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Effectively supporting Culturally and Linguistically Diverse (CALD) young people with their mental health and wellbeing – does this matter or exist in Australia?

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Abstract

This paper presents a systematic review that assessed the different types of mental health programs and interventions available for young people from Culturally and Linguistically Diverse (CALD) backgrounds in Australia, and identified core elements of practice for supporting the mental health of CALD youth, and key barriers that preclude CALD youth from engaging with mental health services. A total of 19 articles met inclusion criteria and a total of six distinct practices were identified: (1) personalization, identity and recognition of trauma; (2) creative expression; (3) cultural competence; (4) self-efficacy and empowerment; (5) social connections and relationships; and (6) information and content delivery. Key barriers related to engagement with CALD youth mental health programs included language and literacy barriers, stigma and shame, and service providers' limited cultural competency, and lack of diverse understandings of wellbeing. The findings from this review suggest several avenues for ensuring practice effectively meets the unique mental health needs of CALD young people and reduces barriers to their access and engagement.

Keywords: Culturally and Linguistically Diverse, CALD, young people, mental health, Australia, practice

Introduction

Australia is a highly multicultural nation, with the latest census revealing nearly half of Australians (48%) have a parent born overseas, and over a quarter (28%) report being born overseas (ABS, 2022). The term, *Culturally and Linguistically Diverse* (CALD), is often used to represent this diversity. CALD is typically used in Australian services and public policy to distinguish people with ethnic minority backgrounds from Anglo or Indigenous backgrounds (Katz, 2015). While other English-speaking countries use terms like Black and minority ethnic (BME)" in the UK, or "Black, Indigenous, people of colour (BIPOC)" in the US, one criticism of CALD is that it represents a highly diverse group which can mask racial and socio-economic barriers faced by ethnic minorities (Sawrikar & Katz, 2009). Indeed, health and social policy scholars have pointed out that CALD is defined and applied inconsistently across different contexts (Pham et al., 2021; Roberts, 2014; Sawrikar, 2017).

Because the CALD term inadvertently treats a range of migrants, refugees, or native-born non-Anglo Australians as a single category, one consequence is that services may not be well-equipped to provide culturally appropriate and tailored services to meet the needs of particular communities. Youth mental health is one such area that has been receiving a great deal of recent attention. Findings from the nationally representative and longitudinal Household, Income and Labour Dynamics in Australia (HILDA) study revealed that rates of psychological distress among Australians have increased to 30% in 2019 (compared to 21%) in 2007) and the most vulnerable group appear to be young people in the 15-24 age group (Wilkins et al., 2021). While there are limited empirical studies that directly compare mental health outcomes and service usage between groups, numerous sources suggest that there are lower rates of health service utilisation among CALD youth when compared to non-CALD youth (Commissioner for Children and Young People WA, 2013; Hugo et al., 2014; Roberts, 2014). For certain cultural groups in CALD communities, there may be a reluctance to seek

help due to stigma toward mental illness (Productivity Commission, 2020). In addition, CALD young people from non-English migrant or refugee backgrounds are likely to have unique mental health needs due to unique challenges they experience including discrimination, pre-migration stress or trauma, a sense of displacement, lack of social supports, intergenerational family conflict, and navigation of cultural identity and expectations from family and community (Kaur, 2012; Roberts, 2014).

The detrimental impacts of mental ill-health when not effectively addressed can directly or indirectly permeate all aspects of people's lives, resulting in distress, disrupted education and employment, breakdown of relationships, stigma, and loss of life satisfaction or opportunities (Productivity Commission, 2020). For CALD youth experiencing mental health issues, their unique experiences and needs combined with the specific barriers they face accessing and receiving appropriate mental health support means they are likely to suffer poor outcomes in the absence of culturally appropriate and evidence informed interventions. It is vital that the benefits of multiculturalism that are continually recognised in Australia are applied to service delivery and practice in a way that reflects the diversity of the population. This paper provides a systematic review of the different types of mental health interventions available for young people from CALD communities in Australia. Whilst the use of CALD is problematic (as raised earlier), the term will be used in this paper because of its widespread usage in service provision, and it will focus on people who are born in a non-English speaking country or whose family originates from a non-English speaking country, including refugees and asylum seekers, and for whom would be considered part of an ethnic minority group in Australia.

CALD youth and seeking help for mental health issues

CALD young people are a highly diverse group, with differences in help-seeking based on the specific cultural groups they identify with, whether they are Australian or overseas-born, their journeys to Australia, and the level of family or social support they receive (Roberts, 2014; Wyn et al., 2018). Current models of practice in psychology, social work, and public health often do not recognize the unique experiences of CALD children, young people, and families experiencing vulnerability as these disciplines adhere to Western frameworks of child and youth development ([Author names omitted for blind review]; Shepherd et al., 2021). For CALD communities, the lack of mental health knowledge surrounding available services, a distrust of those services and the cultural stigma associated with emotional wellbeing and help-seeking are prominent (Brown et al., 2016). In addition to cultural stigma, current scholarly and practice knowledge suggests that young people are reticent to approach mental health service because mainstream therapeutic interventions are traditionally not cognizant of diversity and marginalization (Valibhoy et al., 2017). Limitations of Western counselling and psychotherapy models are also argued to play a role in the continuing exclusion and oppression of marginalized communities (Ziaian, 2012).

Currently, there is very little research on how to support the mental health of CALD youth in Australia. A systematic review by Savaglio et al. (2022) of community mental health programs for Australian youth aged 10-25 years within the past 10 years identified a significant gap in the number studies representing Aboriginal and Torres Strait Islander and CALD young people. In focusing on migrant or refugee communities in the UK, USA, Norway, the Netherlands, and Australia, a systematic review of 11 studies by Colucci et al. (2014) found an underutilization of mental health services by children and young refugees and mental health support needs were not well met. One conclusion from this review was that

most policies and programs for refugee children and youth in countries of resettlement were based on minimal evidence and there was a vital need for further research.

The review of Marshall et al. (2016) of mental health counselling approaches for refugee youth in Canada suggested several factors are important for effective practice. For example, cultural competency of practitioners is vital as well as a capacity to establish trust and safety with refugee youth. It was also important to acknowledge the strength and resilience of refugee youth, which is often underplayed in discussions about their mental health. Extending counselling to the family unit could also be appropriate for some youth, as well as the adoption of creative therapy techniques or online environments to support and engage refugee youth in a tailored way. Similarly, a synthesis of preventative mental health interventions for refugee children and adolescents by Fazel and Betancourt (2018) indicated that interventions which draw on creative arts, drama therapy, creative expression workshops, and art therapy appeared to produce better outcomes for children, whereas there is little evidence to support the use of acute mental health interventions such as psychological first aid.

