THE STATE OF MULTICULTURAL MENTAL HEALTH IN AUSTRALIA

RESEARCH REPORT

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REPORT DESIGN

This report was designed by Roy Peake.

ACKNOWLEDGEMENT OF COUNTRY

With respect for Aboriginal cultural protocol and in recognition that its campuses are located on unceded Aboriginal land, Western Sydney University acknowledges the Darug, Dharawal, Gadigal, Gundungurra and Wiradjuri peoples and pays respect to Elders past and present. We honour the continuation of cultural, spiritual and educational practices of all Aboriginal and Torres Strait Islander peoples today and thank them for supporting our work on their lands (Greater Western Sydney and beyond).

ACKNOWLEDGEMENT OF LIVED EXPERIENCE

We acknowledge the individual and collective wisdom of people with lived or living experience of a mental health condition, their carers, families and loved ones, to inform, influence and enhance research. Their insights guide this report and remain essential to improving Australian multicultural mental health policy and practice.

FOREWORD

The state of multicultural mental health in Australia has preoccupied scholars, mental health practitioners, governments and culturally and linguistically diverse (CaLD) communities since the early 1970s. Given the demographic composition of the Australian population, a focus on the mental health of migrants (including refugees) has increasingly been reflected in the content of Commonwealth and state/territory mental health laws and policies, and in principles statements of mental health professional organisations and service agencies.

The State of Multicultural Mental Health in Australia Research Report consists of three quite different, substantial and complementary research projects, along with a synthesis of their findings. Combined, they address many of the key concerns in multicultural mental health.

The research team was invited to answer two key questions:

(1) What is currently known about the state of multicultural mental health in Australia?

(2) What are the current and emerging good practices for supporting the mental health of multicultural communities?

This research report is a timely examination of the extent to which mental health policy intent, legal obligations and fundamental principles – such as commitments to equity and the *diversity principle* in Victoria's mental health law – are being realised in practice. It also identifies examples of emerging good practice with the potential to be adopted at scale and contribute to the realisation of policy objectives.

The rigorously conducted work reported here has been carried out by an impressive research team with the wide array of research skills required to answer the questions raised. As might be expected, the findings raise further questions about whether national and state mental health systems are adequately responding to the demographic realities of the populations they serve.

Based on the research findings, the authors provide a comprehensive suite of recommendations. These recommendations constitute a clear guide to action by multiple mental health system actors.

The report, and particularly the recommendations, should be read and acted upon by:

- national and state and territory policymakers
- officials responsible for financing and implementing mental health policies
- designers of mental health programs and services, and the agencies and professionals delivering them
- officials overseeing mental health information systems and the continuous evaluation of programs and services

Mental health practitioners, CaLD community leaders and agencies, and people with lived experience, who should be centrally involved in all the above activities, will be able to rely on this report, in continuing advocacy and, more importantly, in co-design of policies, programs and services.

I commend the team for its excellent work and for a clear and concisely written report. It is a valuable contribution to the continuing task of making our mental health systems fit for the actual Australian population they are meant to serve.

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LIST OF SHORTENED FORMS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
BRiTA	Building Resilience in Transcultural Australians
CaLD	Culturally and Linguistically Diverse
CBT	Cognitive Behavioural Therapy
CD	Compact Disc
CFH	Child and Family Health
CMHTs	Community Mental Health Teams
COVID-19	Coronavirus Disease 2019
FICT	Families in Cultural Transition
GP	General Practitioner
JBI	Joanna Briggs Institute
MBS	Medical Benefits Scheme
MHeC-S	Mental Health eClinic – Spanish (MHeC for Spanish speakers)
MHFA	Mental Health First Aid
MHL	Mental Health Literacy
MIEACT	Mental Illness Education ACT
NAATI	National Accreditation Authority for Translators and Interpreters
NDIS	National Disability Insurance Scheme
NGO	Non-Governmental Organisation
NSMHW	National Study of Mental Health and Wellbeing
NSW	New South Wales
OR	Odds Ratio
PBS	Pharmaceutical Benefits Scheme
PCC	Population–Concept–Context
PLIDA	Person Level Integrated Data Asset (spine used to link across datasets administered by Australian Bureau of Statistics)
PHN	Primary Health Network
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
PTSD	Posttraumatic Stress Disorder
QLD	Queensland
RCT	Randomised Controlled Trial
SA	South Australia
STARTTS	(NSW) Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
STS	Strength to Strength (program)
TAS	Tasmania
TOL	Tree of Life
TRT	Teaching Recovery Techniques
TYS	Tell Your Story (intervention)
tMHFA	Teen Mental Health First Aid
UNHCR	United Nations High Commissioner for Refugees
VIC	Victoria
WA	Western Australia
WHOQOL-BREF	World Health Organization Quality of Life Instrument – Short Form
YMHFA	Youth Mental Health First Aid

KEY TERMS AND DEFINITIONS

Asylum seekers are people who have come to Australia and are seeking protection. Their request for refugee status, or complementary protection status, has yet to be processed, or they may not yet have requested asylum, but they intend to do so. (1, 2)

Culturally and Linguistically Diverse (CaLD) describes people of non-English-speaking background, those born outside Australia, and those whose first language is not English. (3) It recognises differences in religion, spirituality, racial background, ethnicity and language across the Australian population. (4-6) See also note on use of terms.

Intersectionality refers to the interconnected nature of social categorisations such as race, class and gender as they apply to a given individual or group, creating overlapping and interdependent systems of discrimination or disadvantage. (7)

Intervention (for health) is any deliberate action taken by an individual, organisation or government to improve health, such as medical treatment, psychosocial therapy or population-level prevention campaigns. (8)

Lived experience (in the mental health context) generally refers to any individual who has either current or past first-hand experience of a mental health condition and/or first-hand experience as a carer, family member, or other significant supporter of someone living with a mental health condition. (9) However, in stakeholder consultations conducted during this research it was clear that this term was also applied to people with lived experience as a migrant or refugee and to signify belonging to a particular CaLD community group.

Mental health is a state of well-being that enables individuals to deal with what life throws at them. It is about feeling resilient, enjoying life, connecting with others, coping with everyday stresses, being productive and contributing to the community. (10)

Mental illness (or mental health condition) refers to a clinically diagnosable disorder that substantially interferes with an individual's cognitive, emotional or social abilities. It covers a spectrum of disorders that vary in severity and duration, including anxiety disorders, affective or mood disorders (such as depression), psychotic disorders and substance use disorders. (8)

Migrants are people who were born overseas and whose usual residence is Australia. The term includes people holding permanent visas or long-term temporary visas who intend to stay 12 months or more, and excludes foreign diplomats and their families. (11)

Multiculturalism/Multicultural can be understood as a descriptive term for the presence of cultural diversity in a society in Australia. Multiculturalism recognises, values and promotes the contributions of the diverse cultural heritages and ancestries of all people. A multicultural society continually evolves and is strengthened by the contributions of its diverse peoples. (5, 6, 12) See also note on use of terms.

Refugees, as defined in the Migration Act 1958, are people who are in Australia, living outside their country of nationality or former habitual residence (their home country), and who are unable or unwilling to return to their home country or seek protection in that country because of a "well-founded fear of persecution". Most applicants in this category are identified and referred to Australia by the United Nations High Commissioner for Refugees. (1, 11, 13)

A NOTE ON USE OF TERMS

'Culturally and Linguistically Diverse' and 'Multicultural'

The term 'CaLD' is widely used by Australian governments, public and private sectors, and academic institutions to describe people with diverse languages, ethnic backgrounds, nationalities, traditions, societal structures, and religions. However, it typically excludes those whose ancestry is Anglo-Saxon or Anglo-Celtic and Aboriginal and Torres Strait Islander peoples. (6) Throughout this report we have mostly utilised 'CaLD' to refer to individuals and communities born outside Australia who are of non-English-speaking backgrounds, or whose first language is not English[1]. Further, we have used 'CaLD' interchangeably with 'multicultural', in line with common usage in the Australian context. (14)

'Best Practice' versus 'Good Practices'

Although widely used in the health and human services fields, the term 'best practice' has been critiqued as being vague and subjective, and having multiple meanings. Common variants include 'good practice' or 'promising practice' or 'preferred practice'. (15) Furthermore, the notion of a single best practice at any particular moment can be problematic. It is often more useful to consider what works for whom and in what context. (16) Such consideration is particularly pertinent when it comes to multicultural mental health interventions, for which the evidence base, though growing, remains limited. The need to rely solely on research using experimental or quasi-experimental designs to validate interventions is also contested, with arguments for the inclusion of community-defined evidence; i.e., practices that communities have used over time and have produced positive outcomes as determined by community consensus, and which may or may not have been measured empirically. (17) In this research report, we deliberately use the terms 'good practice' or 'good practices' (plural), as this is consistent with the six pillars of evidence model that we have adopted as an overarching research framework. (18)

Mental health service users

The term 'client' was used in this report in preference to 'consumer' or 'patient' because it was frequently used in the research literature reviewed and the most commonly used term among the target stakeholder groups.

[1] In the secondary analysis of the National Study of Mental Health and Wellbeing 2020–2022 (chapter three), the populations of interest were categorised into two groups: individuals born in Australia and those born overseas. This was due to dataset limitations that prevented more detailed classification, including wide confidence intervals and the suppression of results for privacy reasons.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

EXECUTIVE SUMMARY AND RECOMMENDATIONS

In Australia's rapidly changing demographic and social landscape, ensuring equitable access to timely high-quality mental health care for culturally and linguistically diverse (CaLD) communities, a significant proportion of our population, is a shared responsibility.

In 2024, 31.5% Australians were born overseas and over half (51.5%) had a parent born overseas. At the 2021 Census, Australians reported having 320 different ancestries, speaking 429 languages (including 183 First Nations languages) and identifying with over 30 religions. Despite repeated calls to improve knowledge and mental health systems for multicultural Australia, the mental health status of CaLD communities, and their mental health service and support needs, remained relatively unknown.

This research report was designed to provide a contemporary overview of multicultural mental health in Australia, specifically addressing two questions:

1. What is currently known about the state of multicultural mental health in Australia?
2. What are the current and emerging good practices for supporting the mental health of multicultural communities?

The research had three components:

1. A secondary analysis of the 2020–2022 National Study of Mental Health and Wellbeing (NSMHW), with a focus on the prevalence of 12-month anxiety and affective disorders, associated socio-demographic and health characteristics, and mental health service use.
2. A rapid literature review of Australian studies from 2012 to 2025 that have focused on community-based mental health interventions for and with CaLD populations, to identify examples of good and emerging practices, as well as barriers and enablers to access.
3. A series of national stakeholder consultations with multicultural community members and health and community service providers using the nominal group technique, designed to elicit consensus on the most effective strategies for supporting multicultural mental health.

Key insights and findings

Australia has an increasingly diverse multicultural profile, with immigrants arriving under different migration streams growing and enriching our society. This increasingly diverse population presents significant challenges for mental health policy and practice. Responding to these challenges requires inclusive, innovative approaches informed by a sound understanding of evolving CaLD community needs and strengths, while recognising context dependence, complexity and intersectionality.

In 2025, evidence on prevalence of mental disorders among immigrant groups in Australia remains scarce. Studies suggest that some groups, particularly refugees and asylum seekers, experience increased vulnerability to mental health disorders yet engage less frequently with mental health services. The 2020–2022 NSMHW provides an important foundation for understanding the mental health status of the Australian adult population, notwithstanding limitations such as the exclusion of individuals with limited English proficiency and constraints around disaggregating data for meaningful CaLD population groups. Our secondary analysis found that, compared to Australian-born individuals, overseas-born individuals had lower 12-month prevalence rates for anxiety (18.8% vs. 10.3%) and affective (mood) disorders (8.8% vs. 4.6%). Among the overseas born, recent arrivals (2012–2022) had a higher likelihood of experiencing anxiety (increased by 24%) and affective disorders (increased by 18%) compared with those who had arrived earlier. Females and younger individuals demonstrated greater vulnerability to anxiety disorders in both the Australian and overseas-born groups.

In terms of mental health service use, compared to Australian-born individuals, a smaller proportion of overseas-born individuals with anxiety disorders reported having 20 or more consultations (72.2% vs. 49%). Of particular concern, overseas-born individuals were more likely than the Australian born to delay treatment for 10 years or more for both anxiety (57.6% vs. 49.3%) and affective disorders (45.7% vs. 37.3%). While the reasons for these disparities cannot be determined from the current data, it is likely that factors such as limited availability of culturally appropriate services and lower mental health literacy contribute.

With respect to current and emerging good practices for supporting multicultural mental health, findings from the 41 studies included in our rapid review demonstrated a small but growing body of work, especially from 2019 onwards. A range of interventions are required to meet evolving multicultural mental health needs. Overall, the limited evidence suggests that culturally safe, integrated and strengths-based models of care that have been co-designed with community can significantly enhance mental health outcomes for CaLD Australians. Furthermore, culturally tailored mental health literacy and anti-stigma campaigns, targeting both the general community and service providers, can improve recognition of mental health issues, promote help-seeking behaviours, and foster inclusive service environments.

Stakeholder consultations, undertaken in 12 metropolitan and regional locations across the five mainland states, deepened our appreciation of local realities with respect to the principles and enablers of good practices. Findings reinforced that multicultural mental health care must be based on culturally safe, trauma-informed and strengths-based principles, and supported by both community engagement and structural reform. Working with CaLD communities was considered both as a principle and as an enabler. This includes community partnerships for co-designed services and programs, supported by adequate resourcing of community-led organisations. Integrating mental health support within existing community infrastructure can improve access, alongside expanding the bilingual/bicultural workforce, strengthening language services, and building cultural responsiveness across all sectors to ensure inclusive high-quality care.

The absence of a dedicated national multicultural mental health policy and supportive structures and systems at the organisation level was considered by stakeholders to be a major impediment to achieving mental health equity in a society becoming ever more diverse. A human rights-based approach with measurable objectives, sustained funding and genuine stakeholder engagement—including lived experience—is essential to achieving systemic change across government, organisations and services. Likewise, nuanced insights and timely, context relevant data are essential to enhancing policy and practice. Knowledge and understanding of the state of multicultural mental health, and how it can best be supported, remains hindered by lack of attention to key CaLD population groups in the national mental health survey and the limited research literature.

Recommendations

Based on the research findings, we propose a series of recommendations to guide governments, and the mental health and non-government sectors, in strengthening culturally responsive mental health care and supporting the wellbeing of multicultural communities. They are grouped into six strategic areas: (1) interventions, (2) access and equity, (3) community partnerships, (4) leadership and culture, (5) workforce, and (6) knowledge and data.

RECOMMENDATION 1

The Australian and state/territory governments should fund the development of culturally and linguistically tailored interventions to meet personal and population-level multicultural mental health needs, adopting a systems approach. This would enable the mental health and non-government sectors, including multicultural and settlement services, to improve access to culturally responsive mental health care and reduce disparities for CaLD communities by:

1.1 Conducting place-based community campaigns using a range of formats and media to raise awareness of mental health, increase mental health literacy and reduce stigma.

1.2 Creating welcoming environments where CaLD clients feel secure to share their experiences, with high-quality care that is trauma-informed and draws on cultural and community strengths.

1.3 Delivering services in the client's preferred language and dialect, using bilingual/cultural staff or professional interpreters matched for gender and other relevant characteristics, and addressing concerns around confidentiality.

1.4 Providing person-centred and family-centred care that considers intersectionality, generational differences and social and economic factors, and does not rely on generalisations or diagnostic labels.

1.5 Providing psychoeducation to clients and their families and carers, practical assistance and links to other health and community services, and addressing spiritual needs.

1.6 Working collaboratively to deliver culturally responsive holistic models of care.

RECOMMENDATION 2

The Australian and state/territory governments must provide adequate and sustained funding so mental health services and non-government organisations can remove access barriers and deliver equitable mental health care for CaLD communities at both local and systems levels. With this funding, mental health services and non-government organisations must improve access and engagement by:

2.1 Implementing available multicultural frameworks, seeking out good practices and embedding these into organisational culture and practice.

2.2 Providing mental health information in multiple languages using diverse formats (e.g., audio, video, infographic) and preferred broadcast and social media, ensuring it is relatable to the target group.

2.3 Increasing mental health service availability through flexible delivery models, including outreach clinics and telehealth options.

2.4 Providing 'soft entry points' to specialist services and simplified referral pathways, supported by service navigation and transport assistance when required.

2.5 Ensuring equitable access to services and affordability by:

2.5.1 Removing restrictive government and service eligibility criteria that exclude certain groups.

2.5.2 Providing coordinated, cross-sector services and support for clients with complex needs.

2.6 Primary Health Networks (PHNs) should reduce place-based inequities by embedding cultural safety considerations into commissioning processes to address gaps in multicultural mental health services including regional disadvantage.

RECOMMENDATION 3

The mental health sector must build stronger connections with CaLD community members with lived experience and their extended family and carers, and CaLD communities more broadly, to ensure they actively shape mental health services that reflect their needs and values. This should involve:

3.1 Partnering with community services and organisations to design, deliver and evaluate multicultural health and wellbeing programs, using culturally tailored co-design approaches.

3.2 Empowering communities:

- 3.2.1 Working with cultural leaders to identify key people to promote mental health.
- 3.2.2 Educating and empowering CaLD community members as advocates within the mental health system.
- 3.2.3 Promoting cultural identity, particularly among young people, and fostering a sense of pride and belonging.

3.3 Developing governance structures that include CaLD community representation, and an inclusive organisational culture:

- 3.3.1 Implementing internal referral pathways, guidelines and performance measures to support inclusive practices.
- 3.3.2 Implementing quality standards and reporting guidelines, and monitoring performance.

RECOMMENDATION 4

The Australian and state/territory governments should ensure CaLD community voices and leadership are included in multicultural mental health policy development, implementation and evaluation in all jurisdictions, supported by and through:

4.1 Coordinated multicultural mental health policy and plans, based on human rights and legal frameworks.

4.2 Dedicated and sustained funding for multicultural mental health that includes remuneration for the contributions of people with lived experience.

4.3 Harnessing CaLD community expertise, strengthening existing community infrastructure, funding capacity building for CaLD community organisations and groups, and providing grants for community mental health initiatives.

EXECUTIVE SUMMARY AND RECOMMENDATIONS – CONTINUED

RECOMMENDATION 5

The Australian and state/territory governments should make funding and policy commitments to build workforce capability and sustainability by investing in bilingual/bicultural mental health professionals and the broader workforce, including:

5.1 Providing incentives to enable services to recruit and retain more bilingual/bicultural staff, including interpreters, clinicians and peer workers, from the communities served, and building leadership roles.

5.2 Supporting CaLD community members to gain new or additional qualifications in relevant fields, and engage with training and education providers and industry to develop pathways from education into employment.

5.3 Supporting bicultural/bilingual students to pursue mental health qualifications such as psychology, social work or counselling through the provision of targeted scholarships and bursaries.

5.4 Funding an increase in the number of interpreters with specific mental health training, and training more interpreters in the languages of newly-arrived communities.

5.5 Ensuring that national and state/territory funding agreements mandate cultural training for senior personnel and all mental health service managers and providers to improve cultural competence, leading to safer, more inclusive and responsive care for CaLD communities.

5.6 Mental health, primary health and community service providers should make the following commitments, supported by sustainable funding from the Australian and state/territory governments:

- 5.6.1 Build understanding of mental health and cultural issues and trauma awareness among health and community providers who work with CaLD communities, including general practice and first responders.
- 5.6.2 Address the needs of CaLD clients with psychosocial disabilities through culturally competent mental health training for NDIS workers and other support providers.
- 5.6.3 Develop clinician tools and resources, e.g., multilingual patient information and appointment reminders, lists of multicultural community services and affordable bilingual counsellors, and transcultural mental health advice.

RECOMMENDATION 6

The Australian Government should make a commitment to providing adequate funding to enable researchers, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare and others to build scientific knowledge around multicultural mental health and addressing outstanding data gaps. This should involve improving the relevance and consistency of data collected and includes:

6.1 Implementing targeted oversampling of selected CaLD communities in national surveys particularly the National Study of Mental Health and Wellbeing, to enable more granular and meaningful insights into the mental health needs of underrepresented groups, while addressing issues of statistical reliability and ethical data suppression.

6.2 Ensuring national surveys and data collections adequately reflect multicultural Australia, with variables and data definitions that are meaningful to CaLD communities.

6.3 Commissioning targeted research to inform service and policy development, including CaLD community needs assessments, service evaluations and intervention studies, emphasising the use of culturally sensitive participatory approaches and co-design.

6.4 Working with services and organisations to build data literacy and infrastructure to enhance CaLD mental health data collection and use.

6.5 Supporting a culture of continuous quality improvement that incorporates CaLD client, carer and community feedback.

1. Introduction

1. Introduction

1.1 Why understanding multicultural mental health in Australia matters

Understanding the mental health of Australia's Culturally and Linguistically Diverse (CaLD) communities is important because of their unique and multifaceted stories, which can have an impact on experiences of mental illness and their access to, and engagement with, mental health services. (19) Such understanding is essential if we are to ensure effective mental health support and equitable access to care for these populations. Mental health is crucial to overall health and wellbeing, and participation in society. Inclusion, which involves working together to dismantle barriers and get services right, is imperative for a successful multicultural Australia for all (20).

1.2 Report background and purpose

In 2013, Minas et al. reported on the state of mental health research and service provision in Australia, specifically focusing on data collection, research coverage and policy implementation as it related to multicultural communities. (21, 22) Their research included a brief review of what is known about mental health in, and mental health service use by, migrant and refugee communities; an examination of national data collections to determine the extent to which relevant cultural variables are included in the collections; and an examination of published mental health research to determine the extent to which migrant and refugee communities are included as participants. (21, 22)

The review findings were highly variable, with fragmented research and mostly small-scale studies. Although there was a broadly consistent pattern of lower rates of utilisation of specialist public mental health services by migrants and refugees, attributed to communication barriers, stigma and systemic exclusion, the absence of adequate population epidemiological data prevented judgments about whether this constituted underuse. There was virtually no data on quality-of-service outcomes. The examination of national data collections revealed multiple gaps. National surveys frequently excluded non-English speakers, and mental health outcomes for CaLD populations were not reliably measured. The examination of articles in four key Australian journals revealed a high rate (9.1%) of specific exclusion from studies (usually due to low English proficiency), alongside widespread neglect of population diversity in study design and reporting. (21, 22) Overall, Minas et al. concluded that, despite Australia's increasingly diverse population, national mental health policies often failed to translate inclusive intentions into actionable programs, leaving CaLD communities under-represented in research and under-served by mental health services. (21, 22) That report made eight recommendations, including improving data collection standards, ensuring inclusive research practices, and developing a multicultural mental health research agenda to foster equity and inclusion across Australia's mental health system. (21, 22)

In 2024, over a decade later, the state of mental health in multicultural Australia was considered “relatively unknown”. Understanding was largely reliant upon anecdotal reports due the absence of contemporary academic literature and formal reports focussed on the topic. Commissioned by Mental Health Australia and funded by the Department of Health, Disability and Ageing under the Embrace Multicultural Mental Health Project (the Embrace Project), this report was designed to help fill this gap. The report aligns with the Australian Government’s commitment to improving mental health supports for priority population groups, including CaLD communities, and improving access and equity for people seeking mental health services. It is intended to be disseminated to the broader mental health and multicultural sectors, wider community and government, to enhance capacity and capability for multicultural mental health and to promote an awareness of how better outcomes can be achieved for multicultural Australia.

This report is based on research conducted over a twelve-month period beginning in late 2024. The research sought to answer two questions:

1. What is known about the state of multicultural mental health in Australia?
2. What are the current and emerging good practices for supporting the mental health of multicultural communities?

1.3 Report structure

The report is divided into six chapters. Chapter 2 provides a brief overview of Australia’s current multicultural landscape to contextualise the research. Chapters 3, 4 and 5 focus on the three research components, each of which had a different objective, outlining their methodology and findings. Additional details relating to each of the components are provided in the appendices. Chapter 6 draws on the findings from all three studies to answer the research questions and concludes with a suite of recommendations designed to enhance government and sector capacity and capability for adopting good practice approaches that support the mental health of CaLD communities. This project could not have been completed without the support and assistance of many organisations and people. A list of acknowledgements is provided at the end of the main report, before the extensive references.

1.4 Research approach

To answer the two questions, our consortium, comprising internationally recognised experts in mental health, public health, epidemiology, biostatistics, and health and social policy, adopted a phased, multi-method research design that drew on the Six Pillars Model of Scientific Knowledge described below. (18)

Stakeholder engagement was guided by an advisory group established in collaboration with Mental Health Australia’s Embrace Project team, which included the Embrace Lived Experience Group, the Embrace Stakeholder Group, and Alliance Partners. In addition, the advisory group included representatives from the NSW Transcultural Mental Health Centre,

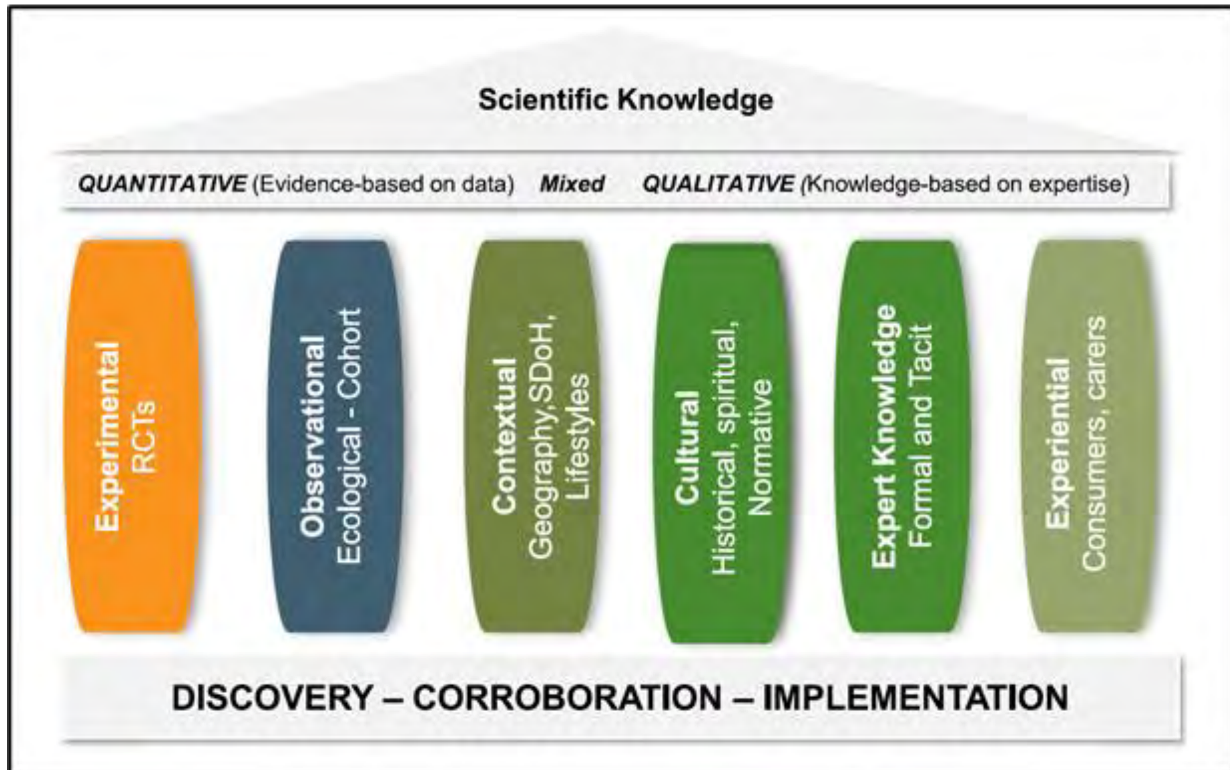
South Western Sydney Primary Health Network, NSW Refugee Health Service, Western Sydney Community Forum, Assyrian Resource Centre, Arab Council of Australia, CORE Community Services, and CASS Care Ltd. Their collective expertise and insights were important in advising the project to enable an inclusive and culturally responsive approach when undertaking the stakeholder consultations.

Six Pillars Model of Scientific Knowledge

The 'six pillars model' is a multi-domain alternative to the traditional Evidence-Based Medicine (EBM) hierarchy, in which scientific knowledge is organised on a one-dimensional pyramid, with low quality-evidence (expert 'opinion' and case studies) at the bottom and high-quality evidence at the top (metanalyses from randomised controlled trials [RCTs]). In this relatively new model, scientific knowledge is represented as a Greek temple supported by six different pillars (domains of knowledge) built on a contextual foundation, with the whole aimed at producing implementation research that is transferable to policy and practice, rather than only ranking study designs.

The model was developed as a response to the difficulties of traditional EBM in addressing the complex problems faced in many areas of health systems and services research, including mental health research. Complex problems require multiple types of knowledge, explicit framing of values and context, and different inferential logics. This calls for a richer classification scheme and representation. (23) As depicted in Figure 1.1, the model has six columns (pillars) representing the main sources or types of knowledge needed to address complex questions, mainly from a real world or realist perspective (i.e., What Works, for Whom, and under What Circumstances?). (24)

Figure 1. The Pillars Model of Scientific Knowledge



[Image adapted from Salvador-Carulla et al., 2017 (18) Cambridge University Press License]

The pillars are interrelated but also distinct sources of information. They cannot be merged into a single dimension, as each contributes a different type of scientific knowledge that must be combined and integrated to build the overall knowledge base needed to answer complex questions under conditions of uncertainty. From left to right, the pillars represent:

1. Experimental evidence (RCTs)
2. Observational evidence (cohort and case-control studies and routine data)
3. Contextual evidence (system, geographic, ecological and service-mapping data)
4. Cultural knowledge (history, narratives, laws, regulations and norms)
5. Expert knowledge (explicitly elicited expert knowledge based on consensus on the prior knowledge base, including classifications, position papers and summaries of available evidence)
6. Experiential/user knowledge (consumer experience, qualitative insights and quantitative-ordinal measures of patient reported outcomes and experiences).

The roof of the temple represents the final aggregated scientific knowledge resulting from the information provided by the different pillars. It also shows the main type of research related to every domain or pillar: predominantly quantitative for the experimental, observational and contextual domain; and predominantly qualitative for the cultural, expert and experience pillars. The roof also refers to purpose and end use, which should include recommendations and guidelines, providing pragmatic decision support for real-world

practice, not only abstract 'best evidence'. The foundation of the temple represents the stage of research: Discovery, Corroboration (confirmation of evidence) or Implementation.

The six pillars model has been used in studies conducted by the Mental Health Policy Unit at the University of Canberra in the fields of mental health, drug and alcohol, chronic care and indigenous health, and in disability research studies in 35 countries. (18, 23-25)

1.5 Research focus and components

Improving multicultural mental health, and ensuring accessible and equitable care, has many aspects. Among them, understanding CaLD community mental health needs and care preferences; developing policy, including health systems and financing arrangements; developing information systems; delivering culturally safe and responsive services and programs; promoting mental wellbeing; and conducting epidemiological, health services, clinical and social research. Given the available resources and time, it was decided to focus this research on understanding patterns of prevalence and service utilisation for common mental disorders, and community-based mental health interventions.[2]

This research had three components:

1. A secondary analysis of the 2020–2022 National Study of Mental Health and Wellbeing (NSMHW), with a focus on the prevalence of 12-month anxiety and affective disorders, associated socio-demographic and health characteristics, and access to mental health services for these conditions. Additional insights were gained by reviewing the Australian Bureau of Statistics (ABS) analysis of linked 2011 Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data.
2. A rapid literature review of Australian studies from 2012 to 2025 that focused on community-based mental health interventions for and with CaLD populations to identify current and emerging good practices that support the mental health of multicultural communities, as well as barriers and enablers. This included assessing cultural adaptations, mental health outcomes, and service user experiences and feedback where available.
3. A series of national consultations with multicultural community members, service providers, and professionals across the health and community sectors aimed at eliciting consensus on the most effective strategies for supporting mental health in CaLD populations. Use of the Nominal Group Technique (NGT) to structure the small group discussions allowed diverse participants to express their perspectives and priorities and consider practical solutions relevant to their context.

[2] This is in no way intended to diminish the importance of hospital-based services and psychosocial support for CaLD community members with severe and disabling mental disorders. Additional research is clearly needed in these areas.

Together, the three components encompass information from all pillars of the six pillars model. (18) The secondary analysis of the 2020–2022 NSMHW contributes observational and contextual evidence, as it draws on large-scale, population-level data to identify patterns and service use within real-world systems. The rapid literature review, which synthesises evidence from empirical studies undertaken in Australia, contributes experimental and observational evidence. Finally, the stakeholder consultations recognise the important role of expert and experiential knowledge, as well as cultural knowledge, by integrating insights from professionals, service providers and individuals with lived experience.

2. A changing multicultural landscape

2. A changing multicultural landscape

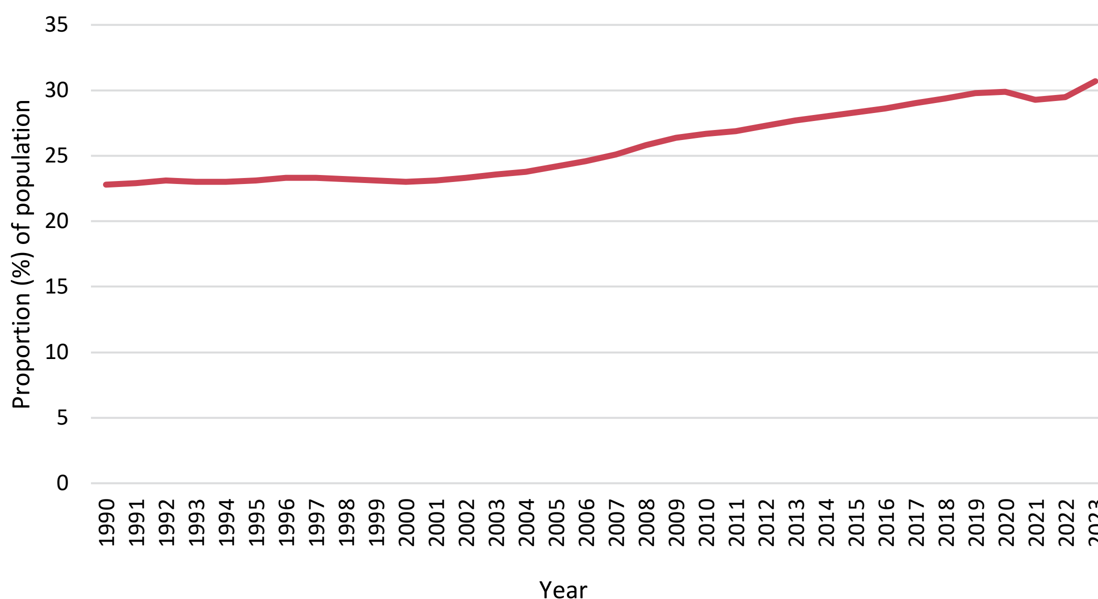
2.1 History of migration to Australia

Australia today is a nation built on rich cultural diversity and grounded in the enduring presence and traditions of Aboriginal and Torres Strait Islander peoples, whose connection to Country spans more than 65,000 years. With 183 Indigenous languages still spoken, this heritage reflects one of the world's oldest and most resilient living cultures. (26, 27) The arrival of British settlers in the late 1700s initiated a long period of colonisation marked by violence, dispossession and systemic marginalisation, and heralded a significant shift in the continent's cultural and social fabric. (28) Despite this, Australia's First Nations peoples have maintained their cultural practices and knowledge systems. (26)

Migration has become a defining feature of Australia's national identity, especially following the Second World War and the dismantling of the White Australia Policy, with the country experiencing multiple waves of migrants from around the world. (29) These waves include: Europeans after WWII, Southeast Asians during the 1970s, Middle Eastern communities in subsequent decades, and more recent arrivals from Africa, South Asia, and Latin America. (29) Each community has contributed unique customs, languages, and traditions, shaping Australia into one of the most vibrant and multicultural societies in the world. (29)

The proportion of overseas-born residents has steadily increased since 1990, exceeding 30% by 2023, as illustrated in Figure 2.1. On 30 June 2024, 31.5% Australians were born overseas and over half (51.5%) had a parent born overseas. (30) The 2021 Census of Population and Housing highlighted the diversity of Australia's CaLD population, which includes communities from a wide array of ethnicities, languages, religions, and cultural traditions. Today, Australia is home to people with more than 300 ancestries. (31) Our increasingly diverse profile has influenced Australian society in profound ways, from policies and politics to language and food, reinforcing migration as both a historical and contemporary force shaping the nation.

Figure 2.1. Proportion of population born outside of Australia
[Figures adapted from ABS, 2023 (30)]



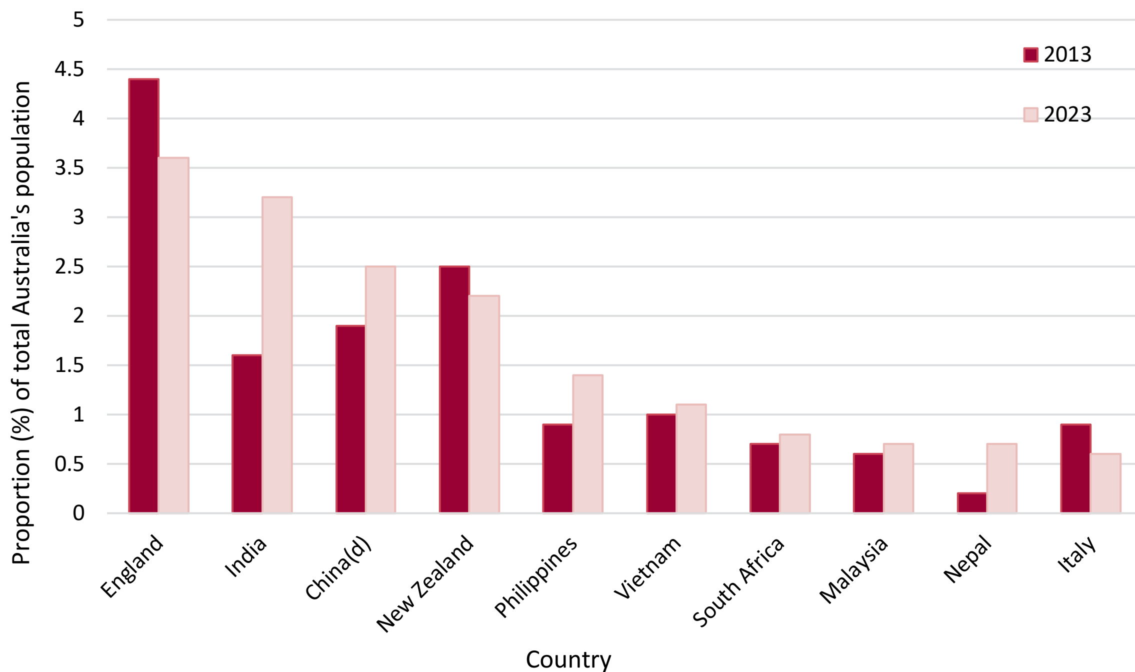
In the mid-1980s, the Australian government restructured the Migration Program into three distinct streams: family, skilled, and humanitarian. This significantly altered the composition of migration. Skilled migration rose sharply, accounting for only 15% of permanent migration in 1984–85 but increasing to 62% by 2015–16. In contrast, humanitarian migration declined from 21% to 8% over the same period. (32) Moreover, policy measures aimed at 'regionalising' migration were introduced to distribute population growth more evenly across the country. These initiatives led to an increasing proportion of CaLD communities settling in regional areas. (33)

2.2 Contemporary migration trends (1990–present)

Decades of evolving immigration policy are reflected in the changing composition of Australia's overseas-born population. While England remains the largest country of birth among migrants, this number has declined from its peak of over one million in 2013. India has now become the second-largest source of overseas-born group, followed by China and New Zealand. (30) Collectively, these four countries account for more than one-third of Australia's overseas-born population. (30)

Over the decade between 2013 and 2023, migrants from India recorded the largest net increase followed by China, Nepal and the Philippines, (30) underscoring a broader trend towards greater migration from Asian countries. As shown in Figure 2.2, there has been a steady decline in the proportion of England-born residents, accompanied by a notable rise in migrants from South and Southeast Asia, further enriching Australia's multicultural fabric.

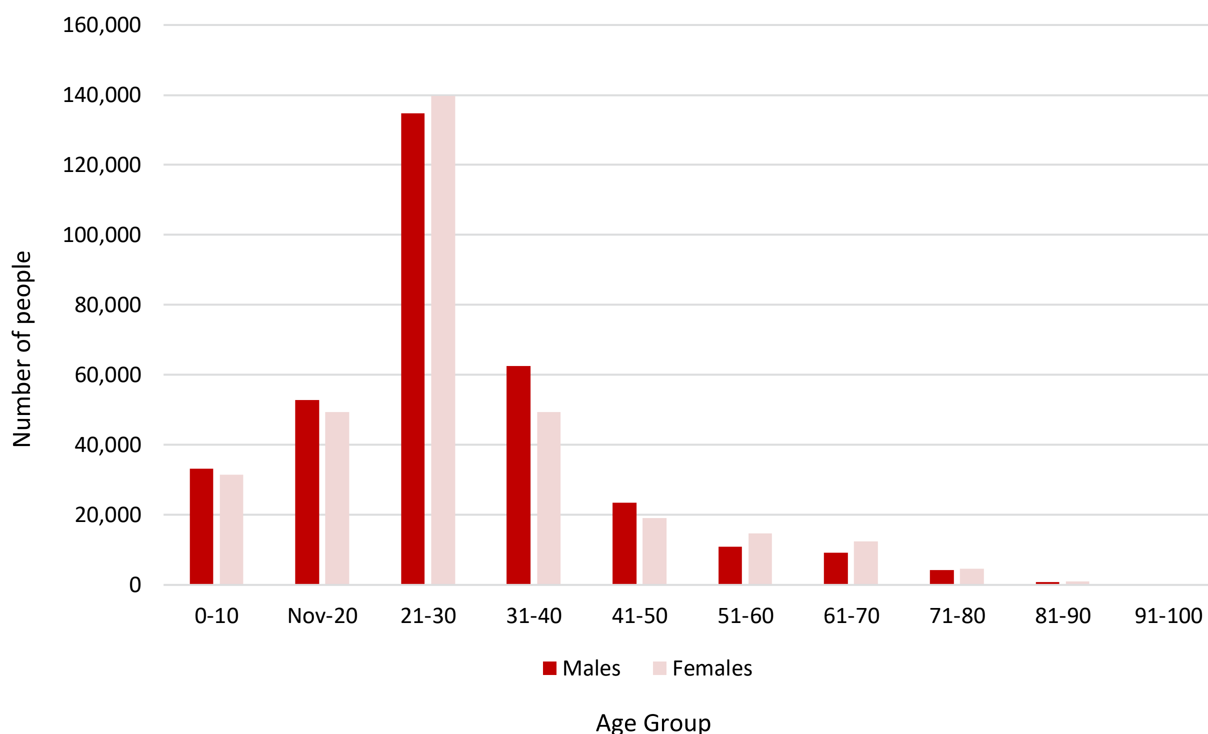
Figure 2.2. Proportion of population born overseas by country of birth in 2014 vs. 2023 [Figures adapted from ABS, 2023 (30)]



The change in migration patterns reflects both the ongoing trends in skilled migration and the increasing significance of the student visa pathway as a route to permanent residency. Today, Australia's CaLD population comprises a wide range of groups, including temporary migrants such as international students and skilled workers, refugees and asylum seekers settled through Humanitarian Support Programs, as well as permanent residents born overseas. (34)

The population age structure reveals the impact of different migration waves over time. Older, well-established communities reflect migration patterns following the Second World War, with Greek-born Australians having a median age of 76 years and Italian-born Australians 73 years, as of 2023. (30) In contrast, newer migrant communities tend to be significantly younger, exemplified by the Nepalese-born population, which has a median age of just 29 years. (30) The overseas-born population is predominantly concentrated in working-age brackets, with the largest segment aged 35 to 39 years (3.1%) and strong representation across the 25 to 39 years age range. As illustrated in Figure 2.3, migration data from 2023–2024 clearly highlight this age distribution, showing the highest concentration of both male and female migrants within the 21 to 30-year-old group. (35)

Figure 2.3. Migrant arrivals in 2023–24 financial year by age and gender [Figures adapted from ABS, 2024 (35)]



International students have become a significant part of Australia's multicultural landscape, both demographically and socially. In 2023–24 alone, there were approximately 207,000 temporary student arrivals, making up 46.4% of net overseas migration. (35) The largest groups came from China, India, Nepal, Vietnam, and the Philippines. (36) For many, study in Australia is a pathway to skilled migration and permanent residency, while for others it represents a temporary but formative life stage. International students are typically younger, concentrated in urban centres, and often experience distinct challenges such as financial stress, precarious housing, academic pressure, limited social support networks, and barriers to accessing health and mental health services. (37, 38) These factors position international students as a distinct and emerging sub-group within Australia's CaLD populations, highlighting the evolving nature of multicultural communities within Australia.

2.3 Religious and linguistic diversity

This demographic transformation has been accompanied by profound changes in the religious and linguistic landscapes, with both becoming increasingly diverse. According to the 2021 census, around 10% of the population identify with a religion other than Christianity, primarily Islam, Hinduism, and Sikhism. (39) This shift reflects broader demographic and cultural changes, including migration patterns and secularisation. Between 2011 and 2021, the proportion of people identifying as Christian declined significantly, from 61.1% to 43.9%,

while the number of people reporting no religious affiliation increased from 23.1% to 38.9%. This shift reflects evolving migration patterns, with over one-third of migrants identifying with non-Christian religions since 1996, compared to predominantly Christian arrivals prior to 1996. (39) The fastest-growing religion since the previous census was Yezidism, which surged from around 60 adherents in 2016 to over 4,000 in 2021. (39)

Australia's linguistic landscape has also evolved. As of 2021, 5.8 million people (22.8%) reported using a language other than English at home, up from 4.9 million (21.6%) in 2016. (40) Australia's multilingual population doubled in size during the first two decades of the 21st century, with particularly rapid growth among younger generations.

Languages other than English are predominantly spoken by first-generation Australians (i.e., those born overseas), who make up 71.8% of those speaking a non-English language at home. (40) Among Australian-born speakers of languages other than English, most have at least one parent born overseas, and nearly half are children under 15 years old, highlighting the intergenerational continuity of language use. Reflecting recent migration trends, Mandarin and Arabic remain the most commonly spoken languages after English, while Punjabi showed the fastest growth, increasing by 80.4% between 2016 and 2021.

Table 1 provides a detailed breakdown of the five most common languages spoken in Australia other than English, highlighting both their prevalence and varying levels of English proficiency across different language groups. Among 5.8 million people who spoke a language other than English at home, 3.4% reported speaking English either not well or not at all. (40)

Table 1. Most commonly spoken languages in Australia [Table adapted from ABS, 2022 (40)]

Language	Number of people who used that language at home	Proportion of Australia's population (%)	Proportion of those who use that language with a low English proficiency (%)
Mandarin	685,274	2.7	25.9
Arabic	367,159	1.4	15.3
Vietnamese	320,758	1.3	30.5
Cantonese	295,281	1.2	23.7
Punjabi	239,033	0.9	8.8

Among those with limited English proficiency, 80.4% were born overseas, and more than half (59.2%) have lived in Australia for over ten years, indicating ongoing language barriers for some long-term residents. Certain language groups in Australia report significantly higher rates of low English proficiency which can represent a significant barrier in accessing mental health services.

As shown in Table 2, communities such as Khmer, Vietnamese, Hazaraghi, Chaldean Neo-Aramaic, and Assyrian Neo-Aramaic speakers report some of the highest proportions of low

English proficiency, ranging from 26% to over 32%. Even amongst those with proficiency of English for everyday use, this may not be the case when it comes to mental health encounters and communicating emotions or sensitive issues. (41)

Table 2. Top 10 languages with the highest proportion of speakers with low English proficiency, 2021 [Table adapted from ABS, 2022 (40)]

Language*	Persons who used language at home (count)	Persons with low English proficiency (count)	Proportion with low English proficiency (%)**
Khmer	40,037	12,909	32.5
Vietnamese	320,758	97,176	30.5
Hazaraghi	41,678	12,478	30.2
Chaldean Neo-Aramaic	21,684	6,322	29.3
Korean	115,531	31,018	27.0
Assyrian Neo-Aramaic	38,534	10,189	26.6
Mandarin	685,274	175,716	25.9
Burmese	18,849	4,644	24.8
Dari	29,828	7,048	23.8
Cantonese	295,281	69,625	23.7

*Out of 50 largest non-English languages in Australia, who speak English not well or not at all.
**This excludes people who did not state English language proficiency

3. Secondary analysis of national survey

3. Secondary analysis of national survey

We undertook a secondary analysis of the 2020–2022 National Study of Mental Health and Wellbeing (NSMHW) focusing on the prevalence of 12-month anxiety and affective disorders, associated socio-demographic and health characteristics, and related mental health service use. Findings indicated higher prevalence rates among Australian-born individuals, however differing patterns of mental health service use suggested disparities in access and engagement for overseas-born individuals. Additional insights were gained by reviewing the ABS analysis of linked 2011 Medicare and Pharmaceutical Benefits data (reported in 2016), undertaken to understand patterns of subsidised mental health services and prescription medication use among different CaLD groups. Very broadly, that study found Australian and overseas-born individuals who spoke English at home consistently exhibited higher rates of service and medication use. In contrast, those born in Asian countries had lower usage rates. However, the patterns varied depending on whether the groups were defined by country of birth, language spoken at home, or a combination of both. Taken together, these findings highlight the challenges in understanding the prevalence of mental health disorders and related health service use among CaLD Australians. These difficulties arise largely due to how we define the groups of interest but also the types of mental health indicators we chose and sampling methods. Further work is urgently needed with detailed consideration by experts, including those with lived experience, of key variables and measures so as to best reflect important issues in multicultural mental health. Oversampling in large-scale surveys is clearly warranted, as is greater attention to currently excluded and under-represented groups. Given the complexity of national datasets and data linkage, future research requires dedicated resourcing and time to allow for detailed insights.

3.1 Objective

International and Australian research has shown that immigrant populations are at increased risk of elevated rates of mental health disorders, (42-44) yet tend to access specialist public mental health services less frequently than the host country population. (45, 46) The objective here was to examine national datasets, specifically the 2020–2022 National Study of Mental Health and Wellbeing (NSMHW), to estimate the prevalence of mental illness and identify associated risk and protective factors (focusing on anxiety and affective disorders[3]) and analyse patterns of mental health service use among Australia's CaLD population.

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[3] Australian Institute of Health and Welfare. Prevalence and impact of mental illness. Canberra, Australia. May 2025 Available from: https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness

3.2 Methods

The 2020–2022 NSMHW is considered a nationally representative survey of Australians aged 16 to 85 years, living in private dwellings across all states and territories. (47-50) It is one of the suites of health surveys conducted periodically by the ABS, with the sampling frame based on the ABS Master Address File. Data were collected in two waves, the first between December 2020 and July 2021, and the second from December 2021 to October 2022, resulting in a combined sample of nearly 16,000 respondents. While most interviews were conducted face-to-face, video interviews were employed when COVID-19 restrictions were in place. Appendix A describes the NSMHW sampling method and data collection tools. (48, 51-55)

The statistical analyses employed in this secondary analysis of the NSMHW data are outlined below. Outcome variables included 12-month prevalence of anxiety and affective (mood) disorders, and respondents' consultations with different types of health professionals for their mental health in the previous 12 months. Covariates included social-demographic and health related characteristics such as such as age, sex, marital status, education, employment, geographic remoteness, self-rated general health, and disability. Also, language spoken at home, English proficiency, and region of birth and year of arrival in Australia for the overseas-born. Table A1 in Appendix A provides the covariate details.

We also reviewed findings from the ABS analysis of the 2011 Mental Health Services–Census Integrated Dataset, which were published in 2016, and report on these in our discussion. This dataset includes actual service use data related to subsidised mental health services and prescription medications, as captured through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). (56) As far as we are aware, this type of study has not been repeated.

3.3 Statistical analyses

Exploratory data analysis was conducted to examine the distribution (percentages and frequency counts) of potential confounding factors, including socio-demographic and health characteristics, comorbidities, and mental health service utilisation, by place of birth (overseas born and Australian born) as reported in Table 3.1. Cross-tabulations were used to estimate the weighted prevalence and 95% confidence intervals (CIs) for any 12-month anxiety and affective disorders across explanatory variables (those described in Table 3.1) and mental health service use data.

This study employed three different logistic regression models for each group: overseas born and Australian born. Because our primary interest was in understanding patterns of association with key mental health outcomes within each group, we did not test for significant differences between groups.

In the first model, for each mental disorder (12-month anxiety and affective disorders), associations were initially examined using odds ratios[4] (ORs) in univariate analyses. A survey-weighted multiple logistic regression model was then applied using a manual elimination approach. Only variables with a univariate p-value ≤ 0.20 (51) were selected for inclusion in the multivariable model. Variables that remained statistically significant ($p < 0.05$) were retained in the final model. Both unadjusted and adjusted ORs from the logistic regression models are presented with 95% CIs.

In the second model, univariate binary logistic regression analyses were conducted to assess associations between each mental disorder and key explanatory variables. These included sex, gender, age group, remoteness, region of birth (for the overseas born), socio-economic levels, and consultation with health professionals for mental health, among others. Analyses were stratified by place of birth.

In the final (third) analyses, multiple logistic regression models were fitted for each mental disorder (treated as binary variables), adjusting simultaneously for the same set of explanatory variables. Unadjusted and adjusted ORs with 95% CIs were also reported.

All weighted analyses were conducted using the survey weights provided by the ABS. (48) Data analysis was performed in R (Version 4.3.0; R Core Team, 2023), using the survey package (57), within the ABS secure DataLab environment.

3.4 Results

The present analysis included approximately 19.8 million participants (weighted total) aged 16 years and over. Both weighted and unweighted proportions were reported separately for overseas-born and Australian-born populations. Table 3.1 presents key socio-demographic and other characteristics of the study population broken down for the two groups.

