant)

Confidentiality was reported commonly in reference to professional codes of conduct governing health professionals’ practice, and for this reason, young people felt they would prefer to seek help from a formal help source as opposed to a family member, friend or community member, who may breach their trust. For some younger people, priests and religious pastors were also a preferred help source as providing confidential counsel was part of their role.

Relevant expertise
The experience, knowledge and skills of health specialists and GPs were valued by some young people, and reported as reasons for seeking help from formal sources. Furthermore, the ability of specialists to conduct an assessment and identify problems provided young people with a sense of assurance. This was the case for young people seeking help about alcohol and drug problems, and to a lesser extent, mental health problems. Peer-based programs were also considered to be acceptable and appropriate sources of help for young migrants.

They [specialists] have the knowledge and they know what they’re doing when they are dealing with young people. They have experience basically in that field. (Interviewee 22)
While it was acknowledged that informal sources may not have specialist training or formal experience related to mental health or alcohol and drug problems, it was important, especially for parents, that these sources had some understanding of the issues.

**Education and awareness**

Parents and young people suggested that providing parents with information about mental health and alcohol and drugs would increase their confidence in regards to managing and helping their children. In turn, this information may facilitate help-seeking. In order for the education and information to be accessible and appropriate for new migrants, there was general consensus that information about mental health and alcohol and drug problems be provided within the context of general well-being due to the high level of stigma attached to these issues. Parents also advocated that information be provided through group-based discussion forums. In addition, parents acknowledged that some migrant communities in Australia are more established than their own, and opportunities to learn from each other’s experience could be helpful regarding parenting adolescents in a new country.

You can always learn from somebody. I think it’s a good idea [to learn from other cultures] because you might only speak with other Africans and, maybe, they only have limited knowledge about different issues. But if you listen to other people, they might have different experiences and ideas, so together you learn more. (Focus group 1, participant)

**3. Health promotion resource development and testing**

**3.1 Developing the resource**

To address the key findings from the individual interviews and focus groups, a health promotion resource was developed to target three key areas: a) improve communication and conflict resolution between parents and their sons or daughters, b) increase mental health and alcohol and drug problem recognition, and c) reduce the stigma about openly discussing mental health and alcohol and drug problems. A strengths-based problem-solving framework, with materials appropriate for use in low English literacy classes, was selected as the model for the development of the resource and materials. The strategies were drawn from migrant specific parenting tools [40, 41] and conflict solution and mental health literacy resources [42].

The resource comprised two pictorial vignettes; one presenting an alcohol and drug problem, and the other a mental health problem. The vignettes were presented in story arc form, a way of describing how a character (or cast of characters) or a situation move from one state to another, to effect change. The characters, context and key messages were written by the project team and translated into pictorial vignettes by BeInSync. The vignettes were designed to encourage discussion about key communication and conflict resolution parenting strategies.

Forty-nine AMES students (four classes) participated in testing the resource. The pictorial vignettes were focus tested for face validity; in particular, their ability to communicate the parenting
messages outside of the context of a structured learning program. The images were tested until a consistent understanding, in line with the intended interpretation of the images, was achieved.

3.2 Resource description

The pictorial vignettes comprised 6-8 scenes. Each scene presented a key theme (e.g., conflict, negotiation, communication) and when linked together, the scenes told the story of a family addressing the mental health or alcohol and drug problem of a teenage child.

The story arc for each story contained three elements.

1. A situation in which there was conflict between parents and their son or daughter.

2. The parents resolving the conflict through seeking help and advice and changing the way they communicate with their son or daughter.

3. Putting in place new routines and ways of communicating to reduce the likelihood of the conflict returning.

The resource was structured to use the vignettes in three steps.

Step 1: Each scene was presented to the group individually and groups were asked to comment on what was happening in the scene. Through this process, the groups discussed the story behind each scene. The scenes were presented in the order they appeared in the vignette (see Appendix 1).

Step 2: The vignette (i.e. all scenes presented together) was presented to the group for comment on the story. Through this process, the group discussed how the scenes worked as a story.

Step 3: The vignettes were presented in a visual device called a ‘story bridge’.
The story bridge presented a scene or a sequence of scenes at each end of a bridge of empty bricks. The groups were asked to identify strategies or approaches parents in the vignette might have used to ‘bridge the gap’ between the scenes. The group’s suggestions were written into the bricks of the bridge. The exercise was finished when the bricks of the bridge were full of suggestions; thus, bridging the gap between the problem and the solution.

