



THE UNIVERSITY OF
MELBOURNE



Multicultural
Centre for
Women's Health

Migrant and refugee women's mental health in Australia: a literature review

October 2020

Claire Sullivan, Associate Professor Cathy Vaughan and Judith Wright
Centre for Health Equity, School of Population and Global Health, University of Melbourne.

Commissioned by Multicultural Centre for Women's Health.

Suggested citation: Sullivan, C., Vaughan, C., Wright, J. (2020). *Migrant and refugee women's mental health in Australia: a literature review*. School of Population and Global Health, University of Melbourne.

Table of Contents

1. Background	3
Definitions.....	3
2. Methodology	4
Objectives and questions.....	4
Search strategy.....	4
Peer reviewed literature search	4
Grey literature search.....	5
3. Findings	5
3.1. Explanatory models of mental health	5
3.2. Prevalence of mental health conditions.....	6
Limitations of prevalence data	6
Population-wide prevalence of mental health conditions	7
Prevalence within different populations of migrants and refugees	8
Prevalence and gender	8
3.3. Social determinants and predictors of mental ill health	9
Pre-migration factors.....	9
Contributions of both pre and post-migration factors	10
Post-migration settlement stressors	11
Race and discrimination	13
Gender	14
Intersectional inequalities	16
Immigration system stressors and detention.....	17
3.4. Access to and utilisation of mental health services	19
Barriers	19
Facilitators	22
3.5. Specific disorders	23
Depression	23
Perinatal depression and anxiety	24
Post-traumatic stress disorder	25
Psychotic disorders.....	25
Substance use.....	26
Gambling disorders.....	27
Anxiety.....	27
Eating disorders	28
Suicidality and self-harm	29
3.6. Gaps in the literature	30
3.7. Australian interventions and services for migrant and refugee mental health	31
Response interventions and services	31
Prevention and early interventions and initiatives.....	33
Perinatal mental health initiatives.....	34
3.8. Resources.....	34
Citations	36

1. Background

According to the Australian Bureau of Statistics, approximately four million women – 15% of the Australian population – were born overseas (ABS, 2020). The evidence indicates that migrant and refugee women experience poorer health outcomes compared with Australian-born women and that this disparity is likely to extend to mental health. The advancement and protection of the mental health of both individuals and communities is an area of increasing public health planning and policy interest in Australia as well as globally. However, Australian migrant and refugee populations are at risk of being overlooked or homogenised within mental health policy and planning. It is vital that mental health strategies and initiatives consider the evidence surrounding factors that relate to migration and resettlement which act as social determinants of mental health. The ways in which gendered inequalities intersect with migration-related social inequalities to shape migrant and refugee women's mental health, including their access to and utilisation of mental health services must also be considered. This report explores the available peer reviewed evidence, and a limited selection of grey literature, about the mental health of migrant and refugee women in Australia, and what is known about effective initiatives and interventions.

Definitions

Mental health

Mental health means more than a mere absence of mental health disorders:

“Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2018, para. 2).

Multiple terms that relate to mental health are used in this review to reflect the varied framings and conceptualisations present within the literature, including:

- mental health condition, mental health concern, mental illness, mental ill-health and mental distress;
- wellbeing and other 'positive' mental health terms; and
- biomedical terms defined by psychological and psychiatric diagnostic measures or concepts. This includes mental health disorders which are characterised by a “combination of abnormal thoughts, emotions, behaviour and relationships with others”, and comprise conditions such as schizophrenia or depression (WHO, 2019).

Where particular studies are referred to, we have retained the concepts or terminology employed by the study's authors. This approach has limitations; not only are many concepts problematic, but studies which conceive of mental health in different ways may not be directly comparable.

Migrants and refugees

We understand the terms ‘migrant’ and ‘refugee’ broadly in this review to refer to persons who were born in a country other than Australia, without Australian citizenship status, who have migrated to Australia to reside, including asylum seekers and those on other temporary visas. This recognises that, despite narrow definitions under international law, distinctions between migrants, refugees and asylum seekers are often not clear-cut; asylum seekers may identify as refugees and temporary migrants can become asylum seekers. In the review, we have in large part retained the terminology used by authors when referencing particular studies’ findings; for example, where a study refers to asylum seekers, we have used the term asylum seekers. Similarly, where studies use different terms to refer to migrant and refugee populations, such as ‘culturally and linguistically diverse (CALD)’

people or people from ‘non-English speaking backgrounds (NESB)’, we have also employed such terms.

Women/woman

The terms women/woman here include not only cis women but all those who identify as women. Notwithstanding this, the studies we reviewed generally failed to clarify whether a biological view of sex or a social understanding of gender was employed in their analysis. This is a shortcoming of the literature and thus also the review.

2. Methodology

Objectives and questions

This review sought to collect, evaluate and synthesise the existing evidence regarding mental health among migrant and refugee women in Australia, and explore evidence surrounding initiatives and interventions. The following questions were addressed:

1. What is known from the existing peer-reviewed literature about mental health conditions and concerns among migrant and refugee women in Australia?
2. Based on a review of the peer-reviewed literature and a limited selection of grey literature, what evidence exists surrounding mental health prevention and/or intervention programs for migrant and refugee women in Australia?

Search strategy

Peer reviewed literature search

The review took place between July and August 2020. We searched three electronic databases (Medline, PsycINFO, and SCOPUS) for the period 1990-2020 for Australian studies concerning the mental health of migrant and refugee women in Australia. Though the review was focussed on women, broad population terms were used in place of gendered terms to allow for the inclusion of articles for which the results pertain to both men and women. The following terms were used, alongside Boolean operators “AND” and “OR”:

Search terms
‘depression’ or ‘anxiety’ or ‘posttraumatic stress’ or ‘eating disorder’ or ‘suicide or mental health’ or ‘mental illness’ or ‘mental disorder’ or ‘psychological distress’ or ‘trauma’ and
‘refugee’ or ‘migrant’ or ‘culturally and linguistically diverse’ or ‘ethnic minority’ or ‘asylum seeker’ and
Australia

Articles that were published before January 1990 or published in a language other than English were excluded from the review.

The databases yielded a total of 2,957 articles (Medline: 886, PsycINFO: 784, and SCOPUS: 1,287). We removed 1,206 duplicates from this set. Following title and abstract screening, and review of the full text article, 234 were deemed relevant for our purposes.

Grey literature search

The grey literature search was conducted using Google Australia. Initiatives were eligible if they included a component specifically aimed at improving mental health and/or psychosocial wellbeing of refugee and migrant women in an Australian context. To minimise the influence of Google's algorithms, Google profiles were signed out, history browsing data was cleared and incognito browsing was used. As the purpose of the search was to identify Australian initiatives, the region setting was set to 'Australia'. A series of searches were conducted employing the following key search terms:

- mental health or wellbeing; gambling; alcohol or drug; post-traumatic stress or trauma or violence; anxiety; depression; suicide,
- in addition to (refugee or migrant or asylum seeker) **and** (women or girl) **and** Australia.

For each search, the first 50 websites were retrieved. This yielded 350 results, of which 107 were duplicates. 41 sources met the inclusion criteria for review (14 websites concerning research, 18 containing guides, resources or fact sheets, six concerning interventions or initiatives and three advocacy-related documents).