The current literature on mental health interventions for people from diverse communities mostly originates from countries other than Australia. It is important that there is a focus on the CALD youth in Australia as a specific region because there are limitations to extracting findings from research conducted in other countries. The composition, histories, and socioeconomic factors of racially and ethnically diverse communities differ for each country. CALD is not used universally, and terms used to categorize racial and ethnic minorities vary across countries. In aligning with the current landscape of support for improving CALD young people's mental health, the findings from this review will provide a more nuanced understanding of how programs and interventions in Australia can be better suited for CALD young people than mainstream models. Previous studies have indicated the need for inclusion and diversity to be a key focus for service provision to help resolve racism and discrimination

in the helping professions (Brown et al., 2016). This includes recognizing how sociocultural factors impact young refugee peoples' perceptions of mental health and, if help is sought, who can provide diverse interventions that work well for the young person.

Aims and research questions

Despite repeated calls for a need to focus on the mental health needs of CALD youth in Australia, there is still very little research on this topic. To expand the existing knowledge and practice base, this paper aimed to review and synthesize information about the types of programs and interventions that exist in Australia for CALD youth and identify key common practice components that successfully engage and support their mental health outcomes. The review also sought to identify and summarize barriers to the uptake of mental health services for CALD young people. The key research questions in this systematic review are:

- For CALD young people in Australia, what programs or interventions exist in Australia that address mental health issues?
- What are the core components of these programs that are associated with improvements in engagement and mental health outcomes for CALD young people?
- What barriers exist that preclude CALD young people from taking up mental health services?

Methods

This systematic review utilizes a 'common elements' approach in which the evidence is evaluated to identify discrete practices or techniques for engaging with clients and eliciting behavior change (Centre for Evidence and Implementation, n.d). This involves exploring evidence-based 'kernels' of practice within the 'ear of corn' of a program or intervention (Embry and Biglan, 2008; Weisz et al., 2011) to determine what specific practices are shared

across interventions that address mental health outcomes for CALD youth. The use of this perspective enables the identification of useful program components that can inform practice development to address the needs of the specific population, and goes beyond simply implementing a manualized program which are often resource intensive and costly.

Inclusion and Exclusion Criteria

Based on the PICOS (Participants, Interventions, Comparators, Outcomes, and Study design), the inclusion criteria for the scope of the review were as follows.

Types of participants. Studies were in scope if the primary recipient of the program or intervention was a young person aged 12-25 years living in Australia who identified as Culturally and Linguistically Diverse (CALD) and exhibited signs of mental distress. CALD is a broad term to describe any person of non-English speaking background or whose first language is not English, as well as a person born in a non-English speaking country or whose family originates from a non-English speaking country. Studies reporting on interventions where the target recipient is not the CALD young person were excluded.

Types of interventions. All forms of mental health interventions to assist a young person with mental health presentation, including counselling (the process of meeting with a professional who has counselling skills) and therapy (the process of meeting with a professional trained as a therapist) were included in the review scope. Where the article did not mention a specific mental health intervention or program, but provided detailed accounts of barriers to uptake of mental health services among CALD youth, the article was included.

Types of comparison groups. Because the scope of the review was broad to capture all types of studies, all types of comparison group were in scope, as were studies that contained no comparison group.

Types of outcomes. Studies were included if they considered these specific outcomes related to a reduction in mental health symptoms and engagement with service: the promotion of

helping seeking behavior, effective engagement with service, improvement in mental health, and decrease in mental distress. There were no constraints placed on how these outcomes were operationalized or measured in studies.

Types of study designs. All types of empirical study designs were included, including randomized controlled trials (RCTs), quasi-experimental designs (QEDs), pre-test/post-test designs, descriptive and qualitative studies, and case studies. Systematic reviews (with or without meta-analyses), literature or narrative reviews, books, theses, dissertations, conference proceedings, editorials, and book chapters were excluded.

Search and Screening Process

Following initial consultations with the university librarian, a search strategy was devised to locate relevant articles in the following electronic databases to cover a range of disciplines: ERIC, CINAHL, Medline, PSYCINFO, Social Services Abstracts, MAIS: Multicultural Australia and Immigration Studies, Family and Society Studies Worldwide, FAMILY: Australian Family & Society Abstracts, and A+Education. The Campbell Collaboration and Cochrane Library databases were also searched for relevant systematic reviews through a keyword search.

Each database was searched based on Boolean-paired key words related to young people, culturally and linguistically diverse, mental health, engagement, mental health programs or services, and Australia. Search terms were adapted based on the requirements of individual databases. Searches in electronic databases were limited to studies published in peer-reviewed journals in the English language between January 2010 and September 2022. The search terms are shown in Table 1.

Table 1. Search terms used in electronic databases

Number	Search string
1	"young people" OR "young person" OR "young adult" OR "young m*n" OR "young wom*n" OR youth* OR teen* OR juvenile* OR adolesc* OR minor OR minors
2	immigrant* OR immigrat* OR refugee* OR migrant* OR culture* OR cultural* OR multicultur* OR multi-cultur* OR ethnocultur* OR ethno-cultur* OR minorit* OR diversity OR diverse OR ethnic* OR linguistic* OR "culturally and linguistically diverse" OR CALD
3	"mental health" OR "mental disease" OR "mental disorder*" OR "mental illness*" OR "mental problem*" OR "mental distress" OR depression OR schizophrenia OR "mood disorder" OR "bipolar disorder" OR "bi-polar disorder" OR anxiety OR "posttraumatic stress disorder" OR "post-traumatic stress disorder" OR "trauma*" OR "suicid*" OR "self harm" OR "help seeking behaviour" OR "help seeking behavior" OR participation OR engagement
4	intervention OR program* OR treatment OR service OR "counselling" OR "counseling" OR "therapy"
5	Australia*

Note. MeSH terms were included and adjusted for each database.

A targeted internet search for grey literature was conducted in key mental health organizations, agencies, and services in Australia to supplement the man search. This involved key word searches (e.g., “mental health services”, “young people”, “culturally diverse”) and manual browsing of article lists. Published and unpublished documents, including reports and practice guides within the review scope were included. Only documents available online were included.