[4] An odds ratio compares how likely an event is to happen in one group compared to a reference group, for example, if females are the reference group and the odds ratio for males is 2.0, it means males are twice as likely to experience the outcome being measured. An *adjusted odds ratio* accounts for other variables in the model such as age.

Table 3.1. Socio-demographic and health characteristics and mental health service use by place of birth (N =19,821,845)

Variable characteristics	Overseas born				Australia born			
	n	%	n *	%	n	%	n *	%
Demographics								
Sex at birth								
Female	2715	51.8	3288117	49.8	5721	54.0	6774289	51.2
Male	2517	48.0	3307960	50.1	4876	46.0	6451479	48.8
Non-binary	#	#	#	#	41	0.4	58506	0.4
Sexual orientation								
Bisexual	43	0.8	44439	0.7	237	2.3	322345	2.4
Gay or lesbian	89	1.7	80032	1.2	225	2.1	223943	1.7
Heterosexual	5039	97.4	6478109	98.1	10031	95.6	12679480	95.9
Gender identity								
Cisgender	5167	98.6	6502424	98.5	10504	98.8	13042230	98.6
Transgender	73	1.4	100156	1.5	132	1.2	183538	1.4
Age categories								
16-25	398	7.6	598995	9.1	1412	13.3	2433156	18.4
26-45	2154	41.1	2800878	42.4	3296	31.0	4308942	32.6
46-65	1435	27.4	2011124	30.5	3174	29.8	4129046	31.2
66-85	1257	24.0	1191583	18.0	2767	26.0	2354623	17.8
Marital status								
Married	2896	55.2	4136632	62.7	4371	41.0	6042546	45.7
Never married	1298	24.8	1586550	24.0	3883	36.5	5232122	39.6
Separated/divorced/widowed	1050	20.0	879397	13.3	2395	22.5	1951101	14.8
Region of birth								
Americas	297	5.7	353265	5.4				
North-East Asia	572	10.9	820709	12.4				
North-West Europe	1364	26.0	1444042	21.9				
North Africa and Middle East	218	4.2	306097	4.6				
Oceania and Antarctica	514	9.8	623798	9.4				
South-East Asia	640	12.2	875197	13.3				
Southern and Central Asia	890	17.0	1254716	19.0				
Southern and Eastern Europe	443	8.4	518122	7.8				
Sub-Saharan Africa	306	5.8	406633	6.2				
Year of arrival to Australia								
Arrived before 2002	2655	50.6	3049207	46.2				
Arrived 2002 - 2011	1315	25.1	1754964	26.6				
Arrived 2012 - 2022	1274	24.3	1798410	27.2				
Main language spoken at home								
English	3431	65.4	3839543	58.2	10506	98.7	13007679	98.4
Other languages	1813	34.6	2763037	41.8	143	1.3	218089	1.6
Proficiency in English (when main language spoken at home is not English)								
Not applicable	3431	65.4	3839543	58.2	10506	98.7	13007679	98.4
Not at all/not well	186	3.5	515397	7.8	#	#	#	#
Well	805	15.4	1183699	17.9	11	0.1	13756	0.1
Very well	822	15.7	1063941	16.1	131	1.2	201028	1.5
Education attainment								
Did not complete high school/unknown	707	13.5	1159558	17.6	2450	23.0	3721654	28.1
Year 12 or equivalent	676	12.9	1108372	16.8	1385	13.0	2342724	17.7

Advanced diploma/diploma/certificate	1346	25.7	1465857	22.2	3607	33.9	3897419	29.5
Bachelor's degree or above	2515	48.0	2868794	43.4	3207	30.1	3263971	24.7
Socio-economic indexes for areas (SEIFA)								
1st quintile (most disadvantaged)	717	13.7	953352	14.4	1678	15.8	2190115	16.6
2nd quintile	997	19.0	1230392	18.6	2025	19.0	2494405	18.9
3rd quintile	1057	20.2	1257566	19.0	2127	20.0	2758644	20.9
4th quintile	1310	25.0	1615780	24.5	2502	23.5	3043636	23.0
5th quintile (most advantaged)	1163	22.2	1545490	23.4	2317	21.8	2738968	20.7
Accessibility/remoteness index of Australia (ARIA)								
Inner regional	423	8.1	484806	7.3	2203	20.7	2865776	21.7
Major cities	4604	87.8	5858138	88.7	7436	69.8	8948373	67.7
Outer regional/remote	217	4.1	259636	3.9	1010	9.5	1411619	10.7
Participation in employment/study								
Fully engaged	2765	52.7	3529100	53.5	5181	48.7	6841637	51.7
Partially engaged	877	16.7	1079364	16.3	1944	18.3	2443777	18.5
No study or employment	1602	30.5	1994117	30.2	3524	33.1	3940354	29.8
Labour force participation								
Employed	3457	65.9	4286070	64.9	6820	64.0	8687258	65.7
Not in the labour force	1674	31.9	2093056	31.7	3617	34.0	4134552	31.3
Unemployed	113	2.2	223455	3.4	212	2.0	403958	3.1
Health related characteristics								
Trauma event								
Interpersonal trauma	143	67.1	4515839	68.4	358	67.9	9021537	68.2
Non-interpersonal trauma	70	32.9	2086741	31.6	169	32.1	4204231	31.8
Self-rated health								
Excellent	1090	20.8	1348411	20.4	1994	18.7	2617356	19.8
Very good	1842	35.1	2309138	35	3928	36.9	4898222	37.0
Good	1563	29.8	2009814	30.4	3037	28.5	3615287	27.3
Poor	214	4.1	269441	4.1	414	3.9	550308	4.2
Kessler Psychological Distress Scale (10-item)								
Low distress	3532	67.5	4428776	67.1	6625	62.3	7930300	60
Moderate distress	1041	19.9	1296633	19.6	2337	22	2854530	21.6
High or very high distress	659	12.6	877172	13.3	1677	15.8	2440938	18.5
Disability status								
No/mild disability	4858	93.4	6167431	93.4	9586	90.8	11952075	90.4
Moderate disability	277	5.3	342440	5.2	787	7.5	1033218	7.8
Severe/extreme disability	66	1.3	92710	1.4	189	1.8	240475	1.8
Health service use for mental illness								
Mental health hospitalisation (admitted overnight or longer)								
No	5224	99.6	6575212	99.6	10570	99.3	13136038	99.3
Yes	20	0.4	27369	0.4	79	0.7	89730	0.7
Mental health professional								
No	4594	87.6	5840961	88.5	8556	80.4	10563152	79.9
Yes	649	12.4	761619	11.5	2088	19.6	2662615	20.1
General practitioner								
No	380	7.2	504224	7.6	475	4.5	612878	4.6
Yes	4864	92.8	6098356	92.4	10174	95.5	12612889	95.4
Psychiatrist								
No	4811	91.7	6091126	92.3	9260	87.0	11466985	86.7
Yes	433	8.3	511455	7.7	1389	13.0	1758783	13.3
Psychologist								

No	4260	81.2	5472594	82.9	7519	70.6	9379931	70.9
Yes	984	18.8	1129986	17.1	3130	29.4	3845837	29.1
Other mental health professional								
No	4643	88.5	5913273	89.6	8602	80.8	10584052	80.0
Yes	601	11.5	689307	10.4	2047	19.2	2641716	20.0
Other health professional								
No	1696	32.3	2296971	34.8	2492	23.4	3453912	26.1
Yes	3548	67.7	4305609	65.2	8157	76.6	9771856	73.9

Respondent characteristics

Female representation was slightly higher among the Australian born (54.0%) than the overseas born (51.8%), while non-binary identification was minimal across both groups. Overseas-born participants were more likely to identify as heterosexual (97.4%) compared to the Australian-born participants (95.6%), with higher proportions of bisexual and gay/lesbian identities among the latter. The age distribution of the two participant groups was similar in the older categories but differed among younger age groups. A higher proportion of Australian-born individuals were in the 16–25 age group (13.3% vs. 7.6%), while overseas-born participants were more represented in the 26–45 age group (41.1% vs. 31.0% for Australian born). Marital status also differed, with overseas-born participants more likely to be married (55.2%) and the Australian-born participants more likely to be never married (36.5%) or separated/divorced/widowed (22.5%). In terms of language use at home, 34.6% of the overseas born spoke a language other than English, compared to only 1.3% of the Australian born. Among the former group, 3.5% reported speaking English not at all or not well.

Region of birth demonstrated a notable representation of overseas-born participants from Europe and Asia. More specifically, the largest proportion originated from North-West Europe (26.0%), followed by Southern and Central Asia (17.0%), South-East Asia (12.2%), and North-East Asia (10.9%). Smaller proportions were born in Southern and Eastern Europe (8.4%), Oceania and Antarctica (9.8%), Sub-Saharan Africa (5.8%), the Americas (5.7%), and North Africa and the Middle East (4.2%). Over half of the overseas-born participants migrated to Australia before 2002, while approximately 25% arrived between 2002–2011 and another 25% between 2012–2022.

Educational attainment was higher among the overseas born in the NSMHW, with 48.9% holding a bachelor's degree or above, compared to 30.6% of the Australian-born, who had higher rates of no formal qualifications (35.4%). Socio-economic status, as measured by SEIFA, showed a comparable distribution between overseas-born and Australian-born participants for most quintiles. For instance, 22.2% of overseas-born individuals and 21.8% of Australian-born individuals were in the least disadvantaged quintile. A slightly lower proportion of overseas-born individuals (13.7%) were in the most disadvantaged quintile, compared to 15.8% of Australian-born participants. In terms of geographic distribution, overseas-born

participants were more likely to reside in major cities (87.8%) than the Australian-born (69.8%). Employment and study engagement was slightly higher among the overseas-born (52.7% fully engaged), while Australian-born individuals had higher rates of no engagement (33.1%). Labour force participation was similar across groups, though unemployment was slightly higher among the Australian-born participants (2.2% vs. 2.0%).

Self-rated health was comparable for both groups, with slightly more overseas-born individuals reporting excellent health (20.8% vs. 18.7%). Psychological distress, measured by the Kessler scale, was higher among the Australian-born (15.8% reporting high or very high distress) than the overseas-born (12.6%). Disability prevalence was marginally higher among the Australian-born, particularly for moderate and severe disability. Mental health service utilisation was consistently higher among Australian-born participants, including contact with mental health professionals (19.6% vs. 12.4%), psychologists (29.4% vs. 18.8%), and psychiatrists (13.0% vs. 8.3%). General practitioner (GP) use for mental health was very high across both groups, though slightly higher among the Australian-born participants (95.5% vs. 92.8%).

Prevalence of individual 12-month DSM-IV mental health disorders for overseas-born, Australian born and overall sample

As shown in Table 3.2, the overseas born had consistently lower 12-month prevalence rates for all categories of mental disorder examined: anxiety disorders, affective (mood) disorders, and any mental disorder[5]. Specifically, 8.8% of Australian-born individuals met criteria for a 12-month affective disorder, almost double the 4.6% observed among those born overseas. For anxiety disorders, 18.5% of Australian-born individuals were affected, compared to 10.3% of overseas-born individuals. Overall, the contrast was most pronounced when considering any 12-month mental disorder: 23.7% of Australian-born individuals met diagnostic criteria, compared to just 13.3% of those born overseas.

[5] ‘12-month any disorder’ refers to the percentage of people aged 16–85 who met diagnostic criteria for at least one mental disorder (including anxiety, affective or substance use disorders) during the previous 12 months.

Table 3.2. Prevalence of 12-month mental disorders by place of birth

Mental disorder categories	Overseas born (%)*	Australia born (%)*	Overall sample (total) (%)*
12-month anxiety disorders			
Generalised anxiety disorder	1.8 (1.5, 2.2)	4.3 (3.8, 4.9)	3.5 (3.1, 3.9)
Panic disorder	1.4 (1.1, 1.8)	3.4 (2.8, 3.9)	2.7 (2.4, 3.1)
Agoraphobia with/without panic disorder	1.1 (0.6, 1.5)	2.8 (2.4, 3.2)	2.2 (1.9, 2.6)
Social anxiety disorder	3.9 (3.3, 4.5)	9.6 (8.9, 10.4)	7.7 (7.1, 8.3)
Obsessive-compulsive disorder	3.1 (2.5, 3.6)	4.8 (4.3, 5.3)	4.2 (3.9, 4.6)
Posttraumatic stress disorder	2.5 (2.0, 3.0)	4.8 (4.3, 5.3)	4.0 (3.6, 4.4)
Any anxiety disorder	10.3 (9.2, 11.4)	18.5 (17.5, 19.4)	15.7 (15.0, 16.5)
12-month affective (mood) disorders			
Major depressive disorder	4.2 (3.5, 4.9)	7.4 (6.8, 8.0)	6.3 (5.9, 6.8)
Dysthymia	1.2 (0.8, 1.5)	1.9 (1.6, 2.1)	1.6 (1.4, 1.9)
Bipolar disorder	0.3 (0.1, 0.4)	1.3 (0.9, 1.6)	0.9 (0.7, 1.2)
Any affective disorder	4.6 (3.9, 5.3)	8.8 (8.2, 9.5)	7.4 (6.9, 7.9)
Any 12-month mental disorder [6]	13.3 (12.1, 14.5)	23.7 (22.8, 24.7)	20.3 (19.5, 21.0)

%*=Weighted prevalence

Prevalence of 12-month mental health disorders categorised by year of arrival in those born overseas

Table 3.3 illustrates prevalence of 12-month mental health disorders categorised by year of arrival in those born overseas. As noted previously, prevalence rates were significantly higher among Australian-born individuals compared to those born overseas across all categories examined. For those born overseas, individuals who arrived before 2002 had a prevalence of 5.9% for any 12-month mental disorder, while those who arrived between 2002–2011 and 2012–2022 had substantially lower rates (3.7% for both groups). This trend was consistent across both anxiety and affective disorders. These findings suggest that more recent migrants report fewer mental health issues than both earlier arrivals and Australian-born individuals.

[6] '12-month any disorder' refers to the percentage of people aged 16–85 who met diagnostic criteria for at least one mental disorder (including anxiety, affective, or substance use disorders) during the previous 12 months.

Table 3.3. Prevalence of 12-month mental disorders stratified by birthplace and arrival period

Mental Disorders	Birthplace		Year of arrival to Australia		
	Born in Australia	Born overseas	Arrived before 2002	Arrived 2002 – 2011	Arrived 2012 – 2022
Any 12-month anxiety disorder	18.5	10.3	4.7	2.7	3.0
Any 12-month affective disorders	8.8	4.6	2.3	1.2	1.1
Any 12-month mental disorder	23.7	13.3	5.9	3.7	3.7

%*=Weighted prevalence

Comparison of factors associated with 12- month anxiety disorders and mental health service use, broken down by birthplace

Table 3.4 shows the similarities and differences in factors significantly associated with 12-month anxiety disorders by place of birth, as well as in patterns of mental health service use.

Predictors of 12-month anxiety disorder

Gender and age significantly influenced the odds of experiencing a 12-month anxiety disorder in the adjusted models for both groups. Males had lower odds compared to females, being 15% less among overseas-born (adjusted OR = 0.85, 95% CI: 0.82-0.89) and 37% less among Australian-born individuals (adjusted OR = 0.63, 95% CI: 0.61-0.64). Age showed a similar protective effect. For overseas-born respondents, odds were 43% lower for those aged 26–45 (adjusted OR = 0.57, 95% CI: 0.54-0.61) and up to 66% lower for those aged 66–85 (adjusted OR = 0.32, 95% CI: 0.29-0.36) compared with the youngest group (16–25 years). For Australian-born respondents, the reduction ranged from 46% (ages 26–45; adjusted OR = 0.54, 95% CI: 0.52-0.56) to 76% (ages 66–85; adjusted OR = 0.24, 95% CI: 0.23-0.25).

Sexual orientation was a significant factor, with individuals identifying as gay or lesbian exhibiting higher odds of anxiety disorders compared to their heterosexual counterparts. This association was evident across both groups, equating to 34% increased odds among the overseas-born (adjusted OR = 1.34, 95% CI: 1.19–1.51) and a 93% increase among the Australian-born (adjusted OR = 1.93, 95% CI: 1.82–2.04). Marital status also influenced risk, with individuals who had never married more likely to experience an anxiety disorder than those who were married (adjusted OR = 1.48, 95% CI: 1.41–1.55 for overseas-born; adjusted OR = 1.07, 95% CI: 1.04–1.10 for Australian-born).

Migrants who arrived in Australia between 2012 and 2022 had 24% higher odds of experiencing a 12-month anxiety disorder compared to those who arrived before 2002 (adjusted OR = 1.24, 95% CI: 1.16-1.32).

For both groups, the odds of a 12-month anxiety disorder were significantly higher among individuals who reported poor self-rated health than those who reported excellent self-rated health (adjusted OR = 1.21, 95% CI: 1.04–1.40 for overseas born and adjusted OR = 1.10, 95% CI: 1.03–1.17 for Australian-born). Psychological distress was also significantly associated with anxiety, with individuals reporting high or very high distress having markedly increased odds compared to those with low distress (adjusted OR = 6.35, 95% CI: 6.00–6.66 for overseas-born; adjusted OR = 7.04, 95% CI: 6.81–7.28 for Australian-born). Individuals living with a moderate disability were more than twice as likely to experience an anxiety disorder compared to those with no or mild disability (adjusted OR = 2.19, 95% CI: 2.03–2.35 for overseas-born; adjusted OR = 2.21, 95% CI: 2.14–2.29 for Australian-born).

Patterns of mental health service use

Among Australian-born individuals, those with a 12-month anxiety disorder had 57% greater odds of consulting a mental health professional compared to their counterparts (adjusted OR = 1.57, 95% CI: 1.53–1.61). Similarly, overseas-born individuals with an anxiety disorder had 49% higher odds of a consulting a mental health professional than their counterparts (adjusted OR = 1.49, 95% CI: 1.42–1.57). A similar pattern was noted for consulting a GP, with individuals with an anxiety disorder more likely to seek help than others (adjusted OR = 1.18, 95% CI: 1.10–1.26 for Australian born; adjusted OR = 1.14, 95% CI: 1.05–1.23 for overseas born).

The proportion of overseas-born individuals with a 12-month anxiety disorder who reported consulting either a psychiatrist or a psychologist was higher than for those who did not seek such care, and these figures exceeded those reported by Australian-born respondents. Overseas-born individuals with an anxiety disorder had 57% higher odds of seeing a psychiatrist (adjusted OR = 1.51, 95% CI: 1.44–1.59) and were nearly three times more likely to see a psychologist (adjusted OR = 2.74, 95% CI: 2.61–2.88). In comparison, Australian-born individuals with an anxiety disorder had 29% higher odds of consulting with psychiatrist (adjusted OR = 1.29, 95% CI: 1.25–1.33) and were twice as likely to consult a psychologist (adjusted OR= 2.01, 95% CI: 1.97–2.06).

Table 3.4. Prevalence, univariate, and multivariate analyses of 12-month anxiety disorder by place of birth

Characteristics variables	Overseas born			Australia born		
	Pr (95%CI)	OR (95%CI)	AOR (95%CI)	Pr (95%CI)	OR (95%CI)	AOR (95%CI)
Demographics						
Gender						
Female	11.9 (11.7, 12.1)	1.00	1.00	22.5 (22.3, 22.7)	1.00	1.00
Male	8.6 (8.4, 8.8)	0.70 (0.68, 0.72)	0.85(0.82, 0.89)	13.7 (13.5, 13.8)	0.55 (0.54, 0.56)	0.63(0.61, 0.64)
Sexual orientation						
Heterosexual	9.9 (9.8, 10.1)	1.00	1.00	16.6 (16.5, 16.8)	1.00	1.00
Gay or lesbian	23.6 (21.7, 25.5)	2.80 (2.50, 3.13)	1.34(1.19, 1.51)	39.9 (38.8, 41.0)	3.33 (3.18, 3.48)	1.93(1.82, 2.04)
Bisexual	27.5 (25.5, 29.5)	3.43 (3.10, 3.79)	0.79(0.69, 0.92)	61.0 (59.9, 62.1)	7.83 (7.45, 8.22)	2.01(1.87, 2.16)
Gender identity						
Cisgender	10.3 (10.1, 10.4)	1.00		18.2 (18.0, 18.3)	1.00	1.00
Transgender	11.7 (10.6, 12.8)	1.16 (1.02, 1.31)		39.0 (37.8, 40.3)	2.89 (2.73, 3.05)	1.19(1.07, 1.31)
Age in categories						
16-25	17.5 (17.0, 18.0)	1.00	1.00	31.2 (30.8, 31.6)	1.00	1.00
26-45	10.9 (10.7, 11.1)	0.63(0.59, 0.67)	0.57(0.54,0.61)	21.7 (21.5, 21.9)	0.61 (0.60, 0.62)	0.54(0.52, 0.56)
46-65	9.8 (9.5, 10.1)	0.56(0.52, 0.61)	0.51(0.47,0.55)	13.8 (13.5, 14.0)	0.35 (0.34, 0.36)	0.37(0.35, 0.38)
66-85	6.0 (5.8, 6.3)	0.37(0.33, 0.41)	0.32(0.29,0.36)	7.6 (7.4, 7.8)	0.18 (0.18, 0.19)	0.24(0.23, 0.25)
Marital status						
Married	7.8 (7.6, 8.0)	1.00	1.00	11.8 (11.7, 12.0)	1.00	1.00
Separated/divorced/widowed	11.4 (11.2, 11.7)	1.53 (1.47, 1.59)	1.11(1.06, 1.17)	17.3 (17.0, 17.6)	1.56 (1.52, 1.60)	0.99(0.96, 1.03)
Never married	16.2 (15.9, 16.5)	2.29 (2.21, 2.38)	1.48(1.41, 1.55)	26.6 (26.3, 26.9)	2.71 (2.65, 2.76)	1.07(1.04, 1.1)
Region of birth						
North-West Europe	12.7 (12.4, 13.0)	1.00				
Oceania and Antarctica	15.5 (14.9, 16.0)	1.25 (1.19, 1.32)				
Southern and Eastern Europe	9.7 (9.3, 10.2)	0.74 (0.69, 0.79)				
North Africa and Middle East	10.9 (10.3, 11.4)	0.83 (0.78, 0.89)				
South-East Asia	8.8 (8.4, 9.1)	0.66 (0.62, 0.70)				
North-East Asia	7.3 (6.9, 7.6)	0.54 (0.50, 0.57)				
Southern and Central Asia	6.2 (6.0, 6.5)	0.45 (0.43, 0.48)				

Americas	15.6 (15.0, 16.3)	1.27 (1.21, 1.32)				
Sub-Saharan Africa	11.3 (10.8, 11.8)	0.87 (0.82, 0.92)				
Year of arrival in Australia						
Arrived before 2002	10.1 (9.9, 10.3)	1.00	1.00			
Arrived 2002 - 2011	10.0 (9.8, 10.3)	0.99 (0.96, 1.03)	0.88 (0.83, 0.93)			
Arrived 2012 - 2022	10.9 (10.7, 11.2)	1.10 (1.06, 1.13)	1.24 (1.16, 1.32)			
Language spoken at home						
English	12.7 (12.5, 12.9)	1.00		18.5 (18.3, 18.6)	1.00	
Other languages	6.9 (6.7, 7.1)	0.51 (0.49, 0.53)		19.3 (18.6, 20.0)	1.06 (1.01, 1.11)	
Proficiency in English (main language spoken at home is not English)						
Very well	7.0 (6.7, 7.3)			18.4 (17.6, 19.1)		
Well	7.4 (7.1, 7.7)			#		
Not well/Not at all	#			#		
Not applicable	12.7 (12.5, 12.9)			18.5 (18.3, 18.6)		
Education attainment						
Bachelor's degree or above	10.2 (10.0, 10.4)	1.00	1.00	18.5 (18.2, 18.7)	1.00	1.00
Advanced diploma/diploma/certificate	11.3 (11.0, 11.5)	1.12 (1.08, 1.15)	0.95 (0.9, 0.99)	18.4 (18.2, 18.6)	1.00 (0.97, 1.02)	0.95 (0.92, 0.98)
Year 12 or equivalent	10.2 (9.9, 10.6)	1.0 (0.95, 1.05)	0.68 (0.64, 0.73)	23.7 (23.4, 24.1)	1.37 (1.34, 1.41)	0.93 (0.9, 0.96)
Did not complete school/unknown	9.3 (9.0, 9.6)	0.90 (0.87, 0.94)	0.88 (0.83, 0.94)	15.2 (15.0, 15.5)	0.79 (0.77, 0.82)	0.84 (0.81, 0.87)
Socio-Economic Indexes for Areas (SEIFA)						
1st quintile (Most disadvantaged)	9.2 (8.9, 9.5)	1.00	1.00	21.2 (20.8, 21.6)	1.00	1.00
2nd quintile	11.1 (10.7, 11.5)	1.23 (1.16, 1.31)	1.07 (0.98, 1.17)	17.5 (17.2, 17.8)	0.79 (0.77, 0.82)	0.96 (0.93, 1)
3rd quintile	10.4 (10.1, 10.7)	1.14 (1.08, 1.21)	1.04 (0.96, 1.13)	19.3 (19.0, 19.5)	0.89 (0.86, 0.91)	1.06 (1.02, 1.1)
4th quintile	10.0 (9.7, 10.2)	1.09 (1.04, 1.15)	0.95 (0.89, 1.03)	17.3 (17.0, 17.5)	0.78 (0.75, 0.80)	0.95 (0.91, 0.99)
5th quintile (Most advantaged)	10.6 (10.3, 10.9)	1.17 (1.11, 1.24)	1(0.93, 1.07)	17.7 (17.4, 18.0)	0.80 (0.78, 0.82)	1.07 (1.03, 1.12)
Accessibility/Remoteness Index of Australia (ARIA)						
Major cities	10.3 (10.2, 10.5)	1.00	1.00	19.1 (18.9, 19.2)	1.00	1.00
Inner regional	10.2 (9.8, 10.6)	0.99 (0.95, 1.03)	0.92 (0.88, 0.98)	17.8 (17.5, 18.1)	0.92 (0.90, 0.94)	1.2 (1.16, 1.23)
Outer regional/remote	9.9 (9.1, 10.7)	0.95 (0.86, 1.06)	1 (0.03, 1.09)	16.1 (15.6, 16.5)	0.81 (0.78, 0.84)	1 (0.96, 1.04)
Employment						
Fully engaged	10.9 (10.7, 11.1)	1.00	1.00	18.8 (18.7, 19.0)	1.00	1.00

Partially engaged	11.8 (11.4, 12.3)	1.09 (1.04, 1.15)	0.97 (0.92, 1.03)	21.1 (20.8, 21.3)	1.15 (1.12, 1.17)	0.97(0.94, 1)
No study or employment	8.3 (8.1, 8.6)	0.74 (0.71, 0.77)	0.83 (0.78, 0.88)	16.2 (16.0, 16.4)	0.83 (0.82, 0.85)	0.07 (0.92, 1.02)
Labour force participation						
Employed	10.8 (10.6, 10.9)	1.00		18.5 (18.4, 18.7)	1.00	1.00
Unemployed	17.2 (16.2, 18.1)	1.72 (1.61, 1.83)		34.1 (33.1, 35.1)	2.27 (2.17, 2.37)	1.19 (1.09, 1.3)
Not in the labour force	8.6 (8.3, 8.8)	0.78 (0.75, 0.81)		16.8 (16.6, 17.0)	0.89 (0.87, 0.91)	1.03 (0.98, 1.08)
Health related characteristics						
Trauma event						
Non-interpersonal trauma	22.4 (20.8, 24.0)	1.00		26.3 (25.2, 27.5)	1.00	
Interpersonal trauma	19.3 (18.1, 20.5)	0.83 (0.73, 0.95)		33.3 (32.6, 34.0)	1.40 (1.30, 1.50)	
Self-rated health						
Excellent	5.4 (5.2, 5.6)	1.00	1.00	10.1 (9.9, 10.3)	1.00	1.00
Very good	8.4 (8.3, 8.6)	1.61 (1.54, 1.68)	1.2 (1.14, 1.26)	15.1 (14.9, 15.2)	1.58 (1.53, 1.62)	1.28 (1.24, 1.33)
Good	12.9 (12.6, 13.2)	2.59 (2.48, 2.70)	1.7 (1.61, 1.79)	22.2 (21.9, 22.4)	2.53 (2.46, 2.61)	1.63 (1.57, 1.7)
Fair	13.2 (12.8, 13.6)	2.66 (2.53, 2.80)	0.99 (0.92, 1.07)	29.1 (28.7, 29.5)	3.65 (3.54, 3.77)	1.22 (1.16, 1.28)
Poor	24.3 (23.2, 25.4)	5.60 (5.21, 6.03)	1.21 (1.04, 1.4)	34.4 (33.6, 35.2)	4.67 (4.48, 4.86)	1.1 (1.03, 1.17)
The Kessler Psychological Distress Scale (10-item)						
Low distress	4.0 (3.9, 4.1)	1.00	1.00	5.9 (5.8, 6.0)	1.00	1.00
Moderate distress	15.6 (15.3, 16.0)	4.45 (4.29, 4.62)	2.9 (2.78, 3.03)	23.5 (23.2, 23.8)	4.90 (4.77, 5.02)	3.23 (3.14, 3.33)
High/very high distress	34.6 (34.0, 35.1)	12.69 (12.24, 13.16)	6.35 (6.0, 6.66)	53.6 (53.1, 54.0)	18.39 (17.91, 18.88)	7.04 (6.81, 7.28)
Disability status						
No/mild disability	8.9 (8.8, 9.0)	1.00	1.00	15.4 (15.2, 15.5)	1.00	1.00
Moderate disability	29.4 (28.4, 30.4)	4.27 (4.06, 4.48)	2.19 (2.03, 2.35)	43.9 (43.2, 44.5)	4.31 (4.19, 4.43)	2.21 (2.14, 2.29)
Severe disability	29.5 (27.9, 31.1)	4.28 (3.94, 4.65)	1.3 (1.15, 1.48)	57.7 (56.5, 58.8)	7.51 (7.16, 7.88)	3.48 (3.28, 3.7)
Health service use for mental illness						
Mental health hospitalisation (admitted overnight or longer for MH in the past 12-months)[7]						
No/not known/refused	10.0 (9.9, 10.2)	1.00	1.00	18.1 (18.0, 18.3)	1.00	1.00
Yes	77.1 (74.6, 79.6)	30.30 (26.07, 35.21)	3.6 (2.89, 4.49)	65.6 (64.3, 66.9)	8.59 (8.09, 9.12)	1.65 (1.52, 1.79)

[7] These estimates should be interpreted with caution, given the small sample size reported among those with hospitalisations.

Mental health professional						
No	7.0 (6.9, 7.1)	1.00	1.00	11.5 (11.4, 11.7)	1.00	1.00
Yes	35.6 (35.1, 36.2)	7.36 (7.13, 7.59)	1.49 (1.42, 1.57)	45.9 (45.5, 46.3)	6.50 (6.38, 6.62)	1.57 (1.53, 1.61)
General practitioner						
No	5.4 (5.1, 5.7)	1.00	1.00	12.4 (11.9, 12.9)	1.00	1.00
Yes	10.7 (10.5, 10.8)	2.10 (1.97, 2.25)	1.14 (1.05,1.23)	18.8 (18.6, 18.9)	1.63 (1.55, 1.72)	1.18 (1.1, 1.26)
Psychiatrist						
No	8.4 (8.2, 8.5)	1.00	1.00	15.0 (14.9, 15.2)	1.00	1.00
Yes	33.1 (32.4, 33.8)	5.40 (5.21, 5.60)	1.51 (1.44, 1.59)	40.8 (40.3, 41.3)	3.89 (3.81, 3.98)	1.29 (1.25, 1.33)
Psychologist						
No	6.2 (6.1, 6.3)	1.00	1.00	10.8 (10.7, 10.9)	1.00	1.00
Yes	30.1 (29.5, 30.6)	6.49 (6.27, 6.72)	2.74 (2.61, 2.88)	37.2 (36.9, 37.5)	4.90 (4.82, 4.99)	2.01 (1.97, 2.06)
Other mental health professional						
No	8.1 (7.9, 8.2)	1.00	1.00	13.4 (13.3, 13.5)	1.00	1.00
Yes	29.4 (28.9, 29.9)	4.75 (4.62, 4.89)	1.76 (1.69, 1.84)	38.7 (38.3, 39.2)	4.08 (4.00, 4.17)	1.58 (1.54, 1.62)
Other Professional						
No	8.9 (8.7, 9.1)	1.00	1.00	20.1 (19.8, 20.3)	1.00	1.00
Yes	11.0 (10.9, 11.2)	1.27 (1.23, 1.31)	1.2 (1.16, 1.24)	17.9 (17.8, 18.0)	0.87 (0.86, 0.88)	0.88 (0.86, 0.91)

Pr = Prevalence, CI: Confidence intervals; OR= odds ratios; AOR= adjusted odds ratios. If 95% confidence intervals (CI) around odds ratios (OR) that lies between 1.00 indicate not statistically significant. #= Data suppressed due to small sample

Figure 3.1 shows the number of consultations with any mental health professional in the last 12 months for individuals with an anxiety disorder. There was a higher proportion of Australian born in each of the treatment volume categories compared with their overseas-born counterparts. This difference was most pronounced among those who had 20 or more consultations in the 12 months prior to the survey, with 72.2% of Australian-born individuals with an anxiety disorder reporting this level of service use compared to only 49% of overseas-born individuals.

Figure 3.1. Number of mental health consultations with any mental health professional for any 12-month anxiety disorders by place of birth

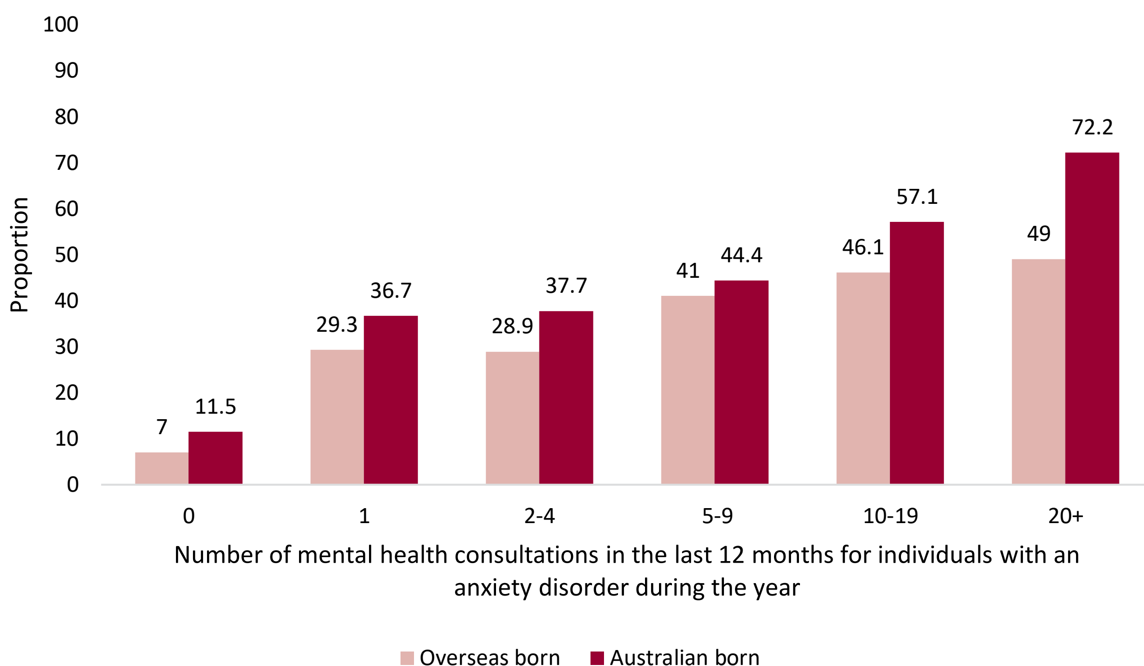
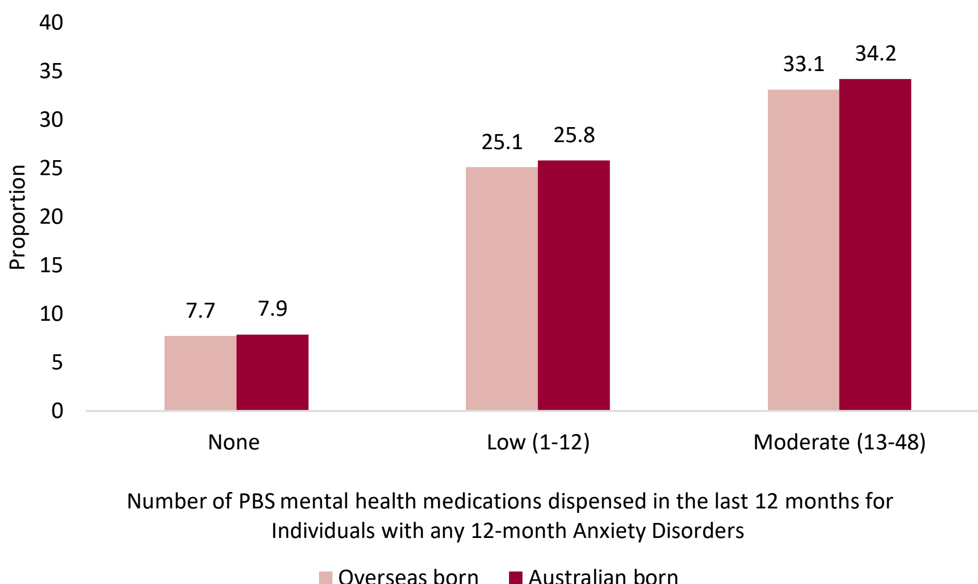


Figure 3.2 shows the number of PBS mental health medications dispensed in the last 12 months for individuals with an anxiety disorder. The pattern was very similar for those born overseas and in Australia.

Figure 3.2. Number of PBS mental health medications dispensed in last 12 months by place of birth



Comparison on factors associated with 12-month affective disorders and mental health service use broken down by birthplace

Table 3.5 presents the factors significantly associated with 12-month prevalence of affective disorders along with patterns of health service use by birthplace.

Predictors of 12-month affective disorder

In the adjusted model, as for anxiety disorder, multiple demographic and social variables were found to be significantly associated with this mental health outcome in both groups. Of particular note, sexual orientation was strongly associated with 12-month prevalence of affective disorders. Overseas-born individuals identifying as gay or lesbian were more than twice as likely to experience an affective disorder compared to heterosexuals (adjusted OR = 2.26, 95% CI:2.06–2.47). Similarly, those born overseas who identified as bisexual were more than twice as likely to have an affective disorder (adjusted OR = 2.37, 95% CI:2.07–2.71). Australian-born individuals also showed elevated odds, though to a lesser extent. Identifying as gay or lesbian increased the odds by 27% (adjusted OR = 1.27, 95% CI: 1.19–1.36) and by 32% for the bisexual subgroup (adjusted OR = 1.32, 95% CI: 1.25–1.40).

Marital status also influenced the odds of experiencing an affective disorder. Individuals who were separated, divorced, or widowed had elevated odds (adjusted OR = 1.75, 95% CI: 1.64–1.88 for overseas-born; adjusted OR = 1.77, 95% CI: 1.71–1.84 for Australian-born), as did those who had never married (adjusted OR = 1.37, 95% CI: 1.27–1.48 for overseas-born; adjusted OR = 1.18, 95% CI: 1.13–1.24 for Australian- born).

Patterns of mental health service use

Australian-born individuals who had an affective disorder had over 2.5 times greater odds of consulting a mental health professional compared to those who did not (adjusted OR = 2.68, 95% CI: 2.58–2.79). A similar pattern was found for overseas-born individuals, whereby those with a mood disorder had almost 2.5 times higher odds of a consultation with a mental health professional than their counterparts (adjusted OR = 2.39, 95% CI: 2.22-2.56). Consulting a GP was 62% more likely in Australian-born individuals with a mood disorder than those without (adjusted OR = 1.62, 95% CI: 1.46–1.80). In contrast, overseas-born individuals with a mood disorder had 40% lower odds of seeing a GP than those without (adjusted OR = 0.60, 95% CI: 0.52–0.69).

A higher proportion of overseas-born individuals with an affective disorder reported consulting either a psychiatrist or a psychologist than those without an affective disorder, and both figures exceeded the corresponding figures reported by Australian-born respondents. Those born overseas had 81% higher odds of seeing a psychiatrist then not doing so (adjusted OR = 1.81, 95% CI: 1.68-1.96) and were over three times more likely to see a psychologist (adjusted OR = 3.14, 95% CI: 2.94-3.37). In contrast, Australian-born individuals with a mood disorder had 51% higher odds of consulting a psychiatrist than not (adjusted OR = 1.51, 95% CI: 1.46-1.56) and 34% higher odds of consulting a psychologist then not (adjusted OR = 1.34, 95% CI: 1.30-1.39).

Table 3.5. Prevalence, univariate, and multivariate analyses of 12-month affective disorder by place of birth

Characteristics variables	Overseas born Pr (95%CI)	OR (95%CI)	AOR (95%CI)	Australia Born Pr (95%CI)	OR (95%CI)	AOR (95%CI)
Demographics						
Gender						
Female	5.0 (4.9, 5.2)	1.00	1.00	10.3 (10.1, 10.4)	1.00	1.00
Male	4.2 (4.1, 4.3)	0.83 (0.60, 1.14)	1.33 (1.27, 1.41)	6.9 (6.8, 7.1)	0.65 (0.64, 0.67)	0.89 (0.86, 0.92)
Sexual orientation						
Heterosexual	4.3 (4.2, 4.4)	1.00	1.00	7.7 (7.6, 7.8)	1.00	1.00
Gay or lesbian	17.6 (16.4, 18.8)	4.79 (2.43, 9.47)	2.26 (2.06, 2.47)	20.3 (19.5, 21.1)	3.07 (2.91, 3.24)	1.27 (1.19, 1.36)
Bisexual	23.8 (21.5, 26.1)	6.99 (2.49, 19.61)	2.37 (2.07, 2.71)	31.7 (30.9, 32.5)	5.59 (5.39, 5.81)	1.32(1.25, 1.4)
Gender identity						
Cisgender	4.7 (4.6, 4.8)	1.00		8.6 (8.5, 8.6)	1.00	1.00
Transgender	#	0.59 (0.12, 2.88)		27.8 (26.7, 29.0)	4.13 (3.89, 4.38)	2.64 (2.38, 2.94)
Age in categories						
16-25	6.7 (6.4, 7.0)	1.00	1.00	14.3 (14.0, 14.5)	1.00	1.00
26-45	4.8 (4.7, 5.0)	0.71 (0.41, 1.20)	1.11 (0.98, 1.25)	10.1 (9.9, 10.2)	0.67 (0.66, 0.69)	0.69 (0.65, 0.72)
46-65	5.3 (5.2, 5.5)	0.79 (0.48, 1.29)	1.07 (0.92, 1.24)	7.5 (7.3, 7.6)	0.48 (0.47, 0.50)	0.67 (0.63, 0.72)
66-85	1.9 (1.8, 2.0)	0.27 (0.15, 0.51)	0.25 (0.21, 0.3)	3.3 (3.2, 3.4)	0.21 (0.20, 0.21)	0.4 (0.37, 0.43)
Marital status						
Married	2.9 (2.8, 3.0)	1.00	1.00	4.7 (4.6, 4.8)	1.00	1.00
Separated/divorced/widowed	7.1 (6.9, 7.3)	2.56 (1.74, 3.78)	1.75 (1.64, 1.88)	11.6 (11.4, 11.9)	2.68 (2.60, 2.77)	1.77 (1.71, 1.84)
Never married	7.8 (7.5, 8.0)	2.83 (1.95, 4.11)	1.37(1.27, 1.48)	12.6 (12.4, 12.8)	2.94 (2.86, 3.02)	1.18 (1.13, 1.24)
Region of birth						
North-West Europe	7.2 (6.9, 7.4)	1.00				
Oceania and Antarctica	7.3 (7.0, 7.6)	1.02 (0.64, 1.63)				
Southern and Eastern Europe	4.9 (4.5, 5.2)	0.66 (0.31, 1.42)				
North Africa and Middle East	6.8 (6.3, 7.3)	0.95 (0.50, 1.82)				
South-East Asia	2.0 (1.9, 2.2)	0.26 (0.14, 0.52)				
North-East Asia	2.2 (2.0, 2.3)	0.29 (0.17, 0.50)				
Southern and Central Asia	2.7 (2.5, 2.9)	0.35 (0.17, 0.73)				

Americas	8.3 (7.9, 8.8)	1.18 (0.65, 2.15)				
Sub-Saharan Africa	3.0 (2.7, 3.4)	0.40 (0.14, 1.18)				
Year of arrival in Australia						
Arrived before 2002	5.1 (4.9, 5.2)	1.00	1.00	#		
Arrived 2002 - 2011	4.5 (4.3, 4.7)	0.88 (0.61, 1.28)	1.02 (0.94, 1.1)			
Arrived 2012 - 2022	4.0 (3.8, 4.1)	0.77 (0.52, 1.15)	1.18 (1.1, 1.27)	#		
Language spoken at home						
English	6.4 (6.2, 6.5)	1.00		8.8 (8.8, 8.9)	1.00	
Other languages	2.2 (2.1, 2.3)	0.33 (0.22, 0.49)		7.8 (7.2, 8.4)		
Proficiency in English (main language spoken at home is not English)						
Very well	2.0 (1.9, 2.1)			7.7 (7.1, 8.4)		
Well	2.9 (2.7, 3.1)			#		
Not well/Not at all	#			#		
Not applicable	6.4 (6.2, 6.5)			8.8 (8.8, 8.9)		
Education attainment						
Bachelor's degree or above	3.9 (3.8, 4.0)	1.00	1.00	8.6 (8.5, 8.8)	1.00	1.00
Advanced diploma/diploma/certificate	5.9 (5.6, 6.1)	1.55 (1.03, 2.33)	1.12 (1.04, 1.21)	9.1 (8.9, 9.3)	1.07 (1.03, 1.10)	0.89 (0.86, 0.93)
Year 12 or equivalent	4.6 (4.3, 4.8)	1.18 (0.70, 2.01)	0.72 (0.66, 0.79)	11.8 (11.5, 12.1)	1.42 (1.37, 1.47)	0.98 (0.93, 1.03)
Did not complete high school/unknown	4.9 (4.7, 5.2)	1.29 (0.78, 2.12)	1.55 (1.4, 1.72)	6.8 (6.7, 7.0)	0.78 (0.75, 0.81)	0.66 (0.63, 0.7)
Socio-Economic Indexes for Areas (SEIFA)						
1st quintile (Most disadvantaged)	3.2 (3.0, 3.4)	1.00	1.00	9.2 (9.0, 9.4)	1.00	1.00
2nd quintile	6.9 (6.6, 7.1)	2.22 (1.27, 3.86)	2.47 (2.25, 2.71)	9.3 (9.1, 9.5)	1.01 (0.97, 1.05)	1.31 (1.24, 1.38)
3rd quintile	4.9 (4.7, 5.1)	1.53 (0.87, 2.71)	1.9 (1.73, 2.1)	9.5 (9.3, 9.7)	1.04 (1.00, 1.07)	1.25 (1.2, 1.31)
4th quintile	4.1 (3.9, 4.2)	1.28 (0.73, 2.24)	1.3 (1.17, 1.44)	8.1 (7.9, 8.3)	0.87 (0.84, 0.91)	1.16 (1.1, 1.23)
5th quintile (Most advantaged)	4.1 (3.9, 4.3)	1.28 (0.72, 2.28)	1.62 (1.46, 1.79)	8.3 (8.1, 8.5)	0.89 (0.86, 0.93)	1.2 (1.14, 1.27)
Accessibility/Remoteness Index of Australia (ARIA)						
Major cities	4.5 (4.4, 4.6)	1.00	1.00	9.3 (9.2, 9.4)	1.00	1.00
Inner regional	5.6 (5.3, 6.0)	1.28 (0.71, 2.30)	1.22 (1.09, 1.36)	8.1 (7.9, 8.3)	0.86 (0.84, 0.89)	1.03 (1, 1.06)
Outer regional/remote	#	1.38 (0.32, 5.96)	1.36 (1.08, 1.72)	7.5 (7.1, 7.8)	0.79 (0.75, 0.83)	1.02 (0.95, 1.09)
Employment						
Fully engaged	4.5 (4.4, 4.6)	1.00	1.00	8.6 (8.4, 8.7)	1.00	1.00

Partially engaged	6.3 (6.0, 6.5)	1.43 (0.97, 2.11)	1.4 (1.29, 1.52)	10.5 (10.2, 10.7)	1.25 (1.21, 1.29)	1.05 (1.01, 1.1)
No study or employment	4.0 (3.9, 4.2)	0.89(0.63, 1.27)	1.03(0.92, 1.15)	8.3 (8.1, 8.4)	0.96 (0.94, 0.99)	0.64 (0.6, 0.69)
Labour force participation						
Employed	4.7 (4.6, 4.8)	1.00		8.3 (8.2, 8.5)	1.00	1.00
Unemployed	9.5 (8.9, 10.1)	2.13 (1.21, 3.74)		19.0 (18.2, 19.9)	2.58 (2.44, 2.74)	1.61 (1.45, 1.78)
Not in the labour force	4.0 (3.8, 4.1)	0.84 (0.58, 1.21)		8.8 (8.7, 9.0)	1.07 (1.04, 1.09)	1.39 (1.29, 1.49)
Health related characteristics						
Trauma event						
Non-interpersonal trauma	#	1.00		16.9 (15.7, 18.2)	1.00	
Interpersonal trauma	12.7 (11.3, 14.1)	2.03(0.32, 12.76)		16.3 (15.7, 16.9)	0.95 (0.87, 1.05)	
Self-rated health						
Excellent	2.1 (1.9, 2.2)	1.00	1.00	3.6 (3.4, 3.7)	1.00	1.00
Very good	2.9 (2.8, 3.0)	1.43 (0.68, 2.99)	0.75 (0.67, 0.83)	6.1 (6.0, 6.2)	1.75 (1.67, 1.84)	1.26 (1.19, 1.33)
Good	5.0 (4.8, 5.2)	2.50 (1.21, 5.15)	0.86 (0.77, 0.95)	9.7 (9.5, 9.9)	2.92 (2.78, 3.07)	1.37 (1.3, 1.44)
Fair	10.1 (9.6, 10.5)	5.32 (2.55, 11.07)	1.35 (1.2, 1.51)	19.1 (18.7, 19.5)	6.41 (6.13, 6.71)	1.78 (1.68, 1.88)
Poor	15.9 (14.9, 16.9)	8.98 (3.75, 21.49)	0.95 (0.81, 1.13)	23.7 (22.8, 24.5)	8.41 (7.87, 8.98)	1.75 (1.61, 1.91)
The Kessler Psychological Distress Scale (10-item)						
Low distress	0.7 (0.7, 0.7)	1.00	1.00	1.6 (1.6, 1.7)	1.00	1.00
Moderate distress	5.3 (5.0, 5.5)	7.90 (4.97, 12.56)	4.98 (4.67, 5.3)	8.3 (8.1, 8.5)	5.50 (5.25, 5.77)	3.31 (3.13, 3.5)
High/very high distress	23.0 (22.5, 23.5)	42.50 (27.26, 66.28)	18.79 (17.46, 20.22)	32.8 (32.5, 33.2)	29.66 (28.39, 30.98)	8.83 (8.33, 9.35)
Disability status						
No/mild disability	3.7 (3.6, 3.7)	1.00	1.00	6.8 (6.7, 6.9)	1.00	1.00
Moderate disability	15.1 (14.5, 15.7)	4.68 (4.45, 4.93)	1.23 (1.12, 1.35)	24.2 (23.6, 24.8)	4.38 (4.21, 4.56)	1.58 (1.49, 1.68)
Severe/extreme disability	28.0 (26.0, 30.0)	10.27 (9.2, 11.42)	1.94 (1.64, 2.3)	37.7 (36.4, 39.0)	8.30 (7.82, 8.81)	2.37 (2.16, 2.6)
Health service use for mental illness						
Mental health hospitalisation (admitted overnight or longer for MH in the past 12-months)						
No/not known/refused	4.5 (4.4, 4.6)	1.00	1.00	8.5 (8.4, 8.5)	1.00	1.00
Yes	#	10.36 (2.35, 45.59)	0.58 (0.51, 0.67)	61.3 (59.8, 62.8)	17.12 (16.03, 18.29)	3.19 (2.88, 3.53)
Mental health professional						
No	2.2 (2.2, 2.3)	1.00	1.00	3.9 (3.8, 3.9)	1.00	1.00
Yes	22.9 (22.3, 23.5)	12.93 (8.60, 19.46)	2.39 (2.22, 2.56)	28.5 (28.2, 28.8)	9.92 (9.64, 10.20)	2.68 (2.58, 2.79)

General practitioner						
No	3.3 (3.0, 3.7)	1.00	1.00	5.5 (5.2, 5.8)	1.00	1.00
Yes	4.7 (4.6, 4.8)	1.43 (0.55, 3.74)	0.6 (0.52, 0.69)	9.0 (8.9, 9.1)	1.70 (1.59, 1.82)	1.62 (1.46, 1.8)
Psychiatrist						
No	3.3 (3.2, 3.4)	1.00	1.00	6.2 (6.2, 6.3)	1.00	1.00
Yes	20.7 (20.1, 21.3)	7.70 (5.35, 11.09)	1.81 (1.68, 1.96)	25.7 (25.3, 26.0)	5.20 (5.07, 5.32)	1.51 (1.46, 1.56)
Psychologist						
No	2.0 (1.9, 2.0)	1.00	1.00	4.6 (4.5, 4.7)	1.00	1.00
Yes	17.5 (17.1, 17.9)	10.55 (7.00, 15.90)	3.14 (2.94, 3.37)	19.1 (18.8, 19.3)	4.86 (4.72, 5.00)	1.51 (1.46, 1.56)
Other mental health professional						
No	3.1 (3.0, 3.2)	1.00	1.00	5.9 (5.8, 6.0)	1.00	1.00
Yes	17.9 (17.4, 18.4)	6.87 (4.84, 9.73)	1.88 (1.76, 2.01)	20.6 (20.3, 21.0)	4.17 (4.04, 4.30)	1.28 (1.23, 1.33)
Other professional						
No	5.0 (4.8, 5.1)	1.00	1.00	10.6 (10.4, 10.8)	1.00	1.00
Yes	4.4 (4.3, 4.6)	0.89 (0.65, 1.22)	0.65 (0.61, 0.69)	8.2 (8.1, 8.3)	0.76 (0.74, 0.77)	0.69 (0.67, 0.71)

Pr = Prevalence, CI: Confidence intervals; OR= odds ratios; AOR= adjusted odds ratios. If 95% confidence intervals (CI) around odds ratios (OR) that lies between 1.00 indicate not statistically significant. #= Data suppressed due to small sample.