The story bridge was designed to encourage discussion of the range of strategies, sources of help and advice and behaviours the parents in the story could draw on in order to resolve the conflict, re-engage with their teenage children and put in place strategies to avoid conflict in the future.
4. Health promotion resource pilot testing and evaluation

The resource was pilot tested in an educational setting and community setting. The resource format and content was very well received, with 100% of participants in both settings indicating interest in attending another or similar session, and 96% of participants reporting they would recommend the resource to friends or family members.

The pilot resource generated lively debate and required very little instruction from the facilitator. Once the simple instructions about using the resource were given and the first few images were presented, the groups understood the format and the conversation that ensued was open, considered, and, at times, quite personal, as illustrated by the exemplars below:

We parents have to realise that if something is going wrong with our children, maybe they are having drugs or alcohol, there are no eyes everywhere to see them. The parents have to know what it is that they [their children] are doing. And this is hard for us, because back home [in Africa] if your child was having drugs or alcohol someone would see them and they would tell the parent. But here, we don’t have that so we have to talk to the children and know what is going on.

We know that it is changing as Africans to hear more about mental health, but this is very new to us. If your child is sick, you take them to the doctor but if your child is sick with mental illness, how do we know? And then the parent gets scared because we don’t know what it means to have mental illness and we don’t really know what to do. I think this family are very lucky to talk to their family and friends like this, maybe this is not always the case.

After each pilot session, participants were asked to rate the resource for its usefulness, relevance as well as the overall presentation, including how the sessions were facilitated and the materials used. Assessments were based on a 3 point scale (e.g., Excellent, Average, Poor). Participants were then asked to qualify these ratings in regard to what they liked about, and learned during, the resource session, and would recommend for future sessions.

a. Educational setting

Group participants in the educational setting rated the health promotion resource sessions as useful (extremely useful [61%] or somewhat useful [39%]), relevant (extremely relevant [50%] or somewhat relevant [50%]) and excellent (55%). Eighty-three per cent felt that the group size (9 students per session) and the time allowed for discussion were appropriate. Overwhelmingly, the responses to, “What did you like about the resource?” focused on the value of talking about these issues in a group and learning from other parents. As one participant wrote, ‘it helps parents to know that other families have struggles and you can help to make them better’.

Responses to, “What did you learn during the resource session?” generally reflected the value of learning to communicate with teenage children, appreciating that the struggles one family may have are more common than previously thought, that talking about these issues is helpful, and parents
need to play a more active role in their sons or daughters’ lives. The responses below indicate the benefits of talking with young people about mental health and alcohol and drug issues:

(We) must stay close to the children so you can help; we must listen and learn from them.

If the children don’t see us talking about this, they will not think they can talk to us about their problems. We need to show them that they can.

Participants were also asked if they had attended similar education or information sessions on the topics covered. Only 22% indicated they had attended a session on parenting young people or alcohol and drug issues, while only 11% had attended a session on mental health issues.

b. Community setting

Participants in the community setting groups rated the resource as extremely useful (75%), 100% rated the resource as relevant to them, and the majority rated the overall resource as excellent (91%). Three quarters felt the group size (6 participants) and the time allowed for discussion were appropriate; however, 25% felt the groups were too small and the time allowed for discussion could have been extended.

Similar to the educational setting groups, responses to, “What did you like about the resource session?” centred around the value of talking about these issues in a group as well as using the pictures to generate discussion; “that the discussion was interactive”, “Being able to open up and talk about these parenting issues”, “Getting a better understanding of the mental health issues affecting young people” “I like talking about this information, it is very important for the future”, “I really enjoyed it thank you it is important we talk about this”.

Again responses to, “What did you learn during the resource session?” were similar to those reported by the educational setting groups and centred around the value of learning to communicate effectively with young people, the parenting tips and stories that were shared and framework to help address these issues; “How to think about the kids and how their life is different to us”, “How to deal with kid issues in a different culture, the challenges involved in sticking to your culture and embracing Australian culture. It is about the balance, this will help parents talk about where the balance is”, ‘Good parenting tips, how to calm down when I am angry”.

Responses to, “What would you like to improve?” included allowing more time and including more people as well as including a session with the children; “I need more information, when is the next session?”

In contrast to the educational setting groups, almost three quarters (73%) of participants had previously attended sessions on parenting young people, alcohol and drugs or mental health.
4.1 Resource feedback

Favourable interpretation of the resource vignettes was generally consistent across all groups in regards to the themes presented in each scene and the overall stories. Where the mental health vignette was distinctly different, however, was in how the scenes presented as a complete vignette changed the perception of the teenage daughter’s behaviour and the parents’ response.