Articles were initially screened by the four authors for relevance based on title and abstract. An initial interrater reliability check was conducted by randomly selecting 20 articles for independent screening; there was 95% concordance between screeners. The remaining references were then evenly distributed between authors and independently sorted into

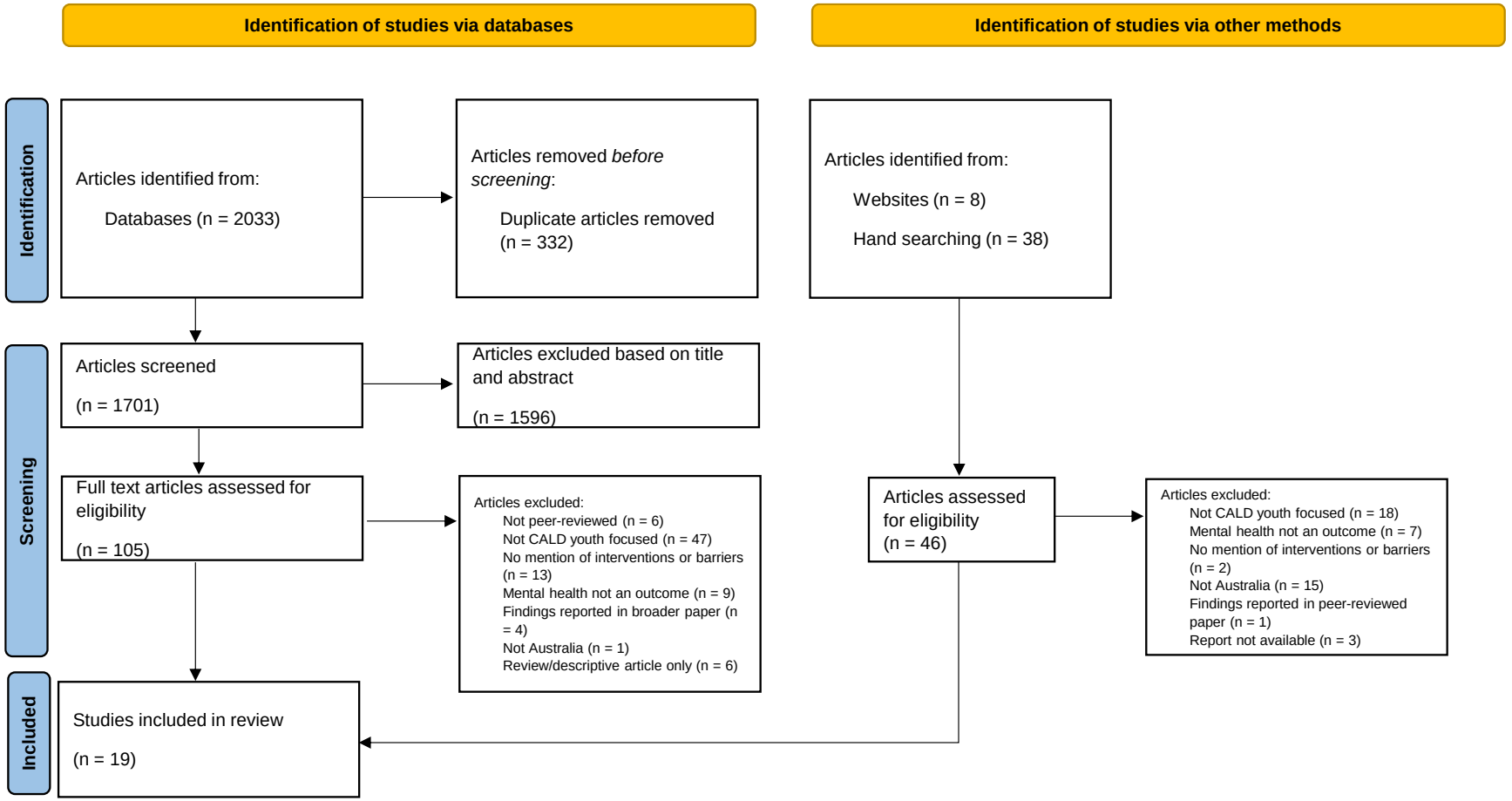
'relevant' or 'not relevant'. Uncertainty about the inclusion of specific references were resolved through discussion between authors.

Following title and abstract screening, the four authors screened the full-text articles to determine inclusion. A separate form based on the PICOS was prepared in which screeners needed to record whether the article: (1) was peer-reviewed, (2) involved CALD young people aged 12-25 in Australia as participants, (3) mentioned an intervention or barriers to engagement, and (4) examined mental health or engagement with services as an outcome. Based on this information, the screener determined whether the article was included or excluded. Any uncertainties or discrepancies were resolved through discussion.

Study Selection

Figure 1 presents a PRISMA diagram of references included in the review (Page et al., 2020). After duplicates were excluded, a total of 1701 peer-reviewed articles obtained via database searches were examined. A total of 1596 was excluded at title and abstract screening, and a further 84 full references were excluded after the full texts were reviewed. A further 46 articles were located via websites and hand searching reference lists of included articles. From these, 44 were excluded for not meeting inclusion criteria at full text review. The final number of references included in the review was 19 (see supplementary material).

Figure 1. PRISMA diagram



Data Extraction

A template was developed based on the research questions to extract information from each article. The template was modified following piloting with three initial articles. Table 2 shows the information collected from each reference, including publication details (e.g., state where study was conducted); details of PICOS; study sample, methods, and findings; program information; and identified barriers to uptake of mental health services. Where information for a specific field was not available in the article, the field was recorded as "NS" (not specified). Further exclusion of articles occurred during data extraction when it was discovered that the full-text did not meet inclusion criteria. The reference lists of studies were hand searched for further references that may be relevant. Quality appraisal of the papers in the review was not carried out due to the heterogeneity of study designs. Instead, the focus of this review was to explore and describe the diversity of research studies available on CALD youth mental health in Australia.