Figure 3.3 reports data from the NSMHW where the number of consultations with a mental health professional were categorised into six treatment volume groups. Across all categories, the proportion of individuals with a 12-month affective disorder was consistently higher among Australian-born individuals than those born overseas. Specifically, prevalence for the Australian-born ranged from 3.9% to 50.3%, whereas for the overseas-born it ranged from 2.2% to 40.6%.

Figure 3.3. Number of mental health consultations, with any mental health professional for 12-month affective disorders by place of birth

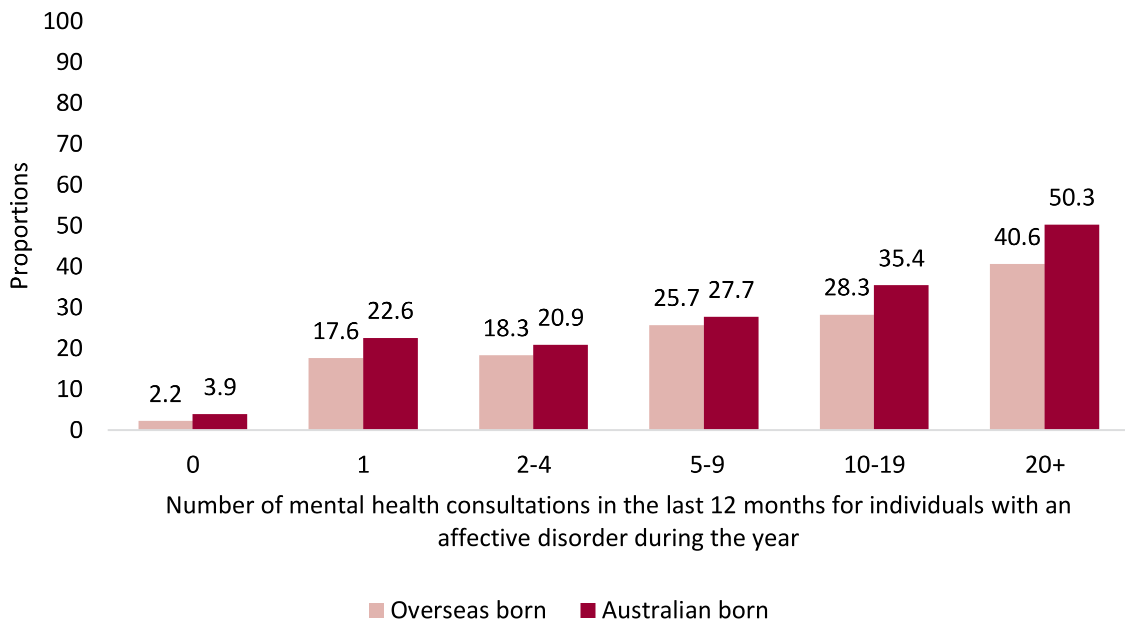
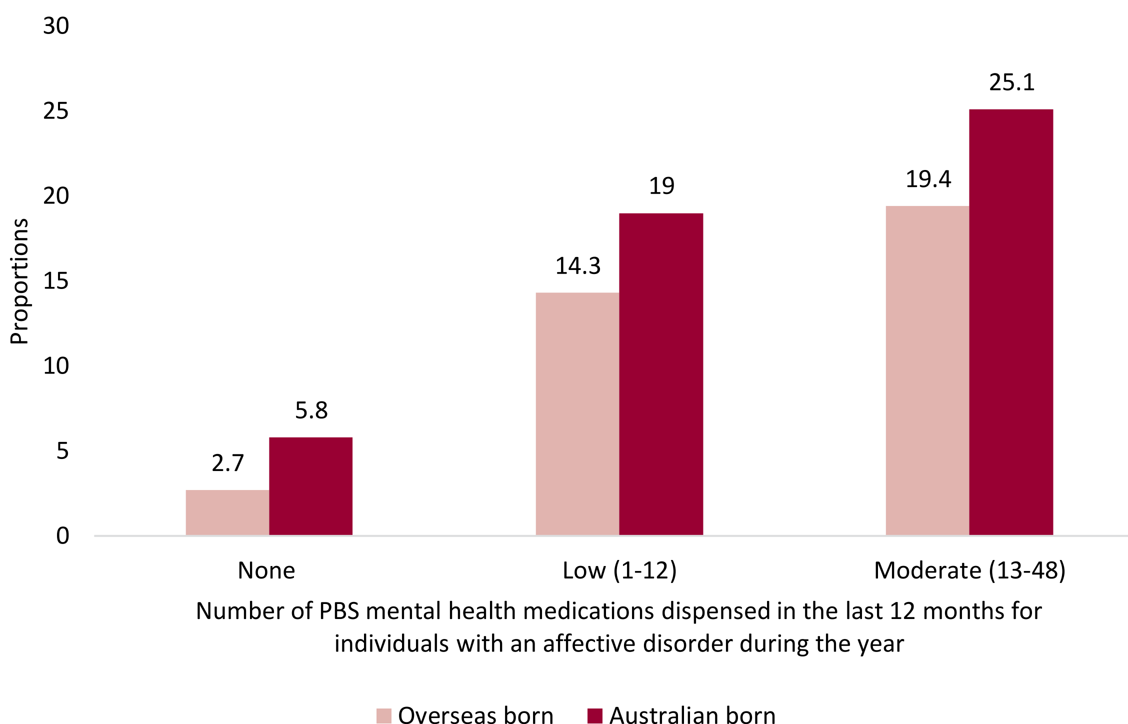


Figure 3.4 shows the number of PBS mental health medications dispensed in the last 12 months for individuals with an affective disorder. A greater proportion of Australian-born individuals were dispensed PBS medication in the low (19.0% vs. 14.3%) and moderate categories (25.1% vs. 19.4%) compared with overseas-born individuals.

Figure 3.4. Number of PBS mental health medications dispensed in last 12 months by place of birth



Time to treatment for Australian and overseas-born individuals

As shown in Table 3.6, the patterns of time to treatment for mental disorders (lifetime) varied in some respects between the overseas and Australian born.

For anxiety disorders, both groups had similar proportions seeking treatment within one year (9.0% for Australian-born; 8.6% for overseas-born). However, by 10 years a greater proportion of Australian-born individuals had accessed treatment (22.5%) compared to overseas-born individuals (14.1%). Notably, over half of overseas-born individuals (57.6%) reported treatment following 10 years or more, compared to 49.3% of Australian-born individuals, indicating a substantial disparity.

For affective disorders, overseas-born individuals were slightly more likely to seek treatment within one year (14.1% vs. 12.7%), but Australian-born individuals were more likely to receive treatment within five and ten years. Again, a higher proportion of overseas-born individuals had treatment delayed beyond 10 years (45.7%) compared to Australian-born individuals (37.3%). Overall, these findings suggest that while overseas-born individuals may seek help earlier for affective disorders, for a large proportion there is a long gap between symptom onset and treatment.

Table 3.6. Comparison of time to treatment by lifetime mental disorders by place of birth

Lifetime mental disorders	Time to treatment	
	Australian born Pr (95%CI)	Overseas born Pr (95%CI)
Anxiety disorder (Lifetime)		
Within 1 year	9.0 (8.6, 9.3)	8.6 (8.1, 9.0)
By 5 years	19.2 (18.8, 19.5)	19.6 (19.1, 20.2)
By 10 years	22.5 (22.2, 22.9)	14.1 (13.6, 14.6)
> 10 years	49.3 (48.8, 49.8)	57. 6 (56.8, 49.8)
Affective disorder (Lifetime)		
Within 1 year	12.7 (12.3, 13.1)	14.1 (13.2, 15.0)
By 5 years	29.7 (29.0, 30.4)	20.7 (19.7, 21.7)
By 10 years	37.3 (36.6, 37.9)	19.5 (18.5, 20.5)
> 10 years	37.3 (36.6, 37.9)	45.7 (44.5, 47.0)

Pr = Prevalence, CI: Confidence intervals.

3.5 Discussion

We undertook a secondary analysis of the 2020–2022 NSMHW because it provides a critical foundation for understanding the mental health status of the Australian adult population. (58) Considered a nationally representative survey, it offers the most comprehensive population-level data on a range of important mental health indicators including prevalence of mental disorders and health service use. Moreover, the study's ability to capture data from both service users and those who do not seek treatment enables a reflection of the needs of all and not just those who contact services. (58) Our analysis focused on the 12-month prevalence of anxiety and affective disorders, associated socio-demographic and health characteristics, and mental health service use among overseas-born respondents, commenting on the comparison with Australian-born respondents where appropriate.

Prevalence

The first key finding, shown in Table 3.2, is that individuals born overseas had lower 12-month prevalence rates for all mental health disorders compared with those born in Australia. This difference was most pronounced for the category 'any 12-month mental disorder', where 23.7% of Australian-born individuals met diagnostic criteria. In this, our findings align with those reported in the ABS analysis of the same dataset, which also found higher prevalence rates among individuals born in Australia compared to those born overseas. (50) However, these are aggregated results and lower overall prevalence rates do not necessarily mean lower prevalence for all CaLD communities.

While the NSMHW is representative of the general Australian population, it does not adequately capture key subgroups with known vulnerabilities. For instance, individuals with limited English proficiency, a recognised risk factor in migrant mental health (42), are under-represented in this survey, with estimates ranging from 0.9% to 5.1%, depending on the definitions used to classify CaLD populations. (59) This concern is heightened by 2021 Census data showing that 25.9% of Mandarin speakers, Australia's largest non-English language group, reported limited English proficiency. (40) Further, the NSMHW does not collect data on migration arrival status. This limitation, along with exclusion of temporary migrants, means that groups such as humanitarian entrants and international students are either not identifiable within the data or entirely excluded. Thus, while the NSMHW offers an opportunity to measure prevalence using standardised diagnostic instruments, insights remain limited by its lack of inclusivity of key CaLD groups. (59, 60) These are important considerations when interpreting the lower prevalence rates observed.

The second key finding on prevalence rates relates to arrival periods among those born overseas. As shown in Table 3.3, individuals who arrived prior to 2002 had higher prevalence rates across all 12-month mental health disorder categories, a pattern consistent with that reported by Minas et al. (2013), based on the 2007 National Survey of Mental Health and

Wellbeing. (21) However, when we considered arrival periods within the adjusted models, a different pattern emerged. Individuals who had arrived most recently (between 2012 and 2022) had 24% higher odds of experiencing a 12-month anxiety disorder (Table 3.4) and 18% higher odds of experiencing a 12-month affective disorder (Table 3.5) when compared with those with those who arrived before 2002. This highlights the complex relationship between length of residence and mental disorders or psychological distress among migrant groups, where mixed findings have been previously documented. For example, Steel et al (2002) observed a steady decline in trauma-related mental illness over time among Vietnamese refugees resettled in Australia (61), whereas others have found that mental disorder prevalence may be lower upon arrival but tends to increase over time. (62, 63) Findings should be interpreted in light of additional factors, including migration stream (e.g., skilled versus humanitarian), the specific types of mental illness assessed, and broader contextual influences such as geo-political stressors that may shape symptomatology. For example, the impact of recent global events, particularly the COVID-19 pandemic, which has been shown to have ongoing mental health consequences for certain population groups, (64) cannot be discounted as playing a role in our adjusted model findings.

Another key finding was that gender and age influenced the odds of experiencing a 12-month anxiety disorder in the adjusted model for both the Australian and overseas-born groups. Specifically, males had 15% less odds of experiencing an anxiety disorder compared with females within the overseas-born cohort, and 37% less odds in the Australian-born individuals. When examining influence of age in the overseas-born respondents, we found that odds of experiencing an anxiety disorder were 43% less for those aged 26–45 years old and 66% less when those aged 66–85 years old compared with the youngest cohort (16–25 years old). A similar pattern was observed for the Australian-born respondents, with odds of experiencing 12-month anxiety disorder ranging from 46% for those aged 26–45 years old through to 76% less for those aged 66–85 years old compared with the youngest cohort (16–25 years old). These patterns suggest that well-established risk factors, namely female gender and younger age, are consistent across populations, irrespective of birthplace. (42, 47)

A recent analysis of time trends across the 2007 and 2020–2022 national surveys revealed a substantial rise in mental health conditions among young people aged 16–24 years, with the prevalence of any 12-month mental disorder increasing from 26.4% in 2007 to 38.8% in 2020–2022. (47) Clearly, there is a need to undertake further investigations, including temporal trends analyses, among overseas-born youth to determine whether similar increases are emerging within this vulnerable subgroup and to understand the underlying contributors.

Mental health service use

Analysis of mental health service use data from the NSMHW revealed a complex picture. Most individuals with a 12-month anxiety disorder were more likely to seek help from GPs, psychologists, and psychiatrists than not, a pattern observed in both overseas-born and Australian-born groups. A similar pattern emerged for affective disorders, with both groups showing increased likelihood of consulting specialist mental health professionals (psychiatrists and psychologists). However, a notable disparity was observed with GP consultations for affective disorders, with overseas-born individuals 40% less likely to seek help from a GP, whereas Australian-born individuals were 62% more likely to do so. This is an interesting finding that warrants further investigation. Previous analyses of the 2020–2022 NSMHW dataset suggest that disparities in access to GPs offering long consultations, often essential for mental health discussions, may contribute to such differences, but country of birth was not reported. (65)

The number of mental health consultations reported by individuals with 12-month anxiety disorders revealed notable disparities based on birthplace (Figure 3.1). Australian-born individuals were more likely to receive 20 or more consultations in the past year (72.2%) compared to those born overseas (49.0%). When examining Figure 3.3, a similar pattern was observed for 12-month affective disorders, with greater proportion of Australian-born individuals represented across all consultation categories (number of sessions received). Given that standardised treatment protocols typically recommend between 10 and 30 sessions for moderate to complex anxiety and depressive disorders, (66, 67) these differences suggest that overseas-born individuals may be receiving less than optimal care. These disparities may be the result of a number of well-documented barriers faced by migrant populations such as language and communication challenges, financial constraints, and systemic issues in service delivery. (68) Our finding that the distribution of PBS-dispensed mental health medications for individuals with 12-month anxiety and affective disorders showed similar patterns across both groups (Figures 3.2 and 3.4) seems to suggest that pharmacological treatment may be more uniformly accessed. This may be due to perceived convenience or the result of systemic influences such as the relative higher cost of non-pharmacological treatments and the limited availability of culturally appropriate psychosocial services. (65, 68)

Across the mental disorders, a notably higher proportion of overseas-born individuals delayed treatment for more than ten years, a finding replicated in a separate analysis of NSMHW. (49) Given the strong evidence that early treatment leads to more favourable mental health outcomes, (69) the observed delay in service use is concerning. Once again, while this data cannot explain the reasons behind this observed gap, previous research has highlighted limited access to culturally appropriate services as a contributing factor. (68) Additionally, stigma surrounding mental health and low awareness of available support may further hinder timely

engagement with mental health care, suggesting that multifaceted solutions are needed to address these barriers. (70, 71)

Other insights on mental health service use come from the ABS analysis of the 2011 Mental Health Services-Census Integrated Dataset[8] which examined the actual service use of CaLD individuals who accessed subsidised mental health services and medications in 2011. (56) The large sample size enabled disaggregation into more granular categories, including by country of birth and language spoken at home. (72) The categories considered were: (1) born in Australia, speaks English at home; (2) born in Australia, speaks a language other than English at home; (3) born overseas, speaks English at home; and (4) born overseas, speaks a language other than English at home. In 2011, 25% of Australians were born overseas and 18% spoke a language other than English at home. These proportions translated to 64% of the population being Australian-born English speakers, 5% Australian-born non-English speakers, 11% overseas-born English speakers, and 13% overseas-born non-English speakers. (68)

Overall, study findings indicated that the rates of use of MBS-subsidised mental health services and PBS-subsidised mental health-related medications varied across groups and specific demographics. For example, Australian-born individuals who spoke English at home had the highest rate of MBS-subsidised mental health service use at 8.0%, followed by 7.5% of overseas-born English speakers, 6.0% of Australian-born non-English speakers, and 5.6% of overseas-born non-English speakers.

When only country of birth was considered, different patterns emerged. When examining the top five most common countries of birth (excluding Australia) for individuals who accessed at least one MBS-subsidised mental health-related service, the United Kingdom was first at 7.6%, followed by New Zealand (6.9%) and Italy (6.0%). In contrast, individuals born in China (3.4%) and India (3.9%) had notably lower rates of service use, which may reflect the strong cultural presence and continued practice of traditional medicine.(73) It is interesting to note that individuals born in Turkey recorded the highest rate of service use at 14.2%, followed by those born in Bosnia and Herzegovina (13.4%) and Iraq (12.1%). These elevated rates may, in part, reflect the impact of war, displacement, and refugee experiences, with Bosnia and Herzegovina experiencing conflict between 1992 and 1995, and Iraq, which has endured prolonged instability due to multiple wars and conflict including the Iran–Iraq War in the 1980s, the Gulf War in 1990–91, and the 2003 invasion and subsequent conflict. (44) Overall, individuals born in Asia tended to have relatively low rates of service use, with 4.6% of those born in South-East

[8] This dataset was created by using linked data from Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) and the 2011 Census of Population and Housing. The linkage process provided over 2.2 million person-records reflecting more than 70% of available MBS and PBS records in 2011.

Asia, 3.8% in North-East Asia, and 4.6% in Southern and Central Asia accessing at least one mental health-related service.

A similar pattern was observed for medications: 13.1% of overseas-born English speakers accessed at least one PBS-subsidised mental health medication, followed by 11.6% of Australian-born English speakers, 9.8% of overseas-born non-English speakers, and only 4.6% of Australian-born non-English speakers. These differences may be attributed, at least in part, to variations in age structure across the groups. For instance, the relatively low rate of mental health medication use among Australian-born non-English speakers (4.6%) is likely influenced by their younger profile, with a median age of just 18 years. Conversely, the higher rate among overseas-born English speakers (13.1%) may be partially attributable to their older age structure, with a median age of 49 years. This aligns with previous research indicating that advancing age is associated with increased psychotropic medication use. (74)

When the medication findings were drilled down to country of birth, the highest usage was recorded among people born in Hungary (25.5%), followed by Italy (24.4%) and Malta (23.8%). Interestingly, of those born in the United Kingdom, 6.3% accessed at least one mental health-related medication, compared to 8.3% of those born in New Zealand, 4.3% in China, and 4.2% in India. Similar to the use of mental health services, individuals born in Asia had relatively low rates of use: 6.2% for South-East Asia, 4.1% for North-East Asia, and 5.1% for Southern and Central Asia.

In summary, that study found that Australian-born individuals and overseas-born English speakers were most likely to make use of MBS mental health services and PBS mental health-related medications. In contrast, those born in Asian regions were least likely to use them. However, the patterns varied depending on whether the groups of interest were defined by country of birth, language spoken at home, or a combination of both. The key message here is how groups are operationalised can lead to markedly different interpretations. While the study (now 14 years old) offers valuable insights into patterns of actual mental health service and medication use among CaLD groups, the MBS and PBS datasets do not contain clinical diagnostic information. Access to mental health services and the dispensing of related medications may suggest the presence of a clinical condition, but this cannot be assumed, nor can types of diagnoses be established with certainty.

Strengths and limitations

Large national data sets are a significant resource, with the 2020–2022 NSMHW providing the opportunity to examine the prevalence of mental health disorders and associated patterns of service use. Its large sample size and standardised methodology support robust comparisons across population groups. However, several limitations with this dataset must be acknowledged. Most notably, the survey provides limited representation of some CaLD

populations, particularly individuals with low English proficiency. (59) Language barriers and cultural stigma may contribute to the under-reporting of mental health concerns and service utilisation (42). Although the survey employed structured diagnostic tools, cultural variations in symptom expression and reporting remain important considerations. (71, 75) Finally, aggregation of CaLD respondents into one broad category (overseas born), due to privacy constraints and small subgroup sizes, risks obscuring important differences related to ethnicity, language and migration experiences, thereby limiting the ability to identify specific community needs.

3.6 Conclusion

The 2020–2022 NSMHW provides a critical foundation for understanding the mental health status of the Australian adult population. In addition to offering comprehensive data on a range of important mental health indicators, the inclusion of data from both service users and those who do not seek treatment is a major strength. Secondary analysis of the NSHMW dataset found lower 12-month prevalence rates among overseas-born individuals compared with Australian-born individuals for affective disorders, anxiety disorders and any mental disorder. Among the overseas-born, recent arrivals (2012–2022) were most likely to report 12-month anxiety and affective disorders. While the predictors of these disorders were generally similar in the two birthplace groups, the level and direction of influence sometimes varied. Differing patterns of mental health service use, particularly GP consultations, suggested disparities in access and engagement for those born overseas. Patterns in time to treatment for lifetime anxiety and affective disorders also varied, with a higher proportion of overseas-born individuals reporting treatment delayed beyond 10 years. Although the NSMHW is considered representative of the general Australian population, the exclusion of people with limited English and problems with breaking down aggregated data (e.g., by country of birth or migration arrival status) are significant limitations.

Additional insights were gained by reviewing the ABS analysis of linked 2011 MBS and PBS data. That study found Australian and overseas-born individuals who spoke English at home consistently exhibited higher rates of service and medication use than their counterparts. Individuals born in Asian countries had relatively low usage rates. The patterns varied depending on whether the groups were defined by country of birth, language spoken at home, or a combination of both. Taken together, these findings highlight the challenges in understanding the prevalence of mental health disorders and related health service use among CaLD Australians. Further work is urgently needed with detailed consideration by experts, including those with lived experience, to identify the key variables and measures most relevant to multicultural mental health. Oversampling in large-scale surveys is clearly warranted, as is greater attention to currently excluded and under-represented groups. Given the complexity of national datasets and data linkage, future research requires dedicated resourcing and time to allow for detailed insights

4. Rapid literature review

4. Rapid literature review

A rapid review of community-based mental health interventions, programs and services was undertaken to synthesise contemporary evidence on approaches that effectively support CaLD populations. The review focused on studies conducted in Australia, including peer-reviewed and grey literature, between 2012 to 2025. A total of 41 studies were identified that met the eligibility criteria, the majority of which appeared after 2018. The studies covered a wide range of CaLD populations, variously defined by country of birth, language spoken and ethnicity. Most of the interventions focussed on health promotion, prevention and early intervention, although some also incorporated elements of treatment such cognitive behaviour therapy (CBT) and trauma therapy. Support groups for people with severe mental illness and continuing care models were also reported. Most interventions included tailoring to the linguistic, cultural and contextual needs of the target communities. Barriers such as mental illness stigma, communication difficulties and limited cultural competence in mainstream services were mitigated when programs integrated cultural values, utilised the bilingual/bicultural workforce, and involved collaboration and co-design with community members, thus ensuring relevance and trust. In addition, systemic barriers and structural inequities were reported and need to be addressed. Overall, the limited but growing evidence suggests that culturally safe, integrated and strengths-based models of care that have been co-designed with community can significantly enhance service engagement and mental health outcomes for CaLD Australians. Furthermore, culturally-tailored mental health literacy and anti-stigma campaigns targeting both the general community and service providers can improve recognition of mental health issues, promote help-seeking behaviours and foster inclusive service environments.

4.1 Objective

To conduct a rapid review of the Australian literature to identify current and emerging good practices that support the mental health of multicultural communities. This includes assessing cultural adaptations, mental health outcomes, and qualitative insights such as service user engagement and feedback where available.

4.2 Methods

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidance was followed throughout this review. (76) A rapid review was conducted to identify relevant literature published between 1 September 2012 and 5 February 2025. This timeframe was selected to capture over a decade of research following the 2013 report by Minas et al. (21, 22)

4.2.1 Search strategy

The search strategy included five electronic databases: MEDLINE, Embase, PsycINFO, Scopus, and CINAHL (see Appendix B for search terms). Additionally, a grey literature search was conducted to identify relevant organisational reports and non-peer-reviewed sources published within the same time frame. Grey literature was identified through targeted searches of government websites, non-government organisation (NGO) publications, health service reports, and online repositories using keywords related to multicultural, refugee, and CaLD mental health services in Australia.

4.2.2 Eligibility criteria

Studies were included if they reported primary data on community-based mental health interventions, programs or services that were targeting migrants, refugees, asylum seekers, ethnic and racial minorities, or culturally and linguistically diverse populations residing in Australia. Only studies conducted in Australia, published in English, and within the specified date range were considered. Studies were excluded if they did not focus on the specified populations or were unrelated to mental health services. Publications outside the date range, and non-empirical works such as editorials, framework or policy documents were also excluded. Detailed inclusion and exclusion criteria are provided in Table 4.1 below, developed based on the PCC framework as recommended by Joanna Briggs Institute (JBI). (77)

Table 4.1. Inclusion and exclusion criteria

Inclusion criteria based on PCC Framework	
Element	**Description**
P (Population)	- Culturally and linguistically diverse populations, including migrants, refugees, asylum seekers and ethnic minorities residing in Australia
C (Concept)	- Community-based mental health interventions, programs, or services aimed at improving mental health, psychosocial wellbeing, service engagement, cultural appropriateness, or user satisfaction
C (Context)	- Australian settings, with a focus on services and outcomes for CaLD populations in community-based mental health care
Additional inclusion criteria	- Published between 1 September 2012 and 5 February 2025 - Published in English
Exclusion criteria	- Studies not focused on the specified populations - Studies unrelated to mental health or psychosocial services - Studies not conducted in or relevant to Australia - Non-empirical works (e.g., editorials, perspective, reviews) - Publications outside the specified date range

4.2.3 Study selection

Studies identified through the electronic databases were collated in EndNote 20 software. Duplicates were removed, and the remaining citations were imported into Covidence systematic review software. Titles and abstracts were screened for relevance according to the inclusion criteria as outlined in Table 4.1. Articles meeting the criteria or requiring further assessment were retrieved in full text. Additionally, potentially eligible studies identified through grey literature and manual search were retrieved in full text. All retrieved full-text articles were assessed against the inclusion criteria as outlined in Table 4.1, and reasons for exclusion were documented (Appendices C and D). Screening was performed by two reviewers and cross-verified. Any discrepancies were resolved through discussion or, where needed, a third reviewer.

4.2.4 Data extraction and synthesis

Standardised data extraction templates were developed for both quantitative and qualitative studies with concepts adapted from Bernal and Sáez-Santiago (78) Additionally, a concept related to community collaboration and co-design was introduced. Each study was assessed using a set of predefined criteria, including cultural adaptation criteria (outlined in Table 4.2), to ensure the details on the interventions capture also recorded whether they were appropriately tailored to the cultural needs and contexts of CaLD populations. This approach was used to evaluate the cultural relevance and responsiveness of mental health interventions across diverse communities.

Table 4.2. Cultural adaptation criteria used to assess the included studies [Adapted from Bernal & Sáez-Santiago, 2006 (78)]

Domain	Description
Language	Materials are provided in the client's preferred language.
Persons	Factors related to client–therapist matching, including shared experiences and the therapist's cultural competence.
Metaphors	Use of culturally relevant materials such as stories, idioms, analogies, or character names that reflect the client's cultural background.
Concepts	Theoretical models used are culturally relevant; for example, the presenting problem is communicated in a way that aligns with the client's cultural understanding.
Goals of Treatment/Program	Therapy or program goals are derived from the client's personal and cultural context; for example, family-centred goals rather than individual-focused ones.
Methods	The program or intervention is adapted for ease of uptake, such as simplifying steps or modifying tasks to accommodate literacy levels (e.g., simplified CBT diaries).
Context	Adaptations consider social, political, or economic factors to improve accessibility; for example, flexible scheduling or inclusion of family members.
Content	Cultural knowledge, values, customs, and traditions are integrated into all phases of treatment; for example, including local remedies or adding modules on spirituality.
Community collaboration and co-design*	The active involvement of community members or representatives in the development, adaptation, or delivery of interventions to ensure cultural relevance, local ownership, and alignment with community values and needs.

*Added to the original cultural adaption criteria of Bernal & Sáez-Santiago (2006) to reflect the importance of lived experience in cultural adaption and community ownership.

Extracted data included study characteristics, population and setting, intervention details, provider details, cultural adaptations, outcomes measured and conclusions. Data were extracted by two reviewers, with clarification provided by a third reviewer if needed. Extracted results were synthesised descriptively; findings were collectively summarised and presented narratively, with accompanying numerical data and frequency counts indicating how often specific adaptations or outcomes were reported across studies.

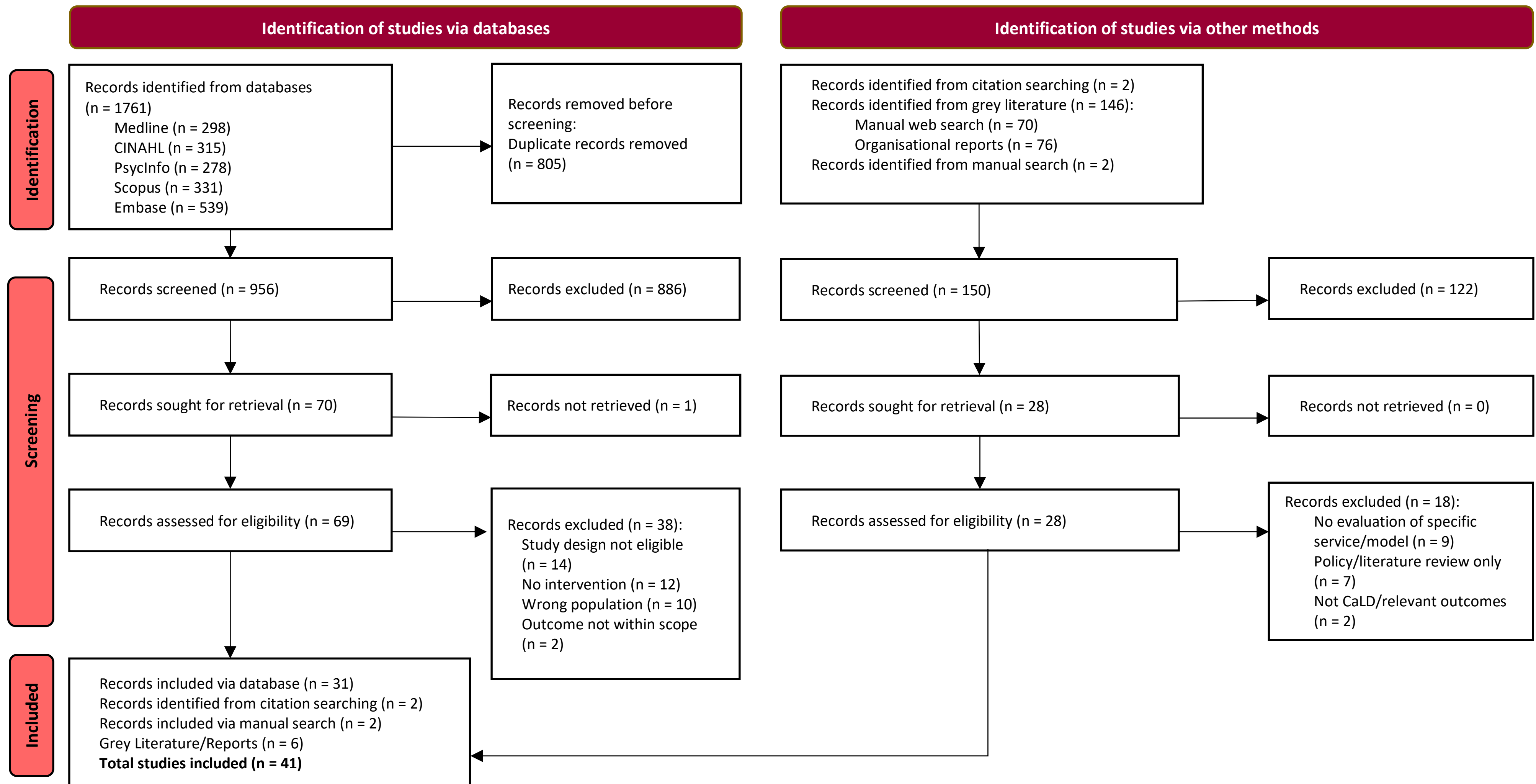
4.3 Results

4.3.1 Search results and study selection

A total of 1,761 peer-reviewed studies were identified through the electronic search in five databases. After removing 805 duplicates, 956 titles and abstracts were screened. Of these,

70 full-text articles were retrieved for full text screening, resulting in the exclusion of 39 studies based on study inclusion criteria. An additional 150 records were sourced through sources other than databases, which included manual search, citation searching and grey literature. Of these, 28 studies were retrieved in full text and assessed for eligibility, with 18 subsequently excluded. The reasons for excluding the full-text articles from both database and grey literature are detailed in Appendices C and D. In total, 31 peer-reviewed studies identified from the electronic databases, two peer-reviewed studies from citation searching, two peer-reviewed studies from manual (hand) searching, and six reports from grey literature were included, resulting in the synthesis of results from 41 studies in this rapid review. The PRISMA flow diagram outlining the study selection process is presented in Figure 4.1.

Figure 4.1. PRISMA flowchart of study identification, selection and inclusion



4.3.2 Characteristics of included studies

Most of the peer-reviewed studies (68.3%; 28/41) involved direct data collection from service user participants, followed by 17.1% (7/41) relying on service provider perspectives, field reports or content analysis of mental health websites. The remaining 14.6% (6/41) were grey literature reports with the majority of these (83.3%; 5/6) involving direct data collection from participants and one (16.7%) with service provider perspectives. Summaries of the key findings and references to the studies are provided in Tables 4.3 and 4.4. Detailed extracted information is provided in Appendix E.

4.3.2.1 Time-trend of publications

A detailed breakdown of the peer-reviewed and grey literature by year of publication is presented in Figure 4.2. Studies published after 2018 accounted for 78.0% (32/41) of the total. The greatest number of studies were published in 2019 (19.5%; 8/41), followed by 2022 and 2023, with 6 and 5 publications, respectively.

Figure 4.2. Number of studies according to year of publication

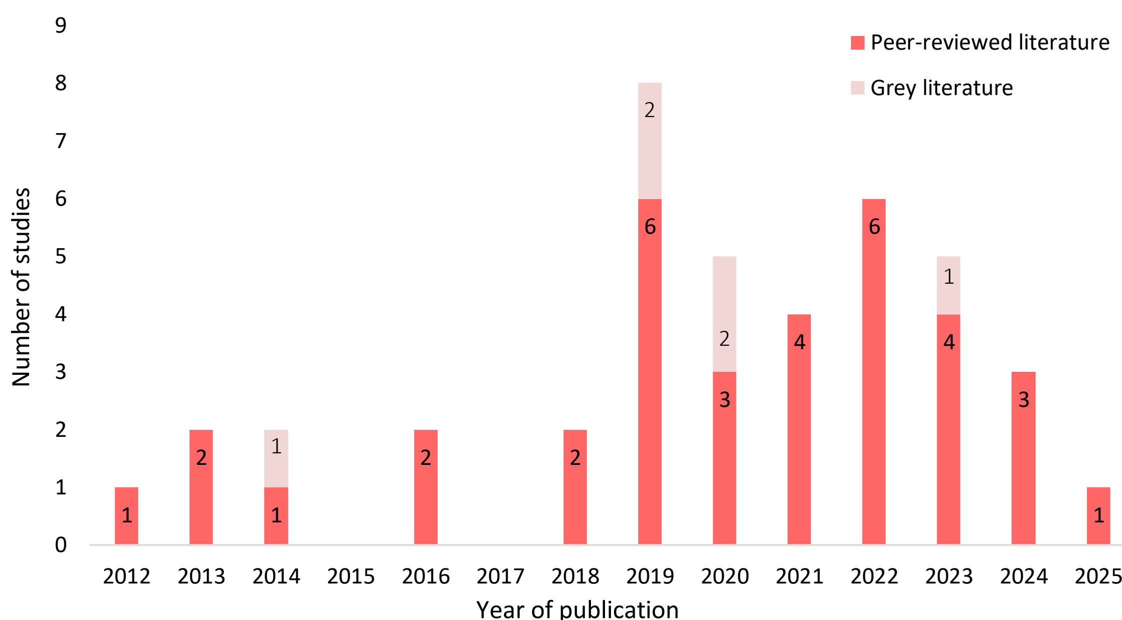


Table 4.3. Summary of data extraction of studies in the rapid review

N	Study	Location	Intervention(s)*	Intervention		Cultural Adaptations									Population	Intervention Details
				Individual	Group	Language	Persons	Metaphors	Concepts	Goals of Tx	Methods	Context	Content	Process		
Studies involving direct data collection from the target population																
1	Blignault 2019 (79)	NSW	Mindfulness and psychoeducation	✓	-	✓	✓	✓	✓	-	✓	✓	✓	✓	Arabic-speaking adults	Psychoeducation and mindfulness program (culturally adapted mindfulness audio program delivered via CD) delivered by a project officer from the community
2	Blignault 2021 (80)	NSW	Mindfulness and psychoeducation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic- and Bangla-speaking adults	Community-based group mindfulness program tailored for Arabic- and Bangla-speaking migrants in improving mental health outcomes delivered by bilingual facilitators (psychologist)
3	Blignault 2022 (81)	NSW	Mindfulness and psychoeducation	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic and Bangla-speaking adults	Community-based group mindfulness program for promoting mental health and wellbeing delivered by bilingual mental health clinicians (psychologists) and community workers
4	Blignault 2023a (82)	NSW	Mindfulness and psychoeducation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic-speaking Muslim women	Psychoeducation and mindfulness program Compact Disc in reducing psychological distress delivered by bilingual (Arabic/English) psychologist with support from bilingual multicultural health worker
5	Bryant 2024 (83)	QLD	Trauma-informed Art therapy and support groups	-	✓	-	-	-	-	-	✓	✓	-	-	Middle Eastern & African adolescent female refugee	Collaborative and side-by-side artmaking in group art therapy reduces social isolation in refugee youth, improves mental health/wellbeing, and fosters peer connections and delivered by Art Therapists (accredited)
6	Chimoriya 2023 (84)	NSW	Psychoeducation and support groups	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic-speaking refugees	Group psychoeducation focusing on Mental health literacy (MHL), reducing stigma, and self-help strategies to promote mental health; delivered in Arabic by experienced bilingual health educators and/or mental health clinicians.
7	Eftimovska-Tashkovska 2016 (85)	NSW	Macedonian Mental Health and Living Skills Program	-	✓	✓	✓	-	✓	✓	✓	✓	✓	-	Macedonian and Serbian migrants with severe mental health conditions	Macedonian Mental Health and Living Skills Program which is a culturally specific mental health support program; weekly, culturally tailored support group program and delivered by Multicultural health officers and bicultural workers; Participants had pre-existing mental health conditions; primarily depression, schizophrenia, or depression with anxiety
8	Gower 2022 (86)	WA	Peer-mentoring empowerment program	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	Middle Eastern and Asian adult female refugee and migrant	Peer-mentoring empowerment program for migrant and refugee women in Western Australia, focusing on improving employability, confidence, and mental health/well-being; mentoring sessions in community settings/online during COVID; delivered by peer bicultural worker and counsellor
9	Hodgins 2025 (87)	NSW	Integrated child and family health (CFH) Hubs	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	Refugee and migrant parents (Service provider also included in study)	Integrated child and family health (CFH) Hubs and develop "building blocks" for successful Hub implementation for migrant and refugee families; hub was run by General Practitioner (GPs engaged where possible), allied health provider (psychologist, speech therapy, occupational therapy) and bicultural worker; provided cultural family interventions and support groups
10	Khawaja 2019 (88)	QLD	BRiTA Futures program	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	CaLD adolescent (12-20yrs)	BRiTA Futures is a flexible, culturally tailored resilience program (acculturation, mental health literacy, and practical settlement skills) for CaLD populations in Australia, adapted for CaLD adolescents; delivered by trained facilitators (school teachers, youth workers, mental health practitioners)
11	Khawaja 2021 (89)	QLD	BRiTA Futures program	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	CaLD adults (≥18 yrs)	BRiTA Futures is a flexible, culturally-tailored resilience program (acculturation, mental health literacy, and practical settlement skills) for CaLD adult populations in Australia; delivered by trained facilitators
12	Khawaja 2022 (90)	QLD	Tree of Life (66) intervention (Narrative therapy)	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	CaLD older Muslim women	Tree of Life (66) intervention in enhancing resilience, wellbeing, and social connectedness among older women; Narrative therapy; delivered by psychologists (registered and provisional)

N	Study	Location	Intervention(s)*	Intervention		Cultural Adaptations									Population	Intervention Details
				Individual	Group	Language	Persons	Metaphors	Concepts	Goals of Tx	Methods	Context	Content	Process		
13	Krstanoska-Blazesk 2021 (71)	NSW	Mental Health Literacy (MHL) training	-	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	Arabic-speaking religious/community leaders	Culturally tailored Mental Health Literacy (MHL) training/workshop program for Arabic-speaking religious and community leaders; delivered by bilingual mental health clinicians.
14	Leone 2014 (91)	NSW SA	CBT groups, psychoeducation and support groups	-	✓	✓	✓	-	✓	✓	✓	✓	-	-	Chinese- and Spanish-speaking dementia carers	Culturally-tailored cognitive behavioural therapy (CBT) intervention for dementia carers in Australia, assessing its impact on depression, anxiety, and stress; delivered by bilingual health professionals with cultural expertise and trained facilitators with clinical backgrounds (Social worker, counsellors)
15	Morawska 2013 (92)	QLD	MHFA training	-	✓	-	-	-	-	-	-	-	-	-	CaLD, (Aboriginal/Torres Strait Islander participants were also included in original study but not extracted)	Mental Health First Aid (MHFA) training in a diverse community setting, particularly focusing on multicultural populations; delivered by qualified MHFA instructor
16	Morse 2024 (93)	ACT	My Mind, My Voice (MMMV) program	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	CaLD adults	My Mind, My Voice (MMMV) program, identify impact-driving processes with a focus on cultural relevance, safety, and inclusivity; delivered by peer workers (lived experience educators), community development workers and MIEACT facilitators
17	Nepal 2023 (94)	NSW VIC TAS ACT	MHFA training	-	✓	✓	✓	-	✓	✓	✓	-	✓	-	Nepalese adults	Mental Health First Aid (MHFA) training in the Nepalese community; delivered by bilingual course instructor (native Nepalese)
18	Nickerson 2019 (95)	NSW	Online cognitive Reappraisal, psychoeducation and social contact modules	✓	-	✓	✓	✓	✓	✓	✓	-	✓	✓	Male refugee with PTSD (Arabic, Farsi or Tamil-speaking)	Online mental health stigma intervention, Tell Your Story (TYS), in reducing self-stigma and increasing help-seeking among refugee men; participants who had at least one clinically significant PTSD symptom; No direct provider involvement (self-guided online program) but community Workers involved in recruitment
19	Ooi 2016 (96)	WA	CBT groups	-	✓	-	-	-	-	-	-	-	-	-	War-affected young migrants (10–17 yrs)	Teaching Recovery Techniques (TRT; a CBT intervention) in improving emotional and behavioural outcomes (PTSD, depression, internalising/externalising problems, psychosocial functioning) in resettled in Australia; delivered by trained facilitators and co-facilitators who had tertiary education in Psychology
20	Ospina-Pinillos 2019 (97)	NSW	Spanish version of the Mental Health eClinic (MHeC-S);	✓	-	✓	✓	-	✓	✓	✓	-	-	✓	Spanish-speaking international Students	Design (design process involved group workshops) and culturally adapt a telehealth service; Spanish version of the Mental Health eClinic (MHeC-S) for Spanish-speaking young people in Australia, focusing on improving accessibility and usability; delivered by mental health clinicians: psychiatrists, psychologists
21	Poon 2020 (98)	NSW	Support groups (99)	-	✓	✓	✓	-	✓	✓	✓	✓	✓	-	Chinese and Vietnamese carers of people with mental illness	Monthly, bilingual support groups which provided culturally and linguistically-tailored mental health education, peer support, and coping strategies; targeted individuals who were carers of people with mental illness from Chinese and Vietnamese background; delivered by Community Workers (Bicultural Worker, Peer Worker), Mental Health Clinical (Social Worker) and Support Services (Interpreter)
22	Poon 2022 (100)	NSW	Support groups (99)	-	✓	✓	✓	-	✓	✓	✓	✓	✓	-	Vietnamese parents caring for children with disabilities	Monthly, Vietnamese-language support groups, providing culturally tailored psychoeducation (e.g., NDIS navigation, disability management), peer-led emotional support, and coping strategies to reduce isolation and stigma; delivered by Trained bilingual group leader (social work background);

N	Study	Location	Intervention(s)*	Intervention		Cultural Adaptations									Population	Intervention Details
				Individual	Group	Language	Persons	Metaphors	Concepts	Goals of Tx	Methods	Context	Content	Process		
23	Radhamony 2022 (101)	VIC	General Mental health services	✓	✓	Not Applicable									CaLD adults	Study is perspectives of Victoria's CaLD community, revealed a need for culturally-adapted mental health services, informing an education package for nurses that addresses language, cultural competence, relevant models, client-led goals, literacy, access, values, and community involvement.
24	Slewa-Younan 2020a (102)	NSW	Mental Health Literacy and brief lifestyle intervention	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic-speaking refugees	Culturally-tailored mental health promotion program in improving mental health literacy and reducing psychological distress; provided psychoeducation and support; delivered by bilingual health educators and/or mental health clinicians
25	Slewa-Younan 2020b (103)	NSW	MHL training	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic-speaking religious and community leaders	Culturally tailored Mental Health Literacy (MHL) training/workshop program for Arabic-speaking religious and community leaders; delivered by bilingual mental health clinicians
26	Uribe Guajardo 2019 (104)	NSW	MHFA training	-	✓	-	-	✓	✓	-	✓	✓	✓	✓	CaLD adolescents and adults (teachers/parents also included)	Teen Mental Health First Aid (tMHFA) and Youth Mental Health First Aid (YMHFA) training; Delivered accredited teen MHFA Instructors with specific training and experience in youth mental health, while the Youth MHFA program for adults was delivered by instructors from CaLD background
27	van Wyk 2012 (105)	QLD	Multiple types	✓	-	✓	✓	-	✓	✓	✓	-	✓	-	Burmese refugees	Therapy included structured skills-based therapy, supportive psychotherapy, expressive therapy, family therapy and CBT/exposure therapy; delivered by Therapists: psychologists, social workers, counsellors
28	Wollersheim 2013 (106)	VIC	Mobile phone-based peer support	✓	✓	✓	✓	-	✓	✓	✓	-	-	✓	Women refugees Nuer background (South Sudanese)	Culturally-tailored mobile phone-based peer support can improve psychosocial health and facilitate settlement; Psychoeducation, support group and telehealth; delivered by community workers
Studies not involving direct data collection from the target population (e.g., data collected from service providers working with CaLD populations, field reports, or content analysis)																
29	Blignault 2023b (107)	NSW	Mindfulness and psychoeducation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Only community partners were interviewed (working with CaLD populations)	Intervention consisted of multi-session group mindfulness programs, with five-week face-to-face sessions and four-week online stress management programs; delivered by bilingual psychologists and trained community workers, with co-facilitators including bilingual psychology interns and community organisation staff
30	Kalantidou 2022 (108)	QLD	Environmental design intervention	✓	✓	-	-	✓	-	✓	✓	-	-	-	Only staff members were interviewed (working with Refugees, migrants and asylum seekers)	Transform a migrant mental health service into a therapeutic space by exploring design interventions that enhance wellbeing and address cultural barriers for CaLD clients; delivered by design researchers
31	Kara 2024 (109)	Two states from Australia	BRiTA Futures	✓	✓	-	✓	-	✓	✓	✓	✓	✓	✓	Mental and allied health practitioners were in Focus group (working with CaLD populations)	BRiTA Futures is a flexible, culturally-tailored resilience program (acculturation, mental health literacy, and practical settlement skills) for CaLD populations in Australia, delivered in group workshops or individual sessions by trained multicultural workers and mental health professionals
32	Karageorge 2018 (110)	NSW	Strength to Strength (STS) program	✓	✓	-	✓	-	✓	✓	✓	✓	✓	✓	Staff of STS were interviewed (working with recently arrived refugee families)	Strength to Strength (STS) program is a community-based family relationships service for recently resettled refugee families in Sydney; Psychoeducation, family therapy, and support groups; delivered collaboratively by bicultural workers and trained family therapists from Relationships Australia NSW.