First impressions: ‘They don’t know what to do because she doesn’t want to go with the family. The daughter is embarrassed about her culture; she wants to be more like her friends. The parents are trying and trying but she is rejecting their culture.’

When the vignette was reconsidered in context of the broader story the teenage daughter’s behaviour was view more empathetically.

Second impression: “… the parents are very worried about her because she is not herself; she is sad. They don’t know she is hurting herself, no, but they know there is a problem and they don’t know what it is. The parents don’t know what to think because they don’t know what could be the problem. This is where the parents need to talk to her in another way so that she will talk to them, and tell them the problem.”

When the groups were asked more specifically to explain how the conflict in each vignette was resolved through the use of the story bridges, a more detailed understanding of the complexity of the issues was revealed. Two key revelations made in regards to the different social and cultural demands placed on newly arrived teenage migrants were:

1. Although parents recognised that their children are growing up in very different social and cultural environments to them, parents didn’t know how to manage this.

2. Parents feared that their (and the community more generally) inability to manage these issues was fracturing their family and communities, and ruining the lives of their children.

When asked what parents could do, there was consensus that parents were motivated to find ways to better understand and communicate with their son or daughter in order to keep them connected with their families and safe from mental health or alcohol and drug harms. Suggestions provided from the groups regarding what parents needed to do to move from conflict to resolution included: staying calm, not raising their voice, listening to their sons and daughters, remaining non-judgemental, discussing the immediate and future risks of alcohol and drug use with children, and considering the situation from the young person’s perspective.

… you have to let them talk and not judge them; if you tell them they will not listen. This is hard, I know. I find this with my own son, but I listen to him, and then I can see where I can lead him to the better way.

Suggestions of who parents can go to for help and advice were largely family, friends and the community. The role of informal supports included providing advice or speaking to the teenage child on the parent’s behalf. Professional help-seeking was considered a last resort unless the advice from friends and family encouraged formal help-seeking.

Talk to your brothers and ask them for help. Ask them to talk to your child.
The groups acknowledged that parents are less likely to engage with services than young people and that parents need to better identify and understand the services available. The groups also acknowledged that the way these issues are seen by parents and children is very different. They indicated that it is appropriate for parents to be concerned, but they had to adapt better ways of dealing with the situation to be able to communicate with their children.

Because we don’t know the services, where they are, what they do, we don’t know what is the way to solve the problem. We, the parents, need to learn this. I think that is what the community is telling the parents. They are saying, ‘you must go and get the right information from the doctor. We don’t know about this problem because we never saw it in our country. Maybe it was there, but we never saw it.’

The device of the story bridge encouraged the groups to consider how parents could work through the issues and the resources from which they could draw upon. The groups were able to acknowledge that how they wanted to tackle mental health and alcohol and drug problems was not necessarily the most effective way to resolve the issues, and parents should be more open about discussing problems in their families. The groups acknowledged the stigma associated with divulging these personal problems as the most significant barrier to addressing these issues within families and the broader community. The groups also discussed that parents needed to be the drivers of change in their communities. As one participant explained:

When you come here [Australia] you don’t want people to think you have problem, so you hide and not tell anyone …. But this is bad and why we are not happy. How can we change and make it better? I don’t know, but we have to talk and see if we can try.

**Summary and next steps**

Discussions within the pilot resource sessions identified the capacity for the health promotion resource to be delivered in an educational and community setting. Feedback from AMES staff involved in piloting the resource indicated that it was appropriate for use in an educational setting. In particular, the use of the story bridge to engage the class and encourage discussion was a key strength of the resource. Overall, the existing framework of a migrant-specific educational setting meant that the resource could be utilised within existing curricula.

Feedback from the community participants indicate a community member with the requisite knowledge of mental health or alcohol and drug problems could facilitate the session using the resource. Alternatively, a co-facilitator approach would be acceptable, whereby a community leader could co-facilitate the session, using the resource with a culturally competent health service provider with content knowledge of mental health or alcohol and drug problems. This would enable the community to develop expertise around the issue, as well as tackle stigma associated with mental disorders. However the logistics involved in determining an appropriate model of delivery within community settings, requires further examination.
5. Key findings and next steps

This section provides a summary of the key findings from each phase of the project.