Table 2. Data extraction template to collect article information

Field	Details
Reference	Citation details
State	State in Australia where study was conducted
Population	Summary of population
Intervention(s)	Summary of intervention type
Design	Summary of study design; e.g., RCT, QED, Descriptive, Systematic review
Outcome(s)	Summary of study outcomes; e.g., engagement, mental health outcome
Aim of the study	Aims of the study
Methods of the study	Methods used in the study
Sample size	Sample size in the study
Age range	Age range of young people in the study
Cultural background(s)	Cultural backgrounds of the young people in the study
Gender	Genders of the young people in the study
Presenting issue	Presenting issue and reason for referral to intervention
Mental health outcomes measured	What mental outcomes were measured and how? e.g., anxiety scores on a standardized clinical assessment
Main findings of the study	Summary of the key results in the study
Program description (summary)	Summary of the program described in the study
Delivery mode	The mode of delivery for the program; e.g., online, face-to-face
Who delivers the program	Person who delivers the program; e.g., counsellor, therapist, facilitator
Duration	How long the program goes for, including number of sessions and session lengths
Program origins (theoretical basis)	Information about how the program was developed and the theoretical frameworks it draws from
Program components	Summary of the different practices and approaches used in the program to targeted intended outcomes
Identified barriers in uptake of mental health services	Summary of key barriers to uptake of mental health services identified by article authors

Results

Types of populations

In the studies selected for full review there were three main descriptors used to classify the cultural backgrounds of participants; culturally and linguistically diverse (CALD), migrant, and refugee. The most frequently used term in the literature was refugee (*n* = 9), with CALD (*n* = 5) and migrant (*n* = 2) appearing least frequently. There were three papers which comprised participants of a specific cultural or ethnic group without noting whether they had a migrant or refugee background (e.g., young native Spanish speakers, Sri Lankan young adults).

The majority of papers gave information on the specifics of the participants cultural backgrounds (*n* = 15) through providing information about country of birth or cultural group. The remaining articles (*n* = 4) did not report on the specific of cultural backgrounds. Most studies (*n* = 18) specified an age range of participants. The youngest age reported on was seven years of age with the oldest range being thirty years of age. Some studies involved professionals as part of the focus on CALD youth mental health (*n* = 2).

Types of studies

The core aim of this review was to explore the types of mental health interventions for young people from CALD backgrounds, the core elements of these interventions and the potential barriers to uptake. Of the 21 articles included in the review, six papers were specifically focused on a program or intervention, 10 focused on barriers to the uptake of mental health services among CALD young people, and four focused on both a program as well as barriers to uptake. The majority (*n* = 12) of the studies favored a qualitative approach, which was used as either as the sole method (*n* = 10) or in a mixed methodology (*n* = 2). The sole qualitative studies used

interviews (*n* = 2), focus groups (*n* = 1), a case study (*n* = 1), participatory design workshops (*n* = 2) and combination of interviews and focus groups (*n* = 4). The mixed methods studies utilized interviews and surveys (*n* = 2). The remaining studies (*n* = 7) used quantitative methodology. The quantitative studies comprised cluster randomized controlled trials with standardized measures (*n* = 2); controlled trial with standardized instruments (*n* = 1), repeated measures designs using surveys and/or standardized measures (*n* = 2); and cross-sectional designs using surveys and/or standardized measures (*n* = 2).

Program components

Of the 10 articles examined for common elements of practice to support the mental health of CALD youth, the majority explored a specific named program or practice (*n* = 9) and the remaining articles describing recommendations for practice and intervention without referring to a specific program (*n* = 1). A broad range of treatment approaches were used including, creative and arts-based counselling cognitive-behavioral groupwork, psychoeducational groups, non-specified counselling, grief and loss counselling, resilience-based intervention, trauma informed counselling, and non-specified targeted intervention for health risk behaviors. Six common elements of practice identified in these programs are expanded in further detail below. Their presence across the 10 articles are also summarized in Table 3.

Personalization, identity, and recognition of trauma

A total of eight out of 10 papers reviewed for common elements to support CALD youth mental health referred to the importance of ensuring the unique experiences of migrant and/or refugee youth were recognized and factored into the delivery of support. This came, for example, in the form of using appropriate assessments in a trusting environment and acknowledging that

assessment may be perceived as uncomfortable or trauma-inducing. Two research papers had a strong focus on the assessment component of their respective programs, specifically the triage aspect of young CALD peoples. In terms of prioritizing each person according to risk, general themes were identified including ways to improve outreach triage processes in health clinics or health visitations within schools (Ospina-Pinillos et al., 2019). One article established the MHeC which consists of a visible triage system for those requiring help including an online physical and mental health self-report assessment; a results dashboard; a booking and videoconferencing system; and the generation of a personalized well-being plan (Ospina-Pinillos et al., 2019). Tailoring and personalization of support based on specific needs and characteristics such as sex, culture, location, disability, and group size (n = 4) were also noted as important. For example, Valibhoy et al. (2017) showed mixed responses from CALD youth about the effectiveness of strategies like exercise, relaxation, socializing with others, and concentration strategies or distraction, where some perceived these strategies to be inappropriate or invalidating.

While most papers alluded to trauma informed care in some way, such as integrative treatment models which pay attention the person's psychosocial and historical background only a few papers spoke directly to the provision of trauma informed care within their programs. Alongside personalization of services to match the needs of CALD youth, programs specifically referred to the need to address trauma, loss and grief (n = 3) experienced during pre-migration (e.g., violence, persecution, civil unrest) or resettlement. One method was to explore and incorporate trauma experiences and personal stories through a *narrative* approach (n = 2). Two programs, Tree of Life (Schweitzer et al., 2014) and HEAL (Quinlan et al., 2016), utilized narrative theory and invited CALD youth to build self-reflection and meaning-making skills by integrating their country of origin, family history, and stories of self and exploring alternative self-stories and

their current sense of belonging. In the BriTA Futures program (Mitchelson et al., 2010), trauma informed care was discussed through the use of a capacity building model which implements a series of modules addressing the concepts of cultural and personal identity; cross cultural communication; understanding and managing emotions; stress; using humor and spirituality to build resilience and building positive relationships.

Among four papers, CALD youth's self-identity and cultural identity were emphasized as important for mental health. This included a recognition that there may be difficulties navigating an identity within a Western culture (Pittaway & Dantas, 2022), how resilience and acculturation stress can be addressed through the lens of cultural and personal identity (Quinlan et al., 2016), and the importance of the relationship between experiences of home and belonging with individual and community identities (Schweitzer et al., 2014). Allowing CALD youth to comprehensively define their intersecting identities was also valued when designing a health information technologies (Cheng et al., 2021).