N	Study	Location	Intervention(s)*	Intervention		Cultural Adaptations									Population	Intervention Details
				Individual	Group	Language	Persons	Metaphors	Concepts	Goals of Tx	Methods	Context	Content	Process		
33	Murray 2021 (111)	Australia	Content analysis of Government-funded mental health websites	✓	✓	Not Applicable									Content analysis of websites (Target population: CaLD)	Only a small proportion of the mental health websites reviewed offered translated content, culturally inclusive materials, or multilingual support services for CaLD communities, with limited accessibility and representation overall.
34	Nemorin 2019 (112)	NSW	Multiple types	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Field report of multiple interventions (Target population: Rohingya refugees)	STARTTS delivered a range of trauma-informed interventions for the Rohingya community in Lakemba, including individual and family counselling, school-based therapeutic groups, teacher training, and community workshops like Families in Cultural Transition (FICT). They also supported social inclusion through sports partnerships and empowered community leadership through refugee advocacy and training initiatives.
35	Uribe Guajardo 2018 (113)	NSW	MHFA training	-	✓	-	-	✓	✓	✓	✓	-	✓	✓	Training to community-based workers (Target population: Iraqi refugees)	Intervention was a seven-hour Mental Health First Aid course, delivered across two sessions in a single day to Community-based workers, based in Western Sydney, assisting Iraqi refugees on their resettlement; was delivered by trained Mental Health First Aid instructor also a primary researcher in the study

Note: "✓" indicates that the study reported on the category in the manuscript, whereas "–" indicates that the study did not mention that category in the text used for data extraction. *Named interventions as described by the authors.
Abbreviation: ACT: Australian Capital Territory; BRiTA: Building Resilience in Transcultural Australians; CaLD: Culturally and Linguistically Diverse; CBT: Cognitive Behavioural Therapy; CD: Compact Disc; CFH: Child and Family Health; FICT: Families in Cultural Transition; GP: General Practitioner; MHeC-S: Mental Health eClinic (Spanish version); MHFA: Mental Health First Aid; MHL: Mental Health Literacy; MIEACT: Mental Illness Education ACT (Australian Capital Territory); NSW: New South Wales; PTSD: Posttraumatic Stress Disorder; QLD: Queensland; SA: South Australia; STARTTS: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; STS: Strength to Strength; TAS: Tasmania; tMHFA: teen Mental Health First Aid; TOL: Tree of Life; TRT: Teaching Recovery Techniques; VIC: Victoria; WA: Western Australia; YMHFA: Youth Mental Health First Aid;

Table 4.4. Summary of data extraction of studies from grey literature

N	Study	Location	Intervention(s)*	Intervention		Cultural Adaptations									Population	Intervention Details
				Individual	Group	Language	Persons	Metaphors	Concepts	Goals of Tx	Methods	Context	Content	Process		
Studies involving direct data collection from the target population																
1	Slewa-Younan 2019 (114)	NSW	Teen & Youth MHFA	-	✓	-	✓	✓	✓	-	✓	✓	✓	✓	Year 10 students from CaLD/refugee backgrounds and teachers and responsible adults who work with them	Culturally-adapted MHFA curriculum; new CaLD case vignettes; local resource list; two Fairfield-specific videos; delivered by accredited CaLD instructors (bilingual MHFA instructors from the CaLD background); evaluated pre/post/3-month. Overall, relational, trauma-informed, culturally-responsive practice was key to sustained use of services.
2	Vaughan 2020 (115)	VIC SA TAS	Sector Capacity-Building & Service-Coordination, Psycho-social support	✓	✓	✓	✓	-	-	-	✓	✓	✓	✓	Migrant & refugee women	Mixed-methods study about family violence experience for migrant and refugee women: 3 pre- & 3 post-consultative workshops; also conducted a national survey with n = 378; 47 provider interviews + 11 refugee-women interviews; 4 participatory workshops (n = 47); produced recommendations (e.g., embed risk-assessment & referral protocols, fund bicultural workforce, trauma-informed training) to strengthen early-intervention support through settlement/multicultural services; delivered by bicultural/bilingual workers & volunteers, bicultural clinicians in torture-&-trauma services; external interpreters/ language services
3	Woodland 2019 (116)	NSW	Mindfulness and psychoeducation	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Arabic- and Bangla-speaking adults	Community-based 5-week group mindfulness program tailored for Arabic- and Bangla-speaking migrants, delivered by bilingual mental health clinicians and psychologists; 24 groups (16 Arabic, 8 Bangla); weekly 2-hour sessions + home practice; 81% completion; delivered by bilingual mental-health clinicians, bilingual community workers, NAATI translators prepared materials
4	Valibhoy 2014 (117)	VIC	Practitioner-guidance (qualitative)	✓	-	✓	✓	-	-	-	✓	✓	✓	✓	Refugee-background youth (aged 18–25 yrs)	Project Talking with Young Refugees about Experiences of Services (TYRES): Semi-structured interviews with refugee youth were thematically analysed and distilled into a culturally-responsive practice guide for mental-health clinicians (psychologists, counsellors, social workers). The guidance covers addressing stigma and confidentiality, building trust through attuned listening, trauma- and loss- informed care, the collaborative use of interpreters, and flexible service parameters to enhance engagement.
5	So 2023 (118)	NSW	Pilot brief-treatment clinic	✓	-	✓	✓	-	✓	✓	✓	✓	✓	✓	Recently arrived Afghan & Sri Lankan Tamil adults with refugee or asylum-seeker	NSW Refugee Health Flexible-Fund project; free service; approx. 7 sessions mean dose; high attendance, psycho-education on stress & sleep, grounding/relaxation skills, problem-solving, social-prescribing to community supports; holistic care plan; delivered by bilingual clinicians or with NAATI interpreters via clinic rooms, telephone or video; integrates early screening (K10, WHOQOL-BREF) and warm transfer to GP, STARTTS, MH-CLSR or public CMHTs for higher-level care; aims to prevent deterioration and restore day-to-day role functioning.
Studies not involving direct data collection from the target population (e.g., data collected from service providers working with CaLD populations)																
6	De Silva 2020 (119)	VIC	Organisational capacity-building	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	Staff (support workers, managers, peer workers) of working on transcultural and community mental health	The program used a mixed-delivery model: most activity was group-based (20 cross-site workshops, six reflective-practice sessions, a monthly champion network and state-wide communities of practice) while key leaders received one-to-one mentoring, case consultations and on-call advice; interpreter guidelines and culturally safe intake procedures were adopted across all Victorian sites

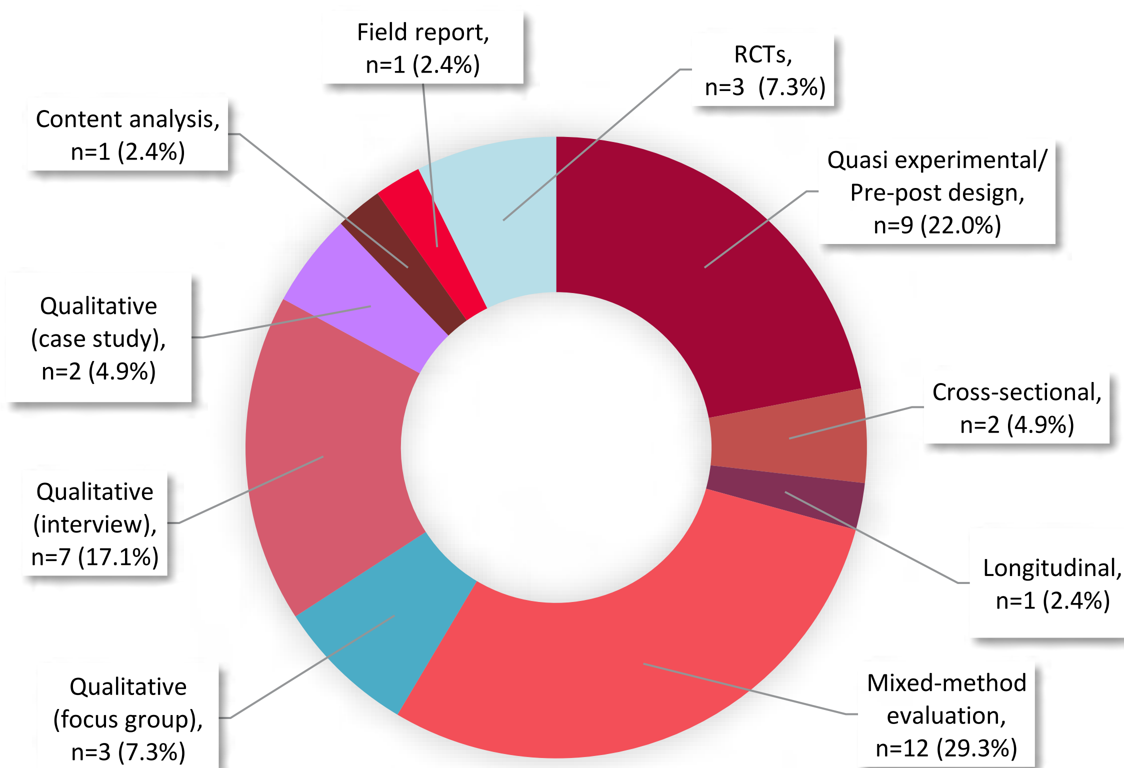
4.3.2.2 Location of studies

Most of the studies (87.8%; 36/41) were conducted in a single state. Of these, 22 studies (53.7%) were conducted in NSW, followed by seven studies (17.1%) in Queensland, and four studies (9.8%) in Victoria. Two studies (4.9%) were from Western Australia, and one (2.4%) from the Australian Capital Territory (ACT). Additionally, five studies (12.2%; 5/41) were conducted across multiple jurisdictions (including, one or more studies from NSW, South Australia, Tasmania, Victoria, and ACT). One study (2.4%) referred to two states without explicitly naming them, and one study (2.4%) covered all jurisdictions.

4.3.2.3 Study design

In terms of research design, 15 studies (36.6%) were quantitative, 14 (34.1%) were qualitative, and 12 (29.3%) used mixed-methods. Among the quantitative studies, three (7.3%) involved randomised controlled trials (RCTs), including one cluster RCT, and nine employed quasi-experimental or pre-post designs (22%; 9/41). Cross-sectional and longitudinal designs were used in two studies (4.9%) and one study (2.4%), respectively. The 12 mixed-methods studies (29.3%) were predominantly evaluations. Among the qualitative studies, semi-structured interviews were the most frequent method (seven studies, 17.1%), followed by focus groups (three studies, 7.3%), case studies (two studies, 4.9%), content analysis (one study; 2.4%), and field report (one study; 2.4%). A detailed breakdown of study design is provided in Figure 4.3.

Figure 4.3. Breakdown of study design of included studies



4.3.2.4 Characteristics of population included

The studies included a wide range of CaLD populations, with notable representation from Arabic-speaking (24.3%; 10/41) and Bangla-speaking groups (7.3%; 3/41), followed by Vietnamese (4.9%; 2/41), Chinese (4.9%; 2/41), Tamil speakers (4.9%; 2/41), and Spanish speakers (4.9%; 2/41). Smaller numbers of studies focused on Farsi- and Nuer-speaking groups, as well as specific ethnic groups such as the Nepalese, Burmese, South Sudanese (Nuer), Afghan, Rohingya, Sri Lankan Tamil, and Iraqi communities. In terms of migration stream or status, 22% (9/41) of studies focused exclusively on refugees or asylum seekers. The remaining studies addressed mixed or general CaLD populations without specifying a particular ethnic group or migration status. Most studies focused on adults (87.8%; 36/41), with only five (12.2%; 5/41) specifically targeting adolescents or individuals under the age of 18. Gender-specific studies were limited, with 14.6% (6/41) focusing on women and one focusing on men. Three studies (7.3%) focused on carers, including those caring for individuals with mental illness, dementia, or disabilities. Other target groups included youth and students, religious or community leaders, and healthcare or support staff.

4.3.3 Type of care and service settings

The majority of studies (85.4%; 35/41) reported interventions that were delivered in group settings, while 51.2% (21/41) reported individual interventions (with or without group intervention). Psychoeducation was the most common type of care, frequently combined

with support groups (85, 86, 98, 100) and mindfulness-based interventions. (79-82, 107). Culturally tailored cognitive behavioural therapy (CBT) was used for specific groups such as war-affected youth (96) and dementia carers. (91) Delivery was commonly outreach-based (e.g., community centres, religious settings and schools) or took place in outpatient non-hospital settings, with increasing use of telehealth/online formats during the COVID-19 pandemic. (80, 81, 109) For example, Nickerson et al. evaluated "Tell Your Story" (TYS), an online, culturally tailored intervention combining psychoeducation, social contact, and cognitive reappraisal to reduce mental health stigma and increase help-seeking among refugee men with PTSD symptoms, delivered via a web-based platform without clinician support. (95) Similarly, most of the interventions were time-limited (e.g., 4–8 weekly sessions) although mentoring programs were longer. (86)

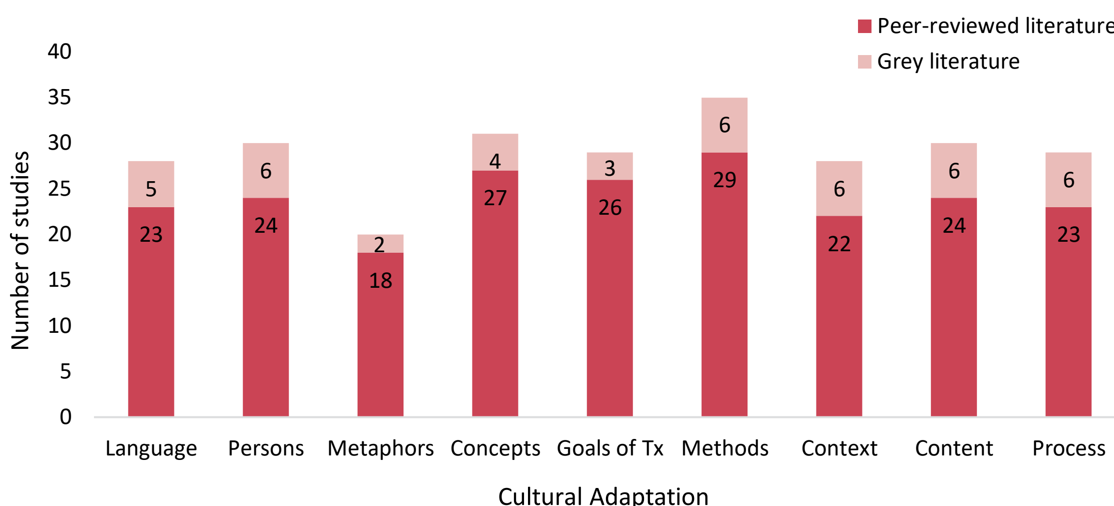
In terms of the spectrum of care, studies focused heavily on health promotion, including building mental health literacy and reducing stigma, (71, 102, 103) and prevention or early intervention for at-risk groups experiencing distress, acculturative stress or isolation. (79, 80, 82, 83, 88-90) Treatment was incorporated in some of the interventions, such as CBT for posttraumatic stress disorder, (96) and multimodal interventions including exposure-based therapy. (105) One study reported on a living skills support group for severe mental illness (85), while continuing care also featured in long-term support models. (85, 87, 108) Integrated care models, such as co-located services in community hubs (87) or collaborations between community organisations and health services, (107, 112) were also reported.

Service providers were predominantly bilingual/bicultural mental health clinicians (e.g., psychologists and social workers) and bilingual/bicultural community workers or peer facilitators. This strategy combined professional expertise with cultural and linguistic knowledge and skills and lived experience. (86, 93) Programs were often implemented through partnerships between Primary Health Networks (PHNs), Multicultural Health Services, ethno-specific NGOs, and cultural/religious organisations. For example, studies demonstrated partnerships with South Eastern Sydney Local Health District, (79) Central and Eastern Sydney Primary Health Network, (80) Queensland Transcultural Mental Health Centre partners, (88) and STARTTS. (112) Training community leaders (71, 103) and peers, (86, 106) was a key strategy to augment reach and sustainability of the intervention.

4.3.4 Cultural adaptation

Almost all studies reported interventions that had involved some form of cultural adaptation. The most reported domain was methods, which was included in the majority of studies (85.4%; 35/41). Figure 4.4 presents the number of studies (out of a total of 39) that reported various domains of cultural adaptation. For two studies, the domains were not applicable, as Radhamony et al. solely focused on general experiences in mental health services, and Murray et al. focused on content analysis of websites. (101, 111) Two studies did not report undertaking any cultural adaptation within the manuscript. (92, 96)

Figure 4.4. Number of studies reporting cultural adaptation



4.3.4.1 Language and persons

As described in Table 4.2, language adaptation refers to the use of materials in the client's preferred language to facilitate understanding and engagement. The persons domain encompasses factors related to the client–therapist dynamic, including cultural competence, shared lived experiences, and efforts to build trust through cultural alignment. Together, these domains focus on the importance of linguistic accessibility and culturally-attuned interpersonal relationships in delivering effective and respectful mental health care. The language domain was reported as culturally adapted in 28 studies (68.3%), and the persons domain in 30 studies (73.2%). Most programs provided materials and conducted sessions in participants' native or first languages (such as Arabic, Bangla, Chinese, Vietnamese, Nepali and Spanish) to support comprehension and engagement. Moreover, several studies reported simplifying clinical terminology (91) and incorporating visual aids (93) to accommodate participants with diverse literacy levels. Many interventions utilised bilingual/bicultural facilitators who shared linguistic, ethnic or migration backgrounds with participants, thereby fostering trust and rapport. Community leaders, peer supporters, (98, 106) and individuals with lived experience were often involved in program delivery to enhance cultural congruence and relevance. (86, 93)

4.3.4.2 Culturally resonant metaphors and concepts

Metaphors refer to the use of culturally relevant materials, such as familiar stories, idioms, analogies, or character names that reflect the values, traditions, and lived experiences of the target cultural group, helping to convey meaning in a more relatable and resonant way. Concepts, on the other hand, involve the use of culturally appropriate theoretical models or frameworks, where the presenting problem is communicated in a manner consistent with the cultural beliefs, values, and explanatory models of the population being served. Concepts were reported to be culturally adapted in 31 studies (75.6%), while metaphors were

mentioned in only 20 studies (48.8%). Several studies integrated culturally relevant metaphors and concepts to enrich the resonance and effectiveness of mental health interventions. For example, mindfulness practices were linked to Islamic values such as “sabr” (patience), (79) and therapeutic frameworks such as the “Tree of Life” narrative were used to foster emotional connection and cultural relevance. (90) Culturally-tailored vignettes (such as using characters like “Dawood” for Iraqi refugee participants) helped contextualise mental health issues within familiar cultural and religious (Islam/Christianity) narratives. (71, 84, 102, 103, 113) Moreover, spiritual and religious teachings, including Quranic references and the incorporation of prayer, were often integrated into interventions to ensure alignment with participants’ belief systems. (79, 82)

Western psychological models, such as CBT and trauma-informed care, were adapted to reflect collectivist values that emphasise family values and community resilience. (95) Some interventions blended clinical approaches with traditional healing practices, acknowledging the complementary role of spiritual counselling alongside psychotherapy. (81, 89) Mental health was often explained through culturally familiar idioms and expressions, including somatic symptoms and metaphors to align with the linguistic and conceptual frameworks of participants. (71, 84, 102, 103, 113)

4.3.4.3 Culturally aligned intervention goals

Culturally aligned intervention goals refer to the extent to which therapy or program objectives are shaped by the client’s personal values, cultural priorities, and social context. Goals of treatment were reported to be culturally adapted in 29 studies (70.7%). Many programs prioritised culturally aligned goals that reflected the lived experiences and values of participants, often focusing on client-derived outcomes such as family cohesion (90, 91, 96, 98, 100), and acculturation support and community reintegration, (105, 109) rather than focusing solely on individualistic clinical goals. Intervention objectives frequently addressed migration-related stressors, including challenges associated with resettlement, (105, 110) intergenerational conflict, (89, 93, 109) and experiences of discrimination, (89, 90, 101) ensuring that the programs remained relevant and responsive to the specific needs of CaLD populations.

4.3.4.4 Adapting methods and content

Adapting methods and content refers to modifications made to both the delivery and content of interventions to enhance cultural relevance and accessibility. Methods include practical adjustments such as simplifying steps, reducing literacy demands (e.g., modifying CBT diaries), or tailoring delivery formats. Content involves incorporating culturally specific knowledge, values, customs, and traditions throughout the intervention. Methodological adaptations were reported in 35 studies (85.4%) and content adaptations were reported in 30 studies (73.2%). Many interventions simplified their structures to accommodate participants’ needs, for example by using flexible sessions, (97, 104) oral storytelling, (90) and

role-plays in place of literacy-dependent tasks. (88, 89) Flexible delivery modes, including in-person, online and hybrid formats, as well as the use of community-based settings such as mosques and cultural centres, (80, 81, 103) enhanced accessibility and participation. Nonverbal methods such as art therapy and music were used to overcome language barriers. (83)

4.3.4.5 Adapting to context

Adapting to context refers to modifications that account for the broader social, political and economic circumstances of the target population. Context adaptations were reported in 28 (68.3%) programs. Programs frequently integrated cultural values and traditions, including communal rituals such as prayer (84, 90, 102, 103, 114), traditional coping mechanisms, and collectivist approaches to problem-solving. (98, 100, 106) Several studies also addressed stigma related to mental health services, particularly scepticism towards Western clinical models. By validating and integrating traditional healing practices alongside biomedical approaches, these interventions fostered greater cultural congruence and community acceptance of mental healthcare. (81, 112)

4.3.4.6 Community collaboration and co-design

Community collaboration and co-design refer to the active involvement of community members or representatives in the development, adaptation, or delivery of interventions to ensure cultural relevance, local ownership, and alignment with community values and needs. Community collaboration was reported in 29 studies (70.7%). Many interventions were co-designed with CaLD community members, elders, and organisations to ensure cultural relevance and responsiveness. (71, 84, 102, 103, 106, 109, 113) This collaborative approach promoted shared ownership and trust in the intervention process. Iterative feedback mechanisms, such as community advisory boards, and ongoing consultation, were used to refine programs based on participants' input, allowing for continuous adaptation and improvement. (95)

4.4 Discussion

We conducted a rapid review to identify and synthesise evidence on community-based mental health services for CaLD populations in Australia. We included empirical studies published between September 2012 and February 2025 that examined community-based interventions, programs or services aimed at improving mental health and wellbeing, service access, or user experiences for these populations. The trend analysis demonstrated there has been an increase in publications in this area. However, the relatively small number of studies suggests that research in this area remains limited and under-developed.

4.4.1 CaLD community attitudes and experiences

Included studies reported that mental health and illness are often conceptualised through cultural, religious or spiritual frameworks, with psychological distress frequently expressed in somatic terms or understood as a manifestation of social or spiritual imbalance. (98, 100-102, 117) Further, high levels of stigma remain a pervasive barrier to help-seeking among CaLD populations. (71, 95, 102-104) Fears of being labelled, bringing shame to the family, harming marriage and other prospects, or being perceived as weak often deter individuals from accessing formal services. (71, 84, 94, 98, 101, 102)

Mistrust of the healthcare system is not uncommon, particularly among refugee populations who may carry trauma related to past experiences with authorities. This mistrust is compounded by negative encounters with mainstream mental health services, which may involve rushed consultations, poor cultural understanding, or inadequate communication, even in the presence of interpreters. (101, 109, 113, 117) Consequently, the studies reviewed, highlighted there is a strong preference for informal sources of support, such as family members, close friends, religious leaders and respected community elders. (103, 105, 106, 110) Many also seek holistic approaches to care that address broader settlement challenges, such as employment and legal issues, alongside mental health concerns, recognising the interplay between social and psychological wellbeing. (86, 112, 117, 118)

Positive service experiences are closely tied to culturally safe practices, including the use of professional interpreters and bilingual/bicultural workers, respectful engagement that fosters trust, understanding of migration and resettlement histories, and the creation of welcoming, non-judgmental therapeutic spaces. (82, 108, 117)

4.4.2 Barriers to access and engagement

Our review found that barriers to mental health access for CaLD communities exist at multiple, intersecting levels and significantly impact service engagement. Language and communication challenges are central, and many services lack access to qualified interpreters, particularly for less common languages or specialised mental health terminology. (98, 101, 105) Moreover, translations of mental health resources are often of poor quality or lack cultural appropriateness. (109, 111) Even when interpreters are available,

individuals may avoid using them due to concerns about confidentiality, fear of community stigma, or a preference for workers with shared cultural and linguistic backgrounds. (101, 117) Cultural insensitivity in service delivery further exacerbates disengagement. Mental health practitioners often lack adequate understanding of cultural worldviews, expressions of distress, family roles, and the complexities of migration and resettlement. (101, 109, 117) Spiritual beliefs and traditional healing practices are also frequently misunderstood. (98, 103) Importantly, stigma remains a major barrier, and individuals often internalise shame or fear judgment from their community and family. (71, 84, 95, 98)

Systemic and structural barriers also play a significant role. Financial constraints such as service and medication costs, transport expenses and limited access to bulk-billing pose additional obstacles, particularly for individuals with temporary or precarious visa status. (98, 101, 118) Practical challenges include lack of transport, inflexible appointment scheduling, childcare responsibilities, and long waiting times. (86, 101, 106) Access to culturally appropriate services is even more limited outside major urban centres. Further compounding these issues is a widespread lack of awareness in CaLD communities about mental health conditions, available support options and help-seeking pathways. (71, 101, 102) For many refugees and asylum seekers, past experiences of persecution, trauma, and betrayal by state authorities have fostered deep mistrust of systems, including healthcare, which can hinder their willingness to engage with services. (95, 105, 112, 118)

4.4.3 Enablers to access and engagement

Culturally adapted interventions included this review consistently demonstrated high levels of engagement, acceptability and effectiveness, particularly when programs were specifically tailored to language, cultural values, beliefs, and community contexts. Our findings indicate that language and communication considerations are integral. Effective programs are delivered in the preferred language of participants to foster understanding, comfort and trust. (79-82, 88, 90, 98, 100, 102, 103, 107, 114) Cultural concepts and framing further enhance relevance by aligning mental health interventions with participants' spiritual, familial and community values. For example, mindfulness has been framed within Islamic spiritual practices (79, 80, 82), and metaphors such as the "Tree of Life" have been adapted to resonate with Islamic values. (90) Similarly, culturally grounded case vignettes improve comprehension and relatability. (71, 84, 102, 103, 114)

Programs are more effective when goals reflect culturally valued outcomes, such as maintaining family harmony, strengthening community connections, enhancing practical coping, and supporting spiritual well-being, rather than narrowly focusing on symptom reduction. (86, 88-90, 110) Also, when they use methods of delivery that have been adapted to literacy and learning preferences of the community. For example, storytelling, art, group discussions, and role-play; supported by flexible formats such as online sessions, home visits, and practical skill-building workshops. (83, 88, 89, 106) A bilingual/bicultural workforce is

critical for facilitating engagement. Across the health system, workers who share the client's cultural and linguistic background can fulfill an important cultural broker role, enhancing communication, building trust and bridging gaps in understanding. (89, 102, 103, 107, 110)

Collaboration and co-design further strengthen program relevance and sustainability. Actively involving community members in the design, implementation, and evaluation of interventions ensures cultural legitimacy along with fostering a sense of ownership. (93, 95, 112, 119) Delivering care in trusted community settings, such as places of worship, community centres, schools, or migrant resource hubs and through community gatekeepers, and including elders, faith leaders, and established local organisations, significantly enhances access and credibility. (71, 79-82, 85, 87, 102) A focus on integrated and holistic care recognises the interplay between mental health and broader social determinants of health such as housing, employment, financial security, and legal status. Coordinated service provision across mental health, settlement, social, and primary care sectors has also been shown to improve outcomes. (86, 87, 112, 118)

Moreover, trauma-informed and culturally safe practices are fundamental, especially for refugees and asylum seekers. These approaches centre on understanding trauma across the migration journey, and fostering safety, trust, empowerment, and choice, while avoiding re-traumatisation. (87, 105, 110, 112) Culturally-tailored mental health literacy (MHL) programs targeting both community members and leaders improve the ability to recognise mental health problems, reduce stigma, increase help-seeking intentions, and build the confidence to support others. (71, 91, 92, 94, 102-104, 113)

Table 4.5 presents a summary of the key barriers and enablers to mental health service access and engagement for CaLD populations identified in this review.

Table 4.5. Barriers and enablers to mental health service access and engagement for CaLD populations

Barriers	
Language and communication	- Lack of qualified interpreters (especially for uncommon languages/mental health terms) - Poor-quality or culturally inappropriate translations - Reluctance to use interpreters due to confidentiality concerns and stigma - Predominance of English-only services
Cultural and social factors	- Cultural insensitivity and lack of understanding of worldviews, distress expression, family roles - Misunderstanding of spiritual and traditional healing practices - Internalised and community stigma
Systemic and structural issues	- Financial constraints: service/medication costs, transport, limited bulk billing - Practical barriers: transport, appointment times, childcare, wait times - Lack of services in rural/regional areas - Limited awareness of mental health and help-seeking pathways - Mistrust due to prior trauma or persecution (especially refugees/asylum seekers)
Enablers	
Culturally adapted interventions	- Tailored to language, values, beliefs, community context - Delivered in preferred language - Cultural framing of interventions - Focus on family, spirituality, community; not just symptom reduction
Flexible and inclusive methods	- Use of storytelling, art, role play, group discussions - Online sessions, home visits, practical workshops - Literacy-sensitive approaches
Workforce and delivery	- Bilingual/bicultural staff act as cultural brokers - Shared cultural and linguistic backgrounds improve trust and communication
Community partnership and co-design	- Involvement of community in design, delivery, evaluation - Use of trusted settings (e.g., mosques, schools, community hubs) - Involvement of elders, religious leaders, gatekeepers
Integrated support	- Linked services: mental health, settlement, social care, primary care - Addressing social determinants: housing, employment, legal status
Trauma-informed care	- Understanding trauma from migration journey - Emphasis on safety, empowerment, trust, and avoiding re-traumatisation
Mental health literacy	- Community and leader-targeted programs to improve recognition, reduce stigma, and promote help-seeking

4.4.4 Current and emerging good practices

Programs such as STARTTS' work with Rohingya communities (112), co-designed mindfulness interventions (79-82, 107) and peer mentoring approaches (86, 106) demonstrate the importance of community partnership throughout all phases. A well-supported bilingual/bicultural workforce is fundamental to the success of such initiatives, as these workers play a critical role in building trust, ensuring accurate communication and bridging cultural gaps. (110, 112) Integrated care models that bring together mental health, primary care, settlement support, parenting programs, and social services within accessible community settings show strong potential to address service fragmentation and complexity. For instance, the Child and Family Health Hubs exemplify how co-located services can reduce barriers and enhance holistic care. (87) Digital tools when culturally adapted and strategically developed, can expand reach and accessibility, particularly when they are complemented by human support. For example, a participatory design approach was used to co-develop a culturally adapted Spanish-language Mental Health eClinic (MHeC-S) for Spanish-speaking young people, addressing language barriers and the need for tailored content. The well-received prototype featured self-assessments, video consultations, and personalised well-being plans, with smartphones as the main access point. (97) Another example is Tell Your Story, highlighting how technology can be harnessed effectively in CaLD contexts. (95) Programs such as BRiTA Futures (88, 89), Tree of Life (90), and Capoeira Angola (112) shift the narrative away from deficits by focusing on cultural strengths and resilience.

These approaches recognise and build upon existing coping strategies within communities, along with providing culturally meaningful avenues for healing and growth. Importantly, promising practices must extend beyond individual programs to the broader health and social service systems. Organisational commitment to cultural responsiveness, workforce training in cultural safety and trauma-informed care, culturally appropriate intake and assessment processes, robust interpreter services, and meaningful data collection on CaLD populations are also essential. (108, 111, 119) Moreover, sustained efforts to enhance mental health literacy and reduce stigma are vital. Culturally-tailored MHL and anti-stigma campaigns for CaLD communities, including CaLD health and community service providers help to improve recognition of mental health issues, promote help-seeking behaviours, as well as foster inclusive service environments. (71, 93, 102, 103)

4.4.5 Strengths and limitations

This rapid review included both peer-reviewed and grey literature, thus helping to mitigate publication bias. However, the analysis was limited to the period between 2012 and 2025 and relied exclusively on publicly available sources. As a result, it is unlikely that all community-based programs or service innovations conducted during this period were captured. Moreover, a formal quality assessment of the included studies was not undertaken. Further work needed to explore variations in needs and outcomes across different cultural and

linguistic subgroups, as well as among long-established (and ageing) and more recently arrived populations (including international students and seasonal workers).

4.5 Conclusion

This rapid review of the recent literature on community-based multicultural mental health interventions revealed a marked increase in the number of empirical studies published since 2019, reflecting growing recognition of the distinct mental health care needs of Australia’s CaLD populations, including migrants, refugees and asylum seekers. However, the relatively small number of studies identified (41 in total) suggests that research in this area remains limited and under-developed. A significant investment in research is needed to inform future policy and practice. Included studies highlighted that within CaLD communities, mental health and illness are often conceptualised through cultural, religious or spiritual frameworks, with psychological distress expressed in somatic terms or understood as a manifestation of social or spiritual imbalance. High levels of stigma remain a pervasive barrier to help-seeking, but stigma is only one of the many barriers that exist at multiple, intersecting levels and significantly impact access and engagement. Language and communication issues are central. Systemic barriers and structural inequities were also reported and need to be addressed. Most interventions included tailoring to the linguistic, cultural and contextual needs of the target communities. These culturally adapted evidence-based services and programs consistently demonstrated high levels of community engagement, acceptability and effectiveness. Overall, the growing evidence suggests that culturally safe, integrated and strengths-based models of care that have been co-designed with community can significantly enhance mental health outcomes for CaLD Australians. Furthermore, culturally tailored mental health literacy and anti-stigma campaigns, targeting both the general community and service providers, can improve recognition of mental health issues, promote help-seeking behaviours and foster inclusive service environments.

5. Stakeholder consultations

5. Stakeholder consultations

Stakeholder engagement is critical to understanding the lived experiences, service barriers and enablers, and priorities of CaLD communities in Australia. To capture these, we undertook a series of national consultations with multicultural community members, service providers, and professionals across the health and community sectors. The Nominal Group Technique (NGT) enabled structured, participatory discussions, allowing all participants to voice perspectives, prioritise challenges and consider practical solutions relevant to their context. The findings from this study highlight that good multicultural mental health care must be based on culturally safe, trauma-informed and strengths-based principles, and supported by both community engagement and structural reform. Stakeholders consistently emphasised the importance of trust, empathy, and equity in service and program delivery, alongside the need for a diverse and supported bilingual workforce, inclusive planning and cross-sector collaboration. Importantly, lived experience was considered integral to shaping responsive care, with community voices calling for services that reflect the realities of migration, settlement and the social and political determinants of health, and recognise intersectionality. While elements such as data and practitioner self-care were ranked lower, thematic analysis revealed their continued relevance when implemented meaningfully. Overall, the study underscores that sustainable and equitable multicultural mental health care requires a systems-level approach—one that integrates grassroots insights with policy, governance, and investment to ensure lasting impact.

5.1 Objective

To facilitate small group discussions with key stakeholders including multicultural community members using the Nominal Group Technique (NGT), with the aim of building consensus on the most effective strategies for supporting mental health in CaLD communities, with attention to local context.

5.2 Methods

5.2.1 Study design

In the third/final component of this project, the Nominal Group Technique (114) was used to facilitate structured, small-group discussions aimed at building consensus on good practice principles and enablers for addressing the mental health needs of multicultural communities in Australia. The NGT was selected for its strengths in promoting equitable participation, mitigating the influence of dominant voices, and enabling the prioritisation of ideas through a structured ranking process. (120, 121) This method is particularly well-suited for engaging diverse stakeholders, including those with migrant and refugee backgrounds. (122) Ethical approval for the study was obtained from the Western Sydney University Human Research

Ethics Committee (HREC No. H16409). Participation was voluntary and all participants provided written informed consent.[9]

5.2.2 Settings and participants

Twelve nominal groups were conducted in metropolitan and regional locations across Australia. The locations were purposefully selected, based on ABS census data and Advisory Group recommendations, to reflect a wide range of multicultural community profiles. They included Sydney (Fairfield, Parramatta and Kensington) and Wollongong in New South Wales (NSW); Melbourne, Geelong and Shepparton in Victoria; Brisbane and Townsville in Queensland; Perth and Kalgoorlie in Western Australia, and Adelaide in South Australia.[10]

Local community organisations played an important role in promoting and/or arranging the sessions held outside NSW: Victorian Transcultural Mental Health; Foundation House, the Victoria Foundation For Survivors of Torture Inc.; Queensland Transcultural Mental Health Centre; the Ethnic Communities Council of Queensland; Northern Queensland Primary Health Network (NQPHN); and Kin Disability Advocacy in Western Australia. Illawarra Shoalhaven Local Health District Multicultural and Refugee Health Service assisted with the Wollongong group. Venues were chosen for community familiarity and ease of access. They included community-based facilities belonging to the project collaborators and local councils, and Western Sydney University and UNSW Sydney.

At each location, participants were invited from three key stakeholder groups: multicultural community members with lived experience as mental health service users—clients or carers; multicultural community service providers or leaders; and mental health care providers. It was planned to recruit 9–10 participants to each nominal group, with a balance of representatives from each stakeholder category.

5.2.3 Recruitment

Recruitment was undertaken in a two-step process using an online Qualtrics platform, supported by email and phone. The first step involved completing an Expression of Interest (EOI) form, which was distributed via community networks, service providers, and stakeholder organisations. This included media platforms of Embrace Multicultural Mental Health and the Federation of Ethnic Communities' Councils of Australia (FECCA) as well as social media platforms such as LinkedIn. The EOI collected basic demographic and eligibility information, including age group, gender, stakeholder category, state and postcode, and preferred contact method. The inclusion criteria required participants to be over 18 years of

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[9] Those who participated outside paid work were remunerated in accordance with Australian Government Remuneration Tribunal rates.

[10] A second South Australian group in Murray Bridge was planned but generating sufficient interest in this regional location proved difficult within the tight timeframe for data collection.

age, belong to one of the target stakeholder groups, and reside or work in one of the target states. Individuals who did not meet these criteria were automatically screened out via the survey logic.

Eligible individuals were contacted by a member of the research team to provide further information and invited to complete the Participant Information Sheet (PIS) and Consent Form, hosted on Qualtrics. Upon providing consent, they were thanked and informed that a research team member would follow up with session details. Demographics collected at the consent stage to support final selection (diversity of voices) and report on group composition included occupation, country of birth, years living in Australia, and languages spoken at home. A confirmation/reminder message, including venue details, session outline and the questions for consideration, was sent to all participants before the session. Printed PIS and consent forms were available on the day for individuals who were unable to complete the online consent form, or who turned up without making contact beforehand as happened in three groups (Adelaide, Kalgoorlie and Wollongong).

5.2.4 Procedure

To support consistency across the different groups, an NGT facilitator manual was developed specifically for this project. Each group was led by a trained facilitator from the research team, with a co-facilitator drawn from the research team or, for the Western Australian groups, from the collaborating organisation. Several groups included observers from the research team or the local collaborator. Post-session debriefings provided an opportunity to reflect on the learnings and refine the process. The sessions were expected to take around three hours with a short break in the middle, although most took a little longer. All sessions were conducted in English, with language assistance provided for clients and carers where necessary (Assyrian for the Fairfield group, Nepali for Westmead, Dari and Pashto for Adelaide, Burmese and Karenni for Wollongong, and Mandarin for Kensington).

Sessions began with a Welcome, an Acknowledgement of Country and an Opening Statement, in which the value of their individual contributions was emphasised and the nature and aims of the study were explained, followed by housekeeping and introductions. The remainder of the session was structured around two core questions:

1. What are the principles underlying good practices for multicultural mental health in Australia?
2. What are the enablers of good practices in your context?

We explained that by ‘enablers’ we meant strategies for facilitating good practice and overcoming the barriers. When necessary, we clarified the difference between values (core beliefs that shape our preferences and actions) and principles (specific behaviours or actionable rules that operationalise those values, bringing them to life).

For each question, participants were presented with findings from the rapid literature review for consideration [11] and then invited to contribute three additional ideas. This was followed by discussion to clarify and consolidate all ideas, then voting and ranking. The whole process, consisting of seven steps, is outlined in Box 5.1.

Box 5.1. NGT steps

1. Presentation and clarification of ideas
2. Individual (silent) generation of new ideas
3. Round robin sharing of new ideas
4. Group discussion and consolidation of all ideas
5. Individual (client) ranking of top five ideas
6. Tallying and review of rankings
7. Review and confirmation

Worksheets were prepared for steps 1 and 2 (consideration and generation of ideas) and step 5 (ranking of top five ideas in order of importance, 5 being the highest). Whiteboards and butchers paper were used to display and record the outcomes in step 3 (round robin) and step 4 (discussion and consolidation). Coloured post-it notes numbered 1–5 made it easy to tally the votes in step 6. In keeping with the wishes of some participants, none of the sessions were audio-recorded, however additional qualitative data were captured in field notes. Following each session, a detailed report was produced documenting the NGT outputs at each step for the two questions, as well as the group process (content drawn from field notes and facilitator debriefing/reflections). A summary of the quantitative findings was emailed to group participants for their information and use (several wanted to take photos during the session).

5.2.5 Analysis

Quantitative data from the ranking exercises were used to identify consensus priorities. The data were initially analysed within the group (providing a basis for group feedback), before being transferred to a single Excel spread sheet for overall analysis. For each principle or enabler, the number or frequency of votes (count) and the sum of the votes or strength of score (111) were calculated, and the ideas were ranked in terms of their importance. In the overall analysis, if two ideas had an equal score, the idea with the highest number of votes was prioritised first. To support analysis of the additional ideas, the raw data were subjected to secondary coding with similar ideas brought together. As the additional ideas were generated within the groups, they were not considered by all participants (unlike the literature-generated ideas). Some participants were unable to stay until the end of the session; therefore, fewer votes were cast for enablers than for principles.

[11] The literature-generated ideas were identified through a review of the 41 included studies.

Qualitative data were analysed to provide additional context and insights, including the underlying rationale for ideas and justification for rankings. A coding framework with nine broad themes was developed drawing on the 12 group reports and used as a basis for exploring further subthemes.

5.3 Results

5.3.1 Group composition and participant characteristics

The average group size was eight people, with a range from two (Shepparton) to 14 (Adelaide). The project engaged a total of 95 participants across the 12 groups: 28 multicultural community members with lived experience as mental health clients or carers; 33 multicultural community service providers or leaders; and 34 mental health care providers. Participant demographics are summarised in Table 5.1. Appendix F contains a breakdown of stakeholder category and demographics by group.

Table 5.1. Participant characteristics across all groups (N=95)

Participant characteristics		
Stakeholder category	*Number*	*Percentage*
Multicultural mental health service user – client or carer	28	29.5%
Multicultural community service provider or leader	34	35.8%
Mental health care provider	33	34.7%
Age group	*Number*	*Percentage*
18–24 years	3	3.2%
25–34 years	23	24.2%
35–44 years	24	25.3%
45–54 years	21	22.1%
55–64 years	20	21.1%
65 years and over	4	4.2%
Gender	*Number*	*Percentage*
Female	69	72.6%
Male	23	24.2%
Non-binary	2	2.1%
Prefer not to say	1	1.1%
Length of time in Australia (years)		
Mean (SD) = 18.9 (13.8) Median = 16.0		
Languages mainly spoken at home		
Anuak, Arabic, Assyrian, Bengali, Burmese, Chaldean, Chinese, Dari, Dutch, English, Farsi, French, Fullah, Haianese, Haryani, Hausa, Hindi, Indonesian, Italian, Karen languages, Karenni, , Kirundi, Korean, Krio, Lingala, Malay, Mandarin, Nepali, Ngaanyatjarra [Aboriginal language], Oromo, Pashto, Punjabi, Serbian, Shona, Somali, Spanish, Surinamese, Swahili, Swedish, Tagalog, Tamil, Urdu, Vietnamese		
Country of birth		
Afghanistan, Argentina, Australia, Austria, Bangladesh, Canada, China, Colombia, DR Congo, Egypt, Ethiopia, Ghana, India, Iran, Iraq, Israel, Kenya, Kosovo, Liberia, Malaysia, Myanmar, Nepal, New Zealand, Nigeria, Pakistan, Palestine, Philippines, Saudi Arabia, Serbia, Sierra Leone, South Africa, South Korea, Sweden, Syria, Tanzania, Taiwan, Vietnam, Zimbabwe		

A total of 85 (89.5%) participants were overseas-born and had the lived experience of being a migrant or refugee. Reflective of multicultural Australia, they were born in 38 different countries (including Australia) and spoke 43 different languages at home (including English). Overall, there was a good age range with roughly equal numbers of people in the 25–34, 35–44, 45–54, and 55–64 age groups. The participants were predominantly female (72.6%).

5.3.2 Quantitative results

Principles for good multicultural mental health practice

Principles are specific behaviours or actionable rules that bring values to life; they outline how things should be done to achieve the desired outcome. All 12 groups considered the ten literature-generated principles, and all agreed with them. With the exception of the last group, which had only two members, each group generated at least one additional principle (range = 0–5, mean = 2.3). After secondary coding, the additional principles were reduced from 27 to 12, giving a total of 22 literature and group-generated enablers. Table 5.2 below presents the overall results. Appendix G presents the breakdown of results by group.

Table 5.2. Voting and ranking of principles across all groups (N=93)

Principles	Vote		Rank
	Sum	Count	
Literature-generated			
1. Use the right language	109	36	6
2. Go beyond translation/Deliver culturally appropriate care	168	57	**1**
3. Work with the community from the start	158	48	**2**
4. Support all levels of mental health care	148	51	**3**
5. Be flexible with time and location	55	23	11
6. Avoid mental illness stigma	86	30	7
7. Staff who understand the culture and language	120	40	**4**
8. Use data that matters	28	15	14
9. Be trauma-informed and strengths-based	116	41	**5**
10. Be agile to fill service gaps	65	26	9
Group-generated*			
1. Adopt a systems approach/Build connections	71	21	8
2. Address social determinants and settlement issues	33	10	13
3. Address regional community needs	7	3	19 tie
4. Address mental health across the lifespan	3	1	22
5. Holistic models of care – Work with intersectionality and complexity	16	4	17
6. Build a multicultural mental health workforce	21	8	16
7. Recognise and use lived experience	7	3	19 tie
8. Support carers and family	24	9	15
9. Strengthen governance and infrastructure	60	15	10
10. Emphasise equity and inclusion in policy frameworks	42	12	12
11. Develop culturally-tailored in-language resources	3	2	21
12. Build awareness among service providers and communities	13	5	18

*****After secondary coding, not all groups voted for all ideas.

Among the literature-generated principles, which were voted on and ranked in terms of importance by all 12 groups (93 participants), it can be seen that the top five (also the top five overall) were: (1) ‘Go beyond translation/Deliver culturally appropriate care’, (2) ‘Work with the community from the start’ (3) ‘Support all levels of mental health care’, (4) ‘Staff who understand the culture and language’, and (5) ‘Be trauma-informed and strengths-based’ (Table 5.2). These five principles accounted for 51% of the total vote, with the first three accounting for 34% and the next two for an additional 16.9%. ‘Use the right language’ was

ranked number 6. Although 'Use data that matters' received relatively few votes, it was considered an important enabler of good practice.

The group-generated additional principles were not considered by all 12 groups, affecting their overall vote and ranking. However, it is noteworthy that six groups ranked one (or more) of their additional principles in their top five, and three groups ranked it number 1. Overall, 'Adopt a systems approach/Build connections' (suggested in four groups) was ranked 8 of the 22 principles, while 'Strengthen governance and infrastructure' (suggested in two groups) was ranked 10. 'Policy frameworks that emphasise on equity and inclusion' (suggested in two groups) was ranked 12, and 'Address the social determinants of health and settlement issues' (suggested in four groups) was ranked 13.

Enablers for good multicultural mental health practice

All 12 groups considered the four literature-generated enablers, and all agreed with them. All groups generated at least two additional enablers (range = 2–6, mean = 3.6). After secondary coding, these were reduced from 43 to 13, giving a total of 17 literature and group-generated enablers. Table 5.3 below presents the overall results. Appendix H presents the breakdown of results by group.

Table 5.3. Voting and ranking of enablers across all groups (N=74)

Enablers	Vote		Rank
	Sum	Count	
Literature-generated			
1. Support the bilingual/bicultural health workforce	185	58	**1**
2. Provide friendly, welcoming services	158	58	**2**
3. Ensure privacy and confidentiality	79	30	6
4. Work together across services	143	55	**3**
Group-generated*			
1. Improve accessibility	84	27	**5**
2. Work with communities	135	38	**4**
3. Collect culturally relevant client and local community data	39	14	9
4. Systemic change – Develop governance and policies	77	22	7
5. Conduct community awareness and education campaigns	69	20	8
6. Create multilingual resources	13	5	14
7. Address social inequity and other contextual factors	29	10	10
8. Incorporate religious and spiritual support	7	3	16 tie
9. Support and involve families	15	6	13
10. Provide early intervention	23	7	12
11. Address mental health needs of clients with psychosocial disabilities	7	3	16 tie
12. Build capacity all sectors	29	9	11
13. Prioritise practitioner self-care	9	4	15

*After secondary coding, not all groups voted for all ideas.

Of the four literature-generated enablers, which were voted on and ranked in terms of importance by 74 participants, the top three (also the top three overall) were: (1) 'Support the bilingual/bicultural health workforce', (2) 'Provide friendly, welcoming services', and (3) 'Work together across services.' Together, these three literature-generated enablers accounted for 38.6% of the total votes received. While 'Ensure privacy and confidentiality' received much less support, it was ranked number 6 overall.

Although the group-generated enablers were not considered by every group, they accounted for 45.4% of votes cast and 48.4% of the total vote. After secondary coding, the most frequently endorsed and highest scoring new ideas were 'Work with communities' (suggested by seven groups and ranked 4 overall) and 'Improve accessibility' (suggested by five groups and ranked 5 overall). Together, the top five enablers accounted for 61.4% of the total vote. 'Systemic change – Develop governance and policies' (suggested by five groups) and 'Conduct community awareness and education campaigns' (suggested by four groups) were ranked 7 and 8, respectively. Next came 'Collect culturally relevant client and local community data' (suggested by five groups and ranked 9) and 'Address social inequity and other contextual factors' (suggested by three groups and ranked 10 of 17).

5.3.3 Qualitative findings

Analysis of the qualitative data revealed a number of shared values: No judgment, empathy, compassion, respect, equity and social justice. Nine major themes were identified relating to service delivery; community engagement and education; informal care; accessibility; workforce; policy, funding and structural support; lived experience and intersectionality; context; and data. Each major theme was broken down into two or three subthemes, as described below. Table 5.4 presents the detailed findings including a few illustrative short quotations—words and phrases used by participants.

Service delivery

The structured format ensured that all groups discussed effective mental health service delivery for multicultural communities at length during the session. Subthemes included culturally safe and responsive care, effective two-way communication, and service quality (Table 5.4).

In summary, stakeholders want to see services that are friendly and welcoming, staff who are non-judgmental and empathetic and understand the different migration journeys and settlement challenges (permanent and temporary migrants, refugee and asylum seekers). They want to see culturally safe and responsive care in the client's preferred language and that takes into account their community background, and cultural and religious practices as appropriate. Also, a person-centred and family-centred approach that recognises diversity among and within Australia's CaLD communities, applies an intersectional lens, and values lived experience. They want to see mental healthcare providers working collaboratively with

CaLD clients and carers and other service providers (a systems approach) to deliver high-quality services within a holistic model of care that addresses both clinical and non-clinical needs.

Community engagement and education

Working with CaLD communities was seen both as a principle and an enabler for good multicultural mental health practice. Community engagement, which encompassed co-design, co-production and partnerships, and psychoeducation for the wider community as well as for clients and their families and carers, were key subthemes (Table 5.4).

Stakeholders want to see strong mental health service and community connections, with services and programs shaped by lived experience and community perspectives, and community awareness and mental health education initiatives that acknowledge different cultural understandings of wellbeing and levels of language and digital literacy. Long-term relationships with two-way learning and mutual benefit will build trust and support further community engagement.

Informal care—extended family and carers

Informal care was brought up in nine groups, the exceptions being Fairfield, Melbourne and Geelong. It was a particularly strong theme in Shepparton, where mental wellbeing was related to identity and family dynamics, belonging and connection. Other groups also mentioned intergenerational tensions and mental health concerns among second generation immigrants. Subthemes included caring for someone with a mental health condition, carers needing support themselves, and family conflict (Table 5.4).

Stakeholders want services to value the informal care provided by extended family, friends and significant others in CALD communities, and to involve them in in decision-making and treatment planning and recovery where appropriate. Carers may also need support, including practical assistance and respite. In immigrant families, children who speak English easily become carers. Family-centred mental health support and family-focussed interventions will benefit both clients and carers.

Accessibility—getting help when needed

Accessibility was highlighted in 11 groups, Westmead being the exception, with seven groups suggesting it as an additional enabler: Fairfield, Adelaide, Perth, Wollongong, Kensington, Townsville and Shepparton. Four groups mentioned affordability (an element of accessibility) as a key issue: Kalgoorlie, Perth, Melbourne and Geelong. Subthemes concerned information and service accessibility, and the problems faced by regional communities (Table 5.4).

The numerous barriers faced by multicultural communities in accessing timely, affordable and effective mental health care are well-documented, with access in regional areas being

especially problematic (see Chapter 4). As indicated in Table 5.4, stakeholders identified several strategies for improving information accessibility and service accessibility that will make it easier for everyone to get help when needed.

Workforce development and capacity building

Workforce issues were discussed at length in all groups. Subthemes encompassed valuing and growing the workforce to support multicultural mental health, and workforce support and sustainability (Table 5.4).

Stakeholders see opportunity to leverage the expertise and experience that resides within CaLD communities by expanding the bilingual/bicultural mental health workforce, including clinical and peer worker roles and strengthening language services. Concurrently, it is vital to continue building cultural responsiveness and "cultural humility" among other mental health service providers[12], and knowledge of mental health and culture among primary health and community service providers.

Policy, funding and structural support

Policy was often discussed in the context of data, one of the main uses being to inform policy. Outside this, it was raised in four groups: Adelaide, Kensington, Brisbane and Melbourne. Supportive structures and systems, including funding and governance structures, were raised as enablers in nine groups, all except Kalgoorlie, Townsville and Geelong. Each subtheme was further broken down according to level within the system (Table 5.4).

In summary, stakeholders want to see policy that is human-rights based and informed by lived experience and grassroots knowledge, with practice driving systemic change to support mental health in multicultural Australia at all levels, including national and state/territory governments and organisations. Funding and structures are required to support policy implementation.

Lived experience and intersectionality

The terms 'lived experience' and 'peer', as used by participants, encompass migration journey and stream (including visa type); country of birth; cultural and religious background; language; identity and belonging; and mental health service use. The immense value of lived experience was commented on in all groups; brought up in relation to workforce and service and program delivery (peer workers and peer support/mentors), as well as in service, program and policy development, where co-design and strategic involvement and advocacy were emphasised (Table 5.4).

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[12] The term "cultural humility" was used in four groups (Adelaide, Wollongong, Brisbane and Melbourne) and "cultural competence" in three groups (Brisbane, Melbourne and Geelong).

Intersectionality (multiple social and political identities) was associated with complexity. Gender was brought up in seven groups (Adelaide, Kalgoorlie, Perth, UNSW, Brisbane, Melbourne and Shepparton), religious and spiritual beliefs in four groups (Westmead, Adelaide, Perth and Melbourne), sexuality in three groups (Perth, Brisbane and Shepparton where it was a major theme), disability in two groups (Kalgoorlie and Perth where the collaborating organisation was Kin Disability Advocacy), visa status in two groups (Brisbane and Melbourne), and physical health in one group (Brisbane).

Stakeholders see an opportunity to leverage the lived experience of CaLD mental health clients and carers by integrating them into the mental health workforce as peer workers, engaging them in community education and anti-stigma campaigns, and involving them in service, program and policy development and evaluation. Clients are multidimensional and many have complex needs, such as mental health and disability, requiring coordinated, cross-sector services and support.

Context

Contextual factors were raised by six groups, with different factors highlighted. Four groups (Adelaide, Wollongong, Brisbane and Geelong) raised housing, employment and legal concerns. Three groups (Kalgoorlie, Townsville and Wollongong) raised regional access.[13] Two groups (Westmead and Kalgoorlie) raised settlement/integration issues. The Kensington group spoke about the general public's negative perception of international students and its effect on their mental health and wellbeing, while the Shepparton group discussed evolving gender roles and generational differences that create tensions within families. Within this theme, three subthemes were identified: contextual influences on mental health, host community adjustments, and regional disadvantage (Table 5.4).

The migration journey and settlement bring many challenges for individuals, families and communities beyond those encompassed by culture and language. Stakeholders want to see greater recognition of, and attention to, the social and economic determinants for mental health and wellbeing. Visa restrictions on service eligibility complicate care, as do unrealistic expectations of Australia. On their part, service providers need to stay current as cultures and communities evolve. Regional communities are generally under-serviced, and mental health services and support (including support for service providers) are less accessible than in metropolitan areas.

[13] Kalgoorlie and Townsville are classified as RA3/Outer Regional. Wollongong, though classified as RA1/Major City, is the tertiary centre for a regional local health district. https://able.adelaide.edu.au/housing- research/data-gateway/aria

Data

Data, as a principle, was consistently ranked low in importance across all groups and did not appear in the top five. However, five groups (Fairfield, Kalgoorlie, Kensington, Brisbane and Geelong) suggested it as an enabler. Within this theme, three subthemes were identified: service-level data (relating to users and to providers and the delivery environment), population-level data, and research (Table 5.4). In an increasingly multicultural Australia, stakeholders want to see service and population-level data collected and, just as importantly, used to support mental health service and program delivery as well as to inform policy and planning. Culturally competent research and evaluation (using participatory approaches and co-design) are important enablers. Client and carer feedback is critical for continuous quality improvement.