Based on the qualitative interviews with young people and focus groups with parents, several key themes were identified about help-seeking.

**Help-seeking barriers**

- Poor mental health literacy about early problem recognition and the availability of professional support and treatment, particularly among parents. Among young people, dismissing early signs of alcohol-related problems, and only seeking help when problems became serious, were common. Also, the perceived low level of mental health literacy among parents, according to young people, meant young people may not seek help from parents.

- Parents acknowledged the problems associated with mental health issues and alcohol and drug use, and the impact these had on teenage children; however, parents were often unsure how to approach the issues without creating conflict with their son or daughter.

- Stigma associated with disclosing mental health and alcohol and drug problems was reported frequently. Fears associated with disclosure meant that young people and parents were reluctant to seek help within their particular migrant community. This was particularly an issue for parents as informal community networks were their preferred way of addressing other health issues. Stigma was also identified as an obstacle to seeking help from professional services.

- Differences in help-seeking were compounded by language and cultural differences, with parents favouring family and community support, whereas young people preferred to seek help from friends, and at times, professionals, instead of family. This created challenges for young people in terms of involving their parents if they had accessed professional support.

- Differing levels of community connectedness meant some recently established communities lacked the necessary social capital to support young people. This was perceived as a vulnerability of the community, and a barrier to addressing mental health and alcohol and drug problems.

- Parental concerns around the cultural competency of health professionals meant this form of support may not be viewed as a viable or preferred option.

- The financial cost of accessing and receiving professional treatment was identified as a barrier to help-seeking.
Help-seeking facilitators

- The trust and familiarity of close friends, and the bond between families facilitated help-seeking through informal sources. For young people, encouragement and emotional support provided by family and friends also facilitated access to professional help.

- Young people and parents recognise the importance of community as a form of support, with well-established community networks and systems that support help-seeking from informal and formal sources. Strong cultural affiliations enable parents and young people to capitalise on existing resources within their own community and as means of providing access to professional support.

- The perceived expertise of health professionals, in dealing with mental health, alcohol and drug or young people’s behaviour, increased some young people’s confidence in seeking help from formal services.

Based on these findings, a health promotion resource addressing problem recognition and the stigma of openly discussing mental health, drug and alcohol problems, was developed. The resource includes pictorial vignettes, and key messages that are communicated through group-based discussion.

Piloting and evaluating the health promotion resource

The health promotion resource was piloted and evaluated in a migrant-specific educational setting and a general community setting. Key outcomes from the resource sessions were:

- The resource was well received and considered helpful, relevant and appropriate. The groups who attended the sessions indicated an increase in awareness of the signs and symptoms of mental health, alcohol and drug problems; an acknowledgement of the stigma associated with seeking help; and an increased willingness to engage in help-seeking for mental health, alcohol and drug problems. However, further evaluation is required to measure the impact of the resources on reducing the stigma and increasing help seeking behaviours.

- The groups embraced the opportunity to come together and talk about health-related issues affecting young people in their communities, and the difficulties parents have around having conversations with their son or daughter about mental health, alcohol and drug problems.

- The resource, including pictorial vignettes, facilitated open, non-threatening discussion. The vignettes allowed issues to be discussed through an intermediary without the participants having to disclose personal information. They also allowed the difficulties encountered by
parents when parenting young people in a new cultural context to be normalised. Normalising these experiences was acknowledged as helping to reduce the stigma of discussing these issues.

- Findings indicate that the resource may be suitable and appropriate for educational and community settings. However, the most appropriate models for delivering this resource, in a sustainable and effective manner, require further investigation.

5.1 Next steps
The health promotion resource was found to be accessible and appropriate in facilitating discussion about mental health, alcohol and drug problems. The next question is how to disseminate the resource in a way that leads to improved help-seeking amongst newly established migrant communities. Potential options include:

1. Investigate how to further develop the resource so it can be housed on relevant websites, such as beyondblue, to make it accessible to a range of recipients, including community groups, teachers and service providers.

2. Develop and trial models, whereby community members can be trained and supported to deliver the resource within their own communities as a way to increase dissemination and ensure the sustainability of the resource.

3. Develop briefing materials for services and government departments about migrants’ help-seeking practices and preferences. This information could be used to improve the cultural competence of services.

4. Develop and pilot a suite of culturally appropriate images to ensure broader application of the resource to other communities.
6. References


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7. Appendix 1: Health Promotion Resource Vignettes

VIGNETTE 1: ALCOHOL & DRUG PROBLEM