Creative expression

Two papers used creative expression to portray feelings and experiences that were beyond words. For instance, the Tree of Life program (Schweitzer et al., 2014) used visual components and symbolism to represent links between emotional, cognitive, and sensory elements to psychological growth and healing. The Tree of Life intervention centered on metaphors for different parts of the tree like the roots (personal history), ground (daily activities), trunk (personal strengths), branches (future hopes), and leaves (important people) as youth explored alternative stories of self to emphasize cohesion with outsider witnesses to help instill hope. Creative expression was also expressed using arts therapy and music therapy. The HEAL program (Quinlan et al., 2016) used a range of art activities such as painting, sand play, collage,

photography, mask-making and sculpture with clay as well as music activities such as song-writing, lyrical analysis, improvisation, sharing of important cultural or religious songs, ad dancing. The Tree of Life program (Schweitzer et al., 2014) used colorful representations to reflect the rich internal experiences or rituals as something to be recognized and celebrated.

Cultural Competence

Practitioners' or providers' cultural competence was highlighted in five papers. It referred to the need for practitioners to recognize and accommodate the nuances of different ethnic and religious identities of youth within context and not stereotyped (Valibhoy et al., 2017); show openness, flexibility, communication skills, cultural expertise and proficiency, and knowing when to generalize or be exclusive, and acknowledge that different cultures may define or approach mental health differently (Cheng et al., 2021). The need for easy-to-understand language and lay terms to explain mental health concepts were also noted, and was particularly relevant for mental health interventions delivered via health information technology (Cheng et al., 2021) and eClinics (Ospina-Pinillos et al., 2019). The integration of multilingual options and interpreters were also regarded as important for youth and/or family members. In addition, having practitioners or providers also from CALD backgrounds were valued (n = 2), which allowed the language and content to be tailored to the diverse needs of clients.

Self-efficacy and empowerment

Seven papers highlighted the importance of empowering CALD youth and building their self-efficacy and confidence. Four of these papers referred to ensuring youth were in control of deciding what topics mattered to them and experiences they wanted to talk about. Allowing youth to negotiate treatment goals and make informed decisions about care options also facilitated their sense of agency (Cheng et al., 2021). Playing sport was also perceived as

building youth's control and agency through creating a sense of calm and releasing energy (Pittaway & Dantas, 2022).

Empowerment came about through facilitators who motivated youth to take charge of their own health and learning hands-on skills such as cooking and self-defense in the Girls on the Go program (Tirlea et al., 2016). This 10-week program was designed to improve self-esteem, body image, and confidence using an empowerment model. Acknowledgement of the complex and unique individual was also important so that youth could perceive themselves as multi-faceted and more than just their mental illness (Cheng et al., 2021). The term 'strengths-based' was also explicitly mentioned in three papers to denote the approach used in the intervention or program, focusing on strengthening of protective factors and celebrated achievements and strengths (Cheng et al., 2021; Mitchelson et al., 2010; Quinlan et al., 2016).

Social connections and relationships

Eight out of 10 papers referred to the importance of social connections and relationships for CALD youth, whether that was family members, connection with the facilitator or service providers, or with other CALD youth participating in group programs. Hearing other people's stories about experiences of alienation and racism, or normalizing mental health struggles helped CALD youth feel connected with others and not alone (Cheng et al., 2021; Pittaway & Dantas, 2022). Many of the programs and interventions used a group format (n = 5), whether in the classroom (Mitchelson et al., 2014; Quinlan et al., 2016; Uribe Guajardo et al., 2019), via group-based cognitive behavior therapy (Ooi et al., 2016), and sharing of experiences and reflections with peers and outsider witnesses (Schweitzer et al., 2014).

The relationships between CALD youth and the facilitators or practitioners were also noted as important aspects. In the BRiTA Futures program, facilitators were usually classroom teachers,

teachers' aides, school counsellors, child and youth mental health workers, community leaders and volunteers who were already familiar to the young people. Some youth saw practitioners as a trusted friend or substitute family member who allowed the young person to feel heard, cared for, recognized, and understood (Valibhoy et al., 2017), and it was acknowledged that it may make take time for trust and rapport to be built over time.

Information and content delivery

Programs and interventions relied on interactive and experimental approaches for delivery (n = 2). Some of the reviewed programs had a curricula or psychoeducational components (n = 2). For instance, the mental health aspect within the Girls on the Go program involved discussion of topics areas related to body image and self-esteem, safety and assertiveness, a healthy mind, physical activity, healthy eating, trust and confidence, and connections (Tirlea et al., 2016). Group cognitive behavioral therapy is designed as psychosocial-education intervention which aims to educate children about their symptoms and teach adaptive coping strategies such as creating self-coping statements, relaxation, and exposure strategies (Ooi et al., 2016). Introduction of psychoeducational components was also important, with the need to promote a gradual understanding of key concepts as youth may be encountering clinical terminology for the first time (Cheng et al., 2021).

Table 3. Common practice elements identified within programs and interventions for CALD youth

	Program name	Creative expression	Cultural Competence	Information and content delivery	Self-efficacy and empowerment	Social connections and relationships	Personalization, identity, and recognition of trauma
Cheng et al. (2021)	Health Information Technology		X	X	X	X	X
Mitchelson et al. (2010)	BRiTA Futures program		X	X	X	X	X
Ospina-Pinillos et al. (2019)	Mental Health eClinic (MHeC) - Spanish version		X				X
Ooi et al. (2016)	Group Cognitive Behavioral Therapy			X		X	
Pittaway & Dantas (2021)	Sports in coping			X	X	X	X
Quinlan et al. (2016)	Home of Expressive Arts and Learning (HEAL)	X			X	X	X
Schweitzer et al. (2014)	Tree of Life	X			X	X	X
Tirlea et al. (2016)	Girls on the Go (GOG)			X	X		
Uribe Guajardo et al. (2019)	Adaptation of Youth Mental Health First Aid		X			X	X
Valibhoy et al. (2017)	N/A		X		X	X	X

Barriers to access

Young people of CALD background have varying conceptions of mental health, illness, and treatment and services. A total of 15 papers included in this review identified several barriers to service uptake. These barriers are summarized below and grouped into three broader, albeit interlinked, headings.

Personal Attitudes Toward Mental Health Issues

Some reported barriers were those held within perspectives of CALD youth or communities, which limited their willingness to seek and access mental health services.