Table 5.4. Qualitative findings

Theme and subthemes	Strategies and issues
Service Delivery	
Culturally safe and responsive care	• Create welcoming environments where CaLD clients feel secure to share their experiences, and offer services inclusive of family • Take extra time to build rapport and connect with CaLD clients • Provide person-centred (and family-centred) care that considers intersectionality, generational differences and social and economic factors, and that does not rely on generalisations or diagnostic labels • Explore the client's understanding of mental health and illness, and differentiate between situational challenges (e.g., unemployment-related distress) and clinical mental disorders • Provide psychoeducation to clients and their families and carers, and care that is trauma-responsive and draws on cultural and community strengths • Provide practical assistance (e.g., website navigation) and links to other services and community organisations (e.g., disability, alcohol and drug and settlement services) • Address and support spiritual needs (e.g., through collaboration with community and religious leaders).
Effective two-way communication	• Provide care in the client's preferred language and dialect (often their *"mother tongue",* NG1), using bilingual/cultural staff or professional interpreters • Avoid mental illness (and other) stigma by using respectful and non-pathologising language; even the word 'mental' can be problematic • Match interpreters for gender and other relevant characteristics • Address concerns around interpreter confidentiality.
Service quality	• Develop guidelines and workflows to ensure consistent high-quality care • Maintain cultural safety and service quality through monitoring and evaluation • Establish CaLD client and carer feedback loops.
Community engagement and education	

Community engagement	• Ensure people with lived experience as clients and carers and other CaLD community members are involved in shaping mental health services that reflect their needs and values—*"Recognise community has the answers"* (NG3), *"They are experts on their own"* (NG9)
	  ○ Collaborate with religious and cultural leaders to provide holistic care
	  ○ Use CaLD client and carer feedback to improve service models
	• Work in partnership with community organisations and groups to design, deliver and evaluate community-based mental health and wellness programs; build long-term relationships

Theme and subthemes	Strategies and issues
	• Empower CaLD community members as advocates within the mental health system.

Community education	• Recognise cultural mental health beliefs—*"Not just the western model"* (NG3)
	• Conduct place-based community campaigns to raise awareness, build mental health literacy and reduce stigma
	    ○ Inform people that mental health conditions are real and can happen to anyone and address myths and misconceptions, using appropriate non-stigmatising language
	    ○ Peer leadership—*"Brave storytelling that is safe and supported"* (NG7)
	    ○ Consider subgroup needs and preferences, e.g., youth, women, men, international students and seasonal workers
	• Make services known to communities, especially new arrivals—*"In order to access services, people need to know where they are, what they do, how to engage them, and eligibility criteria"* (NG5)
	    ○ Settlement services, schools, and child and family health services as points of contact
	• Educate and empower communities so they can provide mental health support and follow-up, thereby increasing support networks and reducing isolation and stigma.
	• Work with cultural leaders to identify key people to promote mental health
	    ○ Empower communities by promoting cultural identity, particularly among young people, and fostering a sense of pride and belonging.
	• Provide access to training, such as Mental Health First Aid (MHFA), for everybody.

Informal care—extended family and carers	
Caring for someone with a mental health condition	• Importance of extended family and local information and support networks—*"Word-of-mouth is still king"* (NG4) • Provide psychoeducation for carers to strengthen their role in care and recovery; involve carers in decision-making and treatment planning where appropriate and with consent.
Carer support needs	• Carers can include parents, other family members and friends—a *"constellation"* (NG5) of people ○ In immigrant families, children who speak English easily become carers • Provide practical assistance and accessible carer respite.
Within family conflict	• Family conflict (e.g., around gender roles and children's behaviour) can contribute to mental health issues ○ Identity issues and sense of belonging, especially for second generations • Provide family-centred mental health support and family-focussed interventions.
Accessibility—getting help when needed	
Information accessibility	• Provide information in multiple languages using diverse communication formats and approaches (e.g., audio, video, visual/pictorial, social media, written, visual arts and theatre), ensuring it is relatable to the target group ○ Use preferred social media (e.g., Facebook, WhatsApp and WeChat)

Theme and subthemes	Strategies and issues
	• Regularly update community and mental health resource lists, including affordable bilingual/bicultural counsellors.

Service accessibility	• Access to services is impeded by numerous practical and systemic barriers, and long waiting lists
	• Solutions include increasing service availability and flexible delivery models that take into account community responsibilities and priorities (e.g., family, employment, English language classes)
	  ○ Outreach clinics at familiar CaLD community venues, also at schools and playgroups; home visits
	  ○ Phone and online options; a multicultural mental health helpline to support community and health and community service providers
	  ○ Transport assistance and childcare
	  ○ Co-location of services (*"1-stop shop",* NG1 and NG7) to support coordinated holistic care
	• *"Make it easy to get help"* (NG2)*, "No wrong door"* (NG3), *"Soft entry points"* (NG8) to formal services and simplified referral pathways; assistance with service navigation
	• Funding models that ensure affordability for everyone; remove restrictive eligibility criteria that exclude certain groups (e.g., international students, asylum seekers).

Regional constraints	• Limited services covering large geographic area; limited transport ○ Address workforce shortages and staff turnover; enhance service availability using flexible delivery models including telehealth and outreach.
Workforce development and capacity building	

Valuing and growing the workforce	• Bilingual/bicultural mental health professionals and workers
	  ○ Acknowledge and value the existing workforce; provide recognition, professional development and resources for those doing language work outside their official roles
	  ○ Recruit more bilingual/bicultural staff, including clinicians and peer workers, from the communities served through targeted recruitment; increase identified positions
	  ○ Strengthen retention through long-term contracts, ongoing upskilling, mentoring and career pathways; build leadership roles
	  ○ Support CaLD community members to gain new or additional qualifications in relevant fields
	  ○ Develop pathways from education into employment; engage with training and education providers and industry (language test for courses is a major barrier)
	  ○ Provide early workforce exposure through undergraduate and postgraduate placements; scholarships and traineeships that lead to an ongoing position.
	• Other mental health and primary health and community service providers

Theme and subthemes	Strategies and issues
	○ Make cultural training mandatory in all mental health services that work with CaLD communities (service providers and managers); train staff in *“using interpreters respectfully”* (NG6) ○ Embed cultural safety and responsiveness requirements in mental health service position descriptions ○ Address the needs of clients with psychosocial disabilities through mental health training for NDIS workers ○ Build understanding of mental health and cultural issues among all health and community providers who work with CaLD communities, including general practice and first responders; empower community services to identify and provide mental health support. • Interpreters ○ Address concerns around confidentiality when using professional interpreters ○ Aim for continuity of interpreters for trust and therapeutic consistency (especially in trauma contexts) ○ Provide all interpreters (employees and contractors) with appropriate support, supervision and opportunities for upskilling ○ Increase the number of interpreters with specific mental health training and train more interpreters in the languages of newly-arrived communities.
Workforce support and sustainability	• Upskill all mental health service providers and interpreters in cultural context, community knowledge and trauma awareness ○ Ensure responsibilities for CaLD clients are shared to avoid over-reliance on one individual • Provide clinician tools and resources, e.g., multilingual patient information and appointment reminders, lists of multicultural community services and affordable bilingual counsellors, and access to transcultural mental health advice • Support practitioner self-care and wellbeing (vicarious trauma) • Conduct reflective practice seminars; involve community leaders.
Policy, funding and structural support	
Policy to drive systemic changes	• Governments ○ Coordinated multicultural mental health policy and plans at national and state levels, based on human rights and legal frameworks ○ Recognition of the diversity among and within CaLD communities ○ Community voice and leadership. • Organisations ○ Authorising environment/strategic approval framework ○ Inclusive ethos/culture—*"Embed cultural humility across the organisation, not just one-off training”* (NG10) ○ Cultural safety framework and action plan; anti-racism.

Theme and subthemes	Strategies and issues

Funding and structures to support policy implementation	• Government and systems level
	  ○ Dedicated and sustained funding for multicultural mental health—*"Encourage collaboration, not competition"* (NG3)
	  ○ Linkages between sectors and services, integration of primary and specialist services with simplified referrals—*"Remove the hoops people have to jump"* (NG3)
	• Organisation and service level
	  ○ Governance structures that include CaLD representation
	  ○ Workflows, practice guidelines and performance measures
	  ○ Quality standards and reporting guidelines
	• Community infrastructure
	  ○ Capacity building for community organisation and groups—*"Weave mental health support throughout existing community infrastructure rather than creating separate services"* (NG12)
	  ○ Grants for community mental health initiatives.

Lived experience and intersectionality	
Learn from lived experience	• Integrate CALD clients and carers into the mental health workforce as peer workers where they bring language skills, cultural understanding and lived experience, and a direct connection with their community • Engage people with lived experience in community education and anti-stigma campaigns where they provide relatable examples • Involve people with lived experience in service and program development and evaluation—codesigning and co-creating/producing interventions, and providing feedback to support continuous improvement • Involve people with lived experience in policy development and advocacy—amplifying the voices of multicultural communities so that policy reflects their needs and values.
Recognise intersectionality	• Culturally safe and responsive care recognises diversity and intersectionality (culture, ethnicity, religion, disability, physical health, gender identity, sexuality, migration status etc.) and incorporates support as needed—*"Not all Africans are the same"* (NG4) • Provide holistic and collaborative case management incorporating cultural perspectives • Address identity conflicts within community and generational contexts • Promote cultural identity and foster a sense of belonging.
Context	
Contextual influences	• Mental health exists within broader social, cultural and political contexts • Addressing underlying issues (e.g., unemployment, social isolation or migration status) may resolve psychological symptoms • Mental health care, particularly in acute settings, is impacted by workforce shortages with clinician turnover reducing continuity of care; even within capital cities there is place-based inequity.
Host community adjustments	• Just as settlement involves adjustment to the Australian community [acculturation], the host community adjusts to the presence of new arrivals from a different culture

Theme and subthemes	Strategies and issues
	• Successful integration is supported by cultural understanding on the part of service providers who need to stay current as cultures and communities evolve—*"Know their beliefs and values"* (NG11)
Regional disadvantage	• Heavy reliance on new graduates, thus external support is required for mental health workers ○ Long-term contracts desirable to build community knowledge, trust and continuity of care • Access to interpreters for new and emerging communities is particularly problematic • Limited regional mental health data and resources • Pre-departure orientation for new arrivals downplays regional limitations in infrastructure and services, leading to unrealistic expectations.
Data	
Service-level data	• Users ○ Data directly relevant to care and reflective of the diversity of CALD communities, including timely follow-up (outcomes) ○ Client and carer feedback and suggestions for improvement • Providers/environment ○ Number of bilingual/bicultural staff, including clinicians, peer workers and administrative ○ Cultural safety measures ○ Service evaluation, including accessibility and effectiveness
Population-level data	• Surveys that are representative of contemporary multicultural Australia, including previously *"invisible clients not in data"* (NG6) ○ Variables and data definitions that are meaningful to multicultural communities (e.g., 'volunteering' is problematic).
Research	• Co-design—the meaningful engagement and active involvement of service users and community members in the design and conduct of research to ensure cultural relevance and alignment with community values and priorities • Social research to inform service and policy development • Community needs and assets assessment to identify gaps and areas of strength • Feedback research findings to community for their information and use

5.4 Discussion

5.4.1 Principles underlying good practices

The principles identified from the literature and then endorsed and ranked as most important by stakeholders included delivering culturally safe and responsive care that goes beyond translation, engaging with communities from the outset, supporting all levels of mental health care, employing staff who understand the culture and language, and adopting trauma-informed, strengths-based approaches. When reviewing the rankings across all stakeholder consultations, the ten principles identified through the rapid review were consistently placed within the top 15. This alignment demonstrates consistency between the Australian literature and local stakeholder perspectives. Importantly, four additional principles generated from stakeholder discussions were also ranked highly. These included adopting a systems approach that fosters connections, strengthening governance and infrastructure, developing policy frameworks that prioritise equity and inclusion, addressing the social determinants of health and settlement challenges, and supporting carers and families. Taken together, these stakeholder-generated principles reflect a broader, systems-level understanding of mental health support, emphasising structural equity, service and community connections, and the need to address the contextual factors that shape wellbeing.

It is also important to consider those principles identified in the review which were ranked as less important in the consultations. For example, both flexibility of time and location (ranked 11 overall) and using data that matters (ranked 14) were ranked below other stakeholder-generated principles. Flexibility around service provision may have been perceived by participants as implicit within other priorities, such as community engagement or being trauma-informed, or it may reflect an awareness that local constraints (e.g., workforce, funding, geography) are of immediate priority thus reducing its perceived immediacy. Moreover, while the importance of data was acknowledged by most of the groups, its overall ranking suggests that its use (at least in its current form) is not widely viewed as a key element in good practices. This may reflect the fact that the benefits of data are often less visible to frontline staff and community members than the results of more immediate, practice-based activities. It is clear that for mental health data to be meaningful to multicultural communities, both at the service level and in larger- scale collections, , it must be shaped through broad engagement with experts, including those with lived experience. Going forward, this should be considered a priority, given the critical importance of data and evidence for policy development and service and program design, and for monitoring and evaluation.

Equally noteworthy was the emergence of two stakeholder-generated principles, adopting a systems approach to foster connections (ranked 8) and strengthening governance and infrastructure (ranked 10), which were not present in the original literature but were included in the top ten. This is a critical finding, as it indicates that stakeholders value structural and

policy levers alongside frontline clinical and therapeutic priorities and community education initiatives. Sustainable services require not only appropriate service models (e.g., language access, workforce diversity, stigma reduction) but also system-level reforms (e.g., governance, cross-sector collaboration, policy frameworks). In other words, both culturally and linguistically responsive practice and the institutional scaffolding to support it.

The implications are clear. First, the alignment between literature and stakeholder input supports prioritising investments to strengthen the delivery of culturally appropriate care, community co-design, workforce development, and trauma-informed strengths-based practice. Second, the emphasis on systems and governance highlights the need for implementation plans that include policy levers such as commissioning arrangements, accountability frameworks, cross-sector pathways, and funding to support multilingual and bicultural workforce development. Third, principles such as culturally-tailored multilingual resources, family and carer support, and spiritual support should be integrated into health promotion and service design.

5.4.2 Enablers of good practices

Much has been written about the challenges faced by people from CaLD backgrounds in dealing with the Australian health and welfare system (34, 123), including impediments to accessing and engaging with mental health services. (45, 101, 124) These challenges may persist even after many years of residence. (101) Despite long-standing recognition of the problems and the need for solutions, our rapid review found that barriers still exist at multiple levels. They include language and communication, cultural and social factors such as mental illness stigma and racism, and systemic and structural issues such as affordability and financial constraints (see Chapter 4).

During the stakeholder consultations, 17 enablers for multicultural mental health were identified. Participants agreed with the four enablers identified in the rapid review: supporting the bilingual and bicultural health workforce, creating welcoming and friendly services, strengthening collaboration across services, and ensuring privacy and confidentiality. These priorities reflect the central role of trust, safety and cultural responsiveness in shaping engagement with mental health services for people from diverse backgrounds. Interestingly, only the first three of these were ranked in the top five, with two stakeholder-generated enablers ranked more highly than ensuring privacy and confidentiality.

The fourth most highly ranked enabler, *working with communities*, reflects a collective desire to create inclusive and flexible services and the suggested systemic change to embed multicultural perspectives in service planning and delivery. This aligns with a substantial body of literature on service inclusion, which emphasises the fundamental role of community involvement in designing more inclusive systems (125, 126). Accessibility, including cultural

and regional accessibility, was ranked fifth, highlighting the importance of ensuring services are reachable and relevant to diverse populations. While other enablers were ranked lower, they still represent important dimensions of holistic care and should not be overlooked in practice, as highlighted by the thematic analysis.

Stakeholder consultations emphasised the need for a multi-layered approach. At the service level, investment in a diverse workforce and welcoming environments can directly improve service uptake and user experience. At the system level, policies that prioritise accessibility through co-design with communities will allow for culturally relevant governance that is essential for sustainability and accountability. Although areas such as practitioner self-care and early intervention received less emphasis, they still reflect broader workforce and public health considerations that may warrant attention in future planning. It is possible that these areas, along with principles such as confidentiality were viewed as already embedded within general mental health care, rather than being specific to multicultural contexts.

Again, our findings are consistent with the literature on multicultural mental health in suggesting that good practices must extend beyond mental health services and programs to the broader health and social service systems. Organisational commitment to cultural responsiveness, workforce training in cultural safety and trauma-informed care, culturally appropriate intake and assessment processes, accessible language services, and meaningful data collection on CaLD populations are all essential components. (108, 111, 119) Moreover, sustained efforts to enhance mental health literacy and reduce stigma are vital. Culturally tailored in-language mental health literacy and anti-stigma campaigns within CaLD communities as well as among providers help to improve recognition of mental health issues, promote help-seeking behaviours, as well as foster inclusive service environments all of which are enablers of good mental health practice. (71, 93, 102, 103)

5.4.3 Stakeholder voices (Lived experience and community perspectives)

Complementing the consensus ranking process, the thematic analysis identified nine interconnected themes shaping multicultural mental health care: service delivery, community engagement and education, informal care, accessibility, workforce, policy and structural support, lived experience and intersectionality, contextual factors, and data. Across all groups, participants consistently emphasised the importance of embedding core values within mental health services; namely non-judgment, empathy, compassion, respect, equity, and social justice. These values were seen as essential in guiding both the principles and enablers of good mental health care for CaLD communities.

Services were considered more attractive and engaging when they were welcoming, culturally safe, family-inclusive, and holistic. A clear message emerged that culturally responsive care must go beyond language access to include an understanding of diverse migration journeys, settlement challenges, and recognition of spiritual and community strengths. Accessibility

remained a critical barrier, particularly in regional areas. Participants highlighted affordability, restrictive eligibility criteria, and workforce shortages as factors compounding existing inequities.

Trusted networks and family members often provide the first point of support, and carers themselves require psychoeducation, respite, and formal recognition of their roles. While similar findings were noted in a few studies from the rapid review, the existing literature was limited to Vietnamese, Chinese, and Spanish-speaking populations. (91, 98, 100) One pilot study, which adapted a cognitive behavioural intervention for Chinese and Spanish dementia carers, reported significant reductions in depression, anxiety, and stress. (91) The literature also suggests that some carers experience culturally unsafe practices in mainstream services, reinforcing the need for culturally safe, holistic approaches. Culturally and linguistically tailored support groups show promise in addressing the complex needs of migrant carers and guardians. (98, 100)

A diverse and supported bilingual and bicultural workforce was identified as essential, yet stakeholders noted that this workforce is undermined by limited training opportunities, casualisation, and a lack of clear career pathways. (127, 128) The emphasis on lived experience and intersectionality was another key finding. Stakeholders stressed the importance of integrating the voices of CaLD clients and carers into workforce development, service design, policy and education. There was strong appreciation of the nuanced and multifaceted nature of multicultural communities and individuals, recognising that diversity extends beyond language, religion and ethnicity to include gender, sexuality and disability. (129)

A consistent message from consultations was that mental health cannot be separated from contextual factors such as housing, employment, visa status, and regional disadvantage. This reinforces the need to address social and political determinants of health alongside clinical care. (98, 117, 118) Although data was only ranked 14 as a principle, it was ranked 9 as an enabler, suggesting that stakeholders recognised its potential, particularly when collected and used in culturally competent and participatory ways. Data can drive accountability, continuous improvement, and policy reform when it reflects the realities of multicultural communities. (130)

Taken together, these insights make clear that good multicultural mental health care requires both grassroots and community engagement, supported by structural reform. In other words, multicultural, community-led, lived experience–driven approaches can only be effectively implemented when backed by supportive policy, funding and workforce systems.

5.4.4 Strengths and limitations

By combining evidence from a rapid literature review with stakeholder consensus, the findings reinforce and extend the existing evidence on current and emerging good practices to support the mental health of multicultural communities. Our research design phase included diversification of study sites across states, urban/regional areas and CaLD populations to ensure broad representation, and purposive participant recruitment. (131, 132) The structured consensus process enabled equitable participation and transparent prioritisation, ensuring diverse voices were represented. It is important to acknowledge that a lower ranking does not equate to lesser importance, as several lower-ranked items were emphasised strongly in the thematic analysis; a lot depends on context. Moreover, the integration of thematic analysis with ranked priorities provided in-depth insight into why certain enablers were valued, an important consideration for future policy and practice. (133)

Notwithstanding these strengths, there are certain limitations that should be acknowledged. Although the NGT provides useful consensus signals on relative priority, it has potential limitations such as dominance, artificial prioritisation and facilitator dependence. (121, 134) Similarly, group composition and local context dynamics may influence results, for example, if provider perspectives outweigh lived-experience voices. We were able to mitigate those limitations through structured procedures, pre-identified themes, and trained facilitators and co-facilitators conducting the sessions. We did not hold consultations in Tasmania or the two territories, and recruiting participants in regional locations was challenging in the project timeframe. We did not capture participants' current or on-arrival migration status. Respecting the wishes of potential participants we did not record the sessions, thus participants' comments were not captured verbatim. Finally, while we did not have interpreters at all groups although language facilitators were present.

5.5 Conclusion

The final component of our research demonstrates the value of stakeholder consultations with service users and providers in generating nuanced insights into good practices for multicultural mental health; insights that are not readily available from population surveys or clinical research. Across the 12 nominal groups, participants identified 22 principles and 17 enablers for good multicultural mental health practices, ranked in order of importance. Overall, there was good alignment between principles and enablers generated from the literature and presented to the groups, and those generated within the groups. However, the stakeholder-generated principles reflected a broader, systems-level understanding of mental health support; emphasising structural equity, service and community connections, and the need to address the contextual factors that shape wellbeing. Analysis of the qualitative data revealed a number of shared values and nine major themes.

The findings demonstrate that good multicultural mental health care is based on culturally safe, trauma-informed and strengths-based principles, supported by both community

engagement and structural reform. Stakeholders emphasised the importance of trust, empathy, and equity in service and program delivery, alongside the need for a diverse and supported bilingual workforce, inclusive planning, and cross-sector collaboration. Importantly, lived experience was considered integral to shaping good practices, with community voices calling for services and programs that reflect the realities of migration, settlement and the social and political determinants of health, and recognise intersectionality. While elements such as data and practitioner self-care were ranked low, thematic analysis revealed their continued relevance when implemented meaningfully. As demonstrated in the ranking process, local context makes a difference and should not be underestimated in program design and implementation. Sustainable and equitable multicultural mental health care requires a systems-level approach, one that integrates grassroots insights with policy, governance and investment to ensure lasting impact.

6. Synthesis and recommendations

6. Synthesis and recommendations

6.1 Introduction

As set out in the introductory chapter, this commissioned research report was designed to provide a contemporary overview of multicultural mental health in Australia, specifically addressing two questions:

1. What is currently known about the state of multicultural mental health in Australia?
2. What are the current and emerging good practices for supporting the mental health of multicultural communities?

The research had three components:

1. A secondary analysis of the 2020–2022 NSMHW, with a focus on the prevalence of 12-month anxiety and affective disorders, associated socio-demographic and health characteristics, and mental health service use.
2. A rapid review of Australian studies from 2012 to 2025 that focused on community-based mental health interventions for and with CaLD populations to identify examples of good and emerging practices, as well as barriers and enablers to access.
3. A series of national stakeholder consultations with multicultural community members and health and community service providers designed to elicit consensus on the most effective strategies for supporting multicultural mental health.

Together, the three components encompass information from all pillars of the Six Pillars Model of Scientific Knowledge. (18) This final chapter brings together the key findings from each component in relation to the two questions. These are followed by a suite of recommendations to enhance government and sector capacity and capability to adopt good practice approaches to support mental health in CALD communities. Before this, we present lessons learnt from this complex multipart project.

6.2 Lessons learnt

6.2.1 Addressing critical knowledge gaps requires a multidisciplinary team

A key lesson from this project is the importance of assembling a multidisciplinary team. By bringing together internationally recognised experts in mental health, public health epidemiology, biostatistics and policy, we ensured methodological rigour and a depth of analysis that was essential for tackling the complex challenges of multicultural mental health. This collaborative approach enabled us to generate nuanced, contextually grounded insights aligned with the Australian Government's commitment to supporting priority populations.

6.2.2 Multi-method, phased research enhances depth of knowledge

Employing a phased, multi-method research design, guided by the Six Pillars Model of

Scientific Knowledge, proved invaluable. This approach facilitated the development of robust findings and practical lessons that reflect the complexity of mental health service and program delivery in CaLD communities and are transferable into policy and practice.

6.3.3 Stakeholder engagement is crucial

The national consultations demonstrated the critical role of key stakeholders, especially individuals with lived experience as clients and carers, in generating rich and meaningful insights. Their contributions enriched the project's findings and highlighted the depth of expertise and commitment within the multicultural mental health sector. This engagement helped deepen understanding of the key enablers of good practice across different contexts.

6.2.4 Data limitations must be addressed

While secondary analysis of the NSMHW offered valuable insights, inherent limitations with this dataset, such as the exclusion of individuals with limited English proficiency and challenges in disaggregating data by birthplace and migration status, were major constraints. We echo previous calls for inclusive data collection in such national surveys, thereby allowing for more categorisation to better reflect the diversity of CaLD populations. Leveraging the Person Level Integrated Data Asset (PLIDA), a secure data asset that allows combination of health, education and other data, and population demographics, can address some of these challenges, but it requires adequate time and resources to access and navigate.

6.2.5 Large and complex projects require additional time and resources

Relatedly, the project's tight timeline, just over 12 months from start to final report, played a role in restricting the project scope. Navigating complexities such as ethics approvals, obtaining data custodian permissions, and clearing all NSMHW findings prior to export from DataLab systems all took time. Limited resources restricted the number of stakeholder consultations and the availability of language support. Realistic timelines and adequate resources are essential for this type of work.

6.2.6 Important areas that remain under-explored

Despite the breadth of this project, several critical areas, such as leadership and governance, financing, policy development, and system-level monitoring and evaluation remain underexplored. Additionally, hospital-based services and specific subpopulations, including children, youth, older migrants, and people with disabilities, warrant dedicated investigation. Suicide prevention strategies tailored to CaLD communities also require urgent attention.

6.3 Question 1

What is currently known about the state of multicultural mental health in Australia?

Multicultural Australia is becoming ever more diverse

Australia's rapidly changing demographic and social landscape presents a challenge for multicultural mental health policy and practice. (40) Findings from both the literature review and stakeholder consultations highlighted that working with CaLD communities, including people with lived experience, is essential to achieving equity in mental health access and outcomes. Communities and individuals are multifaceted, thus recognising and responding to local context and intersectionality is essential for developing effective and inclusive mental health services and programs. Individual identities can shift over time, along with changes to migration status, socioeconomic circumstances and physical health and disability, which can influence mental health care needs. (135) While use of standardised terminology to define CaLD status would assist in making epidemiological research comparable, (3) we should not lose sight of the nuanced and varied ways in which multicultural communities can be identified in understanding and responding to their mental health needs. (135)

The limitations of the ABS indicators, such as country of birth, language spoken at home, English proficiency, ancestry and duration of residence in Australia, were emphasised in the consultations. Moreover, these indicators should not be considered in isolation; increasingly, attributes such as ethnicity, sex, gender, sexual orientation and disability are recognised as integral to how individuals identify and therefore experience mental health services. (59, 60)

Prevalence of common mental disorders and mental health service use

There is a noticeable absence of Australian studies reporting the prevalence of mental disorders among immigrant groups, despite continuing calls for this to be corrected including by Minas et al. (2013). (21, 22) Available evidence suggests that some migrant groups, particularly refugees and asylum seekers, experience increased vulnerability to mental health disorders (42, 61) yet engage less frequently with mental health services. (45, 46) These patterns are often attributed to a complex interplay of stigma, cultural perceptions and systemic barriers to care, though interpretation is complicated by methodological limitations such as small sample sizes and reliance on self-report measures.

We undertook a secondary analysis of the 2020–2022 NSMHW because it is considered a nationally representative survey and is able to offer population-level data on a range of important mental health indicators such as prevalence and associated service use. (58) We found that overseas-born individuals had lower 12-month prevalence rates for common mental disorders compared to those born in Australia. For example, the prevalence of 12-month anxiety disorders was 18.8% among Australian-born individuals, compared to 10.3% among those born overseas. For 12-month affective disorders, the rates were 8.8% and 4.6%, respectively. Past studies have reported mixed findings in relation to prevalence, with rates

varying depending on the methodology and other factors. (61, 136)

Gender influenced prevalence, with females and younger individuals demonstrating greater vulnerability to anxiety disorders across both Australian and overseas-born cohorts. We found that recent arrivals (2012–2022) had significantly higher odds of experiencing anxiety (increased by 24%) and affective disorders (increased by 18%) compared to those who arrived before 2002.

Analysis of the data on mental health services, revealed that both overseas and Australian-born individuals with 12-month anxiety or affective disorders were more likely to seek help from most types of health professionals, than not seek help. However, disparities emerged when examining the quantity of consultations received and time to treatment. For example, Australian-born respondents reported substantially more consultations, with 72.2% receiving 20 or more sessions for anxiety disorders versus 49.0% among overseas-born. Moreover, overseas-born individuals were more likely than Australian-born individuals to delay treatment for 10 years or more for both anxiety disorders (57.6% vs. 49.3%) and affective disorders (45.7% vs. 37.3%). While the reasons for these disparities cannot be determined from the current data, systemic factors such as limited availability of culturally appropriate services, as well as individual factors such lower mental health literacy, may contribute to reduced treatment frequency and delayed initiation. (65, 68, 70, 71)

Limitations in the dataset necessitate cautious interpretation of these findings. For example, while lower prevalence rates among overseas-born respondents might suggest better mental health, this does not necessarily reflect all multicultural communities in Australia. Although the NSMHW is regarded as nationally representative, it under-represents subgroups with known vulnerabilities, such as individuals with limited English proficiency, a recognised risk factor in migrant mental health. (42) Depending on the definitions used, estimates of the inclusion of such individuals range from 0.9% to 5.1%. (59, 60) Collapsing all the overseas-born respondents into one group, means that differences by country of birth or language groups, were obscured. Additionally, migration status was not captured.

Nevertheless, several knowledge gaps remain that warrant further investigation. While the adjusted models revealed higher odds of anxiety and affective disorders among recent arrivals, the complex interplay between migration timing, migrant category, and mental health outcomes requires deeper exploration. The observed disparities in service use, particularly the lower number of consultations and delayed treatment among overseas-born individuals, also point to the need for research into the structural and cultural barriers that hinder timely and adequate care.

Further, while anxiety and affective disorders were the focus of the current analysis, other mental health conditions remain underexplored in multicultural populations and require

dedicated research attention to ensure a comprehensive understanding of mental health needs across diverse communities. Finally, although youth (16 years and over) are represented in the NSMHW, there is a need for specific research with overseas-born young people to determine mental health trends within this subgroup.

In summary, although the NSMHW is the major resource for understanding mental health trends in Australia, it has restricted utility in capturing the experiences of multicultural communities due to limited representation from aforementioned CaLD subgroups and the exclusion of others such as international students. These challenges could be addressed, in this and other population surveys, by oversampling selected CaLD subgroups to enable more reliable and insightful analysis of specific health issues.

Policy and infrastructure

Despite long-standing recognition by the Australian Government of the health inequities faced by multicultural communities, and its ongoing commitment to national mental health reforms since the launch of the first National Mental Health Policy in 1992, the visibility of multicultural communities in both national and state/territory mental health plans remains limited[14]. Multicultural communities are frequently subsumed under broad labels such as "diverse" or "priority populations,"[15] with strategies that do not adequately address their specific needs. Alternatively, CaLD mental health is subsumed under CaLD health more generally (e.g., NSW Plan for Healthy CaLD Communities and NSW Refugee Health Plan). Stakeholders highlighted the absence of a national multicultural mental health policy and planning framework grounded in human rights as a major impediment to progress. This is despite recommendations made by Minas and others calling for CaLD populations to be central in mental health policy-making, and for CaLD-relevant policies to be translated into funded, actionable objectives. (21, 22, 137)

It is clear that policies to drive systemic changes to support mental health in multicultural Australia are required at all levels of government. Moreover, as articulated in the Productivity Commission (2025) report, commitment to a national plan should include specific, measurable and achievable outcomes, with funding linked to the objectives. (138) All mental health policy and planning should involve diverse stakeholders and be informed by lived experience and

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[14] Western Australia Mental Health Commission produced a 'Multicultural Plan 2022-25' with a charter, a vision and a series of actions organised under three key policy priority areas. https://www.mhc.wa.gov.au/awcontent/Web/Documents/2015-2024/multicultural-plan-2022-2025.pdf

[15] Victoria's 'Diverse Communities Mental Health and Wellbeing 10-Year Framework (2025–2035)' and related blueprint, released in October 2025, which focuses on LGBTIQA+ Victorians, multicultural Victorians, and Victorians with disability, is a recent example. https://www.health.vic.gov.au/diverse-communities-mental-health-wellbeing-framework-blueprint

grass roots knowledge and practice. Funding and structures are required to support policy implementation. Policies and frameworks, accompanied by sustained funding and infrastructure support, are also needed at the organisation and service levels, including systems for quality assurance and monitoring and evaluation.

Barriers and enablers to access and engagement

We examined the barriers and enablers to access, and continued engagement reported in the studies included in our literature review. Broadly speaking, there was greater focus on barriers, with the findings largely reinforcing what has been known for some time. For example, language and communication challenges were reported regularly, particularly for less common languages or specialised mental health terminology, (112) and often related to limited availability of qualified interpreters and culturally-tailored multilingual resources. (98, 101, 105) Experiences of cultural insensitivity by health professionals and systems, further solidify feelings of mistrust, particularly among refugees and asylum seekers, hindering engagement. (101, 109, 117) Systemic barriers such as financial constraints, restrictive intake criteria, transport difficulties, inflexible scheduling, and limited services in regional areas further compound these challenges. (85-87, 101, 106) Other contributors to under-utilisation of services are: limited knowledge about mental health disorders and treatments, shame and stigma surrounding mental illness, and lack of awareness about available support pathways. (71, 84, 95, 98)

In contrast, it appears that evidence on enablers is still emerging. From the studies we reviewed, it was clear that effective engagement is supported by culturally adapted interventions that align with community values, language preferences, and spiritual frameworks (see Chapter 4 Table 4.3 for full description of the reviewed interventions). In the stakeholder consultations, improving accessibility was ranked as one of the top five enablers of good practices, with provision of friendly, welcoming services ranked number 2. Using flexible delivery methods such as online sessions can also enhance accessibility. (82) (86)

A bilingual/bicultural workforce plays a vital role in building trust and bridging cultural gaps. (94, 110, 112) In the stakeholder consultations, of all the enablers considered, it was ranked number 1 in importance. Community partnerships, co-design, and delivery in trusted settings foster ownership and legitimacy. (86, 106, 112) Integrated care models and trauma-informed practices address broader social determinants and migration-related trauma. (83, 87, 95, 107, 112) Finally, culturally-tailored mental health promotion and mental health literacy programs help reduce stigma and promote help-seeking within CaLD communities. (104, 113)

6.4 Question 2

What are the current and emerging good practices for supporting the mental health of multicultural communities?

Working with the community
There was strong alignment between findings from the literature review and the stakeholder consultations regarding what constitutes good practices in multicultural mental health. In particular, working with CaLD communities was considered by stakeholders both as a principle and as an enabler of good practices. CaLD community organisations and leaders are widely trusted as sources of information and advice. Informal care networks, including extended family and friends, play a vital role in mental health support. These carers require psychoeducation, practical assistance and respite. In newly arrived refugee and migrant families, children often assume caregiving roles. Families should be involved in treatment planning and recovery where appropriate, recognising their influence on mental health outcomes. Generational differences and intersectionality add to complexity.

Communities should be involved, as partners, in the co-design of services and programs and the co-production of resources. This work can only be undertaken when community-led organisations are appropriately resourced and supported. Integrating mental health support in existing community infrastructure will facilitate access to services and information. As mental health service providers engage with different communities, they, in turn, will build knowledge and skills. Community involvement that informs action and produces real benefit will strengthen trust and overall system capacity to support multicultural mental health. All stakeholders must take an active role to respond to intersectionality within their scope of practice and actively incorporate it into multicultural mental health responses.

Services and programs
Notwithstanding the increasing diversity of Australia's population and the challenges of multicultural mental health, access to services and information for CaLD communities remains limited, particularly (but not only) in regional areas and for new arrivals. As indicated in our analysis of 2020-2022 NSMHW data, time to treatment for mental disorders is more frequently delayed for people born overseas compared with those born in Australia.

A range of interventions are required to meet evolving multicultural mental health needs. Improving CaLD mental health and wellbeing requires accessible, culturally safe and responsive services, shaped by community members with lived experience and service providers, together with programs that educate and empower CALD communities to support their own mental health and wellbeing. Our literature review identified many community-based services and programs that were tailored to the linguistic and cultural needs of local CaLD communities. These programs were trauma-informed and employed various evidence-based therapeutic modalities such as mindfulness, CBT, and art-based therapies. While we did

not conduct a formal quality assessment of studies, there are clear directions in what is being reported across Australia for CaLD communities. Effective models of care should be embedded in routine service delivery and scaled up, with adaptation for other populations and settings as necessary, and new innovative models should be developed and evaluated.

Building on the review findings, the stakeholder consultations indicated broad consensus on the principles and enablers of good multicultural mental health practices. Services should be welcoming, with empathic and non-judgmental staff who understand the different migration journeys of the people who access them and recognise cultural and community strengths. Care should be person- and family-centred, as well as trauma-informed, and involve service providers working collaboratively to deliver high-quality services that address mental, physical, social and spiritual needs. Concurrently, there is an urgent and widespread need for community awareness and mental health education initiatives that acknowledge different cultural understandings of wellbeing and levels of language and digital literacy.

The whole workforce matters

Findings from both the literature review and the stakeholder consultations reinforced the depth of expertise and lived experience within multicultural communities. They also highlighted the critical importance of developing and strengthening the whole workforce to enhance the quality and reach of multicultural mental health care. Working in mental health settings, where needs are often complex and require multisectoral responses, can be particularly challenging. This is especially true when supporting refugees and other recent arrivals from conflict-affected regions.(89, 110, 115)

Expanding the bilingual/ bicultural mental health workforce, including both clinical and peer worker roles, and strengthening language services in the mental health area are fundamental to ensuring high-quality care. Concurrently, it is critical to continue building cultural responsiveness across the broader mental health workforce, including primary care, settlement and disability service providers. The responsibility for provision of good mental health care for CaLD communities sits with all; not just bilingual/bicultural staff and others with CaLD backgrounds.

For sustainability, it is essential to prioritise not only recruitment but also retention and development of bilingual and bicultural staff, including peer workers. Clients and carers from CaLD communities bring valuable lived experience; services will benefit if they are integrated into the workforce. Organisations and services should establish career pathways for bilingual and bicultural health staff including the peer workforce, as well as embedding culturally safe and responsive care in their organisational culture. This should be supported with ongoing training of other service providers and expanding language services to meet the needs of emerging communities. Pre-workforce education initiatives are also required.

Data, research and continuous quality improvement

Accurate and timely data are essential to enhancing mental health policy and practice for multicultural communities. However, their usefulness depends on what is collected, from whom, and for what purpose. Australian population-level surveys do not adequately reflect the diversity of these communities, restricting their capacity to generate meaningful insights. Further, while the number of studies in this field is growing, evidence to guide service and program development to better meet the needs of different populations and subgroups, remains limited.

Stakeholders considered that client and carer feedback was critical for high-quality service delivery and continuous improvement, however not everybody recognised the value of service- or population-level data. The limitations of the ABS indicators such as country of birth, language spoken at home, English proficiency, ancestry and duration of residence in Australia were emphasised. (59) Moreover, as noted previously, these particular indicators should not be considered in isolation.

6.5 Conclusion

Australia’s growing population diversity is a national strength. However our understanding of the state of multicultural mental health remains hindered by factors such as lack of attention to key population subgroups in national mental health surveys and the limited research literature. Studies highlight the continued importance of communication in service access and engagement, along with the impact of cultural and social factors and systemic and structural barriers. Relatively less is known about the enablers of culturally safe and responsive practices, and this became the focus of our work in answering question 2.

Good practices for multicultural mental health include elements such as co-design with CaLD communities, culturally safe and trauma-informed care, and integration of such services into trusted community settings. Expanding bilingual/bicultural workforce and the provision of culturally-tailored mental health programs is critical. Importantly, enablers to undertake this work include workforce development with a focus on bilingual/bicultural staff, flexible service models, and mental health literacy initiatives. Finally, it is clear that for continuous improvement there needs to be a focus on development of inclusive data and CaLD client, carer and community feedback.

6.6 Recommendations

Based on the research findings, we propose a series of recommendations to guide governments, and the mental health and non-government sectors, in strengthening culturally responsive mental health care and supporting the wellbeing of multicultural communities. These are presented below, grouped into six strategic areas: (1) interventions, (2) access and equity, (3) community partnerships, (4) leadership and culture, (5) workforce, and (6) knowledge and data.

Recommendation 1

The Australian and state/territory governments should fund the development of culturally and linguistically tailored interventions to meet personal and population multicultural mental health needs, adopting a systems approach. This would enable the mental health and non-government sectors, including multicultural and settlement services, to improve access to culturally responsive mental health care and reduce disparities for CaLD communities by:

1.1 Conducting place-based community campaigns using a range of formats and media to raise awareness of mental health, increase mental health literacy and reduce stigma.

1.2 Creating welcoming environments where CaLD clients feel secure to share their experiences, with high-quality care that is trauma-informed and draws on cultural and community strengths.

1.3 Delivering services in the client's preferred language and dialect, using bilingual/cultural staff or professional interpreters matched for gender and other relevant characteristics, and addressing concerns around confidentiality.

1.4 Providing person-centred, and family-centred, care that considers intersectionality, generational differences and social and economic factors, and that does not rely on generalisations or diagnostic labels.

1.5 Providing psychoeducation to clients and their families and carers, practical assistance and links to other health and community services, and addressing spiritual needs.

1.6 Working collaboratively to deliver culturally responsive holistic models of care.

Recommendation 2

The Australian and state/territory governments must provide adequate and sustained funding so mental health services and non-government organisations can remove access barriers and deliver equitable mental health care for CaLD communities at both local and systems levels. With this funding, mental health services and non-government organisations must improve access and engagement by:

2.1 Implementing available multicultural frameworks, seeking out good practices and embedding these into organisational culture and practice.
2.2 Providing mental health information in multiple languages using diverse formats (e.g., audio, video, infographic) and preferred broadcast and social media, ensuring it is relatable to the target group.
2.3 Increasing mental health service availability through flexible delivery models, including outreach clinics and telehealth options.
2.4 Providing 'soft entry points' to specialist services and simplified referral pathways, supported by service navigation and transport assistance when required.
2.5 Ensuring equitable access to services and affordability by:
    2.5.1 Removing restrictive government and service eligibility criteria that exclude certain groups.
    2.5.2 Providing coordinated, cross-sector services and support for clients with complex needs.
2.6 PHNs should reduce place-based inequities by embedding cultural safety considerations into commissioning processes to address gaps in multicultural mental health services including regional disadvantage.

Recommendation 3

The mental health sector must build stronger connections with CaLD community members with lived experience and their extended family and carers, and CaLD communities more broadly, to ensure they actively shape mental health services that reflect their needs and values. This should involve:

3.1 Partnering with community services and organisations to design, deliver and evaluate multicultural health and wellbeing programs, using culturally-tailored co-design approaches.
3.2 Empowering communities:
    3.2.1 Working with cultural leaders to identify key people to promote mental health.
    3.2.2 Educating and empowering CaLD community members as advocates within the mental health system.
    3.2.3 Promoting cultural identity, particularly among young people, and fostering a sense of pride and belonging.

3.1 Developing governance structures that include CaLD community representation, and an inclusive organisational culture:
   3.1.1 Implementing internal referral pathways, guidelines and performance measures to support inclusive practices.
   3.1.2 Implementing quality standards and reporting guidelines, and monitoring performance.

Recommendation 4
The Australian and state/territory governments should ensure CaLD community voice and leadership in multicultural mental health policy development, implementation and evaluation in all jurisdictions, supported by and through:

4.1 Coordinated multicultural mental health policy and plans, based on human rights and legal frameworks.
4.2 Dedicated and sustained funding for multicultural mental health that includes remuneration for the contributions of people with lived experience.
4.3 Harnessing CaLD community expertise, strengthening existing community infrastructure, funding capacity building for CaLD community organisations and groups, and providing grants for community mental health initiatives.

Recommendation 5
The Australian and state/territory governments should make funding and policy commitments to build workforce capability and sustainability by investing in bilingual/bicultural mental health professionals and the broader workforce, including:

5.1 Providing incentives to enable services to recruit and retain more bilingual/bicultural staff, including interpreters, clinicians and peer workers, from the communities served, and building leadership roles.
5.2 Supporting CaLD community members to gain new or additional qualifications in relevant fields and engage with training and education providers and industry to develop pathways from education into employment.
5.3 Supporting bicultural/bilingual students to pursue mental health qualifications such as psychology, social work or counselling through the provision of targeted scholarships and bursaries.
5.4 Funding an increase in the number of interpreters with specific mental health training, and training more interpreters in the languages of newly arrived communities.
5.5 Ensuring that national and state/territory funding agreements mandate cultural training for senior personnel and all mental health service managers and providers to improve cultural competence, leading to safer, more inclusive, and responsive care for CaLD communities.

5.6 Mental health, primary health and community service providers should make the following commitments, supported by sustainable funding from the Australian and state/territory governments:

- 5.6.1 Build understanding of mental health and cultural issues and trauma awareness among health and community providers who work with CaLD communities, including general practice and first responders.
- 5.6.2 Address the needs of CaLD clients with psychosocial disabilities through culturally competent mental health training for NDIS workers and other support providers.
- 5.6.3 Develop clinician tools and resources, e.g., multilingual patient information and appointment reminders, lists of multicultural community services and affordable bilingual counsellors, and transcultural mental health advice.

Recommendation 6

The Australian Government should make a commitment to providing adequate funding to enable researchers, the ABS, AIHW and others to build scientific knowledge around multicultural mental health and addressing outstanding data gaps. This should involve improving the relevance and consistency of data collected and includes:

6.1 Implementing targeted oversampling of selected CaLD communities in national surveys particularly the National Study of Mental Health and Wellbeing, to enable more granular and meaningful insights into the mental health needs of underrepresented groups, while addressing issues of statistical reliability and ethical data suppression.

6.2 Ensuring national surveys and data collections adequately reflect multicultural Australia, with variables and data definitions that are meaningful to CaLD communities.

6.3 Commissioning targeted research to inform service and policy development, including CaLD community needs assessments, service evaluations and intervention studies, emphasising the use of culturally sensitive participatory approaches and co-design.

6.4 Working with services and organisations to build data literacy and infrastructure to enhance CaLD mental health data collection and use.

6.5 Supporting a culture of continuous quality improvement that incorporates CaLD client, carer and community feedback.

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Acknowledgment of contributions

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Appendices

Appendix A: Details on NSMHW methods

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Appendix A: Details on NSMHW methods

Appendix A: Details on NSMHW methods

A.1 NSMHW methods in full

A.1.1 Design

The 2020-2022 National Study of Mental Health and Wellbeing (NSMHW) is a nationally representative survey of Australians aged 16 to 85 years, living in private dwellings across all states and territories. (47, 48) The study excluded individuals residing in very remote areas, non-private dwellings (e.g., hospitals, aged care facilities), and discrete Aboriginal and Torres Strait Islander communities. The sampling frame was based on the Australian Bureau of Statistics (ABS) Master Address File, ensuring comprehensive national coverage.

A stratified, multistage, area-based sampling method was used to randomly select households, ensuring representation across urban and regional areas. Within each selected household, one individual aged 16–85 years was randomly selected using the "next birthday" method. To improve the precision of estimates for younger Australians, individuals aged 16–24 years were intentionally oversampled. This approach enabled a more detailed understanding of mental health trends in a key developmental age group. The final sample included 15,893 respondents. Survey weights were applied to adjust for sampling probabilities and non-response, ensuring that the results reflected the broader Australian population. This robust sampling design supports reliable, nationally representative insights into mental health conditions, service use, and associated risk factors.

A.1.2 Data Collection

Data were collected in two waves, the first between December 2020 and July 2021, and the second from December 2021 to October 2022, resulting in a combined sample of nearly 16,000 respondents. While most interviews were conducted face-to-face, video interviews were employed when COVID-19 restrictions were in place.

A.1.3 Diagnostic Assessment

Diagnostic information was collected using the World Health Organisation Composite International Diagnostic Interview, version 3.0 (WMH-CIDI) (51), based on definitions and criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) and has been widely used internationally as part of the World Mental Health Survey Initiative. (54) By applying a lifetime time frame and combining questions about symptoms experienced in the previous 12 months with lifetime diagnoses, the WMH-CIDI enables the establishment of 12-month prevalence estimates. Diagnostic exclusion rules were applied unless explicitly stated.

The mental and substance use disorders assessed in the 2020-2022 NSMHW were consistent with those included in the 2007 national survey and were categorised into three major classes: mood disorders, anxiety disorders, and substance use disorders but only mood and anxiety disorders are considered in this report. Mood disorders included major depressive disorder, dysthymia (currently referred to as persistent depressive disorder), and bipolar disorder. Anxiety disorders included agoraphobia (with or without panic disorder), social phobia (currently known as social anxiety disorder), panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), and posttraumatic stress disorder (PTSD).

A.1.4 Outcome variables

In addition to 12-month prevalence of anxiety and affective disorders (as operationalised above), other outcomes assessed related to mental health treatment. This included assessing respondents' consultations with different types of health professionals for their mental health in the previous 12 months. In the 2020–2022 survey, the types of health professionals were general practitioners (GPs), psychiatrists, psychologists, mental health nurses, other mental health professionals (including social workers, counsellors or occupational therapists), specialist doctors or surgeons (including cardiologists, gynaecologists or urologists) and other health professionals (including dietitians, physiotherapists or pharmacists).

We also assessed differences in the delay to treatment between the two subgroups. This was calculated by subtracting the age at first consultation with a health professional for a mental health concern from the earliest reported age of onset of symptoms. This variable represents the number of years between the onset of symptoms and first engagement with professional care. (49)

A.1.5 Impairment and psychological distress

The short form of the 12-item WHODAS 2.0 (52) was used to evaluate the extent of functional impairment attributed to mental disorders across six key life domains: cognition, mobility, self- care, interpersonal relationships and interactions, life activities (domestic, work/school activities) and community participation. The 12 Likert-style scale questions have possible responses ranging from “none” to an “extreme” amount of difficulty with an area of function in the past 30 days. Simple scores are obtained by summing the values attributed to each answer, wherein “none” = 1, “mild” = 2, “moderate” = 3, “severe” = 4, and “extreme” = 5. Possible scores for the 12-item WHODAS 2.0 range from 12 to 60; a score of 12 indicates that for all items, endorsement was “none.” The total score was standardised to range from 0 to 100 with the following cutoffs: no problem (0–4%), mild disability (5–24%), moderate disability (25–49%), severe disability (50–95%), and extreme disability (96–100%). (52, 53) The ‘None’ and ‘Mild’ categories were combined into a single group representing minimal disability, while the ‘Severe’ and ‘Extreme’ categories were also combined to represent high

disability. Individuals with any missing WHODAS answers were not scored.

The Kessler Psychological Distress Scale (K10) was used to evaluate psychological distress experienced in the four weeks preceding the interview. (55) The K10 yields a total score ranging from 10 to 50, which can be grouped into severity categories indicating levels of psychological distress. Categories examined were low distress (scores between 10-15), moderate distress (16–21) and high to very high distress (≥ 22).

A.1.5 Covariates

Covariates included in the analysis encompassed key sociodemographic and health-related factors such as age, sex, education, employment status, household income, marital status, geographic remoteness (as measured by the Accessibility/Remoteness Index of Australia Plus; ARIA+), and self-reported general health. Detailed variable definitions and category breakdowns are provided in Table A.1.6

A.1.6 Covariates used in the current analysis

Table A.1.6: Characteristics and levels of the covariates and each reference category.