3. Findings

3.1. Explanatory models of mental health

The Australian research concerning migrant and refugees' mental health tends to be dominated by a psychopathology lens and investigates symptoms and diagnoses of mental health conditions. Some studies explore measures of mental health beyond diagnostic psychological conditions, using concepts such as 'flourishing' (du Plooy et al., 2019), 'wellbeing' (Copolov et al., 2018; Khawaja et al., 2016; Wood et al., 2019), 'posttraumatic growth'(Copping et al., 2010) and 'resilience' (Babatunde-Sowole et al., 2020; Lenette et al., 2013). Reconceptualising understandings of mental health to include health concepts such as these can help to depathologise migrant and refugees' experience of mental health issues, and counter reductive victim narratives. An ethnographic study with single refugee women with children in Brisbane explored their experiences of resilience and found that it should not be understood as a fixed personal trait; rather resilience was continuously produced by women in the study through a series of everyday, mundane and relational acts that take place over time, informed by environmental context (Lenette et al., 2013). Framing resilience in this way challenges discourses that centre on "refugees' 'extraordinary' resilience as well as notions of 'deserving' citizens" which work to 'otherise' and perpetuate "'who is in' and 'who is out' categorizations" (Lenette et al., 2013, p. 649).

Other studies have investigated the mental health experiences of migrants or refugees beyond psychopathological frameworks by exploring different explanatory models of mental health. Such studies argue for the importance of acknowledging migrants and refugees' own constructions of and approaches to their mental health, and the complex factors that affect it (Rees et al., 2009). Examples of different cultural mental health concepts explored in the literature include *dua sakit* among West Papuan refugees (Rees et al., 2009), Macedonian migrants' notion of *nervoza* (Misev & Phillips, 2019), and the experience of *susto* among South American refugees (Allotey, 1999). Several studies have specifically explored varying meanings and experiences of depression among migrant and refugee communities (Antoniades et al., 2017; Brijnath & Antoniadis, 2018; Fozdar, 2009; Kokanovic et al., 2010; Tilbury, 2007). Wagner et al. (2006) conducted a study with Vietnamese community members in Sydney and found that most participants did not make clear distinctions between 'stress', 'anxiety' and 'depression'. Further, the authors note that participants had a "negative cultural attitude" towards people experiencing mental health problems, as well as negative associations with the mental health system generally (Wagner et al., 2006, p. 259).

Some researchers have also explored how, in particular migrant and refugee groups, explanatory models of mental illness differ between men and women (Minas et al., 2007; Wong et al., 2012). One study found that Turkish migrant women were more likely to attribute illness to supernatural causes compared with men (Minas et al., 2007). In contrast, Wong et al. (2012) found Chinese speaking-male Australians were more likely than Chinese-speaking women to approve of traditional Chinese medicine explanatory models of mental illness and traditional medicinal interventions.

Although employing different cultural frames to recast or discredit psychopathological mental health concepts may be useful, there is also a danger that focussing on cultural constructions will obscure the structural factors that underpin mental health. Exploring Indian migrants' views of depression, Brijnath and Antoniadis (2018) affirmed the need for explanatory models of mental health to account for the role of socio-structural factors in shaping experiences rather than relying upon cultural explanations: "there is need to go beyond the preoccupation with culture to a broader understanding of the social contexts that shape distress" (Brijnath & Antoniadis, 2018, p. 243). Indeed, the authors emphasise how differences that are often framed as 'cultural', are in fact, underpinned by circumstantial factors such as socio-economic position and migration.

An over-emphasis upon biomedical explanations has been criticised by others for defining mental health solely through the lens of "individual dysfunction" (Brough et al., 2003, p. 206). In her research with East African communities in Western Australia, Tilbury (2007, p. 454) argues that framing emotional distress through a biomedical frame does four things:

"It universalises an emotion state, rather than recognising its cultural situatedness; it individualises an emotion state, rather than recognising its social embeddedness; it rationalises an individualistic solution to the problem through medication or individual counselling, rather than recognising structural and social causes of despair; and it collapses mental, emotional, and biological loci of dysphoric states, again while ignoring the social."

Indeed, through both biomedical and cultural explanatory models, governments and the broader host community can evade responsibility for addressing the structural and intersecting disadvantages that migrant and refugee populations face (Tilbury, 2007; Tilbury & Rapley, 2004).

3.2. Prevalence of mental health conditions

Limitations of prevalence data

There are many complexities associated with collecting mental health prevalence data across different populations (X. Lin et al., 2016; Severino & Haynes, 2010). How survey questions are interpreted by respondents depends both on levels of language proficiency, as well as upon constructions of mental ill-health which can vary across and within different populations. Indeed, instruments that measure the prevalence of mental health conditions within different populations may not be universally applicable or reliable. Steel et al. (2009), for example, examined the prevalence of mental disorders in communities living in the Mekong Delta region of Vietnam (n=3,039), Vietnamese immigrants residing in New South Wales (n=1,161) and an Australian-born population (n=7,961) using two different measurement instruments: the Composite International Diagnostic Interview (CIDI) and the Phan Vietnamese Psychiatric Scale (PVPS). The CIDI is a tool developed by the World Health Organisation to assess mental disorders according to the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). It has been used in research and clinical contexts and is intended to have cross-cultural applicability. The PVPS is a questionnaire which seeks to assess mental disorders through expressions and concepts that are culturally relevant to Vietnamese populations. Employing the CIDI alone, Steel et al. (2009) found that

1.8% of those residing in Vietnam, 6.1% of Vietnamese migrants in Australia and 16.7% of the Australian-born population suffered from mental disorders. When respondents from Vietnamese backgrounds were asked questions from the PVPS in addition to those in the CIDI, the prevalence of mental disorders increased to 8.8% for those in Vietnam and 11.7% for Australian Vietnamese migrants (Steel et al., 2009). The findings from this study illustrate how differences in the cultural expression or construction of mental distress are likely to affect the results of prevalence studies.

In addition to complexities associated with prevalence measurement tools, other methodological limitations inform the available Australian prevalence data. Current population-wide prevalence estimates are generally based on results from Australia wide surveys, such as the 2007 National Survey of Mental Health and Wellbeing (NSMHW) and the Household, Income and Labour Dynamics in Australia (HILDA) longitudinal surveys. The robustness of prevalence findings from these surveys concerning migrant and refugee communities is questionable; the surveys are generally conducted in English and are unlikely to include sufficient numbers of respondents from migrant and refugee communities to form representative samples or enable meaningful disaggregation based on country of birth, language spoken or duration of residence (Minas et al., 2013a; Watson & Wooden, 2002). As such, reliable population-wide evidence regarding the rates and prevalence of biomedical mental health conditions within migrant and refugee communities remains unavailable. Minas et al. (2013a) note that data generated from Australian population-wide surveys play a role in the development of government policies and funding decisions, and as such their limitations concerning migrant and refugee communities have practical implications. The data also have implications for the equitable and ethical resourcing of mental health promotion and responses to mental ill-health. The Australian Bureau of Statistics is scheduled to conduct an Intergenerational Health and Mental Health Study in 2020, which will form the most comprehensive mental health survey conducted since the 2007 NSMHW; however, it is not known what measures will be taken to ensure data collected within migrant and refugee communities is representative.

Population-wide prevalence of mental health conditions

The available prevalence data concerning migrant and refugees' mental health that arises from Australian population-based studies is sparse and at times contradictory (Minas et al., 2013a). It is sometimes reported that migrants have better mental health compared with the general Australian population, where others report poorer outcomes (AIHW, 2018; Jatrana et al., 2018; McEvoy et al., 2011). Though the sample was not necessarily representative, the 2007 NSMHW collected some relevant demographic data pertaining to migrant populations, such as country of birth and year of arrival which has been analysed. Those born outside of Australia were found to have a lower prevalence of anxiety disorders, substance use disorders, or any mental disorder lasting 12 months, with recently arrived migrants the least likely to experience such disorders (ABS, 2008; McEvoy et al., 2011). However, further analysis of the NSMHW data conducted by Sharma (2012) found that levels of psychological distress in the month before the survey were higher among migrants and refugees born in non-English-speaking countries (3.1%) than those born in English-speaking countries (2.0%) or people born in Australia (2.6%).