Stigma and cultural shame. Related to language barriers, the stigma of mental health issues, and fear of shame or embarrassment was a recurrent theme across 10 included papers and deterred young people from seeking treatment (Raymundo et al., 2021; Ziaian et al., 2012). For young CALD people, the term ‘mental health’ tended to be associated with illness (Saberi et al., 2021), perceptions that conditions were lifelong (de Anstiss & Tahereh, 2010), and indication of a person’s weakness or failure (McCann et al., 2016)), with some noting that their parents were likely to view mental health issues as equivalent to being a criminal or drug addict (Pittaway & Dantas, 2022). A study of Sri Lankan young adults living in Australia showed that culture, country of birth, gender, and family relationships influenced stigmatizing attitudes towards mental illness and help-seeking (Mudunna et al., 2022). These stigmatizing preconceptions towards being a mental health client were illustrated in words such as “crazy” (Baak et al., 2020; Valibhoy, 2017) and being reluctant to be seen accessing services that mentioned ‘Mental Health’ in the service’s name (Posselt et al., 2017). In one article, refugee adolescents equated mental illness with terms like “craziness” and described the mentally ill as “retarded”, “weird”, “sick”, “crazy”, “abnormal”, and “psycho” (de Anstiss & Tahereh, 2010). For many, disclosing

one's mental health condition was seen to likely result in social exclusion and isolation (Saberi et al., 2021) and bringing shame to their family and community (McCann et al., 2016).

Limited mental health literacy. Alongside the stigmatization and shame surrounding mental health issues was a low level of mental health literacy, as referenced in eight of the included papers. It was common for young people to report not being familiar with terms like mental illness, depression, or anxiety, and to be unaware of available treatment or support services (de Anstiss & Tahereh, 2010; Posselt et al., 2017). This also extended to being unable to recognize initial signs of mental health issues and to seek help early (Colucci et al., 2015; McCann et al., 2016; Ospina-Pinillos et al. 2019). In the study by Saberi et al. (2014), young refugees noted that 'mental health' as a concept or service was not prevalent in their country of origin and that their own parents were not aware of what mental health was. Indeed, CALD youth often knew more about mental health needs than their parents but felt unable to raise their concerns or be supported due to the limited understanding among their parents or community (Pittaway and Dantas, 2022; Raymundo et al., 2021).

Privacy and confidentiality. Seven papers identified issues relating to family privacy and confidentiality as a barrier to seeking mental health support. A study by Saberi et al. (2021) with Hazara refugees indicated that cultural expectations of stoicism contributed to not seeking help as many believed that sharing of problems would make matters worse. These cultural expectations also comprise keeping personal problems hidden from people outside the family due to shame or fear, although these issues tended not to be addressed within the family either (de Anstiss & Tahereh, 2010; Valibhoy et al., 2017). There were also concerns about professionals, including interpreters, disclosing the young person's difficulties to their parents or

to community members if that professional was well known in the broader ethnic community (de Anstiss & Tahereh, 2010; Baak et al., 2020; Colucci et al., 2015; Posselt et al., 2017).

Trust of mental health services. Related to the theme of privacy and confidentiality, five articles referred to CALD youth's distrust of mental health services and professionals as being a barrier to uptake. Lack of trust in service providers can stem from previous lived experience with violent and corrupt government authorities or institutions (Colucci et al., 2015; Pittaway & Dantas, 2022), or concerns that the current Australian government may use their mental distress as grounds to reject citizenship or visa applications (Zialan et al., 2012; Posselt et al., 2017). Professionals were seen by CALD youth as untrustworthy because they are essentially "strangers" who would be unable to help with their issues (de Anstiss & Tahereh, 2010).

Service and Practice Barriers

Other barriers were related to practice and delivery issues within mental health services and the sector.

Access to mental health services. Nine out of the 15 papers pertaining to barriers referred to difficulties with accessing mental health services. The lack of access to services extended to location (Colucci et al., 2015; Valibhoy, 2017), long waiting times (Baak et al., 2020), limited opening hours (Raymundo et al., 2021) financial costs (Baak et al., 2020; McCann et al., 2016), having a stable internet connection (Cheng et al., 2021), and having limited access to information about available services to access psychological support (Ospina-Pinillos et al., 2019; Posselt et al., 2017). McCann et al. (2016) also noted that access to mental health services was perceived by some people as not available to those holding Refugee Visas.

Lack of flexibility. A lack of flexibility in eligibility criteria and delivery was noted in four papers. Participants in Valibhoy (2017) indicated that services needed to be responsive, appropriate to their needs, and provide flexible scheduling. Participants in Raymundo et al. (2021) pointed to restrictive age criteria and a lack of youth-friendly environments as reasons for not accessing mental health services. Two papers (Colucci et al., 2015; Posselt et al., 2017) reported barriers due to rigid appointment systems, lack of a drop-in service, strict time limits, and a limited number of sessions available for CALD clients who may require more time to engage. There was also a lack of flexibility in the system where clients are refused services due to strict inclusion criteria; for example, if they have comorbid conditions, or were not diagnosed with a major psychiatric disorder. Complex referral processes and fragmented services meant that clients experienced constant "handballing" between different services, which resulted in further disengagement of clients with multiple needs (Colucci et al., 2015; Posselt et al., 2017).

Lack of practitioners' understanding of settlement issues for migrant and refugee clients. Four papers referred to difficulties due to practitioners not being mindful of the unique experiences of migrants and particularly refugees. For example, from the experience of young people, trauma was often not addressed appropriately. Sometimes past trauma was brought up too early, given too much focus compared to current needs, or required clients to repeatedly describe past distressing experiences (Colucci et al., 2015; Valibhoy, 2017). For some refugee youth, mental health was not a priority compared to other concerns like family separation and housing or financial stability (Colucci et al., 2015). Conversely, professionals were sometimes reluctant to bring up youth's past trauma and believed they needed to move on from past experiences, which showed a limited understanding of the ongoing effects of trauma (Baak et al., 2020). Similarly, limited understanding or acknowledgement of the impact of resettlement was a

barrier to engagement (Colucci et al., 2015). This could lead to negative consequences for clients where practitioners misinterpret presenting symptoms as indicative of a diagnosable psychiatric disorder rather than a reasonable reaction to past losses or trauma (Posselt et al., 2017).