Covariate	Definition/classification	Reference Category
Demographics		
Gender	Female	Female
	Male	
Sexual orientation	Gay or lesbian	Heterosexual
	Gay or Lesbian/bisexual/different term	
	Bisexual	
	Gay or lesbian	
	Not stated	
Gender identity	Inadequately described	Cis gender
	Transgender	
Age in categories	16-25	16-25
	26-45	
	46-65	
	66-85	
Marital status	Married	Married
	Separated/divorced/widowed	
	Never married	
Region of birth	North-East Asia	North-West Europe
	North-West Europe	
	Americas	
	North Africa and Middle East	
	Oceania and Antarctica	
	South-East Asia	
	Southern and Central Asia	
	Southern and Eastern Europe	
	Sub-Saharan Africa	
Year of arrival in Australia	Arrived before 2002	Arrived before 2002
	Arrived 2002-2011	
	Arrived 2012-2022	
Language spoken at home	English	English
	Other languages	
English proficiency	Very well	Very well
	Well	
	Not well/Not at all	
	Not applicable	
Educational attainment	Did not complete school/unknown	Bachelor’s degree or above
	Year 12 or equivalent	
	Bachelor’s degree or above	
	Advanced diploma/diploma/certificate	
Socio-economic indexes for areas (SEIFA)	1st quintile (Most disadvantaged)	1st quintile.
	2nd quintile	
	3rd quintile	
	4th quintile	
	5th quintile (Most advantaged)	
Accessibility/remoteness index of Australia (ARIA)	Major cities	Major cities
	Inner regional	
	Outer regional/remote	

Employment	Fully engaged	Fully engaged
	Partially engaged	
	No study or employment	
Labour force participation	Employed	Employed
	Unemployed	
	Not in labour force	
Health related characteristics		
Trauma event	Non-interpersonal trauma	Non-interpersonal trauma
	Interpersonal trauma	
Self-rated health	Excellent	Excellent
	Very good	
	Good	
	Fair	
	Poor	
The Kessler Psychological Distress Scale (10-item)	Low distress	Low distress
	Moderate distress	
	High/very high distress	
Disability status	No/mild disability	No/mild disability
	Moderate disability	
	Severe disability	
Medical Service and Medication Utilisation		
Mental health hospitalisation (admitted overnight or longer for MH in the past 12-months)	No/not known/refused	No/not known/refused
	Yes	
Mental health professional	No	No
	Yes	
General practitioner	No	No
	Yes	
Psychiatrist	No	No
	Yes	
Psychologist	No	No
	Yes	
Other mental health professional	No	No
	Yes	
Other professional	No	No
	Yes	

Appendix B: Search strategies across electronic databases

Appendix B: Search strategies across electronic databases

Medline Search

1	Refugees/ or "Ethnic and Racial Minorities"/ or ethnicity/ or cultural diversity/ or "Emigration and Immigration"/ or "Emigrants and Immigrants"/ or "Transients and Migrants"/	149123
2	(migrant* or refugee* or (Ethnic adj3 Minorit*) or immigrant* or emigration or emmigrant* or diaspora or War Affected or (cultur* adj6 divers*) or CALD or asylum seeker*).ti,ab.	105592
3	1 or 2	203856
4	mental health services/ or community mental health services/ or mental health/ or Mental Disorders/ or Psychosocial Intervention/	281087
5	((mental health or mental disorder* or mental Illness* or wellbeing or community or psychosocial) adj3 (service* or project* or group* or program* or intervention* or train* or course*)).ti,ab.	127016
6	4 or 5	373790
7	Program Evaluation/ or Feasibility Studies/ or Practice Guideline/ or Cultural Competency/ or Culturally Competent Care/	198590
8	(Evaluat* or ((best or promising or preferred) adj3 practice*) or feasibility or pilot* or effectiveness or clinical utility or (cultural* adj3 (tailor* or competen* or adapted)) or intervention* or guide*).ti,ab.	7323009
9	7 or 8	7373626
10	exp Australia/	181143
11	(Australia or South Australia or Western Australia or New South Wales or Victoria or Northern Territory or Australian Capital Territory or Tasmania or Queensland or NSW or Vic or SA or NT or ACT or WA or Qld).ti,ab.	607775
12	10 or 11	699876
13	3 and 6 and 9 and 12	388
14	limit 13 to dt=20120901-20250204	296

CINAHL Search

S1	TI (migrant* OR refugee* OR (Ethnic N3 Minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR “War Affected" OR (cultur* N6 divers*) OR CALD OR asylum seeker* OR multicultur*) OR AB (migrant* OR refugee* OR (Ethnic N3 Minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR “War Affected” OR (cultur* N6 divers*) OR CALD OR asylum seeker* OR multicultur*))	(55,606)
S2	(MH "Refugees") OR (MH "Ethnic Groups") OR (MH "Immigrants") OR (MH "Cultural Diversity") OR (MH "Emigration and Immigration") OR (MH "Migrants")	(88,040)
S3	S1 OR S2	(109,824)
S4	TI ((mental health OR mental disorder* OR mental Illness* OR wellbeing OR community OR psychosocial) N3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*)) OR AB ((mental health OR mental disorder* OR mental Illness* OR wellbeing OR community OR psychosocial) N3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*))	(95,769)
S5	(MH "Mental Health Services") OR (MH "Community Mental Health Services") OR (MH "Mental Health") OR (MH "Mental Disorders") OR (MH "Psychosocial Intervention")	(168,629)
S6	S4 OR S5	(236,078)
S7	TI (Evaluat* OR ((best OR promising OR preferred) N3 practice*) OR feasibility OR pilot* OR effectiveness OR clinical utility OR (cultural* N3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*) OR AB (Evaluat* OR ((best OR promising OR preferred) N3 practice*) OR feasibility OR pilot* OR effectiveness OR clinical utility OR (cultural* N3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*)	(1,849,413)
S8	(MH "Program Evaluation") OR (MH "Pilot Studies") OR (MH "Practice Guidelines") OR (MH "Cultural Competence") OR (MH "Transcultural Care")	(247,908)
S9	S7 OR S8	1,934,602)
S10	TI (Australia OR “South Australia” OR “Western Australia” OR “New South Wales” OR Victoria OR “Northern Territory” OR “Australian Capital Territory” OR Tasmania OR Queensland OR NSW OR Vic OR SA OR "NT" OR ACT OR WA OR Qld) OR AB (Australia OR “South Australia” OR “Western Australia” OR “New South Wales” OR Victoria OR “Northern Territory” OR “Australian Capital Territory” OR Tasmania OR Queensland OR NSW OR Vic OR SA OR "NT" OR ACT OR WA OR Qld)	(154,294)
S11	(MH "Australia+")	(134,441)
S12	S10 OR S11	(238,624)
S13	S3 AND S6 AND S9 AND S12 AND EM 20120901-20250207	(316)

PsycINFO Search

S1	TI (migrant* OR refugee* OR (Ethnic N3 Minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR “War Affected “OR (cultur* N6 divers*) OR CALD OR asylum seeker* OR multicultur*) OR AB (migrant* OR refugee* OR (Ethnic N3 Minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR “War Affected” OR (cultur* N6 divers*) OR CALD OR asylum seeker* OR multicultur*))	(102,219)
S2	(DE "Refugees") OR (DE "Racial and Ethnic Groups") OR (DE "Ethnic Identity") OR (DE "Cultural Diversity") OR (DE "Immigration")	(75,814)
S3	S1 OR S2	(133,601)
S4	TI ((mental health OR mental disorder* OR mental Illness* OR wellbeing OR community OR psychosocial) N3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*)) OR AB ((mental health OR mental disorder* OR mental Illness* OR wellbeing OR community OR psychosocial) N3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*))	(132,615)
S5	(DE "Mental Health Services" OR DE "Community Mental Health Services") OR (DE "Mental Health") OR (DE "Mental Disorders") OR (DE "Psychosocial Interventions")	(282,809)
S6	S4 OR S5	(359,836)
S7	TI (Evaluat* OR ((best OR promising OR preferred) N3 practice*) OR feasibility OR pilot* OR effectiveness OR clinical utility OR (cultural* N3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*) OR AB (Evaluat* OR ((best OR promising OR preferred) N3 practice*) OR feasibility OR pilot* OR effectiveness OR clinical utility OR (cultural* N3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*)	(1,383,597)
S8	(DE "Program Evaluation") OR (DE "Mental Health Program Evaluation") OR (DE "Treatment Guidelines") OR (DE "Cultural Competence") OR (DE "Culturally Adapted Interventions")	(41,086)
S9	S7 OR S8	(1,390,670)
S10	TI (Australia OR “South Australia” OR “Western Australia” OR “New South Wales” OR Victoria OR “Northern Territory” OR “Australian Capital Territory” OR Tasmania OR Queensland OR NSW OR Vic OR SA OR "NT" OR ACT OR WA OR Qld) OR AB (Australia OR “South Australia” OR “Western Australia” OR “New South Wales” OR Victoria OR “Northern Territory” OR “Australian Capital Territory” OR Tasmania OR Queensland OR NSW OR Vic OR SA OR "NT" OR ACT OR WA OR Qld)	(178,706)
S11	PL Australia	(94,819)
S12	S10 OR S11	(241,130)
S13	S3 AND S6 AND S9 AND S12	(410)
S14	S3 AND S6 AND S9 AND S12 (limited to Sep 2012-Jan 2025)	(289)

Scopus Search

1	TITLE-ABS (migrant* OR refugee* OR (ethnic W/3 minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR "War Affected " OR (cultur* W/6 divers*) OR CaLD OR asylum AND seeker* OR multicultur*)	19,616 results
2	TITLE-ABS (("mental health" OR "mental disorder*" OR "mental Illness*" OR wellbeing OR community OR psychosocial) W/3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*))	279,371 results
3	TITLE-ABS (evaluat* OR ((best OR promising OR preferred) W/3 practice*) OR feasibility OR pilot* OR effectiveness OR "clinical utility" OR (cultural* W/3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*)	16,030,698 results
4	TITLE-ABS (australia OR "South Australia" OR "Western Australia" OR "New South Wales" OR victoria OR "Northern Territory" OR "Australian Capital Territory" OR tasmania OR queensland OR nsw OR vic OR sa OR "NT" OR act OR wa OR qld)	1,907,396 results
5	(TITLE-ABS (migrant* OR refugee* OR (ethnic W/3 minorit*) OR immigrant* OR emigration OR emmigrant* OR diaspora OR "War Affected " OR (cultur* W/6 divers*) OR CaLD OR "asylum seeker*" OR multicultur*)) AND (TITLE-ABS (("mental health" OR "mental disorder*" OR "mental Illness*" OR wellbeing OR community OR psychosocial) W/3 (service* OR project* OR group* OR program* OR intervention* OR train* OR course*))) AND (TITLE-ABS (evaluat* OR ((best OR promising OR preferred) W/3 practice*) OR feasibility OR pilot* OR effectiveness OR "clinical utility" OR (cultural* W/3 (tailor* OR competen* OR adapted)) OR intervention* OR guide*)) AND (TITLE-ABS (australia OR "South Australia" OR "Western Australia" OR "New South Wales" OR victoria OR "Northern Territory" OR "Australian Capital Territory" OR tasmania OR queensland OR nsw OR vic OR sa OR "NT" OR act OR wa OR qld))	416 results

Embase Search

1	refugee/ or ethnic group/ or ethnicity/ or cultural diversity/ or migration/ or migrant/	294161
2	(migrant* or refugee* or (Ethnic adj3 Minorit*) or immigrant* or emigration or emmigrant* or immigrant* or diaspora or War Affected or (cultur* adj6 divers*) or CALD or asylum seeker*).ti,ab.	123016
3	1 or 2	356788
4	mental health service/ or community mental health service/ or mental health/ or mental disease/ or psychosocial intervention/	604284
5	((mental health or mental disorder* or mental Illness* or wellbeing or community or psychosocial) adj3 (service* or project* or group* or program* or intervention* or train* or course*)).ti,ab.	163584
6	4 or 5	708952
7	program evaluation/ or feasibility study/ or practice guideline/ or cultural competence/ or transcultural care/	822754
8	(Evaluat* or ((best or promising or preferred) adj3 practice*) or feasibility or pilot* or effectiveness or clinical utility or (cultural* adj3 (tailor* or competen* or adapted)) or intervention* or guide*).ti,ab.	10170238
9	7 or 8	10401946
10	exp Australia/	217564
11	(Australia or South Australia or Western Australia or New South Wales or Victoria or Northern Territory or Australian Capital Territory or Tasmania or Queensland or NSW or Vic or SA or NT or ACT or WA or Qld).ti,ab.	788636
12	10 or 11	871435
13	3 and 6 and 9 and 12	676
14	limit 13 to dc=20120901-20250201	535

Appendix C: Reasons for exclusion of studies from peer-reviewed literature (PCC criteria)

Appendix C: Reasons for excluding studies from peer-reviewed literature (PCC criteria)

Reason for exclusion of the study	Study
The study was excluded because the population (P) did not include Culturally and Linguistically Diverse individuals aged 16 years and above.	(139-147)
The study was excluded because the context (C) of study was not in Australia.	(148)
The study was excluded because the concept (C) was not within the scope as described in methods of rapid review (no intervention or outcome not within the scope of the review)	(149-162)
The study was excluded as it did not meet the inclusion study design criteria, which excluded tool validation studies and non-empirical works (e.g., editorials, perspectives, reviews, or conference abstracts).	(163-176)
The study was excluded as full text could not be extracted	(177)

Appendix D: Reasons for exclusion of studies from grey literature (PCC criteria)

Appendix D: Reasons for excluding studies from grey literature (PCC criteria)

Reason for exclusion of the study	Study
The study was excluded because the population did not include Culturally and Linguistically Diverse populations (P).	(178, 179)
The study was excluded because the concept (C) was not within the scope as described in methods of rapid review	(180-188)
The study was excluded as it was non-empirical works (e.g., editorials, perspective, reviews)	(99, 189-194)

Appendix E: Detailed extraction tables for included studies in rapid literature review

Appendix E: Detailed extraction tables for included studies in rapid literature review

Extraction Table 1: Studies involving direct data collection from the target population

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
Blignault 2019 (79)	Quasi-experimental design Funding: South Eastern Sydney Local Health District (SESLHD) Multicultural Health Service grants program (grant awarded to Al Zahra Muslim Women's Association).	The aim of the study is to explore the acceptability and clinical utility of an Arabic-language mindfulness CD for Arabic-speaking adults experiencing psychological distress in Australia.	Arabic-speaking adults	81 Arabic-speaking migrant adults, predominantly Lebanese-born (78.6%) Muslim females (72.9%) aged 26–55 years (72.9%), living in the St George, NSW, (with smaller representation from Iraq, Egypt, Palestine, and Syria, and a minority identifying as Christian). The intervention did not target a specific disease but was aimed individuals experiencing psychological distress.	Outpatient Care (Non-Hospital) (community-based program) Individual intervention of listening Arabic Mindfulness Skills CD approximately 60 minutes per week over 5 weeks, totalling around 5 hours	Psychoeducation Mindfulness-Based Intervention	*Prevention:* Targets high-distress adults to prevent mental illness using mindfulness *Early Intervention:* Uses mindfulness early for those with distress symptoms and progression *Treatment:* Supports existing therapy with mindfulness for managing symptom	Co-located Services • Community Organisation (Al Zahra Muslim Women's Association) • Community Health Centre (St George Community Mental Health Service)	Project officer from community member Bilingual psychologist Bilingual mental health clinicians Bilingual community members	**Language:** The mindfulness CD was translated into formal Arabic, making it accessible to Arabic-speaking participants. **Persons:** The project officer was a respected Arabic community member, enhancing trust and engagement. **Metaphors:** The CD linked mindfulness to Islamic practices (e.g., prayer, Quranic teachings) to improve cultural relevance. **Concepts:** Theoretical model(s) used are culturally relevant such as mindfulness was framed as compatible with Islamic traditions (Sufism, Rumi's teachings) rather than solely Buddhist origins. **Goals of Treatment/Program:** Not applicable as the intervention focused on standardised mindfulness techniques rather than individual goal-setting. **Methods:** Program was adapted for ease of uptake. The CD provided structured, simple exercises (e.g., breath focus, emotion observation) suitable for varied literacy levels. **Context:** Sessions were flexible (home visits, phone check-ins) to accommodate participants' needs. **Content:** The CD explicitly connected mindfulness to Islamic prayer and cultural concepts like "sabr" (patience). **Process:** The CD was culturally adapted through a staged, collaborative process involving bilingual clinicians, community members, and professional translators.	The mindfulness program (culturally adapted mindfulness audio program delivered via CD) was highly effective in improving mental health outcomes, while also showing strong engagement, sustained use, and cultural acceptability among participants. Key findings are summed up below: Mental Health Outcomes • Participants with "very high" distress (K10) decreased from 52.9% (baseline) to 28.6% (post-program) and 14.7% (12-week follow-up) (p < 0.001). • Depression (DASS-21): Severe/extremely severe depression dropped from 27.1% (baseline) to 10% (follow-up) (p < 0.001). • Anxiety (DASS-21): Severe/extremely severe anxiety decreased from 20% (baseline) to 5.8% (follow-up) (p < 0.01). • Stress (DASS-21): Severe/extremely severe stress fell from 45.7% (baseline) to 2.9% (follow-up) (p < 0.001). Qualitative Findings Program Engagement & Acceptability: • High compliance: 91.4% of participants used the CD ≥15 times over 5 weeks. • Sustained use: 94.3% continued mindfulness practice post-program, with 37.1% using it ≥3 times/week at follow-up. • Cultural acceptability: 100% agreed mindfulness fit their cultural/religious practices (32.9% strongly agreed). • Many linked mindfulness to Islamic prayer and concepts (e.g., "sabr").
Blignault 2021 (80)	Mixed-methods evaluation	The aim of the study is to evaluate the effectiveness,	Arabic and Bangla-speaking migrants	271 participants in 23 groups (15/23 women groups) aged	Outreach Services	Mindfulness-Based Interventi	*Prevention:* Targeted distressed individual to	Community Organisation (e.g., migrant	Bilingual facilitators (psychologist)	**Language:** Materials were provided in Arabic and Bangla, including translated handbooks and audio resources.	The mindfulness program demonstrated significant improvements in mental health outcomes, with high engagement and cultural

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
	Funding: Central and Eastern Sydney Primary Health Network (CESPHN)	cultural acceptability, and scalability of a community-based group mindfulness program tailored for Arabic- and Bangla-speaking migrants in improving mental health outcomes.		18–64 yrs including Arabic speakers (15/23 groups; mostly from Lebanon, Egypt, Iraq; Muslims and Christians) and Bangla speakers (8/15 groups; mostly from Bangladesh; predominantly Muslim), located in metropolitan Sydney. The program did not target individuals with specific mental health condition.	Community-based group sessions and online Group-based mindfulness program delivered once a week for five weeks, with each session lasting approximately 1.5 to 2 hours, complemented by individual home practice and optional telephone support between sessions.	on (Group Care) Psychoeducation Groups Support Groups	prevent worsening mental health. *Early Intervention:* Offered mindfulness to those with early signs of distress to manage symptoms early. *Treatment:* Used with standard care as a low-intensity therapy for distressed individuals.	resource centres) Cultural Organisation (e.g., mosques, churches) Religious Organisation	Bicultural Worker	**Persons:** Bilingual mental health professionals and community workers co-facilitated groups, ensuring cultural competence and shared linguistic backgrounds. **Metaphors:** No mention of culturally specific metaphors (e.g., stories or character names) were mentioned in the mindfulness program. **Concepts:** Mindfulness was framed in culturally relevant ways, linking practices to religious rituals (e.g., prayer) and collective wellbeing. **Goals of Tx/Program:** Goals included stress reduction and mental health literacy while emphasizing family and community benefits. **Methods:** Simplified mindfulness techniques were taught, with structured home practice and group discussions for accessibility. **Context:** Sessions were held in community settings (mosques, churches, migrant centers) with flexible scheduling and childcare support. **Content:** Spiritual connections (e.g., mindfulness during prayer) were acknowledged, but no local remedies or traditional healing practices were integrated. **Process:** Adaptations were informed by expert input and community feedback, but no formal co-design with participants was described.	acceptability among Arabic- and Bangla-speaking migrants. Key findings include: Mental Health Outcomes • 80% completion rate (131/168 Arabic speakers; 87/103 Bangla speakers), with most attending ≥3 sessions and practicing mindfulness at home. • Both groups showed statistically significant reductions in depression, anxiety, and stress (DASS-21, *p* < 0.001) and psychological distress (K10, *p* < 0.001). Older participants (56–65 years) showed greater improvements than younger ones. • 30 new referrals to mental health services for high-distress participants. Qualitative Findings • Mindfulness aligned with religious practices (e.g., prayer, Quran recitation) and fostered self-compassion. • Participants reported reduced stress, improved sleep, better family relationships, and integration of mindfulness into daily routines. • Group sessions provided peer connection, with 92–99% sharing skills with family/community. • Some faced initial difficulty focusing but persisted with practice. • The program successfully bridged cultural and clinical needs, demonstrating scalability for migrant communities.
Blignault 2022 **(81)**	Mixed-methods evaluation Funding: Central and Eastern Sydney Primary Health Network	The aim of the study is to evaluate the effectiveness and cultural acceptability of a community-based group mindfulness program for promoting mental health and wellbeing among Arabic	Arabic and Bangla-speaking adults	489 participants (302 Arabic-speaking and 187 Bangla-speaking), with 445 in face-to-face groups (92% female) and 44 in online groups (100% female). The program did not target individuals with	Outreach Services Community-based group sessions and online Intervention group engaged in a 4-week mindfulness program,	Group Psychoeducation Mindfulness Based intervention Peer support Groups	*Prevention:* Reduces psychological distress in at-risk migrants to prevent mental illness. *Early Intervention:* Addresses early symptoms (e.g., stress, anxiety) via group mindfulness *Treatment:* Supports existing therapy with	Face to face (Community centres, migrant resource centres, mosques, and church facilities) Online (via video conferencing)	Bilingual mental health clinicians (psychologists) and community workers	**Language**: Programs delivered in Arabic and Bangla, with materials available in multiple languages. **Persons**: Bilingual clinicians and community workers from the same cultural background. **Metaphors**: Use of culturally relevant examples and spiritual practices (e.g., Islamic teachings, Qur'anic verses). **Concepts**: Integration of mindfulness with cultural and religious beliefs. Stress and mental health were discussed through collectivist lenses (e.g., family roles, migration stressors). **Goals of Tx/Program**: Participants set goals	The culturally tailored group mindfulness program for Arabic and Bangla-speaking migrants significantly improved mental health outcomes and facilitated access to care, with key findings below: Mental Health Outcomes • Significant pre-post reductions in K10 scores (psychological distress) for both Arabic (28.6 vs 21.3, $p < 0.001$) and Bangla speakers (26.1 vs 18.5, $p < 0.001$). • High referral rates; as 23.5% of participants were referred to mental health services (e.g., psychologists, GPs) with higher rates in online groups (43.2% vs. 21.7% face-to-face, $p < 0.01$).

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
		and Bangla-speaking migrants in Australia.		specific mental health condition.	with one session per week, either online or face-to-face.		mindfulness for managing symptom.			around improving family harmony or parenting stress, not just individual wellbeing. **Methods**: Simplified mindfulness practices tailored to the cultural context. Visual aids and oral instructions replaced written materials where needed. **Context**: Sessions timed around prayer/work commitments; childcare provided for F2F groups. Free programs plus digital resources to reduce cost barriers. **Content**: Modules included Islamic teachings on patience, gratitude, and self-compassion. Discussions normalised traditional healing practices alongside clinical care. **Process**: Adaptations derived through consultation with community members and cultural experts. Resources were refined via participant evaluations (e.g., adjusting metaphors for Bangla speakers).	• 95% of participants shared mindfulness techniques with others, reaching 922+ people (average 2.3 per participant), primarily family (78%) and friends (46%). Qualitative Findings • In terms of cultural acceptability, 97% rated the program as "very good/excellent," with themes of religious compatibility and peer support in qualitative feedback. • Over 80% completion rate (362/445 participants face to face and 35/44 online) • Retained 80% attendance despite pandemic shifts, with comparable outcomes to in-person delivery, demonstrating success in online adaptation. • 83 bilingual professionals trained; 60% reported "high impact" on their practice, and 42% facilitated new mindfulness groups.
Blignault 2023a **(82)**	Mixed Methods randomised control cross-over trial Funding: South Eastern Sydney Local Health District Multicultural Health Service	The aim of the study was to evaluate the cultural acceptability and effectiveness of the Arabic Mindfulness Compact Disc (119) in reducing psychological distress among Arabic-speaking adults in Australia.	Arabic-speaking Muslim women	27 women who were form Iraq (n=11), Lebanon (n=4), Syria (n=3), Libya (n=2) residing in Wollongong, NSW. The program did not target individuals with specific mental health condition.	Outreach Services Community-based group sessions. Weekly group sessions for five weeks, with additional home practice twice a week using the mindfulness CDs.	Group Psychoeducation CBT Group Mindfulness Based intervention Peer support Groups	***Prevention:*** Aims to prevent mental illness in high-risk Arabic-speaking women through culturally adapted mindfulness. ***Early Intervention:*** Introduces mindfulness early to manage distress and reduce progression of mental health symptoms.	Community based organisation (Illawarra Multicultural Health Services).	Bilingual (Arabic/English) psychologist with support from bilingual multicultural health worker	**Language:** Materials and sessions in Arabic, preferred language of the target population. **Persons:** Bilingual psychologist and health worker with understanding of Arabic culture and Islamic practices. **Metaphors:** Use of Quranic quotes and integration of mindfulness with Islamic practices. **Concepts:** Mindfulness presented in a culturally relevant way, linking it to Islamic teachings. **Goals of Tx/Program:** Client-derived goals, focusing on stress reduction, emotional regulation, and trauma management. **Methods:** Simplified mindfulness practices for ease of uptake (e.g., breathing exercises, grounding techniques). **Context:** Flexible scheduling (weekly sessions) and inclusion of family members (participants shared CD with family). The participants were also provided with free child minding. **Content:** Integration of cultural and religious values (e.g., Quranic references, Islamic practices). **Process:** Cultural adaptation achieved through	The majority of participants (18/27) reported war-related trauma, with 15 experiencing it firsthand and 3 witnessing it. Most women had visited a GP in the past month, but seeing a mental health professional was uncommon, with five seeing psychiatrist, psychologist or counsellor. The mindfulness-based intervention demonstrated significant improvements in depression, anxiety, and stress, high participant engagement, and strong cultural acceptability with key finding listed below: Mental Health Outcomes • High engagement, with 12/20 attending all 5 sessions and 15/20 logging home practice every week. • Significant improvement in depression, anxiety, and stress levels (measured by DASS21) in the intervention group ($p<0.001$ for depression and stress, $p=0.002$ for anxiety). Wait-list control group showed significant improvement only in anxiety ($p=0.004$) and was maintained after crossover intervention.

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
										co-design based on previous experience with target group, inclusion of bilingual mental health clinicians and involvement of accredited translators.	**Qualitative Findings** •Challenges in Understanding and Applying Mindfulness: Some participants faced challenges in understanding and applying mindfulness concepts, but found alignment with Islamic teachings, which helped them relate to self-compassion and self-care principles. •Dealing with Painful Memories and Trauma: Mindfulness exercises initially triggered painful memories and physical discomfort for some participants, but with continued practice, they gained control over their emotions, found relaxation, and reduced distress. •Assistance with Daily Lives: Mindfulness practice helped participants manage stress, improve relationships, and integrate mindfulness into daily activities, with many finding lasting benefits and comfort in continued practice. •Religious Significance: Mindfulness resonated with participants' religious beliefs, enhancing their focus during prayer and Quranic recitations. •Social Considerations: The group sessions fostered peer support, enhanced emotional awareness, and positively influenced participant's well-being, relationships, and broader communities through shared practices.
Bryant 2024 **(83)**	Mixed-methods evaluation Funding: No explicit mention of external funding	The study aims to evaluate whether collaborative and side-by-side artmaking in group art therapy reduces social isolation in refugee youth, improves mental health/wellbeing, and	Adolescent female refugee from Middle Eastern & African backgrounds	5 female adolescents (14–15 years) from Middle Eastern and African backgrounds living in metropolitan Queensland, Australia. The program did not target individuals with specific mental health condition.	Outreach Services Group art therapy weekly sessions (60-minute) over six weeks	Group Care (trauma-informed, culturally sensitive art therapy) Support Groups	*Prevention:* Targets refugee youth at risk of social isolation to promote resilience, belonging, and mental wellbeing through group art therapy. *Early Intervention:* Provides culturally responsive art therapy to youth with emerging psychosocial challenges to strengthen self-esteem and	Community setting: School (Intensive English-language transition secondary school)	Art Therapists (accredited) Interpreter (used for consent)	**Language:** Not mentioned as the study used interpreters for consent but did not specify if art therapy materials were provided in participants' native languages. **Persons:** No; as the art therapists facilitated the group, but there was no mention of shared cultural backgrounds or lived refugee experiences. **Metaphors:** Not mentioned; the study did not describe using culturally specific stories, symbols, or metaphors in art directives. **Concepts:** The intervention was trauma-informed and culturally sensitive but did not explicitly frame concepts (e.g., social isolation) using culturally relevant models. **Goals of Tx/Program:** Goals focused on peer connection and wellbeing but were not explicitly derived from client cultural values (e.g., family/community-centered aims).	The program improved refugee youths' wellbeing, self-esteem, confidence, and peer connections, with high engagement and culturally inclusive practices, though limited by a small sample size, lack of co-design, and no long-term follow-up. Key results are summarised below: **Mental Health Outcomes** • Refugee youth showed improved wellbeing and peer connections post-intervention. Standardized scales (CORS, ORS, WHO-5) indicated increased self-esteem, confidence, and reduced social isolation, with clinically significant changes for some participants. **Qualitative Findings** • Social connection is important within the

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
		fosters peer connections.					emotional regulation.			**Methods:** Simplified, nonverbal artmaking (e.g., collaborative puzzles, mandalas) accommodated literacy/language barriers. **Context:** No mention of adjustments for socioeconomic factors (e.g., flexible scheduling, family inclusion) were mentioned. **Content:** Multicultural magazines and music playlists acknowledged diversity, but no specific traditions/spirituality were integrated. **Process:** No as the intervention was designed by researchers/therapists without mention of co-design input from refugee youth or communities.	school environment: Participants reported forming friendships and engaging more with peers in school. • Self-esteem and confidence are related to connecting to others and social isolation: Collaborative/side-by-side artmaking boosted confidence and provided a safe space for expression. • There is a sense of safety in artmaking: individually and collaboratively with peers: While no explicit cultural metaphors were used, multicultural materials (e.g., music playlists) fostered inclusivity. • Engagement: High participation observed, with refugee youth initiating group activities (e.g., silent mandala-making, collective artwork displays). Improved school attendance and self-care noted for one participant.
Chimoriya 2023 **(84)**	Cross-sectional study (nested within an interventional pilot study). Fundings: New South Wales Refugee Health Service, South Western Sydney Local Health District, and Anglicare.	The study aims to explore relationships between mental illness stigma, socio-demographic factors, and psychological distress, and to assess factors associated with mental health literacy (MHL) among Arabic-speaking refugee and migrant populations in Australia.	Arabic-speaking refugees in South Western Sydney, Australia	53 participants aged 18–64 years (mean age 52.3), 66% female and 34% male, mainly from Iraq (73.6%), Syria (18.9%), and Lebanon (7.5%), living in Greater Western Sydney. The program did not target individuals with specific mental health condition.	Outreach Services Weekly 3-hour group sessions over 4 weeks, delivered in Arabic.	Group psychoeducation focusing on mental health literacy, reducing stigma, and self-help strategies to promote mental health. Support Groups	*Promotion:* Enhances mental health literacy (MHL) in Arabic-speaking refugees to improve understanding and attitudes toward mental health. *Prevention:* Aims to reduce stigma and incorrect causal beliefs, potentially preventing mental illness in at-risk refugee populations. *Early Intervention:* Identifies distress and improves recognition of PTSD symptoms early in those showing signs but not yet diagnosed.	Community-based setting (Participants recruited from Adult Migrant English Program in South Western Sydney)	Bilingual health educators and/or mental health clinicians	**Language:** Materials and sessions were in Arabic, preferred language of the target population. **Persons:** Experienced bilingual health educators and/or mental health clinicians **Metaphors:** Culturally relevant vignettes (e.g., characters named Dawood or Miriam) were used to depict mental health issues. **Concepts:** The program integrated culturally relevant explanations of mental health disorders, aligning with concept of duality or pluralism of treatment beliefs in the target population. **Goals of Tx/Program:** Therapy goals were tailored to clients' cultural needs, and included exploring mental health, educating on common disorders, explaining the Australian mental health system, and introducing self-help strategies such as mindfulness and relaxation. **Methods:** The intervention was simplified, with clear steps and low-literacy tasks (e.g., mindfulness exercises). **Content:** Embedding spiritual practices (e.g., reading the Koran or Bible), modules on mindfulness aligned with cultural values, and	The study reported cross sectional data rather the impact of the intervention. The key findings are presented below: Mental Health Outcomes Mental Illness Stigma: • Higher psychological distress (K10 scores) was strongly linked to viewing mental illness as "dangerous/unpredictable." Females had greater stigma (e.g., "I-would-not-tell-anyone"). • Longer stay in Australia and more education reduced stigma. Mental Health Literacy (MHL): • Only 52.8% correctly identified PTSD in the vignette. Many attributed mental illness to "weak character" (68.5%) or "God's punishment" (29.6%). Qualitative Findings Intervention Engagement: • The culturally adapted MHL program was delivered in Arabic, but no session attendance or retention rates were reported.

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
										integration of spiritually informed practices (e.g., prayer, religious leaders). **Process:** The intervention was developed in partnership with the NSW Refugee Health Service, and adaptations were co-designed with community elders, mental health experts from the same community, and refugee health expert to ensure cultural relevance and acceptability.	
Eftimovska-Tashkovska 2016 **(85)**	Qualitative Study (Focus groups) Funding: No explicit mention of external funding	The study aims to explore participants' perceptions of a culturally specific mental health support program for Macedonian and Serbian individuals with severe mental illness.	Migrants from Macedonian and Serbian background	22 participants (2 focus groups; 11 in each) aged 18–64 years (mean 63.76, range 40–77), predominantly female (21/22), mainly Macedonian (20) and Serbian (2), living in metro and regional Illawarra, NSW. Participants had preexisting mental health conditions; primarily depression, schizophrenia, or depression with anxiety	Outreach Services (transport provided) Weekly, culturally tailored support group program	Psychoeducation (health sessions) Support Groups (primary intervention)	*Promotion:* Enhances mental, social, and physical wellbeing through culturally tailored education and social engagement. *Treatment:* Provides structured support and psychoeducation for individuals diagnosed with mental illness (e.g., depression, schizophrenia). *Continuing Care:* Offers ongoing weekly sessions to support long-term stability, social connectedness, and relapse prevention.	Community Organisation (Schizophrenia a Fellowship partnership) Cultural Organisation (Macedonian/ Serbian focus)	Multicultural health officers Bicultural workers	**Language:** The program provided health information and discussions in Macedonian (and Serbian), facilitated by bilingual staff. **Persons:** The program was led by multicultural health workers who shared cultural/linguistic backgrounds with participants. **Metaphors:** No explicit use of culturally specific metaphors or stories was mentioned. **Concepts:** Mental health education was delivered in a culturally relevant way, addressing stigma and community-specific beliefs (e.g., spiritual attributions to illness). **Goals of Tx/Program:** Focused on culturally valued outcomes like social connection, reduced isolation, and improved daily functioning. **Methods:** Combined structured health sessions with informal social activities to accommodate low-literacy needs. **Context:** Sessions were held weekly in a community setting, with transport provided for accessibility. **Content:** Included general health topics (e.g., diet, exercise) but did not explicitly integrate traditional remedies or spirituality. **Process:** No details on co-design with participants, but facilitators were culturally aligned with the community.	The qualitative evaluation of the Macedonian Mental Health and Living Skills Program revealed significant benefits for CaLD participants with mental illness, as highlighted by the following key themes: **Qualitative Findings** Improved Social Opportunities: • Participants reported reduced loneliness and isolation, with many forming meaningful friendships both within and outside the group. A sense of Comfort and Belonging: • The shared language (Macedonian) and cultural background fostered a supportive environment where participants felt understood and accepted. Improved Mood: • Regular attendance elevated participants' moods, with many describing increased happiness and reduced depressive symptoms. Increased Motivation: • Participants noted greater engagement in daily activities (e.g., self-care, cooking) and enthusiasm for attending sessions. Better Access to Health Information: • Culturally tailored health education sessions (e.g., diet, exercise) improved health literacy and self-management. Reduction in Hospitalisations: • Most participants reported fewer psychiatric admissions after joining the program.
Gower 2022 **(86)**	Qualitative study using a community-based participatory research	The study aims to examine the effectiveness of a peer-mentoring empowermen	Adult female refugee and migrant from Middle Eastern,	Participants (21 mentors and 32 mentees) were women aged 18–64 years (average 41.66 years), from	Outreach Services (mentoring sessions in community settings)	Psychoeducation (workshops on employment, financial	*Promotion:* Builds social capital, confidence, and sense of belonging among migrant	Community Organisation (Ishar Multicultural Women's Health Services,	Peer bicultural worker (migrant women mentors with lived	**Language:** The program provided matching by language (initially deliberately separated for interaction in English but later overturned). **Persons:** Mentors were migrant women with lived experience, ensuring cultural and experiential alignment with mentees.	The peer-mentoring program improved social connections, self-esteem, and self-efficacy among refugee and migrant women, with key findings below: **Qualitative Findings** Theme 1: Social Connection

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
	(CBPR) approach. Funding: Healthway, the Health Promotion Foundation of Western Australia	t program for migrant and refugee women in Western Australia, focusing on improving employability, confidence, and mental health/well-being.	Asian backgrounds	Middle Eastern and Asian backgrounds (Arabic, Sinhalese, and Hindi-speaking), living in metro Perth, Western Australia. The program did not target individuals with specific mental health condition.	Telehealth Services (used during COVID-19 restrictions) Individual mentoring sessions approximately twice per month and group workshops over a period of 3 to 12 months, depending on the cohort	management) Trauma-Informed Therapy (mentors provided support for trauma-related issues) Support Groups (peer-mentoring groups)	and refugee women. ***Prevention:*** Addresses employment-related isolation and barriers that can lead to poor mental health. Early Intervention: Provides support and mentoring to women at risk of social and employment exclusion. ***Treatment:*** Offers emotional and social support to improve overall well-being during challenging times like COVID-19.	Centacare, cultural societies)	experience and similar cultural backgrounds) Counsellor (mentors provided emotional support)	**Metaphors:** No culturally specific metaphors (e.g., stories or character names) were mentioned in the intervention. **Concepts:** The program was empowerment-focused rather than based on a specific theoretical model, addressing employment and well-being in a culturally relevant way. **Goals of Tx/Program:** Goals were mentee-driven, focusing on employment, confidence, and social integration, tailored to individual needs. **Methods:** Workshops were simplified for varying literacy levels, but no mention of adapted CBT or structured diaries. **Context:** Sessions were flexible (in-person/online) to accommodate family and COVID-19 restrictions. **Content:** No explicit inclusion of cultural traditions, values, or spirituality in program content**.** **Process:** The intervention was co-designed with community partners and refugee/migrant women, ensuring cultural relevance.	Mentoring fostered critical social connections that helped mentees overcome isolation and integrate into the community. • Reducing Isolation: Mentorship provided a vital outlet for social interaction, helping mentees feel less isolated and form meaningful friendships. • Building Social Networks: Mentors supported mentees in expanding their social and professional networks, improving language skills and broadening opportunities. • Cultural Understandings: Mentors helped mentees understand Australian culture and customs, easing cultural barriers and promoting community integration. Theme 2: Self-Esteem The mentoring process significantly boosted mentees' self-esteem by helping them recognize their strengths and potential. • Confidence: Mentees gained newfound confidence to engage socially and pursue personal and professional goals. • Identifying Strengths: Through discussions and activities, mentees became aware of personal strengths they had not previously recognised. • Trusting Self: Mentoring encouraged self-awareness and self-trust, empowering mentees to believe in their abilities. Theme 3: Self-Efficacy Mentoring enhanced mentees' self-efficacy by building practical skills that fostered independence and career readiness. • Simple Financial Management: Mentees received guidance on basic financial management, promoting financial independence. • Legal Rights Knowledge: Mentors educated mentees about employment rights and superannuation, strengthening their workplace autonomy. • Time Management:

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											Mentors introduced time management strategies to help mentees balance family responsibilities and employment. • Occupation and Engagement: Many mentees successfully secured employment, volunteer roles, or enrolled in further study through mentor support. Theme 4: Personal Health and Safety Mentors played a crucial role in promoting mentees' health and safety, particularly during the COVID-19 pandemic. • COVID Information: Mentors provided clear, culturally appropriate information about COVID-19, helping mentees navigate lockdowns safely. • Cyber Safety: Mentors raised awareness about online privacy and cyber safety to protect mentees' personal information. Theme 5: Ongoing Needs Despite gains, many mentees continued to face complex challenges that impacted their ability to achieve employment goals. • Overwhelmed with Stressors: Financial hardship, health issues, and family responsibilities overwhelmed some mentees, impeding progress toward employment. • Desire for Mental Health Support: Mentees expressed a strong need for additional mental health support to manage stress, loss, and parenting challenges in a new culture.
Hodgins 2025 **(87)**	Qualitative study (interviews guided by Consolidated Framework for Implementatio n Research - CFIR) Funding: NSW Health Translational	The study aims to explore barriers, enablers, and experiences with integrated child and family health (CFH) Hubs and develop "building	Refugee and migrant parents of children who had accessed the service	14 parents aged 18-64 years (primarily mothers) and their children aged 0-5 years from diverse CaLD backgrounds (Bangladesh, Nepal, Mongolia, Vietnam, Iraq)	Outreach Services (e.g., home visits, community engagemen t) Outpatient Care (Non-Hospital) (Hub-based services)	Support Groups (e.g., playgrou ps, parenting programs) Family Therapy (implied in	*Promotion:* Improves access to coordinated health and social services to enhance overall child and family well-being. *Prevention:* Reduces barriers to early identification of developmental and psychosocial	Primary Care Network Hub (integrated Hub model) Community Organisation (collaboration with multicultural services)	General Practitioner (GPs engaged where possible) Allied Health Provider (psychologist, speech therapy, occupational	**Language:** The study emphasised in-language support (e.g., interpreters, bilingual staff) but did not specify translated written materials. **Persons:** Hub staff included culturally competent providers, but the study did not mention shared lived migration experiences. **Metaphors:** No explicit use of culturally relevant metaphors (e.g., stories/names) was described. **Concepts:** Trauma-informed and family-centred care was used, but no specific culturally adapted theoretical models were mentioned.	The study identified key building blocks for successful Hub implementation to support migrant and refugee families, including buy-in from stakeholders, strong partnerships, Hub coordination/navigation, cultural relevance, and ongoing service integration. Key findings in 5 themes below: **Qualitative Findings** Theme 1: Buy-In • Stakeholder support is crucial for Hub development, particularly from partner services,

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	Research Grants Scheme	blocks" for successful Hub implementation for migrant and refugee families.		residing in urban areas of Sydney, NSW 32 Service providers The program did not target individuals with specific mental health condition.	Drop-in Services (flexible access mentioned) Integrated, trauma-informed, culturally safe care through Hubs combining primary care, community, and mental health services	integrated family-centred care) Cultural Family Interventions	concerns for migrant and refugee families. *Early Intervention:* Provides timely, integrated support through co-located or connected services to address emerging family needs. *Treatment:* Facilitates ongoing care navigation and referral pathways for families with identified health or social issues.		therapy) Bicultural Worker	**Goals of Tx/Program:** Goals were client-centred, prioritising family and developmental needs over individual-focused outcomes. **Methods:** Simplified navigation (e.g., soft referrals, warm handovers) was used, but no mention of adapted therapy tools (e.g., CBT diaries). **Context:** Flexible scheduling and family inclusion were prioritised to accommodate social/economic barriers. **Content:** Cultural values were integrated (e.g., trust-building, trauma-informed care), but no specific traditions or remedies were noted. **Process:** Adaptations were informed by provider and parent input but not formal co-design with communities.	which play a key role in addressing migrant and refugee families' needs. • The challenges of navigating an unfamiliar health system in a new country were highlighted, with financial barriers and ineligibility for free or subsidized healthcare being key concerns. • Developing a common agenda and ensuring commitment from diverse services (health, social services, education, childcare) are essential for sustainable Hub operations. • Clear communication and role expectations among services are vital to maintaining momentum and collaborative partnerships. Theme 2: Partnership • Successful partnerships between health and social services are fundamental in Hub creation and maintenance. • Transparent collaboration, trust-building, and consistent leadership are needed, especially when changes in staffing could disrupt existing relationships. • Strong partnerships and clear leadership roles are critical to the Hub's success and longevity. Theme 3: Hub Coordination and Navigation • Coordination and navigation are central to maintaining engagement with families. Key roles such as the Hub coordinator and navigator are essential for facilitating communication, building trust, and managing services. • Coordinators help maintain momentum and manage relationships across services, while navigators provide direct support to families, helping them access appropriate services and fostering trust. • Governance support and workforce capability building also contribute to the overall sustainability of the Hub. Theme 4: Relevance for Migrant and Refugee Families • Cultural appropriateness and accessibility are critical factors in ensuring effective engagement with migrant and refugee families.

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											• Providing services in families' preferred languages and creating culturally safe, welcoming environments are vital for sustaining trust and participation. • Flexibility in service delivery, such as soft entry points and proactive outreach, helps address the unique needs of these families. • proximity to families' homes and the establishment of trusting relationships are essential for continued engagement. Theme 5: Ongoing Integration • Sustaining the Hub model requires ongoing integration and coordination between partner services. • Establishing clear referral pathways, regular meetings, and effective client information-sharing mechanisms are key to maintaining service continuity and supporting cross-sector collaboration.
Khawaja 2019 **(88)**	Mixed-methods (quantitative & qualitative), pre-post evaluation Funding: Queensland Transcultural Mental Health Centre (QTMHC)	The study aims to evaluate the effectiveness of the BRiTA Futures program in improving resilience and wellbeing among culturally and linguistically diverse adolescents, and to examine whether outcomes vary based on program format, visa status, gender, or duration of	CaLD adolescent (12-20yrs) from migrant backgrounds living in Queensland.	229 participants (median age 14 yrs; 52.4% males) with 65% from Asia,12% from Africa, 7% from Middle East and 6% Oceania, with >90% speaking other than English at home. The program did not target individuals with specific mental health condition.	Outreach Services BRiTA Futures program is a resilience-building psychoeducational program delivered in English to CaLD adolescents over 2–3 full days, 4–6 half days, or 10 weekly sessions in school or community settings.	Psychoeducation Groups Culturally tailored support group	***Promotion:*** Enhances resilience and wellbeing in CaLD adolescents through the BRiTA Futures program ***Prevention:*** Aims to prevent psychological distress by strengthening coping skills and cultural adjustment ***Early Intervention:*** Targets adolescents at risk of distress by providing support during acculturation	Community based: Schools (70%) and community organisations (e.g., youth services, NGOs, homework clubs)	Facilitators (school teachers, youth workers, mental health practitioners) who were trained from Queensland Transcultural Mental Health Centre (QTMHC) and partner organisations.	**Language:** Sessions were delivered in English with bilingual support available if required. **Persons**: Facilitators (teachers/youth workers) were trained in cultural competence but didn't necessarily share backgrounds with participants; bilingual staff assisted as needed. **Metaphors:** Culturally relevant examples were used (e.g., discussions on balancing heritage/Australian identities), but no specific stories/characters mentioned. **Concepts:** CBT and acculturation frameworks were adapted to address migration-related stressors (e.g., family conflicts, discrimination) in culturally sensitive ways. **Goals of Tx/Program:** Participant-driven goals focused on resilience (e.g., improving cross-cultural communication, family relationships) rather than clinical outcomes. **Methods:** Simplified activities (role-plays, group discussions) replaced complex tasks; no literacy-heavy homework. **Context:** Flexible scheduling (school/community settings) and formats (weekly) accommodated socioeconomic barriers. **Content:** Modules integrated cultural identity	The BRiTA Futures program demonstrated significant improvements in resilience and wellbeing among culturally diverse adolescents **Mental Health Outcomes** • Significant improvement in Resilience (MYRQ) post-intervention ($p < 0.001$), with mean scores increasing from 44.24 to 49.32 • Significant reduction in distress ($p < 0.001$), with mean scores dropping from 11.69 to 8.65 • 87% satisfaction rate to the program among participants. • 85% reported to make specific positive changes within the next week because of attending the program) • No subgroup differences, as results were consistent regardless of gender, visa status (refugee/migrant), or duration in Australia. **Qualitative Findings** • The facilitators' and participant's comments were analysed using content analysis Reported by participants, key learnings included understanding culture and communication styles, developing self-esteem, managing stress,

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		stay in Australia.								exploration and spirituality as resilience factors, but no local remedies or religious practices were detailed. **Process:** Developed by multicultural mental health experts; no explicit co-design with communities mentioned, but feedback shaped iterative improvements.	navigating stereotypes and discrimination, and recognising the value of their own contributions. Observed by facilitators, participants demonstrated increased awareness of cultural diversity, emotional expression, conflict resolution, and cooperation, as well as greater engagement and confidence in sharing ideas.
Khawaja 2021 **(89)**	Mixed-methods evaluation Funding: Queensland Transcultural Mental Health Centre (QTMHC)	The study aims to evaluate the effectiveness of the Building Resilience in Transcultural Adults (BRiTA) programme, a strength-based intervention, in improving acculturation and resilience among CaLD adults in Australia.	CaLD adults (≥18yrs) (including parents) from migrant backgrounds living in Queensland.	192 participants (74% females) with over half had lived in Australia for <5 years, with varying English competency. The program did not target individuals with specific mental health condition.	Outreach Services BRiTA program was a group-based psychoeducational resilience and acculturation program for CaLD adults8 modules (exact session length not specified); weekly or fortnightly with option of condensed weekend formats in multiple languages (e.g., English, Farsi, Arabic, Spanish, Mandarin)	Psychoeducation Groups Culturally tailored support group Cultural Family Interventions	*Prevention:* Targets CaLD migrants to build resilience and acculturation, aiming to prevent psychosocial difficulties and negative mental health outcomes related to migration stress. *Promotion:* Enhances positive acculturation and coping skills through the BRiTA programme, supporting wellbeing and integration in a new society. *Early Intervention:* Addresses acculturation-related stress early for migrants and parents newly settling in Queensland, before more severe mental health issues develop.	Community based organisation (e.g., Relationships Australia, Multicultural Development Association, Salvation Army).	Trained facilitators (bilingual where needed) from Queensland Transcultural Mental Health Centre (QTMHC) and partner organisations.	**Language:** Materials and sessions were delivered in participants' preferred languages including Arabic, Farsi, Spanish, Mandarin and English, with bilingual facilitators ensuring accessibility for those with limited literacy. **Persons:** Trained mental health professionals and community workers from QTMHC, many with shared migration experiences and cultural backgrounds matching participants. **Metaphors:** Culturally familiar scenarios and examples were used throughout, such as stories about family conflicts arising from acculturation gaps or challenges navigating Australian systems while maintaining cultural identity. **Concepts:** The program framed mental health through a culturally attuned resilience lens, validating both Western psychological concepts and traditional coping strategies like spiritual practices and community support. **Goals of Tx/Program:** Therapy goals focused on culturally valued outcomes like improving family communication, balancing cultural identities, developing practical coping skills for migration stressors, and building social connections. **Methods:** Activities were simplified and made interactive, using role-plays and group discussions rather than literacy-dependent tasks, with concepts broken into clear, practical steps. **Content:** The curriculum integrated spiritual beliefs as resilience resources, addressed intergenerational cultural conflicts, and included modules on navigating Australian systems while maintaining cultural traditions. **Process:** Adaptations were co-designed with CaLD community organisations, and migrant community members, with iterative	The BRiTA Futures program demonstrated significant improvements in acculturation and resilience among culturally diverse migrants, with high cultural acceptability and engagement. Quantitative and qualitative results are below: Mental Health Outcomes Participants showed statistically significant increases in acculturation (p=0.001), resilience (p=0.002), and spirituality (p=0.01) post-intervention, measured by the Adult Acculturation and Resilience Scale (AARS). Qualitative Findings Safe spaces and connections created: Participants valued the supportive group environment where sharing migration experiences reduced isolation and fostered hope through shared struggles. Understanding of culture and acculturation: The program helped participants appreciate both their heritage culture and Australian culture while recognising acculturation as key to family wellbeing. Communication and negotiation skills: Participants gained practical conflict-resolution tools, with parents particularly benefiting from skills to improve intergenerational understanding and communication. Resilience skills: The program equipped participants with coping strategies like stress management and positive reframing, increasing confidence in handling migration challenges. Constraints and suggestions: While universally praised, some participants noted logistical challenges like session locations and suggested simplifying written materials for non-English speakers.