This correlation between emigrating from a non-English speaking country or an English-speaking country and mental health outcomes has been observed in other research. A 10-year longitudinal study conducted by Jatrana et al. (2018) based on data from HILDA explored the association between migration and health in Australia, including mental health. The authors found that migrants and refugees born in English-speaking countries generally had better mental health compared with Australian-born populations; however, migrants and refugees born in non-English speaking countries had poorer health. This was true for all health outcomes, including mental health. What is more, limited English language proficiency had a particularly strong association with poor mental health

outcomes. Sharma (2012) and Jatrana et al.'s (2018) findings reinforce the limitations of conclusions drawn from aggregated data in relation to migrant and refugee populations. An approach that homogenises the health of migrants and of refugees, and of people from English-speaking countries with those from non-English speaking countries, will miss important differences between these groups including in relation to mental health.

Prevalence within different populations of migrants and refugees

Migrants and refugees are not a homogenous population and the available evidence suggests that the prevalence of mental health conditions varies widely across populations. The prevalence of mental health conditions depends on different factors such as the condition studied, the location of studies, and details relating to participants including migration pathway and status, length of stay in Australia, language spoken and ethnic background. However, studies conducted with particular ethnic groups or populations of migrants and refugees tend to be small scale and thus it is difficult to make robust prevalence claims.

Some studies have found that refugees and asylum seekers suffer from high rates of mental ill-health, compared with both the Australian-born population and other migrant populations (Kennedy & McDonald, 2006; Nguyen et al., 2016; Derrick Silove et al., 1998; Uribe Guajardo et al., 2016). Analysis of the first wave of data (2013-2014) from the 'Building a New Life in Australia' (BNLA) longitudinal study exploring the experiences of recently arrived refugees on permanent humanitarian visas (n=2,399) found that 31% were suffering from PTSD and 16% had another severe mental illness (Chen, Hall, et al., 2017). This compares to an estimated 12% lifetime prevalence of PTSD among the Australian population generally (AIHW, 2020).

Various studies have explored refugee and migrants' rates of mental distress within or across different age brackets (Heaven & Goldstein, 2001; Liddell et al., 2013; McKelvey et al., 2002; Nickerson, Hadzi-Pavlovic, et al., 2019). The evidence about the prevalence of mental health disorders within migrant and refugee child and adolescent populations compared with the Australian-born prevalence is inconclusive (Alati et al., 2004; Barrett et al., 2002; Klimidis et al., 1994; Minas & Sawyer, 2002). A study exploring Vietnamese migrants (n=1,161) and Australian-born residents' (n=7,964) mental health found that age was a key predictor of mental distress, with migrant youth reporting markedly low rates of anxiety and depression compared with the Australian-born cohort and the Vietnamese migrant cohort as a whole (Liddell et al., 2013). In contrast, Heaven and Goldstein (2001) also compared the experiences of migrant youth from Asia and Anglo-Australians, though with a much smaller sample (n=242), and found that Asian Australian adolescents reported higher levels of depression and lower self-esteem than Anglo-Australian participants. Fewer Australian studies have investigated the prevalence of mental health conditions within older migrant and refugee populations. In their study with resettled refugees (n= 1,625), Nickerson et al. (2019) found that those experiencing symptoms of PTSD or depression/anxiety were more likely to be 'older' (the study did not specify ages). Another study explored the prevalence of mental health conditions in elderly migrant communities from Italian, Macedonian and Spanish speaking communities (Minas et al., 2008). The authors found that the prevalence of mental ill-health varied considerably across the different groups, suggesting the need for further exploration of the complex underlying determinants of ill-mental health as it intersects with age (Minas et al., 2008).

Prevalence and gender

The gaps in understanding of the prevalence of mental health conditions within migrant and refugee communities extend to prevalence among refugee and migrant women. Some of the population-wide studies have made comparisons between migrant and refugee women and Australian-born women,

though again the findings are limited due to a lack of representative samples of migrant and refugee women. Outram et al. (2004) analysed the results of the 1996 Australian Longitudinal Study on Women's Health concerning the mental health status among women aged 45-50 (n=13,961) and found that women from non-English speaking backgrounds experience higher rates of poor mental health compared with Australian-born women. In an analysis of the 2007 NSMHW data, Sharma (2012) compared the prevalence and correlates of psychological distress among people born in Australia and migrants and found that in both cohorts, women experienced higher rates of psychological distress. This highlights the gendered inequalities that underpin mental health generally.

The available evidence regarding prevalence rates of mental distress among women compared with men within refugee and migrant populations is varied. Some studies indicate that migrant and refugee women experience similar rates of psychological distress to men, though the prevalence results tend to vary depending on the particular population under investigation and what is being measured (ie. whether it is the prevalence of common mental disorders such as anxiety and depression, measures of psychological distress, and whether substance abuse disorders are included). In a population-based survey of resettled Vietnamese refugees in Sydney, Steel et al. (2002) found that, overall, mental disorders among men and women were experienced at about the same frequency, except for anxiety disorders and substance-use disorders. Women reported a slightly higher rate of anxiety disorders, but a lower rate of substance-use disorders compared with men (Steel et al., 2002). No significant difference in rates of psychological distress among men and women was reported in studies with various cohorts such as Iraqi refugees (Uribe Guajardo et al., 2016), Muslim migrants (Khawaja, 2007), refugees from Myanmar (Schweitzer et al., 2011) and South African migrants (Khawaja & Mason, 2008).

In contrast, there is also substantial research that reveals higher rates of mental distress among refugee and migrant women compared with men (Cooper et al., 2019; Edwards et al., 2018; Hamrah et al., 2020; Minas et al., 2008; Newnham et al., 2019; Nickerson, Hadzi-Pavlovic, et al., 2019; Schweitzer et al., 2006). A longitudinal study undertaken between 1995 and 1997 with newly arrived migrants found that migrant women were more likely than men to experience 'psychological disadvantage'/'impairment' (Kennedy & McDonald, 2006). In their study with elderly migrants from Italian-speaking, Macedonian-speaking and Spanish-speaking backgrounds, Minas et al (2008) found that women (particularly Italian-speaking women) were more likely to experience poor mental health than men across the different groups. Data from the first wave of the BNLA longitudinal study with newly arrived refugees revealed high levels of psychological distress in the cohort, with women more likely than men to be experiencing moderate to high levels of distress (Edwards et al., 2018). These findings persisted over the initial years of resettlement; Cooper et al.'s (2019) analysis of the first three waves of the BNLA study found that high levels of distress (PTSD and 'high risk of severe mental illness') endured, as did the higher levels of psychological distress among women.

Some research has found that within migrant and refugee communities, women experience greater rates of PTSD (Cooper et al., 2019; Schweitzer et al., 2006), anxiety (Lumley et al., 2018; Schweitzer et al., 2006; D Silove et al., 1997), and depression (Schweitzer et al., 2006). For example, in a study with resettled Bhutanese refugees, Lumley et al. (2018) found that women often experienced greater anxiety and homesickness, but not greater acculturative stress or depression. These studies demonstrate that gender can be a predictor for particular mental health conditions or symptoms.

3.3. Social determinants and predictors of mental ill health

Pre-migration factors

A portion of the Australian refugee and migrant mental health literature centres around the impact of the migration experience, exploring the effect of pre-migration, migration, and post-migration factors upon mental health. Only a handful of studies have focussed specifically on women's experiences of migration-related predictors of mental health, and we have highlighted such findings where possible.