Western-Centric Notions of mental health and wellbeing

Finally, there were barriers that could be attributed to the broadly Western-centric nature of mental health services and notions of psychological wellbeing.

Diverse notions of wellbeing. Six articles alluded to differing cultural concepts of mental distress as a barrier for engaging with mental health services. For example, some CALD communities may hold beliefs that mental distress or illness can be treated only through religion or traditional remedies (de Anstiss & Tahareh, 2010; Saberi et al., 2021). Terms like mental health, illness, and treatment may also be perceived as an exclusively Western concepts that do not apply to them (Posselt et al., 2017), or people may conceptualize these terms differently according to their cultural background (Baak et al., 2020; Colucci et al., 2015). Participants in Valibhoy (2017) noted that practitioners responding not only to the mental distress but to practical and material needs were essential, suggesting that wellbeing may be conceived in diverse communities as holistic and encompassing different aspects of being.

Service providers in the study by Colucci et al. (2015) were critical of the disease-focused model of mental health services that emphasized symptoms and diagnoses, and which did not see the young person as a whole person with their own goals and needs. It was also noted that Western therapeutic approaches may not necessarily be appropriate for all clients with refugee background, although it may be possible if the treatment is delivered in a flexible and culturally appropriate manner (Posselt et al., 2017). For instance, participants may be

unaccustomed to verbalising their emotions and personal experiences in initial sessions, indicating the need for practitioners to require more time to build rapport with CALD clients.

Lack of culturally competent practitioners to address issues. Seven papers outlined how staff were often not culturally competent or well trained to properly address mental health issues of CALD youth. Participants in Saberi et al. (2021) noted feeling misunderstood by mainstream services that were not developed to support multicultural communities. Practitioners' level of cultural sensitivity and capacity to respect and understand the nuances of young people's histories, sociocultural environments, and ethnic or religious identities, without making assumptions or using stereotypes, influenced whether they felt understood or misunderstood (Colucci et al., 2015; Valibhoy, 2017).

A lack of professionals from the same cultural background as clients who could understand the cultural context of mental health concerns was also a barrier to seeking help (McCann et a., 2016). An appreciation of the cultural context was also important for practitioners to understand how CALD youth's family could be involved in the process to support the young person engaging with the service (Colucci et al., 2015). Indeed, Baak et al. (2020) argued the need for practitioners to show cultural competency, respect, and understanding of the client's culture, and emphasized the need for relevant education and training.

Language and literacy barriers. Six papers reported that having mainstream services targeted to people who could speak English reduced the likelihood of CALD youth and communities seeking help for mental health issues. All 32 participants in one study indicated that language was the main barrier to accessing medical or psychological services (Ospina-Pinillos et al., 2019). The lack of interpreters was also cited as a barrier (Posselt et al., 2017) but, when interpreters were available, there were concerns about their suitability and capacity to effectively

translate the content of clinical sessions (Colucci et al., 2015; Valibhoy, 2017). Language barriers were also noted for the parents of young people as they may not be fluent in English and, hence, not understand the mental health support being offered nor how the Australian systems and services operate (Baak et al., 2020).

Discussion

The aim of this paper was to review the different types of mental health interventions available for young people from CALD backgrounds in Australia, determine core components of these mental health programs that engage and deliver positive outcomes for CALD young people, and identify barriers in uptake of mental health services. Our search identified 19 articles that focused on supporting the mental health of CALD youth in Australia. Within 10 papers specifically on interventions and programs, six common elements of practice were identified; all offered a specific approach to promoting the mental health of CALD youth but differed in their focus. For example, some were directed towards acknowledging and addressing the unique needs of CALD youth, including their past experiences (e.g., migration history, trauma) and intersectional identities, as well as ensuring practitioners and services provided were competent in accommodating cultural nuances.

The delivery of information was also important for learning and engagement by ensuring language was simple and easy to understand, and there were opportunities to engage in discussion and interactive experiences. Connection with others was also a key feature of many programs and interventions, which reduced feelings of isolation and resonated with ideas about healing and wellbeing through connection and community. The capacity for CALD youth to creatively express their feelings and feel confident and empowered in expressing themselves and

reflecting on their personal strengths and identities also featured within programs and interventions targeting mental health. These aspects of practice, such as empowering youth and use of creative expression techniques have been raised in previous reviews in Canada (Marshall et al., 2016) and the US (Fazel & Betancourt, 2018). While it was not possible to identify which specific common practice elements or approaches were effective for supporting CALD youth mental health, they provide an opening to further scrutiny and rigorous evaluation.

Key barriers related to engagement with CALD youth mental health programs were language and literacy barriers, stigma and shame associated with seeking mental health services, access to and trust of services, service providers' limited cultural competency and recognition of resettlement issues, and Western-centric notions of mental health that did not include cross-cultural understandings of wellbeing. Such barriers for CALD youth accessing with mental health care services are consistent with existing literature (Brown et al., 2016). Therefore, these barriers need to be addressed in the design and delivery of any services or interventions to support the mental health of CALD young people.

Implications for practice and policy

This paper fills an important research gap (as indicated by Savaglio et al., 2022) in its focus on describing key practice elements of mental health interventions and summarizing the barriers to CALD youth in Australia accessing and engaging with services. However, it is also important to highlight what appears to be missing and needs to be addressed in future practice, policy, and research. For example, a few papers featured input from young people in the context of a program evaluation and CALD youth were asked to comment on its effectiveness or what they needed to support their mental health. However, some papers did not centre the voices of young

people and were based on adults' perspectives (e.g., from professionals, parents) of program effectiveness, likely barriers to seeking mental health support, and views on what CALD youth needed for their mental health. Consultations with CALD young people about what they need for mental health services is crucial. Roberts (2014) noted that this lack of engagement with young people about their strengths, challenges, and experiences of mental health support services has occurred at the local, state and national level, and that consultations along with cultural planning, accessibility issues and targeted promotions strategies are important aspects when planning service delivery. The space that practitioners and researchers who engage with young people operate in is not politically neutral ([Author names omitted due to the blind review]). Who designs, who delivers, who evaluates and who has control over the dissemination of ideas about how to work with CALD young people matters. Ongoing exclusion and reprioritization of lived experience and knowledge is a form of epistemic injustice (Fricker, 2019) that further compromises CALD youth's wellbeing. When CALD young people are treated within the context of Whiteness as the norm and 'othered', they are at risk of being judged as less credible and overlooked in the professional discourse on intervention.