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										refinements based on participant feedback and facilitator observations.	
Khawaja 2022 **(90)**	Qualitative case study Funding: Not explicitly stated	The study aims to assess the feasibility, acceptability, and impact of the Tree of Life (66) intervention in enhancing resilience, wellbeing, and social connectedness among older CaLD Muslim women in Australia.	Older Muslim women from CaLD backgrounds (migrants, refugees, long-term residents)	Nine Muslim women aged 59–80 yrs (mean age 72.78 yrs) from CaLD backgrounds; mostly long-term residents (average 27 years in Australia), English-speaking, and living in Brisbane, Queensland. The program did not target individuals with specific mental health condition.	Outreach Services and drop-in services Tree of Life (66) program, delivered over seven weekly 90-minute group sessions, focusing on personal narratives, resilience, and cultural identity through guided drawing and group discussion.	Group care: support groups Psychoeducation Groups Narrative therapy	*Promotion:* Enhances resilience, connectedness, and wellbeing among older CaLD Muslim women in a community setting through group-based narrative intervention. *Prevention:* Aims to reduce social isolation and psychological issues before clinical mental illness develops by fostering cultural values and empowerment. *Early Intervention:* Supports older adults at risk of mental health concerns by providing accessible, culturally sensitive psychosocial support at the community level.	Community Organisation (IWAA, a non-government Muslim women's centre)	Psychologists (registered and provisional)	**Language:** Sessions were conducted in English (participant's preferred language), with facilitators simplifying clinical terms and using visual aids (tree drawings) to support those with limited fluency. **Persons:** Facilitators included a Muslim psychologist, with cultural competency training and experience working with CaLD communities. **Metaphors:** The Tree of Life metaphor was tailored to Islamic values: roots represented family heritage, fruits symbolized God's gifts, and storms mirrored migration hardships and aging challenges. **Concepts:** Mental health was framed through resilience and faith, blending narrative therapy with Islamic principles (e.g., patience, gratitude, community support). **Goals of Tx/Program:** Goals prioritised culturally meaningful outcomes: preserving intergenerational wisdom (roots), strengthening community ties (leaves), and navigating aging with dignity (branches). **Methods:** Activities used drawing and oral storytelling (no literacy demands), with flexible pacing for emotional processing. Externalising problems as "storms" simplified complex emotions. **Content:** Integrated Islamic practices (prayer as grounding) addressed isolation/discrimination, and highlighted family roles (caregiving as strength). **Process:** Program was co-designed with IWAA (Muslim women's org), with weekly participant feedback shaping sessions. Topics like Islamophobia were vetted by the group.	The Tree of Life (66) demonstrated strong feasibility, acceptability, and therapeutic benefits for older CaLD Muslim women. Below are the key findings: **Qualitative Findings** • Effectiveness of the TOL Program Participants reported significant psychological benefits: feeling "soothed" (67%), increased happiness (78%), improved confidence (56%), and emotional release (89%). Key therapeutic elements: Roots: Childhood values (humility, modesty) provided lifelong resilience. Shared migration stories enhanced group bonding Ground: Daily routines (prayer 5x/day, Quran recitation) boosted mood (92%). Socialising at IWAA reduced isolation Trunk: Recognised caregiving skills (100%) and volunteer work (33%). Valued Islamic identity as core strength Branches: 89% prioritized health/independence in aging. Intergenerational piety hopes (44%) Storms Coping strategies included religious faith (100%), community support (78%) and education against Islamophobia (33%) Group Processes: Peer support statements ("You're not alone") reduced distress. 67% reported increased compassion for others' hardships • Feasibility The program was delivered in an accessible multicultural setting with transport access, achieved 56% retention (9 out of 16 completed all sessions), faced challenges such as noise disruptions in 40% of sessions and initial misconceptions about it being an "art class," while maintaining 90% fidelity to the intervention manual. • Acceptability The program received 100% positive feedback, with participants describing it as "beautiful" and

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											"everything interesting," valuing the cultural tree metaphor, confidentiality, and skill identification. Ninety percent of participants reported feeling more secure, 78% showed improved emotional expression, and all participants (100%) said they would recommend the program to their peers.
Krstanoska-Blazesk 2021 (71)	Cross-sectional survey (pre-intervention data from MHL training evaluation). Funding: South Western Sydney Primary Health Network.	The study aimed to explore mental illness stigma and associated factors among Arabic-speaking religious/community leaders in Australia.	Arabic-speaking religious/community leaders in South Western Sydney.	54 community/ religious leaders with mean age 47.1 yrs; 69.2% female; countries of origin: Iraq (33.3%), Australia (24.1%), Lebanon (14.8%); in terms of religion 65.4% Muslim and 32.7% Christian. The program did not target individuals with specific mental health condition	Outreach Services MHL training; 6-hour one-day workshop, delivered in person.	Group Psychoeducation (MHL training)	*Promotion:* Enhances mental health literacy among community leaders to foster supportive environments. *Prevention:* Targets stigma among Arabic-speaking leaders to prevent mental illness by improving help-seeking. *Early Intervention:* Identifies attitudes that may delay help-seeking and intervenes through training to mitigate this.	Community settings (e.g., religious centres, community networks) in South Western Sydney.	Mental health clinicians.	**Language:** Training delivered in Arabic, with materials and discussions in Arabic. **Persons:** No details are provided about the facilitators' professional backgrounds **Metaphors:** The study used a culturally valid vignette featuring an Iraqi refugee named Dawood to illustrate PTSD symptoms in a relatable context. **Concepts:** Training integrated cultural and religious beliefs (e.g., spiritual healing, prayer) and symptoms were explained in ways that aligned with cultural expressions of distress in Arabic-speaking communities. **Goals of Tx/Program:** The intervention aimed to improve help-seeking behaviours by empowering leaders to guide refugees toward professional care while validating cultural practices (e.g., spiritual counselling). **Methods:** Simplified steps and culturally relevant content to improve uptake. Leaders were taught actionable steps and basic counselling techniques (e.g., active listening). **Context:** Training tailored to the social and cultural context of Arabic-speaking refugees, including addressing barriers to mental health care (e.g., stigma, distrust of Western medicine) and highlighted free/low-cost services. **Content:** Inclusion of culturally informed treatment practices (e.g. spiritual guidance) alongside evidence-based treatments. **Process:** Adaptations derived through consultation with Arabic-speaking mental health professionals and community leaders.	The culturally tailored Mental Health Literacy (MHL) training program for Arabic-speaking religious and community leaders demonstrates several key findings outlined below: Mental Health Outcomes • Female leaders had significantly lower personal stigma (Weak-not-sick subscale) compared to males ($p = 0.036$). • Older age was associated with higher personal stigma ($p = 0.011$) and greater social distance ($p = 0.042$). • Mental Health Literacy (MHL): Correct recognition of PTSD was linked to lower stigma, particularly on the I-would-not-tell-anyone subscale ($p = 0.013$). • Leaders who endorsed "being a person of weak character" as a cause of mental illness had higher personal stigma ($p < 0.05$). • Social distance was not significantly related to PTSD recognition, but age increased social distance. Qualitative Findings • Since many CaLD communities seek help from leaders rather than professionals, equipping them with MHL can improve early intervention and referrals.
Leone 2014 (91)	Quasi experimental study Funding: Dementia	The study aims to evaluate a culturally tailored cognitive	Chinese- and Spanish-speaking carers who is	22 participants who were adult women (85% of Chinese and 87% of Spanish-speaking),	Outpatient Care (Non-Hospital) (Community-based	CBT Groups (Core intervention was CBT-	*Early Intervention:* Delivers CBT-based support to culturally and linguistically diverse carers	Community Organisation (Delivered via ethno-specific NGOs and multicultural	Bilingual health professionals with cultural expertise	**Language:** Materials and sessions were delivered in participants' native languages (Spanish or Chinese) by bilingual health professionals. **Persons:** Therapists were culturally matched (Chinese/Spanish-speaking) and trained in CBT	The culturally adapted CBT intervention was feasible and effective, with clinically meaningful improvements in carers' mental health.

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	Collaborative Research Centre, University of New South Wales, Sydney, Australia	behavioural therapy (CBT) intervention for Chinese- and Spanish-speaking dementia carers in Australia, assessing its impact on depression, anxiety, and stress.	caregiving people with dementia	originating from Chinese-speaking (Hong Kong, Malaysia, Taiwan, China) and Spanish-speaking (Chile, Spain, Uruguay, Argentina) and were located in metropolitan, urban multicultural hubs like Sydney and Adelaide. Participants were excluded if they had an immediate mental or physical health condition requiring referral.	group sessions) Culturally adapted group-based CBT intervention; 7-session, group-based CBT program	based group therapy). Support Groups (Peer sharing and mutual support emphasized). Psychoeducation Groups (Dementia education and coping strategies).	showing signs of distress to prevent progression to mental disorders. *Treatment:* Aims to reduce existing symptoms of depression, anxiety, and stress through a structured, culturally adapted intervention.	health services)	Trained facilitators with clinical backgrounds (Social worker, councillor)	and dementia care. **Metaphors:** No explicit mention of culturally tailored stories or metaphors; focused on practical skills. **Concepts:** CBT was adapted to align with cultural values (e.g., family-centered care, stigma reduction). **Goals of Tx/Program:** Goals addressed culturally relevant stressors (e.g., family communication, caregiver guilt). Methods: Simplified sessions (7 vs. original 13) and adjusted terminology (e.g., avoided "assertive communication"). **Context:** Sessions scheduled in community settings to accommodate carers' respite needs. **Content:** Included dementia education and coping strategies, but no mention of local remedies/spirituality. **Process:** Adapted via collaboration with U.S. developers and Australian multicultural health experts.	**Mental Health Outcomes** • Significant reductions in depression, anxiety, and stress (measured by DASS-21) for both groups: • Spanish-speaking carers: Decreases in all three depression ($p<0.05$), anxiety ($p<0.05$), stress ($p<0.01$). • Chinese-speaking carers: Reductions in depression ($p<0.05$) and anxiety ($p<0.05$), but not stress. **Qualitative Findings** • All 22 participants completed the intervention, with strong attendance and reported satisfaction. • Participants gained better communication strategies, relaxation techniques, and dementia understanding. • Shared experiences in group settings reduced isolation; some adjustments (e.g., avoiding "assertive communication") improved acceptability. • Homework completion was difficult for some, but core concepts were applied successfully in daily caregiving.
Morawska 2013 **(92)**	Quasi-experimental design Funding: Connecting Communities project, funded by the Australian Government under the Mental Health Respite Program	The study aims to evaluate the effectiveness of Mental Health First Aid (MHFA) training in a diverse community setting, particularly focusing on multicultural populations.	CaLD, Aboriginal/ Torres Strait Islander and bilingual participants (participants were from multicultural organizations)	458 participants aged 18-64 years (mean age 39.7yrs), with around 80% being female, including bilingual (19.9%) and Aboriginal/Torres Strait Islander (10%) in an urban/metro area, specifically Brisbane, Australia. The program did not target individuals with specific mental	Outreach Services Mental Health First Aid (MHFA) Training - 12-hour manualised course delivered over two consecutive days.	Psychoeducation Groups (MHFA was a group training program)	*Promotion:* Builds mental health literacy and reduces stigma through Mental Health First Aid (MHFA) training across communities. *Prevention:* Trains community members (especially those working with high-risk groups) to recognise and respond to early signs of mental illness, aiming to prevent escalation.	Community Organisation (training delivered through multicultural community groups)	Qualified MHFA instructor	**Language:** The study does not specify if MHFA materials were provided in languages other than English. **Persons:** No mention of matching trainers and participants based on shared cultural backgrounds or migration experiences. **Metaphors:** No culturally specific metaphors (e.g., stories, character names) were described in the intervention. **Concepts:** MHFA used a standardised mental health literacy model, with no mention of culturally adapted theoretical frameworks. **Goals of Tx/Program:** No indication that treatment goals were individually or culturally tailored (standard MHFA curriculum was used). **Methods:** The intervention followed the standard MHFA format without simplification or literacy adaptations. **Context:** No adjustments for social/economic factors (e.g., scheduling, family inclusion) were mentioned.	The MHFA training significantly improved participants' mental health literacy, reduced stigma, and increased confidence and practical help provided to individuals with mental health issues. Key findings are listed below: **Mental Health Outcomes** • MHFA training significantly improved mental health literacy, with increased recognition of mental illnesses and better alignment with professional treatment recommendations. • Reduced stigma, with lower social distance scores and decreased personal/perceived stigma post-training ($p < 0.001$). **Qualitative Findings** • 78.8% of participants used MHFA skills within 6 months, with 84% providing direct help and 67% making referrals.

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				health condition.			*Early Intervention:* Equips participants to assist individuals showing early symptoms of mental health problems, such as depression or psychosis.			**Content:** No mentions of integration of cultural values, customs, or traditional healing practices into the MHFA content. **Process:** No community co-design or adaptation process was described.	• Increased confidence: Participants reported greater comfort assisting individuals with mental health crises. • Barriers to help: Resistance from affected individuals and lack of follow-up support were noted challenges. • Cultural relevance: While no formal adaptations were made, the standardised MHFA approach was deemed broadly acceptable in multicultural settings.
Morse 2024 **(93)**	Mixed-methods evaluation Funding: Australian Capital Territory Government 'Healthy Canberra Grant'	The study aims to explore the perceived impacts and value of the My Mind, My Voice (MMMV) program, identify impact-driving processes with a focus on cultural relevance, safety, and inclusivity, and evaluate co-designed mental health promotion within CaLD communities.	CaLD communities in Australia (including migrants, refugees, and multicultural groups) residing in Australian Capital Territory (ACT).	9 participants interviewed 32 participated in the survey. All were adult (>18yrs), gender inclusive with diverse background (e.g., Indian, Chinese, Afghan, Iraqi, Macedonian communities) The program did not target individuals with specific mental health condition.	Outreach Services Intervention consisted of community members attending one or more training workshops (e.g., DoNOHarm and Story Crafting), each of which was a single-session format lasting several hours, followed by optional involvement in community mental health promotion events.	Group Psychoeducation Psychoeducation Support groups	*Promotion:* Builds community capacity and mental health literacy among CaLD communities through workshops and co-produced resources. *Prevention:* Equips community members with inclusive language and trauma-informed skills to reduce stigma and prevent mental health issues. *Early Intervention:* Engages individuals with lived experience to share stories and promote early help-seeking behavior.	Community organisations such as cultural & settlement services Online platforms (podcasts, videos)	Peer workers (lived experience educators), Community development workers and MIEACT facilitators	**Language:** Materials were primarily in English, but participants advocated for multilingual resources to improve accessibility. Some participants preferred discussing mental health in English to avoid stigma associated with terms in their native language **Persons:** Facilitators included MIEACT staff and lived-experience volunteers, with community input ensuring cultural relevance. **Metaphors:** Storytelling used lived experiences to bridge cultural gaps, though no specific cultural characters were named. **Concepts:** Mental health was framed holistically, blending Western and non-Western perspectives on wellbeing. **Goals of Tx/Program:** Focused on community-driven outcomes like stigma reduction and intergenerational dialogue. **Methods:** Simplified, interactive approaches (e.g., oral storytelling) replaced literacy-dependent tasks. **Context:** Flexible scheduling and free events addressed socioeconomic and logistical barriers. **Content:** Addressed migration-related stressors but lacked integration of traditional healing practices. **Process:** Co-design with CaLD communities ensured cultural adaptation, with iterative feedback refining the program.	The MMMV program fostered a culturally safe space that empowered multicultural communities to improve mental health literacy, build confidence, and strengthen community connections. The findings of the result were presented in 5 themes listed below: Qualitative Findings • MMMV is culturally relevant and respectful: The program created a culturally safe and respectful environment, encouraging open discussions about mental health through storytelling and valuing diverse perspectives. • The value of cultural and community connections: MMMV strengthened bonds within and across multicultural communities, highlighting shared experiences and promoting intergenerational conversations about mental health. • The importance of safe and accessible language: Participants learned to use inclusive, non-triggering language when discussing mental health, recognising that accessible communication is critical for engaging multicultural communities. • Increased confidence and mental health literacy: Involvement in MMMV boosted participants' confidence to deliver peer-led mental health education and improved their understanding of mental health concepts. • Positive impacts on personal and community

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											attitudes: The MMMV program positively influenced personal and community attitudes by broadening participants' understanding of mental health, validating personal experiences, fostering open discussions to reduce stigma, and inspiring hope, but participants emphasized the need for sustained, long-term efforts to achieve lasting change. • While participants felt better equipped, some expressed a desire for more structured guidance and resources when organising community wellbeing initiatives.
Nepal 2023 **(94)**	Quasi-experimental design Funding: Rotary Club of Parramatta, StudyMelbourne Victoria, Department of Premier and Cabinet Victoria, Cumberland City Council NSW	The study aims to evaluate the effectiveness of Mental Health First Aid (MHFA) training in the Nepalese community in Australia.	Adult of Nepalese background and wanting to learn about mental illness and how to provide support to those who are experiencing mental health issues.	162 Participants (age 18-74 yrs), with 60.5% b female; 98.1% had Nepalese as their primary language, 53.3% had lived in Australia for less than 4 years, 44.1% were students, and 12.3% had previously received mental health training. Participants were from New South Wales, Victoria, Tasmania, and the Australian Capital Territory. The program did not target individuals with specific mental health condition.	Outpatient Care (Non-Hospital) – MHFA training conducted in community settings MHFA course was 12 hours (some extended to 14hrs), which was delivered in 2 days.	Psychoeducation Groups (MHFA training in group format)	***Promotion:*** Builds general mental health literacy and reduces stigma through culturally tailored education. ***Prevention:*** Equips community members with skills to identify and respond early to signs of mental health issues, potentially preventing escalation. ***Early Intervention:*** Trains participants to provide first aid support to individuals showing early symptoms of mental distress or crisis.	Community Setting (Australia Nepal Public Link Inc.)	Bilingual Course Instructor (native Nepalese) (Nepalese-Australian MHFA Instructor)	**Persons:** The MHFA training was delivered by an accredited Nepalese-Australian instructor, ensuring cultural and linguistic alignment with participants. **Metaphors:** Culturally relevant vignettes (e.g., characters named Jagadish) were used to depict mental health issues. **Concepts:** The MHFA action plan (ALGEE) was taught, but no explicit mention of culturally adapted explanations of mental illness. However, discussions included Nepali terms for mental health issues (e.g., distinguishing between "stress," "anxiety," and "depression"). **Goals of Tx/Program:** The primary goal was mental health literacy and first aid skills, not explicitly tailored to family-centred or individual cultural needs. **Methods:** The standard 12-hour MHFA course was extended (some wet to ~14 hours) to allow for additional explanations in Nepali. **Context:** No mention of adjustments for social/economic factors, flexible scheduling, or family inclusion. **Content:** Culturally relevant discussions were included (e.g., appropriate Nepali terms for mental health issues), but no modules on spirituality or traditional remedies. **Process:** The study does not describe co-design or community consultation in adapting the program, rather a standard MHFA training.	The MHFA training led to significant improvements in mental health literacy, confidence, and helping intentions, alongside reductions in stigma and social distance. Participants endorsed the course's relevance and delivery. Mental Health Outcomes • Participants showed an improvement in mental health first aid knowledge ($p < 0.001$). • Confidence in Providing Help increased significantly ($p < 0.001$) • Quality of intended first aid actions improved substantially ($p < 0.001$) • Correct identification of depression in a vignette increased from 46.0% to 56.5% ($p = 0.037$) • Reduction in Stigmatising Attitudes: Scores decreased in all domains: "Mental illness is a sign of weakness" ($p < 0.001$); "Mental illness is not a real medical illness" ($p = 0.002$); "People with mental illness are dangerous" ($p = 0.003$) • Social distance scores improved ($p < 0.001$) Qualitative Findings Participant ratings of the course: Course relevance: 4.82/5; Instructor knowledge: 4.93/5; Ease of asking questions: 4.91/5; Enjoyment of the program: 4.84/5

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Nickerson 2019 **(95)**	Randomized Controlled Trial (RCT) Funding: research grant from beyond-blue with donations from the Movember Foundation	The study aims to evaluate the effectiveness of an online mental health stigma intervention, Tell Your Story (TYS), in reducing self-stigma and increasing help-seeking among refugee men.	Male refugee with PTSD symptoms and from Arabic, Farsi or Tamil-speaking backgrounds	103 refugee men aged 18–64 years with Arabic (76.7%), Farsi (17.5%) or Tami (5.8%)l-speaking backgrounds in Sydney, Australia. The program targeted participants who had at least one clinically significant PTSD symptom (distressing and occurring in the past month).	Telehealth Services (online intervention) Online 11-module intervention, delivered over 4 weeks with each module lasting 15-20 minutes (≤3 modules/week), 4 core themes: introduction/social contact (Modules 1-2), self-reflection (Modules 3-5), cognitive reappraisal (Modules 6-9), and action planning (Modules 10-11)	Psychoeducation Cognitive Reappraisal Trauma-Informed Therapy (focused on PTSD symptoms)	*Promotion:* Enhances mental health literacy and reduces stigma through culturally tailored psychoeducation and personal stories. *Prevention:* Encourages help-seeking and challenges negative beliefs to prevent escalation of mental health issues. *Early Intervention:* Guides individuals to identify early signs and create personalized help-seeking plans without therapist involvement.	Community Setting Online intervention (self-guided, no direct provider interaction)	No direct provider involvement (self-guided online program) Community Workers involved in recruitment	**Language:** Materials were translated and back-translated into Arabic, Farsi, and Tamil, ensuring linguistic accessibility for participants. **Persons:** The intervention was co-developed with Community Advisory Boards (CABs) from Arabic, Farsi, and Tamil-speaking backgrounds to ensure cultural relevance. **Metaphors:** Culturally relevant narratives were used, with refugee men (from the same cultural backgrounds) in videos sharing personal stories of overcoming stigma and seeking help. **Concepts:** The intervention integrated psychoeducation, social contact, and cognitive reappraisal, addressing culturally salient barriers (e.g., distrust in authority, collectivist help-seeking norms). Focused on both formal (e.g., psychologists) and informal (e.g., family, community leaders) support systems. **Goals of Tx/Program:** Primary goals were reducing self-stigma (particularly around professional help-seeking) and increasing help-seeking behaviour. While not explicitly family-centred, the intervention acknowledged collectivist values by including informal support networks. **Methods:** Participants could complete modules at their own pace (though restricted to 3 per week), balancing engagement with feasibility. **Context:** No explicit mention of economic/social adaptations. **Content:** Culturally tailored discussions (e.g., addressing stigma, trust issues) were included. No mention of spirituality or traditional healing, but CAB input ensured relevance to refugee experiences. **Process:** Co-design with CABs ensured cultural alignment and the content was refined based on community feedback. Standardised across languages while maintaining core strategies (psychoeducation, social contact, cognitive reappraisal).	The Tell Your Story programs concluded that culturally adapted, low-cost digital interventions can reduce stigma and increase help-seeking in refugee men. **Mental Health Outcomes** 1. Reduction in Self-Stigma for Help-Seeking: TYS group showed smaller increases in self-stigma (related to seeking professional help) from post-intervention to 1-month follow-up compared to the waitlist control (WLC) group (p = 0.008). 2. Increased Help-Seeking Behaviours: At 1-month follow-up, the TYS group sought help from significantly more new sources than the WLC group (p = 0.007). However, the WLC group showed greater increases in help-seeking intentions from post-intervention to follow-up than the TYS group (p = 0.027). **Qualitative Findings** Program usability • Most (53.7%) accessed it via smartphones, supporting mobile-friendly design for CaLD communities. • 88.7% found it easy to understand, and 86.4% rated it as visually attractive. • 72.7% found the video stories interesting, and 61.3% reported improved mood. • Only 4.5% felt it put them in a negative mood, and just 11.4% said it took too long. • 97.7% found the content at least "a little bit" useful, with 59.1% rating it "quite a bit/extremely useful"
Ooi 2016 **(96)**	Cluster Randomized	The study aims to examine the	Children and adolescents	82 participants from 11 schools in the Perth,	Outreach Services (School-	CBT Groups (Teaching	*Prevention:* Equips war-affected children	Community Setting (School)	Trained facilitators and co-	**Language:** The intervention was delivered in English (limited English was an exclusion), the intervention materials were not mentioned as	No cultural adaptations mentioned in the manuscript beyond translated consent forms.

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	Controlled Trial (RCT) Funding: Western Australia Health Promotion Foundation (Healthway)	efficacy of Teaching Recovery Techniques (TRT; a CBT intervention) in improving emotional and behavioural outcomes (PTSD, depression, internalising/externalising problems, psychosocial functioning) in war-affected young migrants resettled in Australia.	10–17 yrs with self-reported exposure to war or violence, residing in Australia for less than 7 years, and mild to moderate PTSD symptoms currently residing in Perth Metropolitan area.	WA. 64.6% female; background was diverse: African (Burundi, Congo, Sudan, etc.), Asian (Burma, Thailand, Sri Lanka), and Middle Eastern (Afghanistan, Iran, Iraq). Participants were included if they had mild to moderate PTSD symptoms, and excluded if they had a clinical level of PTSD, limited English proficiency, or were currently receiving psychological treatment.	based intervention) 8-week intervention (n = 45) and the control (waiting list) (n = 37). Intervention was five 2-hour sessions, was delivered in eight 60-minute sessions	Recovery Techniques, a trauma-focused intervention) Psychoeducation	with coping strategies to reduce risk of future mental health problems. *Early Intervention*: Addresses early PTSD symptoms (intrusion, arousal, avoidance) in children to prevent progression to clinical levels.		facilitators who had tertiary education in Psychology	being in participants' preferred languages. Only translated consent forms were used **Persons:** No (The facilitators were psychologist, but no mention of bilingual or culturally matched therapists.) **Metaphors:** No mention of culturally relevant stories, character names, or vignettes. **Concepts:** The intervention used standard CBT techniques without explicit mention of culturally adapted explanations of mental health. **Goals of Tx/Program:** The study followed a structured CBT protocol rather than client-derived or family-centred goals. **Methods:** No mention of simplifying steps or adapting literacy requirements for ease of uptake. **Context:** No adjustments mentioned for social, political, or economic factors, such as flexible scheduling or family inclusion. **Content:** No mention of integration of cultural values, customs, traditions, or spiritual practices into the intervention. **Process:** No mention of co-design, community consultation, or culturally informed adaptation processes.	However, the Teaching Recovery Techniques program demonstrated following findings. Mental Health Outcomes • Depression symptoms: Significant reduction in the intervention group compared to the waitlist control (p = 0.024), improvement maintained at 3-month follow-up (p = 0.001). 12% of intervention participants showed clinically meaningful improvement at post-test, increasing to 22% at follow-up. • PTSD Symptoms: No significant group and time interaction. Both groups improved over time (p = 0.004). 21% of intervention participants improved at post-test, rising to 41% at follow-up. • Internalising/Externalising Behaviours: No significant intervention effects. Delayed reduction in internalising (p = 0.015) and externalising (p < 0.001) symptoms at follow-up (but no control group comparison). • Uptake: 6 lost to follow-up (intervention group); 1 control group (n = 7) declined post-waitlist intervention. High fidelity (84–100% content coverage per session).
Ospina-Pinillos 2019 (97)	Qualitative study using participatory design methodologies Funding: Young and Well Cooperative Research Centre	The study aims to co-design and culturally adapt a Spanish version of the Mental Health eClinic (MHeC-S) for Spanish-speaking young people in Australia, focusing on improving	International Student (Spanish-speaking youth in Australia)	10 participants aged 16–30 yrs (median age 24), with a majority being female, from countries including Colombia, Chile, Spain, and Venezuela, and was conducted in Sydney, Australia. The program did not target individuals with	Telehealth Services (primary mode) Outpatient Care (Non-Hospital) (via digital platform) Mental Health eClinic (MHeC-S) is a web-based	Psychoeducation (tailored well-being plans) Mental health service	*Promotion:* Engages Spanish-speaking youth and professionals to co-design an accessible mental health eClinic, promoting awareness and support. *Prevention:* Develops culturally adapted tools to reduce barriers and identify mental health issues early.	Digital platform accessible via smartphones/ laptops	Mental Health Clinicians: Psychiatrists, psychologists	**Language:** Materials were fully translated into Spanish, including assessments and interface. **Persons:** Health professionals involved were Spanish-speaking, but no mention of shared migration experiences. **Metaphors:** No mention of culturally specific stories/names used; focused on universal mental health concepts. **Concepts:** Western clinical models (e.g., CBT) adapted via language, not mention of theoretical frameworks. **Goals of Tx/Program:** Goals aligned with individual mental health care. **Methods:** Simplified digital steps (e.g., mobile-friendly design) but no CBT diary adaptations mentioned.	The study highlighted significant barriers to mental health care for Spanish-speaking international students in Australia, with language as the primary obstacle. The culturally adapted Mental Health eClinic (MHeC-S) demonstrated strong acceptability and usability, though gaps in Spanish-language e-tools were noted. Key findings: Mental Health Outcomes • 100% of participants cited language as the main barrier to accessing care; many lacked awareness of Australia's health system. • All participants used smartphones to access the internet, validating the mobile-first design.

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		accessibility and usability.		specific mental health condition.	mental health platform designed for Spanish-speaking young people		*Early Intervention*: Provides a digital platform for timely mental health assessments and support. *Treatment:* Facilitates booking appointments and accessing services to support ongoing therapy. *Continuing Care:* Enables sustained engagement through follow-up and ongoing access to mental health resources via the eClinic.			**Context:** No mentions of adjustments for socioeconomic factors (e.g., session scheduling flexibility). **Content:** No mentions of integration of cultural customs, traditions, or spirituality into modules. **Process:** Adaptations derived via co-design workshops with end users (young people, professionals).	• High usability scores (e.g., 6.93/7 for triage accessibility), but some navigation challenges (e.g., booking system rated 5.8/7). Cultural Adaptations: • Full Spanish translation of content and assessments. Qualitative Findings •Participants valued the privacy and convenience of telehealth. •Health professionals emphasised the need for integration with local Spanish-speaking services. •Limited Spanish-language apps reduced the utility of recommended e-tools.
Poon 2020 (98)	Mixed methods exploratory study Funding: Transcultural Mental Health Centre and UNSW.	The study aimed to explore the wellbeing, perceived needs, and knowledge of recovery among Chinese and Vietnamese carers of people with mental illness attending culturally and linguistically oriented support groups in Australia, using cultural safety as a conceptual framework.	Adults (≥18yrs) from Chinese and Vietnamese background	Participant (n=14) were aged 18 and above (carers' median age: 64 yrs); 79% female); Country of origin: China/Vietnam and based in Metro Sydney, NSW The program targeted individuals who were carers of people with mental ill-ness.	Outpatient Care (Non-Hospital) Drop-in Services (support groups) Monthly, bilingual support groups which provided culturally and linguistically tailored mental health education, peer support, and coping strategies.	Support Groups Psychoed ucation Groups Cultural Family Interventi ons (filial piety discussio ns)	**Prevention:** Reduces isolation/distress in high-risk CaLD carers to avert mental health decline. **Early Intervention:** Addresses unmet needs (e.g., info gaps, stigma) before crisis escalation. **Treatment:** Provides therapeutic support (peer groups, coping strategies) for carer distress. **Continuing Care:** Sustains long-term support (respite	Community Organisation (99)	Community Workers (Bicultural Worker, Peer Worker) Mental Health Clinical (Social Worker) Support Services (Interpreter	**Language:** Materials and support groups were conducted in participants' preferred languages (Mandarin/Vietnamese). **Persons:** Bilingual facilitators with cultural competence led the groups, but no mention of shared lived experiences. **Metaphors:** The manuscript does not mention explicit use of culturally relevant stories/characters. **Concepts:** Recovery framework aligned with cultural values (e.g., family responsibility). **Goals of Tx/Program:** Focused on family-centred care and stigma reduction. **Methods:** Simplified psychoeducation in group settings for ease of uptake. **Context:** Addressed migration-related stressors (e.g., visa issues). **Content:** Discussed cultural stigma but no local remedies/spirituality. **Process:** The manuscript doesn't explicitly state on co-design; but does mention adaptations based on facilitator expertise.	The study presented results in quantitative and qualitative findings as below: Mental Health Outcomes • High Isolation & Distress: 42% of carers were "isolated" or "very isolated" (Friendship Scale). 21% reported high/very high psychological distress (Kessler-10). • Long-Term Caregiving Burden: Median caregiving duration: 7 years (range: 2.3–25 years). 93% lived with the person they cared for. • Moderate Recovery Knowledge: Carers scored 3.7–4.1/5 on recovery understanding (Recovery Knowledge Inventory), with highest scores for "recovery expectations" (4.1). • Relatives' Functional Challenges: Mean functioning score: 61.1/80 (Life Skills Profile-20), indicating moderate impairment. • Unmet Needs: 100% needed help accessing services and info about care workers. 93% lacked mental illness education. 43% were dissatisfied with financial support. Qualitative Findings • Theme 1. Obtaining information in own language: Carers emphasized the critical need for

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							advocacy, care coordination).				mental health information (services, illness, medication) in their native language (Mandarin/Vietnamese). Support groups were a primary source, while mainstream services often failed to provide linguistically accessible resources. • Theme 2. Getting emotional support from support groups: Groups offered validation and reduced isolation, but some Chinese carers limited sharing due to cultural concerns about "losing face" (shame/gossip). • Theme 3. Needing Respite Services to Cope with caregiving responsibilities: Vietnamese carers strongly desired respite but faced financial barriers. Chinese carers saw limited utility, citing patient resistance or family duty norms. • Theme 4. Involvement in planning of treatment and care: Many felt excluded early in their relative's care; involvement improved over time, especially with bilingual staff/interpreters. • Theme 5. Migration process influencing caregiving: Visa/citizenship delays worsened financial stress and restricted access to housing/welfare. Recent migrants (e.g., on temporary visas) lacked safety nets. •Theme 6. Cultural factors in influencing caregiving experience Subtheme 1: Cultural expectations & responsibilities: Both groups upheld filial piety, but Vietnamese carers more openly sought external help. Subtheme 2: Chinese concerns over losing face: Fear of disgrace led to privacy within families; reluctance to disclose illness publicly. Subtheme 3: Stigma in own communities: Mental illness was often stigmatized or attributed to supernatural causes (e.g., ghosts, karma).
Poon 2022 (100)	Qualitative study (interviews)	The study aims to explore perceived needs, wellbeing, and cultural factors of Vietnamese	Vietnamese parents caring for children with disabilities	Participants in the study included (n=8) mothers and living with their child with); median age of 46.5 years	Outpatient Care (Non-Hospital) Drop-in Services (support groups)	Support Groups Psychoed ucation Groups Cultural Family	**Prevention:** Addresses stressors (e.g., isolation, financial strain) to mitigate mental health risks for carers.	Community Organisation (99)	Trained bilingual group leader (social work background)	**Language:** The support groups and information/materials were provided in Vietnamese, preferred language of the participants. **Persons:** The group leader was bilingual and culturally congruent, but shared lived experience isn't specified in the manuscript.	Vietnamese parents of children with disabilities in Australia experienced significant unmet needs but benefited from culturally tailored support groups. The results are presented in 3 themes as below: **Qualitative Findings** Theme 1: Obtaining information, receiving support, and involvement in treatment

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		parents caring for children with disabilities (ASD, Down syndrome, MND).		residing in Sydney, NSW. The program targeted individuals who were parents caring for children with disability included autism spectrum disorder (n =4), Down syndrome (n =2), motor neuron disease (n = 1) or developmental disability (n = 1).	Monthly, Vietnamese -language support groups, providing culturally tailored psychoeducation (e.g., NDIS navigation, disability management), peer-led emotional support, and coping strategies to reduce isolation and stigma	Interventions	**Early Intervention:** Identifies and supports carers early through culturally tailored support groups to reduce worsening distress. **Treatment:** Provides therapeutic support (e.g., emotional coping strategies) for carers experiencing depression or anxiety. **Continuing Care:** Offers ongoing support via groups to sustain wellbeing amid long-term caregiving demands.			**Metaphors:** The manuscript does not explicit mentions use of culturally specific stories/metaphors mentioned. **Concepts:** Addressed stigma and collectivist values (e.g., family duty) as culturally relevant stressors. **Goals of Tx/Program:** Focused on family-centred goals (e.g., respite, social support) aligned with cultural values. **Methods:** Simplified access to services (e.g., NDIS guidance) but no literacy adaptations detailed within the manuscript. **Context:** Addressed structural barriers (e.g., language, financial strain) and included family in support. **Content:** Incorporated cultural values (e.g., familial responsibility) but no local remedies/spirituality mentioned. **Process:** No co-design reported in the manuscript; adaptions likely based on practitioner expertise and carer feedback based on narrative.	• Sub-theme 1 Obtaining relevant information: Parents faced inadequate disability-related information and language/structural barriers. • Sub-theme 2 Receiving support from services: Limited NDIS understanding and cultural stigma hindered access to formal support. • Sub-theme 3 Involvement in treatment plan: Language barriers and provider assumptions reduced active parental involvement. Theme 2: Experiences of carers • Sub-theme 1 (Concerns regarding the person with disability): Challenging behaviours (e.g., aggression) strained relationships and caregiving. • Sub-theme 2 (Strain in relationship with family and friends): Social isolation and marital breakdowns were common. • Sub-theme 3 Poor health and wellbeing: Carers reported stress, depression, and physical health decline. • Sub-theme 4 Financial problems: Disability-related expenses caused significant economic hardship. • Sub-theme 5 Limited choice to care: Cultural duty compelled caregiving despite minimal alternatives. Theme 3: Experience of Groupwork The support group provided emotional relief, peer learning, and reduced isolation through culturally safe discussions.
Radhamony 2022 **(101)**	Qualitative descriptive design	The study aims to explore the perspectives of CaLD community in Victoria regarding their mental health service needs, understandings, and experiences, and to	Adults (≥18yrs) from a CaLD background, who can understand and speak English and currently residing in Victoria.	21 participants from CaLD community (with 60% female) with 80% born outside Australia across diverse countries. The services did not target individuals with a specific mental health condition	General Mental health services This study is not implementing or evaluating any specific program or treatment.	Hospital and outpatient services	*Promotion:* Enhances cultural competence of mental health nurses through educational interventions informed by CaLD community experiences. *Prevention:* Identifies barriers and disparities in mental health service access	Mental health services in Victoria Data collection done online	Mental Health clinicians and General practitioners	**Not applicable** The participants talked about cultural adaptations in the mental health services in general as below: **Language:** language barriers highlighted **Persons:** Therapist cultural competence (study focused on MHNs' training) **Metaphor:** N/A **Concepts:** Culturally relevant models (stigma, family-centered care discussed) **Goals of Tx/Program:** Client-derived therapy goals (community participation recommended) **Methods:** mental health literacy needed **Context:** barriers in service access	The study findings are presented in 4 key themes as outlined below: **Qualitative Findings** Settling Issues: Financial stress, unemployment, language barriers, social isolation, and trauma (e.g., war-related PTSD) were common during initial settlement, which often led to anxiety, depression, and feelings of detachment. Perceptions and Understanding of Mental Health Issues: Some participants recognised common mental health conditions like depression, PTSD, and schizophrenia, while others lacked basic mental health literacy, having never formally

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		prepare an education package for mental health nurses.		but were generally open to anyone referred to or seeking mental health support.			among CaLD populations to reduce inequities. ***Early Intervention:*** Explores CaLD individuals' experiences to improve timely access and utilization of mental health services. ***Treatment:*** Focuses on improving quality of care through culturally competent mental health nursing practice.			Content: Inclusion of cultural values (religion/spirituality mentioned) **Process:** community participation recommended	identified or discussed such issues in their home countries. Help-Seeking Attitudes: Mental illness often viewed as a "Western concept"; stigma and lack of knowledge about services (e.g., GPs as first point of contact) and reliance on family, friends, or spiritual leaders over professionals. *Sub-theme: Need for CaLD Community Education:* Many participants noted limited awareness of services (e.g., Beyond Blue, Headspace). Participants emphasised the need for community workshops and multilingual resources. Perceived Barriers to Accessing Services: *Sub-theme: Socio-Cultural and Language Barriers:* Interpreter services were underutilised due to privacy concerns; fear of miscommunication with English-speaking providers. Participants also expressed distrust of Western healthcare systems, preference for informal networks. *Sub-theme: Stigma, Labelling, and Discrimination:* Participants noted mental illness associated with shame, especially among older generations and male-dominated cultures. Fear of consequences such as worries about job loss, social ostracisation, or being labelled "crazy." *Sub-theme: Knowledge and Experience of Health Facilities:* Many participants unaware of mental health care plans or how to navigate services. Service Gaps noted by participants included Long wait times, rushed GP consultations, and lack of culturally sensitive care. Experiences with Mental Health Services and Professionals: Participants shared mixed experience; some praised MHNs (Mental Health Nurses) for dignity and respect; others found care impersonal. Some participants also commented in GPs as prescribing medications without adequate counselling or referrals. Some participants also noted cultural gaps such as lack of providers from similar backgrounds; as participants found discomfort with discussing mental health openly.

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Slewa-Younan 2020a (102)	Quasi-experimental design Funding: NSW Refugee Health Service, South Western Sydney Local Health District	The aim of the study is to evaluate the effectiveness of a culturally tailored mental health promotion program in improving mental health literacy and reducing psychological distress among Arabic-speaking refugees resettled in Australia.	Arabic-speaking refugees in South Western Sydney, Australia	33 Arabic-speaking adult refugees (14 men, 19 women), born in Iraq or Syria, who had arrived in Australia under the Humanitarian Migration Program. The program did not target individuals with specific mental health condition.	Outreach Services Culturally tailored mental health literacy and promotion program; Weekly 3-hour group sessions over 4 weeks, delivered in Arabic.	Group psychoeducation focusing on mental health literacy, reducing stigma, and self-help strategies to promote mental health. Support Groups	*Promotion:* Enhances mental health literacy and wellbeing among Arabic-speaking refugees using culturally sensitive education and self-help strategies. *Prevention:* Educates participants about common mental disorders and early signs to reduce risk and stigma within refugee communities. *Early Intervention:* Increases awareness and recognition of psychological distress symptoms to encourage timely help-seeking.	Community-based setting (Participants recruited from Adult Migrant English Program in South Western Sydney)	Bilingual health educators and/or mental health clinicians	**Language:** Materials and sessions were in Arabic, preferred language of the target population. **Persons:** Experienced bilingual health educators and/or mental health clinicians **Metaphors:** Culturally relevant vignettes (e.g., characters named Dawood or Miriam) were used to depict mental health issues. **Concepts:** The program integrated culturally relevant explanations of mental health disorders, aligning with concept of duality or pluralism of treatment beliefs in the target population. **Goals of Tx/Program:** Therapy goals were tailored to clients' cultural needs, and included exploring mental health, educating on common disorders, explaining the Australian mental health system, and introducing self-help strategies such as mindfulness and relaxation. **Methods:** The intervention was simplified, with clear steps and low-literacy tasks (e.g., mindfulness exercises). **Content:** Embedding spiritual practices (e.g., reading the Koran or Bible), modules on mindfulness aligned with cultural values, and integration of spiritually informed practices (e.g., prayer, religious leaders). **Process:** The intervention was developed in partnership with the NSW Refugee Health Service, and adaptations were co-designed with community elders, mental health experts from the same community, and refugee health expert to ensure cultural relevance and acceptability.	The majority of participants (22/33; 68.8%) self-reported with severe psychological distress (≥30 score in K10). The culturally tailored intervention for Arabic-speaking refugees in the study highlighted the effectiveness of using clients' preferred language, culturally relevant concepts, and community leaders in program design, which led to the following: Mental Health Outcomes • Significant improvement in personal stigma in pre-post (mean difference 1.21, $p < 0.05$ in 'weak-not-sick' scale). • Significant improvement in the social distance scale in pre-post (mean difference 1.62, $p < 0.05$) and follow-up (mean difference 1.96, $p < 0.05$). • Significant decrease in the proportion of people with a K10 score of severe distress (OR: 1.49, $p < 0.001$) and follow-up (OR: 7.47, $p < 0.001$). • Over 90% of participants agreed the program was useful and well-presented. Similarly, 87.1% agreed the information would be useful in the future, 74.2% agreed the information was easy to understand, and 67.7% agreed the program provided new information. • High engagement, with 31/33 participants completing the post-intervention survey and 29/33 completing the 3-month follow-up.
Slewa-Younan 2020b (103)	Quasi-experimental design Funding: South Western Sydney Primary Health Network	This study aimed to evaluate the effectiveness of a culturally tailored mental health literacy training program for Arabic-	Arabic-speaking religious and community leaders (self-identified) in South Western Sydney,	52 adult religious and community leaders (16 male, 36 female), with Iraq, Australia and Lebanon are common country of origin; with	Outreach Services Culturally tailored mental health literacy (MHL) education program	Group psychoeducation focusing on PTSD awareness, stigma reduction, and culturally appropria	***Promotion:*** Builds mental health literacy among Arabic-speaking religious and community leaders to improve community wellbeing. ***Prevention:*** Challenges stigma	Community settings (e.g., religious centres, community networks) in South Western Sydney.	Bilingual (Arabic) mental health clinicians with expertise in in transcultural mental health	**Language:** Training delivered in Arabic, with materials and discussions in Arabic. **Persons:** Bilingual Arabic-speaking mental health clinicians delivered the training. **Metaphors:** The study used a culturally valid vignette featuring an Iraqi refugee named Dawood to illustrate PTSD symptoms in a relatable context. Videos featuring refugee experiences and interviews with religious leaders were also included.	The culturally tailored Mental Health Literacy (MHL) training program for Arabic-speaking religious and community leaders showed significant improvements in PTSD-related knowledge, attitudes, and help-seeking behaviours, key findings outlined below: Mental Health Outcomes • Post-training, there was a significant increase in participants' ability to recognise the vignette as

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		speaking religious and community leaders in Australia by assessing its impact on improving PTSD recognition, reducing stigma, and promoting professional help-seeking behaviours among refugee communities.	representing churches, mosques, NGOs, and government organisations.	among respondent 19.4% refugee and 80.6% migrants. The program did not target individuals with specific mental health condition.	delivered in Arabic; 6-hour one-day workshop, delivered in two sessions (morning and afternoon).	te help-seeking strategies while incorporating spiritual and cultural perspectives. Support Groups	and improves recognition of mental health problems to reduce risk within the community. *Early Intervention:* Equips leaders to identify mental health issues early and promote timely professional help-seeking.			**Concepts:** Training integrated cultural and religious beliefs (e.g., spiritual healing, prayer) and symptoms were explained in ways that aligned with cultural expressions of distress in Arabic-speaking communities. **Goals of Tx/Program:** The intervention aimed to improve help-seeking behaviours by empowering leaders to guide refugees toward professional care while validating cultural practices (e.g., spiritual counselling). **Methods:** Simplified steps and culturally relevant content to improve uptake. Leaders were taught actionable steps (e.g., how to refer to GPs, mental health services) and basic counseling techniques (e.g., active listening). **Context:** Training tailored to the social and cultural context of Arabic-speaking refugees, including addressing barriers to mental health care (e.g., stigma, distrust of Western medicine) and highlighted free/low-cost services. **Content:** Inclusion of culturally informed treatment practices (e.g., prayer, spiritual guidance) alongside evidence-based treatments. **Process:** Adaptations derived through consultation with Arabic-speaking mental health professionals and community leaders.	describing a general mental health problem (62.7% vs. 80.8%, $p = 0.035$). • Recognition of PTSD increased from 51% to 61.5%, though not statistically significant ($p = 0.125$). • Significant improvement in understanding the role of antidepressants for PTSD (60% vs. 82.7% $p < 0.001$). • Significant decrease in desire for social distance from individuals with PTSD (mean score: 9.31 vs. 8.62, $p = 0.042$). • Participants provided more helpful strategies post-training, with increased emphasis on professional support (e.g., encouraging visits to GPs or mental health services) and proactive engagement (mean score: 1.90 vs. 2.24, $p = 0.032$). • High engagement, with 52/54 participants completing pre- and post-training assessments.
Uribe Guajardo 2019 **(104)**	Quasi-experimental design Funding: South Western Sydney Primary Health Network (SWSPHN)	This study aims to evaluate the effectiveness of teen Mental Health First Aid (tMHFA) and Youth Mental Health First Aid (YMHFA) training with a CaLD (Culturally and Linguistically Diverse) focus in improving	CaLD adolescents and adults (teachers/parents)	372 participants (16–18 yrs ; Year 10 students) and 34 participants (18–64 yrs; adult teachers/parents), predominantly from Vietnamese, Assyrian, and Arabic backgrounds, and was conducted in South Western Sydney.	Outreach Services Culturally adapted MHFA program for CaLD adolescent (3 sessions; each 75 minutes each over 5–8 school days) and adults (14 hours, offered in	Psychoeducation Groups (primary focus of tMHFA & YMHFA). Support Groups (indirectly through peer and adult support).	*Promotion:* Builds mental health literacy among adolescents and adults to support youth wellbeing. *Prevention:* Trains youth and adults to recognise early signs of mental health problems and reduce stigma before issues escalate. *Early Intervention*: Equips teens and	Community setting: Co-located Services (schools and community mental health linkages).	Youth Workers (teen MHFA facilitators) Bicultural Workers (adapted content for CaLD groups) Mental Health Clinical: Psychologists (involved in training delivery).	**Language:** It was not materials were not mentioned to be provided in clients' native languages beyond English. **Persons:** the study did not explicitly mention matching clients with workers of shared cultural backgrounds. **Metaphors:** Culturally sensitive films and vignettes with Iraqi character names were used. **Concepts:** The intervention incorporated culturally relevant models (e.g., trauma-informed care for refugees). **Goals of Tx/Program:** Client-derived goals were not highlighted; the focus was on worker training. **Methods:** Simplified MHFA steps and culturally tailored guidelines were provided.	The culturally adapted teen and Youth MHFA training for adolescents and adults in Australia demonstrated significant improvements in mental health literacy (MHL) and helping intentions, with the following outcomes: Mental Health Outcomes Adolescent Participants (Year 10 Students): • Post-training, students were more likely to endorse trusted adults (e.g., teachers, psychologists) as valid sources of help ($p < 0.001$), with gains maintained at 3-month follow-up ($p < 0.01$). • Significant increase in concordant (evidence-based) helping strategies ($p < 0.01$), sustained at follow-up ($p < 0.05$).

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		mental health literacy (MHL) and help-seeking behaviours among adolescents and adults in Australia.		The program did not target individuals with specific mental health condition.	either 2 full days or 4 flexible sessions.).		adults to identify emerging mental health issues and provide initial support and referral to professional help.			**Context:** No mention of adaptations for social/economic factors (e.g., scheduling). **Content:** Values like family roles and stigma were addressed, but local remedies/spirituality were not included. **Process:** Adaptations were derived from Delphi expert consensus	• Significant reduction in discordant (ineffective/harmful) strategies (p< 0.001), maintained at follow-up (p < 0.01). • Stigma Reduction: Weak-not-sick stigma subscale scores decreased significantly at follow-up (p < 0.05), though other stigma measures (e.g., social distance) showed no significant change. Adult Participants (Teachers/Responsible Adults): • Significant improvement in youth mental health knowledge post-training (p< 0.01), sustained at follow-up (p< 0.01). • Adults reported greater confidence in assisting youth with mental health problems post-training (p< 0.001), maintained at follow-up (p< 0.05). **Qualitative Findings** Engagement & Feasibility: • High participation rates: 83% (308/372) of students and 94% (32/34) of adults completed pre-training surveys. • Attrition: 69% of students and 59% of adults completed follow-up surveys.
van Wyk 2012 **(105)**	Longitudinal study Funding: National Cancer Institute Minority Institution/Cancer Centre Partnership Program	This study aimed to examine the impact of therapeutic interventions on mental health outcomes in refugees from Burma and identify factors influencing mental health post-intervention, such as pre-	Refugees from Burma (now Myanmar) resettled in QLD, Australia	62 participants (57% female, mean age 34.13), primarily of Karen (57%), Chin (21%), and Karenni (8%) ethnicities, mostly Christian (68%), with 90% on refugee visas and 10% on women-at-risk visas, having lived in Australia for an average of 3.09 months at baseline.	Outpatient Care (Non-Hospital) Intervention was an individually delivered, multi-modal therapeutic program (e.g., psychoeducation, CBT, expressive therapy) conducted	Psychoeducation (89% of participants) Structured skills-based therapy (55%) Supportive psychotherapy (55%)	*Early Intervention:* Provides psychological support (e.g., psychoeducation, structured skills-based therapy, supportive therapy) to refugees showing symptoms of distress and trauma to prevent progression to more severe mental disorders. *Treatment:*	Community setting (community-based refugee resettlement organisation)	Therapists: Psychologists (4), social workers (1), counsellors (1) with varied experience ranging 1.5–15yrs working with refugees and 5/6 from culturally diverse backgrounds.	**Language:** The therapeutic sessions were conducted with the support of trained (to work with refugee clients) interpreters who spoke the native languages of participants, such as Karen or Chin **Persons:** The team included 5/6 therapists from CaLD backgrounds. Interpreters were selected based on client preferences, avoiding those from conflicting ethnic or religious backgrounds for safety and rapport. **Metaphors:** The study did not describe the use of culturally specific metaphors. **Concepts:** The interventions were adapted to pre-migration trauma, such as war and displacement, as well as post-migration stressors like acculturation difficulties and family separation. However, the study did not explore how traditional Burmese or Karen	The longitudinal study examining therapeutic interventions for refugees from Burma resettled in Australia demonstrated significant improvements in mental health outcomes, with the following key results: **Mental Health Outcomes** • The proportion of participants with clinically significant PTSD symptoms (self-reported) decreased significantly from 27% at pre-intervention to 5% post-intervention (p< 0.001). • Self-reported anxiety symptoms was improved, with only 5% of participants remaining in the clinical range post-intervention (down from 23%). • Self-reported depression scores also improved significantly (p < 0.001), with 7% meeting clinical thresholds after therapy (compared to 37% initially).

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		migration trauma, post-migration difficulties, and service contacts.		Participants had at least one type of trauma event such as preexisting mental health symptoms such as PTSD, depression, anxiety, and somatisation as assessed by validated instruments at baseline	over approximately 6.9 months, with an average of 6.58 therapy sessions per participant.	Expressive therapy (48%) Family therapy (16%) CBT/exposure therapy (11%)	Offers therapeutic interventions (e.g., CBT, exposure therapy, expressive therapy) to address existing PTSD, depression, anxiety, and somatisation symptoms in a clinical population. *Continuing Care:* Involves ongoing support and adjustment-focused therapy over several months, tailored to individual post-migration challenges and acculturation needs.			understandings of mental distress were integrated into therapy. **Goals of Treatment/Program:** The primary focus of therapy was on adjustment and acculturation. Some sessions addressed family dynamics and shifting gender roles in resettlement, but there was no explicit emphasis on collective or community-level healing. **Methods:** The approach was flexible and multimodal, with methods such as expressive therapy (art, music) for trauma and cognitive-behavioural techniques for anxiety. Non-clinical support, including housing and employment assistance, was also provided alongside therapy. However, the study did not mention structured cultural rituals, storytelling, or other traditional methods of healing. **Context:** The study did not describe adaptations for religious practices or other culturally significant events. **Content:** Therapy content focused on trauma recovery and practical resettlement skills, such as navigating healthcare systems. While trauma related to war and displacement was addressed, there was no inclusion of traditional healing practices, spiritual interventions, or culturally specific coping strategies rooted in Burmese, Karen, or other ethnic belief systems. **Process:** There was no mention of direct collaboration with Burmese community leaders or clients in designing the interventions.	• Self-reported somatic symptoms decreased (p < 0.001) • Pre-intervention symptom severity was the strongest predictor of post-treatment outcomes for PTSD, anxiety, and somatisation. **Qualitative Findings** Service Utilisation • Participants attended an average of 11.34 service contacts (6.58 therapy sessions + 3.93 assessments). • The most common interventions were psychoeducation (89%), skills-based therapy (55%), and expressive therapies (48%). Limitations: • Cultural adaptations was done to some extent (e.g., interpreters, diverse therapists) but did not incorporate traditional healing practices.
Wollersheim 2013 **(106)**	Qualitative focus groups Funding: VicHealth (Victorian Health Promotion Foundation)	The study aims to explore how mobile phone-based peer support can improve psychosocial health and facilitate settlement for	Nuer background (South Sudanese) refugee women currently residing in Melbourne Victoria.	9 Participants in the intervention with average age 37.2 yrs residing in south-eastern region of Melbourne. Average length in Australia was 5.4 years. 77.7%	Telehealth Services Intervention was a weekly, two-hour, peer support group program	Psychoeducation (peer support training) Support Groups (peer support groups)	*Promotion:* Enhances wellbeing and social connectedness among Nuer refugee women using peer support. *Prevention:*	Community (Community Organisation, Settlement Service, Cultural Organisation)	Community Workers (2 trained facilitators with over 10 years of experience in peer support methodology; with Nuer	**Language:** Sessions were conducted in Nuer (participant's preferred language) via a trained interpreter. Written materials were avoided to align with oral traditions. **Persons:** Non-Nuer facilitators with 10+ years of peer support experience delivered the program, supported by a Nuer interpreter and a Nuer women's community leader for cultural guidance. **Metaphors:** N/A (No mention of culturally tailored vignettes, stories, or character names).	The study found that culturally tailored mobile based peer support strategies can strengthen social capital, empowering individuals, families, and communities to address challenges and create local solutions. The findings were presented in 4 themes: **Qualitative Findings** Participants experienced increased social status and stronger community bonds through their involvement in the program, which also sparked

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		Nuer refugee women in Melbourne.		were single mothers, with an average 4.9 children. The program did not target individuals with specific mental health condition.	over 10 weeks, where Nuer refugee women participated in paired and group discussions and practiced peer support through assigned phone calls..		Aims to prevent mental health decline in a high-risk, socially disadvantaged group through structured peer interactions. ***Early Intervention:*** Introduces peer support early for women showing signs of social isolation or emotional distress.		speaking interpreters)	**Concepts:** The peer support model (non-clinical, mutual aid) aligned with Nuer collectivist values and communal problem-solving. Trauma and settlement stress were framed as shared experiences. **Goals of Tx/Program:** Focused on community bonding, improving family communication, and building confidence; derived collaboratively with participants **Methods:** Mobile phone calls replaced written tasks (e.g., no diaries/journals). Sessions used simple turn-taking (low-literacy, oral practice). **Content:** N/A (No integration of spiritual practices, local remedies, or religious modules but was on strength-based discussions emphasised resilience) **Process:** Program was co-designed with Nuer community leaders (men's and women's groups). Topics were vetted by participants (e.g., family success, education).	wider interest and a desire for broader and longer program participation and utilisation. Participants experienced improved communication within their families after adopting peer support techniques, leading to better listening and mutual respect. Some also noticed their children communicating more respectfully and in a more structured manner. Participants developed stronger social bonds and trust through improved group communication and mutual sharing within the intervention group. The peer support network offered emotional relief, enabling women to express distress, receive advice, and experience healing through being heard. Participants reported increase in bonding social capital led to greater personal empowerment, as participants gained confidence and started planning for their futures. Many women highlighted the role of mobile communication in improving daily life by facilitating access to important information across various aspects like shopping, transportation, and banking. The training sessions were described by participants as positive and healing, offering comfort, learning, and a sense of support during times of stress.