Pre-migration factors as well as factors that manifest throughout the migration journey are associated with mental ill-health and/or increased psychological distress. Pre-migration trauma includes experiences of violence and war, family separation, sexual and gender-based violence, torture, imprisonment and immigration detention, the denial of basic living essentials and other types of trauma (Gorman et al., 2003; Herrman et al., 2010; Markovic et al., 2002; Rees, 2003; Schweitzer et al., 2006, 2018). Experiences of pre-migration trauma do not only affect individuals who have survived traumatic experiences, but also their relationships with their families and communities (Herrman et al., 2010).

The body of research available regarding the effect of pre-migration factors on mental health has focussed upon humanitarian entrants rather than migrants generally (Chen, Hall, et al., 2017; Schweitzer et al., 2006, 2011, 2018). A strong correlation has been found between post-traumatic stress and pre-migration trauma experiences (Schweitzer et al., 2006). In their research with Sudanese refugees, Schweitzer and colleagues (2006) found that high levels of pre-migration trauma were associated with mental distress, particularly post-traumatic stress, alongside other factors such as a person's gender and family separation. Other research indicates that the impacts of pre-migration trauma on mental health are not necessarily resolved over time following resettlement (Hugman et al., 2004).

A small number of Australian studies have explored the impact of pre-migration factors upon particular populations of refugee or asylum seeker women (but not migrant women with other visa statuses) (Jarallah & Baxter, 2019; Markovic et al., 2002; Rees, 2003; Schweitzer et al., 2018). Schweitzer et al. (2018) conducted a study with women who arrived in Australia on 'women-at-risk' humanitarian visas from various countries of origin, exploring their experiences of symptoms of trauma, anxiety, depression, and somatisation, as well as the factors that contributed to their symptoms. Nearly two-thirds of women in the sample had witnessed acts of extreme violence, including the murder of friends and family, or had been forced to go without basic living essentials, such as food, water and shelter. The authors considered these proportions to be similar to reports from other cohorts of refugee women; however, the women-at-risk entrants were twice as likely to report experiences of serious injury, kidnapping, rape or other sexual abuse, and imprisonment or detention than refugee women resettled through other visa streams. They found that the number of pre-migration traumatic events experienced by participants was associated with rates of depression, trauma symptomatology and somatic symptoms, but was not associated with anxiety symptoms (Schweitzer et al., 2018). Other research has confirmed that women arriving through the women-at-risk visa pathway are more likely to report symptoms of mental ill-health compared with other women arriving through the humanitarian program who do not meet the women-at-risk criteria (Jarallah & Baxter, 2019). Rees (2003) investigated the experiences of East Timorese asylum seeker women residing in Australia and also confirmed the ongoing effect of pre-migration trauma on wellbeing; however, her findings also highlight the impact of resettlement factors, such as the asylum application process, in *re-traumatising* women and exacerbating pre-existing trauma.

Contributions of both pre and post-migration factors

Research with refugee populations suggests that although pre-migration trauma may play a role in shaping future mental health, it does so alongside many other factors (Correa-Velez et al., 2020;

Schweitzer et al., 2011, 2018). It is important to bear in mind that pre-migration factors are not easily separable from post-migration factors to enable analysis in studies. Markovic et al. (2002) explored the health of Yugoslavia-born migrant women living in Queensland through in-depth interviews (n=52) and surveys (n=118) and found that although psychological distress was associated with women's pre-migration experiences of violence and war, women's reports of the effects of pre-migration trauma on their mental health were often intertwined with the negative effects of post-migration experiences; this made it "difficult to establish a clear-cut line between health problems caused by pre- and post-immigration experiences" (Markovic et al., 2002, p. 9). Others have also confirmed that the effects of pre-migration trauma are exacerbated by post-migration stress (Brough et al., 2003; Chen, Hall, et al., 2017; Rees, 2003; Derrick Silove & Steel, 1998). One study for example found that newly arrived Iraqi refugees' experiences of psychological distress were much lower than those who had been resettled for approximately five years, indicating that post-migration experiences can have a negative impact on refugees' mental health (Uribe Guajardo et al., 2016).

Some studies have contemplated the relative contribution of pre-migration and post-migration factors in influencing the mental health of refugee populations, and have found that post-migration factors have greater salience (Chen, Hall, et al., 2017; Correa-Velez et al., 2020; Fozdar, 2009; Schweitzer et al., 2011). Chen and colleagues analysed the first wave of data from the BNLA longitudinal study to consider the impact of both pre and post-migration factors affecting the mental health of humanitarian entrants (Chen, Hall, et al., 2017; Chen, Ling, et al., 2017). They found a strong association between social integration and positive mental health outcomes and confirmed that social integration modified the impact of pre-migration experiences of trauma. After controlling for confounding factors and analysing both direct and indirect associations, the authors concluded that post-migration settlement-related factors were the most significant predictors of mental health among refugees (Chen, Hall, et al., 2017). Similarly, a recent study with newly arrived refugee women found that women's social capital and social networks positively predicted their quality of life in resettlement, more than their country of birth and experiences of pre-migration trauma (Correa-Velez, 2020).

Post-migration settlement stressors

The evidence confirms that a multitude of post-migration factors affects the mental health of migrant and refugee women such as: unemployment, lack of recognition of skills and qualifications, poverty and unstable housing, discrimination and Islamophobia, lack of social support and isolation, family violence, gender role stress, ongoing family separation, pressure/desire to send money to family overseas, insecure visa status (particularly for people seeking asylum), delays in visa processing, children, and language stresses. Below we outline and analyse the relevant research findings surrounding the contribution of:

- employment and material factors; and
- social factors.

This is not to suggest, however, that these factors are discrete or should be considered in isolation from one another; post-migration factors such as these are interconnected, as is their impact upon mental health.

Employment and material factors

Employment-related factors during resettlement are associated with mental health outcomes for both refugee and migrant populations, including women (Dowling et al., 2019; Hocking et al., 2015; Jirojwong & Manderson, 2001; Markovic et al., 2002). Kennedy and McDonald's (2006) analysis of the first three waves of the Longitudinal Survey of Immigrants to Australia (1995-1997) found that employment was significantly related to better mental health outcomes among migrants and refugees. The authors found that unemployed migrants displayed higher levels of psychological

distress than employed migrants, and this was true for all the waves. It has been suggested that poor mental health may cause lack of participation in the workforce, rather than lack of participation affecting mental health (Khoo, 2010). To address this, Kennedy and McDonald (2006) investigated the direction of effect between employment and mental health through multinomial logit models. Their findings indicate that mental health status did not directly influence subsequent labour force participation, but that unemployment did have a direct detrimental effect on mental health status.

This and other studies have also found that employment-related stressors are not confined to unemployment, but also under-employment or unsatisfactory employment circumstances. Kennedy and McDonald (2006, p. 450) observed that the mental health of migrants who had low job satisfaction suffered even more than those who were unemployed, implying that a “bad” job can be worse than no job at all”. A study with Chinese migrants attending a General Practice in Sydney found that risk of anxiety or depression was particularly associated with diminished occupational status (Tang et al., 2009). Reduced employment status is likely related to the failure to recognise migrant and refugees’ skills and qualifications by the Australian government and employers, as well as other forms of discrimination.