In addition, it appeared while many papers claimed the important of cultural specificity, they did not consider the different parts of youth's identities that face marginalization or oppression, and intersections of oppression, such as racism, sexism, and homophobia. For example, the stigma of mental health issues within CALD communities was consistently pointed out, but there were few mentions of how the mental health presentations may be in part driven by the mechanisms of racism or due to clients being part of a marginalized group. There were not many interventions that directly addressed these issues or experiences. Many papers mentioned the importance of reducing stigma towards seeking help for mental health challenges among CALD communities,

but the barriers to help seeking at the service or systemic level also need attention. A culturally safe and competent service needs to recognize that a young person's ethnicity, nationality, religion, and language are key parts of that person's identity. There needs to be consideration of whether interventions designed to improve the mental health of CALD young people really target the relationships between cultural identity, other intersecting identities, and their links to wellbeing and mental health. A more critical gaze on the wellbeing of CALD youth is needed to ensure they are included and have agency in decision making processes when receiving support. Scott (1990) wrote about the importance of the hidden transcripts for the survival of peoples who have been oppressed and how bringing these transcripts into the public space can "restore a sense of self-respect and personhood" (p.210). Therapeutic interventions and evaluative methodologies have the potential to become decolonizing practice. To do so, CALD young people must be given their rightful place as authors and co-authors of their healing journey.

Finally, of the practice elements identified, it was apparent that there were papers that highlighted the use or importance of cultural or spiritual healing practices for mental health. For example, Colucci et al. (2015) noted services for CALD youth used Western techniques and approaches to mental health, and highlighted the importance of having the broader community involved, including elders and spiritual advisors, to establish trust and help link young people with services. Participants in Posselt et al. (2017) reported a lack of cultural responsiveness in services and the need for CALD or bi-cultural workers to act as advisors, culture brokers and a resource for staff to improve collaborations between agencies. Some papers, such as de Anstiss et al. (2010) emphasized the need for more research about refugee cultural meaning systems and healing practices and their utilization within service responses. Among other papers, there was an emphasis on Western modes of psychological practice and the medical model. Mudunna et al.

(2022) noted the relationships between culture, stigma, and help-seeking but cultural healing practices were not mentioned in the paper.

There is a greater need to ensure programs and interventions that purport to help CALD youth address the link between cultural identity and connection with wellbeing. Some, albeit few, of the interventions incorporated narrative approaches that asked youth to reflect on the details of their personal stories, cultural backgrounds, family histories and making sense of where they belong (Quinlan et al., 2016; Schweitzer et al., 2014). There is limited emphasis on cultural identity, family or community relationships that could serve as protective factors for CALD youth's mental health (Roberts, 2014). Many studies have called for a shift to culturally safe, person centered, recovery-oriented, and systemic holistic care (Rosenberg & Hickie, 2013). The dominance of Western psychology in conceptions of mental health and a reliance on the biomedical model for solutions to address mental health issues is apparent in the reviewed papers. This approach tends to assign mental health to an issue of personal responsibility in which solutions are located between patient and doctor (Tattersall, 2022) and that mental disorders as diseases of the brain that can be rectified through pharmaceutical intervention (Deacon, 2013). Western approaches to mental health in psychology and social work practice also tend to treat the mind and body as separate, and treat the individual and community as separate (Tascón and Ife 2019), and they do not acknowledge different notions of wellbeing across cultures. Continuing to apply such approaches to a community with vastly different conceptions and understanding of mental health and wellbeing is unlikely to be effective. Settlement services in Australia have been solely responsible for referring refugee children and young people to mental health services. However, one of the issues with migration statuses is access to publicly funded health care perpetuating further disadvantage. The WHO Western

Pacific Region (2018) reports the Australian Government's settlement support arrangements, now provides streamlined mental health access for new migrants including referrals to relevant health professionals upon arrival. In NSW, there are several migrant resource centers and ethnic community-based organizations responsible for helping resettle refugees (DSS, 2016). The current review highlights the nature of CALD communities in the Australian context, where significant determinants of mental health and wellbeing require client-centered interventions across all aspects of social work, counselling, psychiatry, and psychological therapies.

It is also difficult to fully know the scale of the issue with the limited data available on CALD children and young people's wellbeing across different services and indicators. Despite being marked an area of major concern, there is currently no national dataset on CALD youth in areas related to immigration status, disability, criminal justice, or homelessness (Roberts, 2014; Walsh et al., 2021). A lack of linked data means across sectors means it is difficult to follow CALD young people as they move and interact with different social service systems and these records do not necessarily capture their voice or subjective wellbeing. Limited availability of data can be attributed to the resources and funding available for service agencies to prioritize data and record keeping (Posselt et al., 2017). Indeed, the lack of proper and consistent funding creates a CALD child and youth sector that is siloed, under-resourced and lacking coordination, which limits the ability for organizations to build institutional knowledge and skills (Roberts, 2014).

Limitations and future directions

This review was limited to focusing on discrete practices in the context of a service provider or practitioners' interactions with CALD young person. Broader structural and systemic factors to support the wellbeing of CALD youth such as resources, staff training, and geographic distribution are also important to consider and should not be overlooked in the development of

services and interventions to support young people. At present, it is also not known what aspects of specific interventions directly improve the mental health and wellbeing of CALD youth. Further exploration is needed on the specific elements of practice that effectively support CALD youth, and more research is needed on programs and interventions for this population in general. A deeper analysis of anti-oppressive practices within mental health interventions for CALD youth is also needed. Future research can explore the presence and centering of young people's voices (e.g., whether they had any input in the design or evaluation of the program), the impact of political factors and intersections of oppression CALD youth's mental health and wellbeing, as well as the implementation of cultural and spiritual healing practices within interventions designed for CALD youth as opposed to sole reliance on Western standards or practices.

Conclusion

The findings from this review have revealed a number of interventions and core elements of practice that are relevant for supporting CALD youth mental health in Australia. In addition, it has presented key barriers at the personal, practice, and societal level that need to be addressed to better support CALD youth accessing and engaging with mental health services. Further research in this topic needs to be conducted to add to the knowledge and practice base. The review also argues for more meaningful and substantial inclusion of CALD young people's lived experience. Their voices will be critical for ensuring they feel adequately supported and acknowledge the multifaceted and intersecting relationship between identity and metal health.

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* Asterisks indicate which references were included in the review scope.

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