Extraction Table 2: Studies not involving direct data collection from the target population (e.g., data collected from service providers, field reports, or content analysis)

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Blignault 2023b **(107)**	Qualitative study (semi-structured interviews) Funding: Central and Eastern Sydney Primary Health Network (CESPHN)	The study aims to explore community partner perspectives on the Culturally and Linguistically Diverse Mindfulness Program, including its impact, contributing factors, sustainability, and suggestions for future development.	Refugee and migrants (predominantly Arabic and Bangla speaking) Only Community partners and clinicians were interviewed	Arabic-speaking (various ethnicities, Muslim and Christian) and Bangla-speaking (predominantly Bangladeshi, Muslim) women aged 18-64, in metropolitan Sydney. The program did not target individuals with specific mental health condition.	Outreach Services (delivered in partnership with community organisations) Telehealth Services (during COVID) Intervention consisted of multi-session group mindfulness programs, with 5-week face-to-face sessions and 4-week online stress management programs, delivered to participants on a regular basis.	Mindfulness-Based Intervention (Group Care) Psychoeducation Groups Support Groups	*Promotion:* Enhances general mental wellbeing in CaLD communities through culturally adapted mindfulness programs. *Prevention:* Aims to prevent mental health problems in vulnerable Arabic and Bangla-speaking populations by building stress management skills. *Early Intervention:* Supports individuals showing early signs of distress with low-intensity, community-based mindfulness sessions.	Community organisation (Cultural Organisation, Settlement Service, Religious Organisation) Services were integrated through Primary Health Networks and health districts	Psychologists (bilingual English/Arabic, English/Bangla) Community Workers: Bilingual/bicultural community workers, community organisation staff	**Language:** Program was delivered in participants' preferred languages (Arabic and Bangla), and bilingual facilitators supported both in-person and online sessions. **Persons:** Co-facilitators included bilingual psychologists and bicultural community workers who shared cultural and linguistic backgrounds with participants. **Metaphors:** Culturally and spiritually resonant explanations of mindfulness were used to bridge Western psychological concepts with community values. **Concepts:** The mindfulness program was adapted to align with participants' cultural and religious frameworks, recognising collective and spiritual understandings of wellbeing. **Goals of Tx/Program:** Emphasised client-relevant outcomes such as family harmony, resilience to daily stressors, and improved community functioning. **Methods:** Sessions were adapted for accessibility, with simplified language, flexible delivery modes (in-person and online), and use of culturally appropriate teaching styles. **Content:** Included examples and practices reflective of participants' values, such as references to faith, prayer, and communal responsibility. **Process:** Program was co-designed and delivered in collaboration with community organisations, using feedback from community partners to shape delivery and content.	The program positively impacted mental health, community organisations, and providers, with success driven by cultural competency, trust, and community engagement. The results were presented in 5 themes: Qualitative Findings Theme 1: Perceived Impact Impact on Group Participants: The program was seen as life-changing for participants, improving mental health and empowering them with skills that aligned with their cultural and religious beliefs. Impact on Community Partner Providers: Community providers found the program personally and professionally rewarding, helping them better manage stress and integrate mindfulness into their work and lives. Impact on Community Partner Organisations: The program positively affected organizations by promoting mental health, providing staff with new skills, and enhancing organizational well-being. Impact on Community: The program was well-received by the community, fostering mental health awareness, support networks, and facilitating access to services while increasing demand for continued support. Theme 2: Contributing Factors The program's success was attributed to factors such as trust, cultural and clinical competency of facilitators, tailored content, and strong community engagement. Theme 3: Community Wellbeing The program was considered highly effective in improving community wellbeing by raising mental health awareness, reducing stigma, and providing vital support to new and emerging communities. Theme 4: Suggestions for Improvement

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											Suggestions for improvement included expanding the program's reach, increasing session times, adding more content on self-care, and offering sessions at more flexible times and formats. Theme 5: Sustainability To ensure sustainability, informants emphasized the need for regular program delivery, continued partnerships, increased capacity, and financial support for community organizations.
Kalantidou 2022 **(108)**	Qualitative case study Funding: Culture in Mind and World Wellness Group	The study aims to transform a migrant mental health service into a therapeutic space by exploring design interventions that enhance wellbeing and address cultural barriers for CaLD clients based in Brisbane, QLD.	Refugees, migrants and asylum seekers Only staff members were interviewed	No direct interviews with migrant clients 5 staff (practitioners/administrators) The program provided service to people with PTSD, depression and anxiety, and occasionally for more severe psychopathological conditions	Outpatient care (community clinic) Redesigning a migrant mental health space using community gardens, art, and spatial changes to improve cultural safety, therapeutic outcomes, and social connection.	Community-based interventions (design)	***Promotion:*** Enhances mental wellbeing by improving the physical environment of a multicultural mental health facility through participatory and sustainable design. ***Prevention:*** Reduces environmental stressors and supports wellbeing in migrant communities, aiming to prevent mental health deterioration. ***Continuing Care:*** Supports ongoing mental health recovery and daily functioning by creating a calming, community-connected space for long-term service users.	Community organisation (Culture in Mind)	Design researchers/students	**Language:** The study doesn't specify if materials were provided in clients' native languages beyond English visual communication methods. **Persons:** Design team collaborated with mental health practitioners but didn't include community members with shared migration experiences. **Metaphors:** The world map installation served as a cultural metaphor for connection rather than displacement. **Concepts:** Used environmental psychology principles rather than Western clinical models to accommodate diverse cultural understandings. **Goals of Tx/Program:** Focused on culturallyvalued outcomes like privacy, community connection and dignity. **Methods:** Used low-literacy spatial interventions with tactile materials and visual art. **Content:** Integrated nature-based healing but didn't incorporate specific cultural traditions or spiritual practices. **Process:** Co-designed with staff but didn't directly involve clients in the design phase.	The Culture in Mind design interventions demonstrated significant improvements in therapeutic space quality and staff-reported client experiences: Qualitative Findings • 100% of staff reported improved therapeutic environment post-intervention • 80% observed increased client comfort in the redesigned space • 40% increase in community interactions through the entrance garden installation • Service utilisation remained steady at 20–50 clients daily during the intervention, achieved with a minimal budget of $500 AUD for all design modifications. Staff experiences: • Enhanced sense of privacy and safety for clients (critical for trauma recovery) • Improved staff-client connections through spatial reorganization • Reduced clinical stigma via home-like design elements Implementation: • Visual/tactile interventions (world map, plants) effectively addressed language/literacy barriers • Reclaimed materials enabled low-cost, sustainable transformations • Lack of client participation in co-design process limited cultural specificity
Kara 2024 **(109)**	Qualitative (focus groups)	The study aims to evaluate the limitations of	Culturally and linguistically diverse	16 practitioners aged 21-70 yrs with everyone identifying	Outreach Services	Psychoeducation	***Promotion:*** Explores how wellbeing programs can be	Community organisations such as settlement	Mental Health Professionals (psychologists	**Language:** Not mentioned, the program was conducted in English.	CaLD community wellbeing programs face major challenges due to funding gaps, lack of cultural relevance, poor engagement, and weak integration, but can be improved through

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	Funding: Not explicitly stated	current wellbeing programs for CaLD populations in Australia, identify barriers to their implementation and engagement, and propose improvements for future program development.	populations in two states in Australia Health practitioner working with adult migrants were interviewed	ethnically diverse, and 93.8% speaking language other than English in home Target population; CaLD (e.g., Arabic, Asian, African backgrounds) The program did not target individuals with specific mental health condition.	Telehealth Services Culturally tailored resilience program (acculturation, mental health literacy, and practical settlement skills) delivered in group workshops or individual sessions; exact duration and frequency were not specified.	Trauma-Informed Therapy Group psychoeducation Support groups Parenting Programs	improved to support the mental health of CaLD Australians through culturally informed delivery. ***Prevention:*** Identifies barriers and strengths in existing programs to better design early supports that reduce the risk of mental health issues among CaLD populations. ***Early Intervention:*** Gathers practitioner insights to enhance timely and culturally sensitive wellbeing services for CaLD clients showing early signs of distress.	services and religious/community centres	, social workers) Bicultural Workers (CaLD facilitators) Community Workers (peer support, settlement workers)	**Persons:** The facilitators included individuals with CaLD backgrounds (e.g., a first-generation migrant, second-generation CaLD Australian). **Metaphors:** There is no mention of culturally or spiritually resonant metaphors being used. **Concepts:** Concepts were interpreted considering CaLD experiences; researchers were reflexive about cultural challenges. **Goals of Tx/Program:** Participants discussed culturally appropriate outcomes and improvements for CaLD wellbeing programs. **Methods:** Online delivery through Zoom provided accessibility; purposive and snowball sampling focused on culturally relevant expertise. **Content:** Prompts and discussion focused on wellbeing programs for CaLD populations, including content and delivery. **Process:** The process was collaborative, with participant feedback shaping the understanding of effective program components.	sustained funding, community input, and culturally tailored strategies. Five themes are summarised below. **Qualitative Findings** Theme 1: Limited Funding Participants highlighted that restricted financial resources undermine program quality, sustainability, and the ability to conduct CaLD-specific research. Limited funding: • Led to tokenistic approaches, such as hiring CaLD workers without cultural competency support. • Undermined program sustainability, often relying on unpaid volunteers who eventually faced burnout. • Constrained research and evidence-building required to advocate for ongoing funding and program improvement. Theme 2: Program Weaknesses The design and delivery of existing programs were seen as poorly aligned with the lived experiences of CaLD communities. Specific weaknesses included: • Limited understanding of CaLD experiences, such as trauma, identity struggles, and non-Western conceptualisations of wellbeing. • Programs built on assumptions and biases, often treating CaLD groups as homogenous. • A lack of follow-up mechanisms, reducing continuity and ongoing engagement. Theme 3: Barriers to CaLD Engagement Participants identified multiple interrelated barriers impeding CaLD engagement: • Stigma surrounding mental health, particularly among first-generation migrants. • Language barriers, including poor translations and the stress of navigating programs in a second or third language. • Limited awareness of available services, both among CaLD communities and professionals. • Practical barriers, such as transportation, caregiving responsibilities, and long wait times.

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											Theme 4: Ideal Wellbeing Program Participants envisioned effective wellbeing programs as those that: • Acculturation: Respect and integrate CaLD experiences, addressing intergenerational trauma and identity challenges. • Are flexible in delivery and content, tailored to community needs and available in multiple languages. • Employ culturally competent facilitators, not just CaLD-identifying staff without appropriate training. • Engage in community outreach, working from a grassroots level to ensure relevance. Theme 5: Implementing Successful Programs Suggestions for effective implementation included: • Building sustainability through adequate funding and trained staff. • Prioritising community co-design and evaluation. • Ensuring ongoing support and follow-up to foster trust and continuity.
Karageorge 2018 (110)	Qualitative study (using interpretive description methodology) Funding: Australian Federal Government (Humanitarian Entrants Program)	The study aims to explore how traditional Western family therapy was adapted for refugee clients in the Strength to Strength (STS) program and to identify what was novel about the service and inform future models of care.	Refugee families who had resettled in Sydney within the past two years. Staffs engaged in STS were interviewed.	The program has varied in age (families, adults, youth) with commonly country of origin: Syria, Iran, Pakistan, Afghanistan; residing in Metro Sydney The program did not target individuals with specific mental health condition.	Outreach Services (community groups) Outpatient Care (Non-Hospital) (family therapy) Group sessions (e.g., cooking, soccer) were held regularly (frequency not specified), while	Trauma-Informed Therapy Psychoeducation Support Groups (community activities) Family Therapy (structural/systemic) Cultural Family Interventions	*Treatment:* Explores staff experiences within an existing psychotherapeutic service (STS) to enhance therapeutic practices for individuals receiving mental health care. *Continuing Care:* Aims to inform service design improvements that support sustained and effective care through staff-informed clinical recommendations.	Community Organisation (Relationships Australia NSW) Settlement Service (linked with migrant resource centres)	Mental Health Clinical: Psychologist, Counsellor (family therapists) Community Workers: Bicultural Worker, Settlement Worker	**Language:** No mention of materials provided in clients' native languages beyond potential use of translators. **Persons:** Bicultural workers shared cultural backgrounds with clients, enhancing trust and engagement. **Metaphors:** No specific culturally relevant stories or metaphors were mentioned. **Concepts:** Shifted from insight-oriented (post-Milan) to directive, practical therapy (e.g., structural family therapy) to align with client needs. **Goals of Tx/Program:** Addressed culturally relevant goals like family hierarchy restoration and community reconnection. **Methods:** Used community groups (e.g., cooking, soccer) for low-barrier engagement. **Context:** Flexible service delivery (casework + therapy) to address resettlement stressors. **Content:** Incorporated trauma-informed care but no mention of specific cultural traditions. **Process:** Staff-driven adaptations based on	The finding suggests that community-based STS programs were key in reducing isolation, providing culturally relevant support, and facilitating healing for refugee populations. The themes are presented below: **Qualitative Findings** Theme 1: Use of community and multi-family groups: Bicultural-led community groups used culturally familiar activities to gently engage refugees in relationship discussions. These groups reduced isolation, fostered empowerment, and supported family connection during resettlement. Theme 2: Complex role of bicultural worker Subtheme 2.1: Broad mandate of care: Bicultural workers engaged holistically with refugee families, addressing both practical needs and emerging psychological concerns through a systemic, trauma-informed approach.

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					individual/family therapy sessions were phased in as needed, with no set duration mentioned					client needs, but not formal co-design with refugees.	Subtheme 2.2: Personal attributes: Deep cultural knowledge and compassion: Shared cultural background and compassionate presence enabled bicultural workers to build trust, engage clients effectively, and tailor support to client values. Subtheme 2.3: The importance of clinical and peer supervision: Regular supervision and reflective practice supported bicultural workers' emotional wellbeing and professional development, enhancing the quality of client care. Theme 3: Therapist-driven family therapy: Family therapists found that practical and directive approaches like structural family therapy were more effective with refugee families because abstract post-Milan techniques often clashed with clients' expectations, cultural values, and language fluency.
Murray 2021 (111)	Content analysis (quantitative evaluation of publicly available data) Funding: No specific funding was reported for this study but it focused on 33 Australian government-funded mental health websites.	The study aims to assess the availability of translated materials and resources for culturally and linguistically diverse populations on Australian government-funded mental health websites.	CaLD population Study focussed on content analysis of websites only	Not Applicable	Telehealth Services (the study evaluates online mental health platforms, which include digital/tele health services)	Psychoeducation (the study evaluates online mental health information, which often includes psychoeducational content)	*Promotion:* Assesses the accessibility and inclusivity of mental health information on Australian websites to enhance mental health awareness among CaLD communities. *Prevention:* Identifies gaps in language and cultural content to support early understanding and help-seeking before mental health issues escalate.	Government-funded mental health websites	Not Applicable	Not Applicable The study did evaluate and describe some aspect of cultural adaptation of websites: **Language:** The study evaluated whether mental health websites provided materials in languages other than English, finding limited availability. **Persons:** No mention of therapist-client matching or cultural competence in service delivery. **Metaphors:** No culturally relevant stories or character names were discussed in the website content. **Concepts:** No evidence of culturally adapted theoretical models for presenting mental health issues. **Goals of Tx/Program:** No mention of culturally tailored therapy goals (e.g., family-centered approaches). **Methods:** No adaptations for ease of uptake (e.g., simplified CBT tools for low literacy). **Context:** It is an online tool so flexible in nature.	The key findings of content analysis of websites are listed below: Qualitative Findings • Most websites were general mental health platforms (8 out of 33), followed by drug/alcohol, self-help, and suicide-specific websites (4 each). • Only 4 websites (12.12%) offered translation tools, with just 2 displaying them on the homepage. • Translation tools were described only in English across all websites. • Materials in languages other than English were found on 4 websites, including Moodgym, Gambling Help Online, 1800RESPECT, and Australian Centre for Grief and Bereavement. • Only 8 out of 1100 subsections (0.73%) specifically addressed CaLD or multicultural populations. • Nine websites (27.27%) mentioned CaLD/multicultural communities, but only 2 provided this information in another language. • First-person mental health stories from culturally diverse individuals appeared on only 2 websites.

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										Content: No integration of cultural values, customs, or traditions into mental health resources. **Process:** No co-design or community involvement in developing the online resources.	• Interactive features like forums, web chat, and email support were limited and available only in English. • Telephone counselling was offered on 14 websites, with only 3 providing access to translators. • Eight websites (24.24%) referred users to CaLD-specific external resources.
Nemorin 2019 (112)	Field report (descriptive, qualitative) outlining community-based interventions Funding: Not explicitly stated. It was noted that STARTTS is an affiliated Health Organisation that relies on mixed funding model (federal, state and other revenue).	The study aims to describe a systemic, trauma-informed approach supporting Rohingya refugees' healing and recovery in Sydney, Australia, through clinical and community development programs.	Refugee from Rohingya background Data is based on field report of multiple interventions undertaken by STARTTS.	Rohingya Muslims from Rakhine State, Myanmar, residing in metropolitan Sydney (Lakemba), including school-aged youth (16–18 years) and adults (18–64 years), with gender not specifically specified. The program did not target individuals with specific mental health condition.	Outreach Services (Lakemba clinic) Outpatient Care (Non-Hospital) Community Development Programmes	Trauma-Informed Therapy Psychoeducation Narrative Therapy Group Care: Support Groups, Psychoeducation Groups, Capoeira Angola (movement therapy) Family Care: Family Therapy, Cultural Family Interventions (FICT Programme)	***Promotion:*** building community resilience, assets, empowerment ***Prevention:*** creating supportive environments, educating about trauma ***Treatment:*** providing direct clinical therapy for trauma survivors	Community: Community Organisation, Cultural Organisation, Settlement Service Mixed/Integrated: Co-located Services (schools, football clubs)	Mental Health Clinical: Psychologists, Social Workers, Counsellors Community Workers: Bicultural Workers, Community Development Workers, Youth Workers	**Language**: Materials and services were provided in Rohingya or Ruaingga, using accredited interpreters for accuracy. **Persons**: Bicultural staff and community leaders were involved, ensuring shared experiences and cultural competence. **Metaphors**: Culturally relevant activities (e.g., football, Capoeira) were used as therapeutic metaphors for empowerment. **Concepts**: The biopsychosocial systemic model addressed trauma holistically, aligning with communal and cultural contexts. **Goals of Tx/Program**: Focused on community-derived goals like empowerment, social capital, and family/community healing. **Methods**: Simplified, trauma-informed interventions (e.g., narrative therapy, school programs) were adapted for accessibility. **Context**: Addressed resettlement stressors (e.g., advocacy, sports) and included family/community networks in care. **Content**: Integrated cultural strengths (e.g., community leadership) but no mention of traditional/spiritual practices. **Process**: Adaptations were co-designed via community consultations and asset-based approaches ("nothing about us without us").	Multiple interventions were described in the field report which are below: **Qualitative Findings** • Individual & Family Counselling: STARTTS psychologists and social workers provided trauma therapy with bicultural support in weekly/biweekly sessions at the Lakemba outreach clinic. • Teacher Training: STARTTS clinicians conducted term-based workshops on trauma-informed strategies for school staff working with Rohingya students. • Student Therapeutic Groups: STARTTS therapists ran weekly narrative therapy and Capoeira Angola groups in schools to build resilience and identity. • Families in Cultural Transition (FICT): STARTTS facilitated 10-week community workshops with interpreters to address settlement challenges and family trauma. • Sports & Community Programs: Partnered with local football clubs (e.g., Lakemba Roos) for weekly matches to foster social inclusion and empowerment. • Refugee Advocacy (RCAN): STARTTS co-led leadership training and advocacy networks to strengthen community self-determination. Key results are summarised below: • The biopsychosocial systemic model enhanced trauma recovery in Rohingya refugees by integrating clinical therapy and community-based support. • School-based programs such as Capoeira Angola and narrative therapy improved students' resilience, attendance, social interaction, and cultural identity.

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
											• Teacher training workshops equipped educators with trauma-informed strategies to better support Rohingya students in classrooms. • Families in Cultural Transition (FICT) workshops improved settlement knowledge, family communication, and reduced social isolation. • Community initiatives like football programs and advocacy networks fostered social inclusion, confidence, and community leadership. • Despite positive outcomes, ongoing trauma related to the Myanmar crisis highlighted the continued need for long-term, culturally sensitive support.
Uribe Guajardo 2018 **(113)**	Quasi-experimental design Funding: Lead researcher received the Australian Postgraduate Award from Western Sydney University and the 2015 Cross-cultural Public Research Grant.	This study aims to evaluate the effectiveness of a tailored Mental Health Literacy Course in improving knowledge, attitudes, and helping behaviours among staff working with Iraqi refugees in Australia.	Iraqi refugees with mental health problems The training was delivered to Community-based workers, based in Western Sydney, assisting Iraqi refugees on their resettlement	86 community-based workers in Australia assisting Iraqi refugees (with 26.7% born in Australia, 24.4% in the Middle East) 38.4% in government organisation, with 72.1% with university or higher education. The program did not target individuals with specific mental health condition	Outreach Services Intervention was a 7-hour Mental Health First Aid course, delivered across two sessions in a single day.	Psychoeducation Groups (MHFA training).	*Promotion:* Raises mental health awareness and knowledge through culturally-sensitive education and resources. *Prevention:* Equips participants with skills to recognize and respond early to mental health issues to prevent worsening. *Early Intervention:* Provides Mental Health First Aid training targeting early recognition and response to symptoms in refugees. *Treatment:* Supports existing therapy by teaching effective Mental Health First Aid strategies aligned with evidence-based treatments.	Community setting	Trained Mental Health First Aid instructor (also lead researcher and who had received additional guidance experts)	**Language:** The study used English materials but included a culturally adapted video with Iraqi names/scenarios. **Persons:** The training was delivered by a researcher (but incorporated expert-derived cultural guidelines. **Metaphors:** The intervention used an Iraqi refugee character ("Dawood") in vignettes for cultural relevance. **Concepts:** PTSD/depression were framed using both Western clinical models and culturally sensitive explanations. **Goals of Tx/Program:** Focused on improving workers' ability to provide mental health first aid, not client-derived goals. **Methods:** Simplified MHFA steps but no mention of literary adaptations. **Context:** No adjustments for socioeconomic factors (e.g., session flexibility, family inclusion). **Content:** Incorporated Iraqi cultural values (e.g., patriarchal norms, stigma awareness) but no local remedies/spirituality. **Process:** Adaptations were derived via Delphi expert consensus.	The training workshops for community-based workers demonstrated significant improvements in mental health literacy (MHL), stigma reduction, and confidence in helping individuals with PTSD and depression. Key findings include: **Mental Health Outcomes** Mental Health Recognition & Knowledge • PTSD Recognition: Correct identification of PTSD increased from 56.9% (pre-training) to 76.5% (post-training, p=0.001) and remained high at follow-up (75.1%, p=0.032). • Recognition of PTSD as a general mental health problem rose from 71% to 96.5% ($p < 0.001$) and stayed high (98% at follow-up). • Recognition as a general mental health problem increased significantly (77.9% to 97.7%, $p = 0.004$) and remained high at follow-up (95.6%). • Knowledge Retention: Significant improvement in Mental Health First Aid knowledge post-training ($p < 0.001$), but a decline at 6-month follow-up ($p < 0.001$). Treatment Beliefs & Attitudes • Increased endorsement of evidence-based treatments post-training ($p < 0.001$) • Significant increase in support for professional interventions post-training ($p < 0.001$) and at follow-up ($p = 0.010$). Stigma Reduction

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
											• Significant reductions in "weak-not-sick" ($p < 0.001$) and "dangerous/unpredictable" ($p < 0.001$) stigma post-training. • Social distance decreased post-training ($p = 0.006$) and further at follow-up (*p* < 0.001). Depression: • Reduction in "weak-not-sick" stigma post-training ($p = 0.013$). • Social distance decreased significantly by follow-up ($p = 0.007$). Confidence & Helping Intentions: • Confidence in helping improved for both PTSD ($p < 0.001$) and depression ($p < 0.001$) post-training, with sustained gains at follow-up. •Helping intentions increased significantly post-training ($p < 0.001$) but were not maintained at follow-up. Helping Behaviours: • Only 16 participants reported actual helping behaviours; slight (non-significant) improvement in ALGEE-based helping scores at follow-up. Qualitative Findings Engagement & Attrition: • 86 participants completed pre/post-training assessments. • 41 lost to follow-up (48%), leaving 45 participants at 6-month follow-up.

Extraction Table 3: Grey literature data extraction table (included reports which are not peer reviewed)

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
Slewa-Younan 2019 (114)	Mixed Methods evaluation Funding: South Western Sydney Primary Health Network (SWSPHN) to Mental Health First Aid Australia and Western Sydney University	The report aims to evaluate the effectiveness of teen and Youth MHFA programs adapted for CaLD youth and adults to improve Mental Health Literacy (MHL), reduce stigma, and increase supportive behaviours towards mental health issues among adolescents.	CaLD (Culturally and Linguistically Diverse) communities	Year 10 students (adolescents) and teachers/responsible adults from culturally diverse backgrounds, predominantly refugees and migrants. The program did not target individuals with specific mental health condition	Outreach Services Intervention was school-based classroom delivery (3 × 75-min sessions) for students and 14-h Youth MHFA course for adults, both run on-site during school hours.	Psychoeducation Groups (MHFA training).	Early-intervention / prevention (mental-health first-aid skills & literacy).	Community setting	Youth MHFA instructors trained specifically in CaLD adaptation	**Language:** not applicable **Persons:** CaLD Trainers and advisory group of local CaLD professionals **Metaphors:** Culturally resonant vignettes and Fairfield-specific videos **Concepts:** Culturally adapted mental health using trauma- and resettlement-aware explanations **Goals of Tx/Program:** not applicable **Methods:** Interactive role-plays, local resource list. **Context:** Linked to Fairfield services, and fills gap where no headspace centre exists **Content:** Teen/Youth MHFA plus CaLD scenarios/resources. **Process:** CaLD expert advisory-guided adaptation	The CaLD-adapted teen MHFA significantly improved students' knowledge of appropriate help-seeking sources and intentions to provide appropriate mental health first aid while reducing harmful intentions. Youth MHFA significantly improved adults' knowledge of mental health problems and increased confidence in assisting adolescents. Qualitative Findings • Key challenges: Scheduling issues, limited instructor availability, teacher release difficulties, high dropout rates at follow-up evaluations. • Strengths: First culturally-adapted youth-focused MHFA intervention, and significant improvements in key MHL outcomes. • Weaknesses: Lack of control group, high attrition at follow-up, short follow-up period (3 months).
Vaughan 2020 (115)	Mixed Methods evaluation Funding: Australian Government and the Australian state and territory governments	This report aims to examine how multicultural and refugee services support women facing domestic violence and to identify factors and opportunities to strengthen early mental health and safety interventions.	Migrant and refugee women	Focus on migrant and refugee women who have experienced or are at risk of family/domestic violence, including links with mental health service. Online survey (n = 378 workers) Interview: Provider (n = 47, mix of settlement, multicultural & refugee mental-	Not Applicable Intervention included settlement/ multicultural services, including specialist refugee mental health services	Settlement and mental health service	Early Intervention	Community setting	Community Health Workers (including settlement & multicultural staff) Bicultural/Bilingual Staff	**Language:** service support delivered in English and Arabic, Hindi & Punjabi; use of NAATI-accredited interpreters. **Persons:** bicultural/bilingual staff & volunteers; bicultural clinicians in refugee mental-health services. **Metaphors:** not applicable **Concepts:** not applicable **Goals of Tx/Program:** not applicable **Methods:** participatory, co-design workshops **Context:** builds on settlement agencies as first contact **Content**: Culturally DV-laws orientation, safety-planning, referral flow-charts, self-care & debrief resources for staff **Process:** iterative consult-feedback loops, advisory groups in each state; mixed-method triangulation to refine recommendations	Settlement & multicultural services are a key first point of contact for newly arrived migrant/refugee communities, thus uniquely positioned to identify, prevent, and respond to family violence. Qualitative Findings • Currently, staff often go beyond official role and training to assist women with mental health, safety, and service navigation. • Strengthening factors include organisational support, training for staff/volunteers, bilingual/bicultural workforce, stable cross-sector collaborations, and bridging mental health interventions. • Barriers include limited funding/scope, staff turnover, eligibility issues, communication barriers, engagement difficulties, and fragmented collaboration with mainstream family violence and mental health services.

Author/ Organisation Year	Study design & funding	Study aims	Target population	Population Characteristics	Formats of Service Delivery	Type of Care	Spectrum of care	Service Setting	Provider (s) Type	Cultural Adaptations	Key Findings
				health staff across three states) and Volunteers/front-line FGDs (n = 17, orientation guides & bicultural community volunteers) and Refugee-women (n = 11, 7 Middle-Eastern, 3 Central/South-Asian, 1 Sub-Saharan-African) Participatory workshops (n = 47 women): 2 Arabic-language groups, 1 Punjabi, 1 Hindi The program did not target individuals with specific mental health condition							• Strengths: The study used a combination of surveys, interviews, and focus groups, allowing for robust and in-depth data collection from multiple stakeholder perspectives. • Researchers worked closely with advisory groups in Victoria, South Australia, and Tasmania. • Weaknesses: Although the study considers mental health in relation to family violence, it is primarily focused on domestic and family violence responses. Broader mental health service issues may be underexplored.
Woodland 2019 (116)	Evaluation: Mixed-methods Funding: Central and Eastern Primary Health Network (CESPHN) with in-kind support from the Multicultural Health Service, South Eastern Sydney Local Health District (SESLHD).	This report aims to evaluate the acceptability, cultural relevance, and clinical utility of a group-based mindfulness intervention for Arabic-speaking and Bangla-speaking communities, including its impact on	Arabic-speaking and Bangla-speaking	Arabic-speaking and Bangla-speaking participants. Predominantly female, mix of newly arrived migrants/refugees and long-term residents. Most born overseas (e.g., Middle East, Bangladesh). The program did not target individuals with	Outreach Services Intervention included....	Psychoeducation Mindfulness-Based Intervention	Early-intervention / prevention	Community setting	Mental health clinicians Community workers	**Language:** all materials & sessions in Arabic or Bangla **Persons:** bilingual mental-health clinicians, bilingual community workers, NAATI translators prepared materials **Metaphors:** exercises linked to familiar imagery **Concepts:** reframed mindfulness as compatible with Islamic/Buddhist prayer, salah, dhikr & daily ritual; stress explained through culturally relevant roles. **Goals of Tx/Program:** reduce distress, build self-compassion, normalise help-seeking, strengthen community connections **Methods:** group dialogue, story-sharing, facilitator modelling, in-language guided practice, weekly calls	Mental Health Outcomes • High engagement and retention (81%). • Statistically significant decreases in depression, anxiety, stress, and general distress (DASS 21 & K10) from baseline to end of program. • Participants reported better daily functioning and reduced social isolation. Qualitative Findings • "Train the Trainer" approach built workforce capacity (76 bilingual workers trained). • Language barriers and cultural stigma around mental health were noted as common issues for CaLD communities. • Ensuring translations and examples were culturally relevant. • Strengths: High retention rates, pre-post outcomes, culturally tailored resources, in-

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		reducing psychological distress, depression, anxiety, and stress.		specific mental health condition						**Context:** delivered in trusted community settings **Content:** 5 guided modules **Process:** resources co-designed with bilingual working groups	language facilitation, and built workforce capacity. • Weaknesses: Focus on only two language groups, program depends on availability of bilingual clinicians and community workers.
Valibhoy 2014 (117)	Qualitative Interviews Funding: Sidney Myer Fund and William Buckland Foundation	This report aims to explore how young refugees perceive and experience mental health services in Australia and to inform practitioners on effective, evidence-based engagement and support strategies.	Refugees	Refugee-background youth (ages 18–25) who have used or attempted to use mental health services in Australia The program did not target individuals with specific mental health condition.	Not Applicable	Mental health services across public, private, NGO, and educatio n sectors	Not Applicable	Community Setting	Mental health practitioners Interpreters (occasionally involved)	**Language:** interpreters used **Persons:** qualified on-site or phone interpreters & translators **Metaphors:** not applicable **Concepts:** not applicable **Goals of Tx/Program:** not applicable **Methods:** contextualised listening and systemic advocacy **Context:** forced migration, family separation, settlement stress, cultural norms. **Content:** psychoeducation on confidentiality & normalising help-seeking **Process:** flexible intake, outreach, session length; continuity of care.	**Qualitative Findings** • Many youth had negative or inaccurate understandings of mental health services (e.g., “seeing a counsellor means you’re crazy”). Confidentiality concepts were often unfamiliar. • A caring, friendly practitioner was crucial for engagement. • Youth often experienced the relationship as more personal (e.g., a friend, sibling, or parental figure), possibly due to missing family/support structures. This can foster deeper trust, but requires careful navigation of boundaries. • Cultural norms often discourage sharing personal issues with strangers. Youth need time to build trust and disclose at their own pace. • Youth’s distress is linked to past and ongoing traumas (e.g., family members at risk overseas). They vary in whether retelling details of trauma is helpful. • Practitioners should avoid assumptions, show interest in the young person’s background, acknowledge diversity (even within the same ethnic group), and be open-minded. • Interventions must fit clients’ needs, considering the practicality and relevance of strategies for their lives (e.g., advice about sleep hygiene may or may not align with the individual’s lived experiences). • Assistance with stressors like housing, employment, financial and legal matters was paramount; mental health professionals were sometimes the only source of support. • While beneficial, youth highlighted interpreter quality concerns (judgments, omissions). Specialized mental health interpreting skills are needed. • Young refugees benefit from services that allow quick access, flexible session times, continuity of care, and direct outreach. Excessive waiting

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											times, short sessions, or frequent handoffs to new practitioners can be detrimental. • Challenges: Misinformation and stigma about mental health and confidentiality; Discomfort with self-expression and emotional disclosure outside of family; Practical barriers (housing, financial, academic, legal) and ongoing trauma in home countries; Insufficiently flexible and context-aware service systems that do not address refugee-specific realities • Strengths: First-person narratives from diverse refugee youth reveal genuine needs and preferences • Weaknesses: Small sample size (n=16) though from diverse backgrounds; Relies on self-reported experiences
So 2023 (118)	Mixed Methods evaluation Funding: NSW Government through the Refugee Health Flexible Fund 2021-22 to 2022-23	This report aims to enhance timely, culturally responsive, and trauma-informed emotional wellbeing services for Afghan and Tamil-speaking Sri Lankan refugee and asylum seeker communities in Western Sydney through the implementation and evaluation of a short-term "Emotional Wellbeing Clinic" offering psychological	Refugee and Asylum Seeker	Recently arrived refugees (≤5 years in Australia) The program did not target individuals with specific mental health condition, it mention mixed emotional distress, including sleep disturbance, anxiety, low mood.	Online delivery (phone or secure video). Intervention includes up to 10 sessions of brief psychotherapy	Mental health services	Early-intervention	Primary Care/GP Clinic	Bilingual mental health clinicians (psychologists, social workers) Interpreters Supervision by senior clinical leads	**Language:** in-language sessions (Dari, Hazaraghi, Pashto, Persian, Tamil) & translated handouts/videos **Persons:** bilingual/bicultural clinicians (psychologists, SWs, MHPNs), bilingual community & settlement workers, interpreters & translators **Metaphors:** not applicable **Concepts:** explanatory models integrate trauma, displacement, settlement stress & somatic idioms **Goals of Tx/Program:** restore refugee or asylum seekers' day-to-day functioning, reduce distress, strengthen autonomy, link to community resources **Methods:** flexible scheduling, semi-structured narrative interviewing, transfer services **Context:** visa insecurity, settlement stress **Content:** stress & sleep psychoeducation, audio in Dari/Tamil, practical problem-solving **Process:** holistic intake and bilingual reminder texts	Qualitative Findings • Large unmet mental health needs in Afghan and Tamil-speaking Sri Lankan communities, especially women, newly arrived, with limited English proficiency. • Essential to allow multiple session formats (in-person, phone, video) and to prioritize trust, autonomy, and culturally appropriate psychoeducation. • Many clients needed help with practical issues (housing, legal, financial) before focusing on psychological distress. Social prescribing was beneficial. • Difficulty hiring bilingual clinicians. Used short-term sessional staff or interpreters. Partnerships with NGOs, settlement services, and primary healthcare providers were crucial for referrals and continuity. • Challenges: Recruiting suitably qualified bilingual clinicians; Engaging underrepresented groups (e.g., Tamil-speaking asylum seekers) with complex mistrust of government services; Short funding constraints; Navigating electronic medical record systems and confidentiality considerations • Strengths: Built on existing TMHC infrastructure and networks • Weaknesses: Some target groups (Tamil-speaking Sri Lankan) not fully reached due to stigma and recruitment barriers; Lack of formal

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		support and care coordination									outcome measures for all clients (WHOQOL-BREF, K10 only partially completed)
De Silva 2020 (119)	Mixed Methods evaluation Funding: Victorian Transcultural Mental Health (VTMH)	The report aims to document and review a 3-phase partnership (2015-18) between VTMH and Neami National aimed at strengthening organisational cultural responsiveness across community sites of mental health service.	CaLD (Culturally and Linguistically Diverse) communities	Focus on improving service access and cultural safety for people from culturally and linguistically diverse backgrounds who use Neami's psychosocial programs. The program did not target individuals with specific mental health condition; goal is improved cultural safety & access for all CaLD service-users.	Delivered via workshops; Reflective Team Sessions; Mentoring; Organisational Change Activities	Organisational capacity-building	Early Intervention	Community-Based Service	Bicultural/Bilingual Staff	**Language:** interpreter guideline, bilingual recruitment **Persons**: transcultural consultants (some bilingual clinicians) **Metaphors**: not applicable **Concepts**: equity & rights and cultural safety practice integrated **Goals of Tx/Program:** safe access, meaningful participation **Methods**: reflective practice, co-production workshops **Context:** transcultural and community mental health service **Content:** case-based discussions and organisational self-audit **Process**: ongoing feedback loop (staff and organization leaders engaged in an iterative cycle of culturally planning, action, reflection, and adjustment).	**Qualitative Findings** • Internal champion network established at all sites. • 20 training events to 232 staff, and 81–90 % reported positive impact on practice/workplace. • Updated intake procedures, language-service guidelines, and diversity standards. • Advocacy led to increased NDIS language-services funding. • Sector upheaval from NDIS reforms caused staff turnover & program closures, risking continuity. • Strengths: whole-of-organisation approach, sustained leadership buy-in, capacity-building focus enabled sustainability. • Weaknesses: No client-level outcome data; relies on self-reported staff change.

Appendix F: Characteristics of participants by group

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Participant characteristics by group													
	NG1 Fairfield	**NG2 Westmead**	**NG3 Adelaide**	**NG4 Kalgoorlie**	**NG5 Perth**	**NG6 Wollongong**	**NG7 Kensington**	**NG8 Brisbane**	**NG9 Townsville**	**NG10 Melbourne**	**NG11 Geelong**	**NG12 Shepparton**	**Total**
Total number of participants	10	9	14	9	8	11	6	8	5	9	4	2	95
Stakeholder category													
Multicultural mental health service user- client or carer	3	3	3	2	3	2	2	3	-	3	3	1	28
Mental Health care provider	3	3	6	4	3	4	1	2	2	4		1	33
Multicultural mental health service provider or leader	4	3	5	3	2	5	3	3	3	2	1	-	34
Age groups (number)													
18- 24 years	1	-	-	-	-	-	-	-	-	-	2	-	3
25-34 years	2		3	2	3	1	2	4	3	2	1	-	23
35-44 years	2	2	4	4	1	2	2	1	1	4	-	1	24
45- 54 years	3	3	4	1	2	1	2	2	1	1	1	-	21
55- 64 years	-	4	3	2	1	7	-	1	-	1	-	1	20
65 years and older	2	-	-	-	1	-	-	-	-	1	-	-	4
Female	6	5	13	8	6	8	5	7	2	7	2	-	69
Male	4	4	1	1	1	3	1	1	2	2	2	1	23
Non-binary	-	-	-	-	1	-	-	-	-	-	-	1	2
Prefer not to say	-	-	-	-	-	-	-	-	1	-	-	-	1
Length of time in Australia (years)													
Mean (SD)	24.71 (15.03)	18.29 (8.83)	19.43 (16.70)	23.30 (22.25)	24.86 (13.74)	26.25 (16.59)	11.58 (5.39)	19.38 (12.45)	18.20 (18.46)	26.75 (18.05)	12.0 (8.04)	-	-
Median	20	19	16	14.5	29	20	12.5	15	10	30.5	13.5	-	-
Languages mainly spoken at home													
	Assyrian Arabic Chaldean Serbian	Dari Italian Nepali	Arabic Dari English Farsi French Indonesian Kirundi Malay Pashto Punjabi	English Hindi Ngaanyatjarra Punjabi Shona Tamil	Anuak Burmese (Myanmar) Chinese Mandarin English Fullah Krio Urdu	Arabic Burmese English Farsi Karen languages Karenni Spanish	Chinese Mandarin Hainanese Surinamese Dutch Swedish	Bengali Dari English Farsi Hindi Korean Punjabi Somali Urdu	English French Lingala Swahili Tagalog Vietnamese	Arabic Dari English Haryanvi Hindi Mandarin Oromo Somali	English Hausa	English	-

			Spanish Tamil Urdu										
Country of birth													
	Australia Iraq Iran Serbia Syria	Afghanistan Austria Nepal	Afghanistan Australia Colombia Egypt Israel Kosovo Malaysia Pakistan Tanzania Vietnam	Australia Ghana India New Zealand South Africa Zimbabwe	Australia South Africa Sierra Leone Ethiopia Pakistan Myanmar	Argentina Australia Canada Iran Myanmar Palestine	China Sweden Taiwan	Afghanistan Bangladesh Ethiopia Iran New Zealand Pakistan South Africa South Korea	Australia DR Congo Kenya Philippines Vietnam	Afghanistan Australia China Ethiopia India Malaysia Saudi Arabia	Ghana Liberia Nigeria	Australia DR Congo	-

Appendix G: Voting and ranking of principles, results by group

Appendix G: Voting and ranking of principles, results by group

Principles	NG1 Fairfield (n=10)			NG2 Westmead (n=9)			NG3 Adelaide (n=13)			NG4 Kalgoorlie (n=8)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Use the right language	32	9	1	16	5	4	12	5	6	1	1	13 tie
2. Go beyond translation/Deliver culturally appropriate care	10	4	5 tie	32	8	1	30	9	2	6	2	10
3. Work with the community from the start	24	6	2	18	5	3	20	6	5	15	5	2
4. Support all levels of mental health care	16	5	3	7	3	7 tie/8	6	4	9	14	5	3 tie
5. Be flexible with time and location	10	3	5 tie/6	7	3	7 tie/8	2	2	11	1	1	13 tie
6. Avoid mental illness stigma	3	2	10	10	3	5	11	4	7	9	2	6
7. Staff who understand the culture and language	11	5	4	2	1	12	23	7	4	4	2	12
8. Use data that matters	5	3	9	1	1	13 tie	3	2	10	0	0	15
9. Be trauma-informed and strengths-based	8	4	7	19	5	2	7	3	8	7	2	7 tie/9
10. Be agile to fill service gaps	2	2	11	3	1	10 tie	1	1	12	5	2	11
Group-generated												
1. Adopt a systems approach/Build connections	6	2	8				53	15	1			
2. Address social determinants and settlement issues				1	1	13 tie				14	4	3 tie/4
3. Address regional community needs										7	3	7 tie
4. Address mental health across the lifespan				3	1	10 tie						
5. Holistic models of care – Work with intersectionality and complexity										16	4	1
6. Build multicultural mental health workforce				7	4	7 tie				14	4	3 tie/4
7. Recognise and use lived experience										7	3	7 tie
8. Support carers and family												
9. Strengthen governance and infrastructure				8	3	6						
10. Policy frameworks that emphases equity and inclusion							27	7	3			
11. Develop culturally tailored in-language resources				1	1	13 tie						
12. Build awareness among service providers and communities												

Principles	NG5 Perth (n=8)			NG6 Wollongong (n=11)			NG7 Kensington (n=6)			NG8 Brisbane (n=8)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Use the right language	10	2	5 tie/6	19	5	3 tie/4	2	2	8	9	3	7
2. Go beyond translation/Deliver culturally appropriate care	14	4	3	2	5	1	8	4	6	19	6	2
3. Work with the community from the start	7	4	8	13	3	7 tie/8	6	2	7	21	7	1
4. Support all levels of mental health care	5	2	11	13	6	7 tie	15	5	3 tie	15	4	3
5. Be flexible with time and location	16	5	2	10	4	9	0	0	9 tie	0	0	12
6. Avoid mental illness stigma	6	3	9 tie	7	2	11	15	5	3 tie	6	2	8
7. Staff who understand the culture and language	6	2	9 tie/10	19	7	3 tie	16	4	1 tie	14	4	4
8. Use data that matters	0	0	13	1	1	13	0	0	9 tie	5	2	9
9. Be trauma-informed and strengths-based	21	5	1	16	6	5	12	4	5	13	6	5 tie
10. Be agile to fill service gaps	9	3	7	9	4	10	0	0	9 tie	3	1	10
Group-generated												
1. Adopt a systems approach/Build connections	10	3	5 tie	2	1	12						
2. Address social determinants and settlement issues										13	4	5 tie/6
3. Address regional community needs												
4. Address mental health across the lifespan												
5. Holistic models of care – Work with intersectionality and complexity												
6. Build multicultural mental health workforce												
7. Recognise and use lived experience												
8. Support carers and family	3	2	12	20	6	2						
9. Strengthen governance and infrastructure							16	4	1 tie			
10. Policy frameworks that emphases equity and inclusion				15	5	6						
11. Develop culturally tailored in-language resources										2	1	11
12. Build awareness among service providers and communities	13	5	4									

Principles	NG9 Townsville (n=5)			NG10 Melbourne (n=9)			NG11 Geelong (n=4)			NG12 Shepparton (n=2)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Use the right language	6	3	5 tie	2	1	10	0	0	10 tie	0	0	8 tie
2. Go beyond translation/Deliver culturally appropriate care	10	3	3 tie	25	8	2	5	2	6 tie	7	2	2
3. Work with the community from the start	15	3	1	15	5	4	1	1	9	3	1	4 tie
4. Support all levels of mental health care	12	3	2	22	8	3	14	4	1	9	2	1
5. Be flexible with time and location	4	2	8 tie	4	2	8 tie	0	0	10 tie	1	1	6
6. Avoid mental illness stigma	5	3	7	4	1	8 tie/9	10	3	2	0	0	8 tie
7. Staff who understand the culture and language	4	1	8 tie/9	10	4	5 tie/6	8	2	3	3	1	4 tie
8. Use data that matters	2	1	10	7	3	7	4	2	8	0	0	8 tie
9. Be trauma-informed and strengths-based	6	2	5 tie/6	0	0	11	6	3	5	1	1	7
10. Be agile to fill service gaps	10	3	3 tie	10	5	5 tie	7	2	4	6	2	3
Group-generated												
1. Adopt a systems approach/Build connections												
2. Address social determinants and settlement issues							5	1	6 tie/7			
3. Address regional community needs												
4. Address mental health across the lifespan												
5. Holistic models of care – Work with intersectionality and complexity												
6. Build multicultural mental health workforce												
7. Recognise and use lived experience												
8. Support carers and family	1	1	11									
9. Strengthen governance and infrastructure				36	8	1						
10. Policy frameworks that emphases equity and inclusion												
11. Develop culturally tailored in-language resources												
12. Build awareness among service providers and communities	0	0	12									

Appendix H: Voting and ranking of enablers, results by group

Appendix H: Voting and ranking of enablers, results by group

Enablers	NG1 Fairfield (n=9)			NG2 Westmead (n=9)			NG3 Adelaide (n=7)			NG4 Kalgoorlie (n=7)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Support the bilingual/bicultural health workforce	19	8	4 tie	20	8	2 tie	15	4	3	8	3	6
2. Provide friendly, welcoming services	29	9	1	20	6	2 tie/3	13	4	4 tie	9	5	5
3. Ensure privacy and confidentiality	13	4	6	16	6	4	6	2	8	11	5	4
4. Work together across services	26	8	3	11	5	6	17	6	2	15	5	3
Group-generated												
1. Improve accessibility	19	6	4 tie/5				13	3	4 tie/5			
2. Work with communities	27	9	2	5	1	9 tie	20	6	1	43	12	1
3. Collect culturally relevant client and local community data	2	1	7							19	5	2
4. Systemic change – Develop governance and policies												
5. Conduct community awareness and education campaigns				14	5	5						
6. Create multilingual resources				6	2	8	7	3	7	0	0	7
7. Address social inequity and other contextual factors							12	5	6			
8. Access religious and spiritual support				5	1	9 tie	2	2	9			
9. Support and involve families				10	4	7						
10. Provide early intervention				23	7	1						
11. Address mental health needs of clients with disabilities												
12. Build capacity all sectors												
13. Prioritise practitioner self-care												

Enablers	NG5 Perth (n=7)			NG6 Wollongong (n=3)			NG7 Kensington (n=6)			NG8 Brisbane (n=8)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Support the bilingual/bicultural health workforce	18	5	3 tie	5	1	4 tie/6	18	5	1	28	7	1
2. Provide friendly, welcoming services	11	5	3 tie/5	5	2	4 tie/5	10	5	6	12	5	6
3. Ensure privacy and confidentiality	6	2	7	4	1	7	3	2	8	2	1	8
4. Work together across services	12	5	3 tie/4	10	3	1	13	6	2 tie	7	3	7
Group-generated												
1. Improve accessibility	20	6	2	5	3	4 tie	13	4	2 tie/3			
2. Work with communities	27	7	1				13	3	2 tie/4			
3. Collect culturally relevant client and local community data							0	0	9	13	6	5
4. Systemic change – Develop governance and policies							12	3	5	15	4	4
5. Conduct community awareness and education campaigns				7	2	3				17	6	3
6. Create multilingual resources												
7. Address social inequity and other contextual factors				9	3	2	8	2	7			
8. Access religious and spiritual support												
9. Support and involve families												
10. Provide early intervention												
11. Address mental health needs of clients with disabilities	7	3	6									
12. Build capacity all sectors										26	8	2
13. Prioritise practitioner self-care												

Enablers	NG9 Townsville (n=5)			NG10 Melbourne (n=7)			NG11 Geelong (n=4)			NG12 Shepparton (n=2)		
	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank	Sum	Count	Rank
Literature-generated												
1. Use the right language	14	4	3	23	7	3	9	3	3 tie/4 tie	8	2	1
2. Go beyond translation/Deliver culturally appropriate care	19	5	1 tie	12	7	4	13	3	1	5	2	3 tie
3. Work with the community from the start	4	3	6	2	1	6	12	3	2	0	0	7
4. Support all levels of mental health care	19	5	1 tie	8	6	5	3	2	7	2	1	6
Group-generated												
1. Improve accessibility	7	3	5							7	2	2
2. Work with communities												
3. Collect culturally relevant client and local community data							5	2	6			
4. Systemic change – Develop governance and policies	12	5	4	29	7	2	9	3	3 tie/4 tie			
5. Conduct community awareness and education campaigns				31	7	1						
6. Create multilingual resources												
7. Address social inequity and other contextual factors												
8. Access religious and spiritual support												
9. Support and involve families										5	2	3 tie
10. Provide early intervention												
11. Address mental health needs of clients with disabilities												
12. Build capacity all sectors										3	1	5
13. Prioritise practitioner self-care												