Such employment-related factors have been found to affect both men and women. Markovic et al. (2002) found that former Yugoslavian refugee women’s mental health was detrimentally affected by their low socioeconomic status due to barriers accessing the job market following migration. In another study exploring refugees’ health, an Afghan woman reported how employment barriers had resulted in her depression:

“I go to school to become dental assistant. I go every day to study. I left my kids with other people for one year. I get the paper to say I can do job. I look for job but didn’t get. Most said: ‘Your English is no good’ or ‘You wear a scarf. I was so sad cos I trying very hard and I went to many interviews. Then I give up. Too many things pushing me down. I am still very sad, angry about it. It make me feel I am nothing” (Dowling et al., 2019, p. 10).

This woman’s quote illustrates the stress that employment difficulties coupled with discrimination can place upon migrants and refugees.

For migrants and refugees, employment-related mental health issues may increase or decrease depending on age. One study exploring depression, anxiety, and acculturative stress experienced by resettled Bhutanese refugees, found that depression and anxiety increased with participant’s age; however, it reduced after the age of 65 years (Lumley et al., 2018). The authors contend that this tendency may be also be explained by employment-related factors, with those of older working-age experiencing greater losses through the resettlement process compared with younger migrants (e.g. for older migrants, there is can be a loss of social status and greater difficulty finding employment and learning English). After retirement age, lack of employment may be viewed as more acceptable, explaining the reduced mental distress experienced by those over 65. Lumley et al. (2018) also found that proficiency in English had a protective effect on mental health, along with the completion of secondary education and employment.

Employment difficulties are also connected to poverty and housing instability that migrants and refugees may experience in resettlement, which are important post-migration factors that can shape mental health outcomes in their own right (Fozdar & Hartley, 2013). Cooper et al. (2019) found that both PTSD and ‘high risk of serious mental illness’ (HR-SMI) among humanitarian arrivals were associated with financial hardship, and that HR-SMI was also associated with unstable housing circumstances and discrimination. Migrants and refugees on temporary visas without recourse to social supports from the government are particularly at risk of experiencing destitution, which is likely to worsen existing mental health conditions, as well as produce new mental health risks (Herrman et al., 2010).

Social factors

In addition to employment and material stresses, many studies have emphasised the significant impact of social factors on the mental health of migrants and refugees during resettlement. Chen, Hall and colleagues (2017) found that social integration and loneliness play key roles in modifying the effect of pre-migration traumatic factors and in predicting mental health outcomes of humanitarian arrivals. Recent research with women arriving on 'women-at-risk' humanitarian visas similarly stresses the influence of social factors (Correa-Velez et al., 2020; Schweitzer et al., 2018):

“post-migration difficulties of most concern to the women were relational in character, with over two-thirds revealing worry about family overseas, over one-third reporting problems with communication, and nearly one-third reporting difficulties with loneliness and boredom” (Schweitzer et al., 2018, p. 9).

Indeed, according to the literature, separation from family overseas has been found to be a key stressor affecting mental health and wellbeing (Dowling et al., 2020; Mansouri & Cauchi, 2007; Savic et al., 2013; Schweitzer et al., 2011, 2018; Wilmsen, 2013). One study with Sudanese refugees emphasised the detrimental impact of family separation on mental health and found that sending money back to family members overseas was often prioritised above participants' own concerns (Savic et al., 2013). This study also found that mainstream services tended to have little awareness of family separation and the impact this had upon migrants and refugees (Savic et al., 2013). Similarly, findings from a study with refugees from Myanmar indicated that the post-migration factors of greatest salience in predicting mental health outcomes were concerns about family still residing living overseas alongside communication difficulties (Schweitzer et al., 2011).

Social support provided by refugee and migrants' ethnic community in resettlement has also been found to be important in promoting mental health (Schweitzer et al., 2006; see also Nickerson, Liddell, et al., 2019). A small phenomenological study exploring refugees' experiences of migration to Australia found that family, friends and community were all considered important sources of social support in addition to faith or religiosity; however, the role of family in particular was emphasised in the findings (Dowling et al., 2020). The authors also found that social supports tended to be perceived as more important by female participants compared with male. Difficulty learning English was reported to increase feelings of social isolation, as it hampered participants' ability to make new social connections and join the labour force, exacerbating feelings of stress and anxiety (Dowling et al., 2020). This finding highlights how factors such as language, employment, and social integration are oftentimes enmeshed, demonstrating the interconnectedness of post-migration factors that influence mental health.

Race and discrimination

There is strong evidence that racism and discrimination are important post-migration factors that affect migrant and refugees' mental health outcomes, intersecting with other post-migration stressors (Burford-Rice et al., 2020; du Plooy et al., 2019). This is not surprising; racism is a key social determinant of health (Paradies et al., 2015) and British colonial attitudes that position whiteness as the norm, continue to pervade Australian politics and society.¹

The available evidence demonstrates that experiences of racial discrimination in Australia are associated with poor mental health outcomes among both migrant and refugee populations

¹ Note, the damaging impact of racism on Aboriginal and Torres Strait Islander Australians' mental health has been evidenced extensively (Kelaher et al., 2014; Paradies et al., 2015; Ziersch et al., 2011).

(Buchanan et al., 2018; du Plooy et al., 2019; Ferdinand et al., 2015). Ferdinand et al. (2015) conducted a study with people from different racial and ethnic minority backgrounds in four Australian locations (both metropolitan and rural) (n= 1,139) to investigate the relationship between racism and discrimination and psychological distress, as measured by the Kessler 6 (K6) Psychological Distress Scale. Their findings indicate that higher frequency of discrimination is particularly associated with poorer mental health outcomes, and that racism experienced in shops, in the course of employment or government settings was also associated with high or very high psychological distress (Ferdinand et al., 2015). Participants experienced greater rates of discrimination in metropolitan areas than in rural areas. The study also found that men experienced more racism than women, with the exception of Muslim women. This may be related to Muslim women's relative visibility; the authors concluded that people categorised under "very high visibility" (such as Muslim women wearing the hijab and Sikh men wearing dastar) were more likely to experience discrimination (Ferdinand et al., 2015, p. 6). It may also be evidence of the Islamophobia present within the Australian community.

There is also research that indicates that migrant and refugees' mental health is not only influenced by individual, direct acts of discrimination, but also by negative media, political and legislative discourses generally (Apostolidou, 2018; Burford-Rice et al., 2020). Through her work investigating psychological therapy with asylum seekers, Apostolidou (2018) posits that the discriminatory political discourses that surround seeking asylum in Australia produce detrimental impacts upon asylum seeker' mental health. Exploring the experiences of the South Sudanese refugee community resettled in South Australia, Burford-Rice et al. (2020) confirmed that experiences of racism and discrimination had a detrimental impact on participants' mental health, as well as their sense of identity and feelings about the future. In addition to direct acts of racism, the authors found that racist media representations of Sudanese people had a damaging effect on participants' mental health and caused parents, in particular, to worry about their children.

In addition to associations with psychological distress or ill-health, racism and discrimination have been found to have detrimental effects on people's general wellbeing and capacity to 'flourish' (du Plooy et al., 2019, p. 561). This has been noted in adults but also in studies that relate to adolescents or young people. Correa-Velez et al.'s research found that refugee young people's "experiences of social inclusion or exclusion have a significant impact on their subjective wellbeing – the most important predictors being subjective social status in the host community, discrimination and bullying" (2010, p. 1404). Buchanan et al.'s (2018, p. 105) study explored the relationship between discrimination and "psychological and socio-cultural adaptation" to living in Australia for young people from both refugee backgrounds and non-refugee migrant backgrounds. The authors found that young people from both cohorts who had experienced 'perceived' discrimination tended to report lower levels of 'adaptation', which points to the potentially detrimental impact of discrimination and racism (Buchanan et al., 2018, p. 105).

Gender

Various studies have found that gender plays a role in determining the mental health outcomes of refugee and migrant populations (see section 3.2 above in relation to prevalence and gender). However, more research is needed to explore the particular gendered factors and inequalities that shape migrant and refugee women's mental health. Notwithstanding this, two key gendered factors were highlighted in the research: (1) gender-based violence; and (2) gender role stress and changing gender identities.

Gender-based violence can occur in pre-migration, transit and post-migration phases, and can have lasting effects on women's mental health (Costa, 2007; Raphael et al., 2008). Gender-based violence encompasses intimate partner violence (IPV) and family violence, as well as violence perpetrated by

others, such as authorities, soldiers, police and community members. Studies have found that experiences of gender-based violence are associated with mental ill-health or distress among women generally (Ellsberg et al., 2008; Rees et al., 2011; Vos et al., 2006), as well as in studies with refugee and migrant women (Rees et al., 2019). One study explored the relationship between a history of IPV (disclosed in antenatal appointments) and mental health, and found that IPV was associated with higher rates of mental illness (Dahlen et al., 2018). The study found that rates of disclosure of IPV varied across different nations of birth, with Australian-born women the most likely to disclose. For those not born in Australia, Sudan-born women (9.1%) and New Zealand-born (7.2%) reported the most IPV, and women from China and India reported the least. The researchers suggest that this variation reflects differences in willingness to report across populations rather than prevalence rates (Dahlen et al., 2018).

In a participatory research project that took place in Victoria and Tasmania, migrant and refugee women reported that family violence had detrimentally affected their mental health often with long-lasting effects:

"Although the reported health and wellbeing impacts of family violence occurred across a continuum, almost all of the women reported stress, fear and anxiety during the relationship, regardless of the frequency or severity of the perpetrator's violence. Many participants also expressed feelings of isolation, depression, guilt and self-blame, low self-esteem, loss of confidence, and in a number of cases, suicidal thoughts" (Vaughan et al., 2016, p. 53).

Family violence has been found to be a key factor in studies concerning perinatal depression and anxiety (Rees et al., 2019; Shafiei et al., 2018), as well as suicidality and self-harm (FASST, 2019; O'Connor & Ibrahim, 2018) (see section 3.5 below). Women have also reported that their children's mental health and well-being suffered as a result of family violence (Vaughan et al., 2016). In research with Thai migrant women in Brisbane, poor mental health was most often reported to be related to participants' family circumstances, including experiences of family violence (Vatcharavongvan et al., 2014). O'Connor and Colucci (2016) explored the experiences of an Australian Indian migrant community and similarly found that gender-based violence contributes to experiences of social distress, which can have an impact upon Indian migrant women's mental health. The authors conclude that gender-based violence emerges at the intersection of various cultural contexts, such as patriarchy, as well as societal contexts, such as the migration experience, which introduces particular factors that can drive or reinforce violence (e.g. isolation from protective social networks and immigration-related stress) (O'Connor & Colucci, 2016).

Research also confirms that migrant and refugee women face structural barriers to seeking help to address gender-based violence, which can expose women to violence for longer periods and exacerbate the effects of violence (Vaughan et al., 2016, 2020). Indeed, although gender-based violence occurs across all Australian populations, gendered forms of violence experienced by migrant and refugee women intersect with other social, political and economic inequities, such as restrictions tied to visas, to produce coalescing harms (Rees & Pease, 2006, 2007; Vaughan et al., 2016). In their research with refugee communities, Rees and Pease (2007, p. 3) conclude that "social injustices impacting on refugee communities, occurring at multiple sites, requires urgent attention if refugee women are to feel safer in their own homes. This is not to advocate an argument of causality, but rather to emphasise the compounding factors that can make refugee families vulnerable to violence, its effects and outcomes".

The literature also indicates that some refugees may struggle with changes in gender roles and expectations during resettlement, which can play a role in gendered violence as well as have impacts on both men and women's mental health (Fisher, 2013; Hart, 2002; K. Milner & Khawaja, 2010; Rees & Pease, 2007). Indeed, changing social roles generally have been found to have a detrimental impact

on refugees' sense of identity and psychological adjustment during the resettlement period (Colic-Peisker & Walker, 2003). Some men may perceive resettlement to have precipitated a gender role reversal (due to, for example, women receiving social security payments in their own name or finding employment), or may struggle with being unemployed and unable to fulfil their expected role of 'provider' (Fisher, 2013; Straiton et al., 2014). Kennedy and McDonald's (2006) analysis of longitudinal data indicates that migrant women's mental health is not affected by their husbands' participation or lack of participation in the workforce; however, unemployed men's mental health is affected by their wife's participation. The authors investigated whether this effect is the result of financial stress but did not find a significant relationship, suggesting other explanations such as envy or "inadequacy-as-a-provider effects" (Kennedy & McDonald, 2006, p. 454).

Stress associated with gender roles has also been identified as a factor that can affect migrant and refugee women's mental health (Bhugra et al., 2011; Nahas & Amasheh, 1999). For example, a study exploring Jordanian women's experiences of post-natal depression in Sydney found that a perceived failure to live up to the traditional role expectations of mothers and wives, underpinned women's experiences of depression and poor self-esteem (Nahas & Amasheh, 1999). It has also been observed that gender inequalities that arise from family or marriage role expectations can also affect women's engagement with mental health services (Baker et al., 2016).

Intersectional inequalities

Gendered inequalities faced by migrant and refugee women intersect with other inequalities such as those based upon race, religion, disability, age, sexuality and geographical location to shape women's experiences of mental health (Baker et al., 2016). There is a paucity of research, however, that explores the effect of such intersectional inequalities.

The mental health of migrant and refugee women with a disability, both psychosocial and physical, has been neglected in the literature. Liddell et al. (2016) analysed the results of the 2007 NSMHW survey to investigate the prevalence of mental disorders and disability among both first and second-generation Australian migrants. The study found that although overall levels of disability were equal with the Australian-born population, mental health-related disability was higher in the first-generation migrants from non-English speaking backgrounds compared with the Australian population. Indeed, although mental illness can be a form of psychosocial disability in itself, it may also intersect with other types of disability experienced by women from migrant and refugee backgrounds. Although there is limited evidence exploring the experiences of migrant and refugee women's mental health who live with other disabilities, there is clear evidence that mental health is detrimentally affected by the acquisition of disability among the general population. This is due to the interconnected inequities that women with disabilities face; research confirms that declining mental health of those with disabilities is related to social determinants such as unemployment (A. Milner et al., 2014), lower socioeconomic status (Kavanagh et al., 2015), and limited social support (Honey et al., 2011). A recent report identified the heightened challenges faced by refugees with disabilities resettling in Australia, such as lack of adequate and appropriate housing, inadequate NDIS support (including lack of access to language services), and a lack of culturally relevant services (FECCA et al., 2019).

There exist similar research gaps concerning the mental health experiences of Australian migrant and refugee women who identify as LGBTQI. The evidence is clear that LGBTQI women face higher risks of mental ill-health compared with heterosexual women (AIHW, 2018; McNair et al., 2011). We also know that LGBTQI women report less continuity in their general practitioner care, as well as less satisfaction with such services (McNair et al., 2011). Discrimination based upon homophobia affects women's experiences of both mental health as well as their experiences of help-seeking. How such

homophobic discrimination intersects with Australian migrant and refugees' experiences of race-based or class-based discrimination to influence their mental health outcomes is yet to be explored.

“Research on lesbian health in the Australian context... has tended to be conducted in large part with anglo-Australian or US, English-speaking, middle-class, highly educated women... [I]n the process of rendering ‘lesbian health’ visible, this research simultaneously renders lesbians from immigrant and refugee and/or working class communities invisible” (Murdolo, 2008, p. 42).

As many LGBTQI people are forced to seek asylum due to their sexuality, there has been some recent focus given to LGBTQI asylum seekers in the literature; however, this remains limited. International studies have found that LGBTQI asylum seekers experience very high levels of mental distress, influenced by past persecution, as well as social circumstances and barriers to social integration post-resettlement (Fox et al., 2020; Hopkinson et al., 2017; Mulé & Gamble, 2018).

Similarly, there were no Australian studies identified which explore the dimensions of migrant and refugee women’s mental health living in rural locations. One study did highlight the need for culturally relevant mental health resources to be developed for migrant and refugee women living in rural areas (Tan & Denson, 2019). Fraser et al (2002, p. 290) note that a "one size fits all" approach tends to be taken by Australian researchers who investigate rural mental health, erasing the heterogeneity that exists in rural locations. Despite the lack of research, it is clear that migrant and refugee women living in rural areas are likely to face additional challenges which may affect their mental health. Such challenges include lower levels of employment and income, lack of education opportunities, social isolation and insufficient services (both services for the population as whole and services targeted at migrant and refugee communities), including a lack of mental health services and sexual and reproductive health services. The ongoing impacts of environmental factors such as drought and fire upon the mental health women living in rural areas should also be considered.

Immigration system stressors and detention

The evidence is clear that Australia’s immigration policies and procedures can play a role in determining the mental health of migrants and refugees (Killedar & Harris, 2017; Nickerson, Byrow, et al., 2019; Smith, 2015). Although immigration system stressors can be experienced pre-migration, during transit and post-migration, the Australian literature identified in our review focusses upon the post-migration impacts, particularly in relation to temporary or insecure visa status and the use of detention.

Visa status

A large body of literature indicates that insecure or temporary visa status can have adverse effects upon individuals’ mental health, particularly long-term status insecurity (Hocking et al., 2015; Khawaja & Stein, 2016; Liddell et al., 2013; Momartin et al., 2006; Newnham et al., 2019; Nickerson, Byrow, et al., 2019; Steel et al., 2011). Many post-migration stressors are associated with insecure visa status, such as lack of eligibility for basic social services and medical care, inability to work, onerous immigration procedures, long waiting periods for immigration determinations, and fear of deportation, refoulement or detention. However, the impact of insecure visa status can be both symbolic and material. As Mansouri and Cauchi (2007) note, the exclusionary political discourses that surround migration and underpin the government’s temporary visas regime can also have a detrimental impact upon individuals’ mental health. Writing in the context of asylum seekers, Koopowitz and Abhary (2004, p. 500) argue that temporary protection visas confer individuals with the status of ‘non-person’: “Asylum seekers flee to Australia expecting support and [are] not prepared for... another political struggle”.

Insecure visa status and its associated stressors can also exacerbate past traumas. Rees (2003, 2004) conducted a study investigating the impact of temporary visa status on the social and emotional wellbeing of East Timorese asylum-seeking women in Australia and found that within the cohort, the threat of deportation was associated with trauma and re-traumatisation. The majority of women in the study had been living with temporary visa status for five to nine years:

“The effects of living with the threat of forced removal included sleep disturbances, pre-occupation with a forcible return to East Timor and associated intrusive thoughts, inability to make plans for the future despite aspirations to succeed in Australia, concerns about the future of children born or raised in Australia, loss of motivation and low self esteem, and anger particularly evident among the younger and more politically aware asylum seekers” (Rees, 2003, p. 98).

Another study exploring the mental health impacts of insecure visa status among asylum seekers and refugees and found that those with insecure visa status were at least five times more likely to report high or very high depression and anxiety symptoms compared with those who had attained permanent visas (Newnham et al., 2019). The study also indicated that women were almost twice as likely than men to report high or very high symptoms (Newnham et al., 2019).

It should be noted that although insecure visa status affects many types of migrants, most of the Australian research concerns asylum seekers and refugees. There is the general research gap concerning the mental health experiences of non-asylum seeker migrants with temporary immigration status, including women, such as those on student, worker or partner visas. There is some evidence that women who arrive on partner visas face a heightened risk of experiencing mental health issues (MHCS, 2018). Women on partner visas face insecurity as they arrive on temporary visas and transition to permanent visas, such that their status is (or perceived to be) in the control of their sponsoring partner. More research is needed to explore the mental health impacts of such dynamics; however, it is clear that immigration-related violence associated with insecure visa status can inform perpetrators' use of family violence (Vaughan et al., 2016).

Immigration detention

Immigration detention is a clear predictor of mental ill-health in men, women and children (Campbell & Steel, 2015; Coffey et al., 2010; Green & Eagar, 2010; Kenyon, 2017; Mares, 2016; Mares & Jureidini, 2004; Robjant et al., 2009; Derrick Silove et al., 2007). Although (again) much of the discourse surrounding detention concerns asylum seekers, many different types of migrants are placed in immigration detention. Bull et al. (2013) found that over half (56%) of immigration detainees entered Australia on a legal visa and either overstayed or had their visas cancelled. Research has consistently demonstrated that people detained in immigration detention in Australia experience high rates of mental health conditions, including anxiety, depression, post-traumatic stress disorder, psychosis, self-harm and suicidal ideation (Hedrick et al., 2019; Newman et al., 2011; Rivas & Bull, 2018; Sultan & O'Sullivan, 2001; Young & Gordon, 2016). One study in Villawood detention centre reported that a fifth of detainees exhibited psychosis, one third suffered from paranoid delusions, and two-thirds experienced suicidal ideation (Sultan & O'Sullivan, 2001). Such conditions are exacerbated by policies that do not prioritise detainees' mental health. Sultan and O'Sullivan (2001), for example, reported that hospital admittance in relation to mental health conditions was only approved for medical emergencies involving self-harm.

Although pre-migration trauma can play a role in predicting detainees' mental health, psychiatric morbidities are higher among asylum seekers in detention compared with asylum seekers in the community (McGorry, 2002). Steel et al. (2004) found that detention increased adult detainees' experiences of psychiatric disorders threefold, and increased children's experiences tenfold. Detainees, both men and women, have also described experiencing gender-based violence and other

forms of violence in detention, perpetrated by family members, other detainees and detention authorities themselves (Rivas & Bull, 2018; Sultan & O'Sullivan, 2001).

Declining mental health outcomes have consistently been found to be associated with the length of time spent in detention (Green & Eagar, 2010; Steel et al., 2004, 2006; Young & Gordon, 2016). Through an analysis of 720 detainees health records, Green and Eagar (2010) found that length of time detained did not only exacerbate existing conditions but was also associated with the manifestation of new mental health problems. The effects of detention on mental health can be long-lasting; findings from one study indicated that the association between severe mental health conditions and length in detention persisted for three years on average following release from detention (Steel et al., 2006). The length of time in detention has been found to be particularly detrimental to female detainees' mental health (Young & Gordon, 2016).

It should be noted that most of the research regarding the effects of detention on mental health has concerned the adult detained population generally, the majority of which are men. Rivas and Bull (2018) specifically explored the experiences of women in long term detention to address the gap in our understanding of the effects of detention on women. The study found that the majority of the women (approximately 90%) reported suffering from at least one mental health condition. A previous study conducted by Bull and colleagues (2013) with the general population of detainees and found that 60% suffered from mental health conditions, suggesting that women are more likely to experience mental health conditions in extended detention. Almost half the women had experienced torture and trauma before their detention, with detention likely magnifying the psychological impacts of such trauma (Rivas & Bull, 2018). In addition to the length and conditions of detention, women reported that their mental health was affected by uncertainty and anxiety regarding their immigration case and the lack of control they had over their lives, confirming the compounding effect of multiple environmental factors upon women's mental health (Rivas & Bull, 2018).

3.4. Access to and utilisation of mental health services

There is evidence that migrant and refugee communities are failing to access mental health services (Slewa-Younan et al., 2014, 2015; Wohler & Dantas, 2017). Minas et al. (2013b) point out, however, that although data suggests lower levels of service usage compared with other populations, it is difficult to conclude that services are under-utilised without robust mental health prevalence data. Notwithstanding this caveat, the available literature suggests that migrant and refugees face multiple barriers to accessing mental health support, which hinders their ability to access and engage with services.

Barriers

One such barrier exists at the policy level. There is a tendency in Australian policy discourse to discuss migrant and refugee communities as a homogenous group, somewhat paradoxically under the banner of 'culturally and linguistically diverse' or CALD persons (Henderson & Kendall, 2011). Through such homogenising, policymaking processes fail to meaningfully consider the differing needs of both individuals and communities within so-called CALD populations. Problems have also been identified with the way in which governments and policymakers are held accountable for their commitments to migrant and refugee populations within mental health programming. Although government mental health policies and strategies contain positive intentions to meet the needs of CALD communities, there is little reporting by either federal or state governments regarding the actual impacts of programming upon these populations (Minas et al., 2013b). Failure to collect outcomes data that is relevant to migrant and refugee populations means that it is "impossible to evaluate the effectiveness

of mental health services received by immigrant and refugee communities, care utilisation and continuity of care” (Minas et al., 2013b, p. 21).

Much of the literature is concerned with barriers that exist on the supply side. Studies consistently highlight barriers caused by lack of language proficiency and communication difficulties with health professionals (Allotey, 1999; Cross & Bloomer, 2010; Henderson & Kendall, 2011; Leite da Silva & Dawson, 2004). Communication problems can also compromise the capacity of providers to build rapport and trust with clients. The literature also suggests that migrant and refugee communities’ lack of knowledge and awareness of available services remains a key barrier to services (de Anstiss & Ziaian, 2010; Gorman et al., 2003; Henderson & Kendall, 2011; Rintoul, 2010; Wohler & Dantas, 2017). This has sometimes been framed in the literature as “poor mental health literacy”, whereby migrants and refugees do not have sufficient knowledge to recognise, manage and prevent mental health conditions (Blignault et al., 2008; Slewa-Younan et al., 2014, p. 2; Wong et al., 2012). Such a frame tends to place the deficit on the side of the service user rather than the service or broader policies. Mental health information is valued by migrant and refugee women, as S. K. Lee et al.’s., research demonstrates. Their research, conducted in Perth with newly arrived refugee and migrant women, found that access to information regarding mental health issues was identified by women as one of their top priorities, along with information about employment, family violence and other health-related issues (S. K. Lee et al., 2013).

Social stigma surrounding mental health issues and services within both migrant and refugee communities has also been found to limit the utilisation of services (de Anstiss & Ziaian, 2010; ECCV, 2018; Gorman et al., 2003; Haralambous et al., 2016; Russo et al., 2015; Shafiei et al., 2018; Thompson et al., 2002; Valibhoy et al., 2017; Wagner et al., 2006). Research exploring migrants’ and refugees’ experiences of stigma has found that in some communities there is a belief that mental health problems should be kept within the family unit, with some fearing judgment by professionals or that disclosure may put their employment at risk (Blignault et al., 2008; Colucci et al., 2014). The imposition of a diagnostic mental health label upon a person’s experiences can also be distressing due to internalised stigma or fear of community stigmatisation (Wohler & Dantas, 2017).

Individual-level, service-level and sector-level barriers to mental healthcare also operate on the service side. For one, there tends to be a lack of reliable and confidential language services, as well as a lack of trained bilingual-bicultural practitioners working in health services. This is related to funding but also to organisational and sector-level policies. A study exploring the experiences of multi-lingual/bi-lingual psychologists working in Australia found that participants had difficulty entering the profession due to systemic barriers such as language policies (Tan & Denson, 2019). Other service-side barriers to accessing mental healthcare have been identified, such as affordability (Rintoul, 2010; Shafiei et al., 2018) and long waiting lists (Colucci et al., 2015). There is usually a gap between the Medicare subsidy and the cost of services, and there are very few free services in the sector (Rintoul, 2010). What is more, many are ineligible for services, particularly those on temporary visas (Shafiei et al., 2018). Time restraints on appointments have also been identified as a service-side barrier that can compromise trust-building, as health practitioners often lack the ability to address migrant and refugee women’s needs in the limited time available, especially when using interpreters (Allotey, 1999; Valibhoy et al., 2017).

On a broader level, immigration processes and discourse may also act as a barrier to migrants and refugees utilising and engaging with mental health services. In her study concerning asylum seekers, Apostolidou (2018) argues that the distinction between practitioners (‘the inside’) and asylum seekers (‘the outside’) produced by political and legislative discourses surrounding asylum, shapes the relationship between practitioners and clients: “practitioners find themselves in the difficult position of trying to differentiate themselves from the system that is responsible for asylum seekers’

psychosocial reality, whilst they are clearly aware of the position they might quite rightly occupy in their clients' eyes" (Apostolidou, 2018, p. 6). This can compromise practitioners' ability to build the trust necessary to engage the client and make therapeutic progress.

Research has confirmed that practitioners often lack necessary skills, such as an ability to address the effects of large scale collective trauma (Joffe et al., 1996) and cultural competency or responsiveness (Colucci et al., 2014; ECCV, 2018; Shafiei et al., 2018; Wohler & Dantas, 2017), both of which create dissonance between clients and professionals. However, it should be noted that limitations regarding the concept of cultural competency itself have been raised in the literature. A study evaluating the impact of cultural competency training (with a range of interdisciplinary professionals) observed that the term 'cultural competency' may be problematic as it suggests that it is something that can be attained rather than connoting a process of continued learning (Verdon, 2020). Verdon (2020) highlights Kumagai and Lypson's (2009) concept of 'critical consciousness', as an alternative to 'cultural competency', which calls for critical reflexivity and a commitment to address disparities:

"Critical consciousness highlights the need for professionals to move beyond generic skills, knowledge and attitudes towards a critical awareness of themselves, others and the world around them.... [I]t is essential to critically evaluate the society in which practice is contextualised to uncover often unstated or invisible power structures, privilege, biases and inequities that exist, including the professional's position within these social structures" (Verdon, 2020, p. 16).

A critical consciousness approach may help practitioners avoid 'othering' migrant and refugee clients by defining them solely through their 'culture'.

Indeed, migrants and refugees have described feeling 'otherised' and discriminated against by medical professionals, based on religious attire or language proficiency for example, which also hinders service utilisation (Blignault et al., 2008; Omeri et al., 2006; Shafiei et al., 2015). Migrants and refugees have also reported feeling disrespected for holding alternative health beliefs (Henderson & Kendall, 2011). A study with South American refugee women in Perth found that their expression of mental distress through the concept of *susto* (which literally translates to 'fear' but denotes symptoms caused by a 'loss of soul') could not be adequately translated through Australian medical practitioners' diagnostic frames, resulting in women feeling unheard and even seeking assistance in their country of origin (Allotey, 1999, p. 70). Such attitudes towards beliefs perceived as 'non-medical' were also detected in some of the research literature. For example, in a study exploring Iraqi refugees' mental health literacy concerning PTSD, participants suggested that both medical action and spiritual action (such as reading a religious text) would be useful interventions, which prompted the researchers to note: "it is interesting that reading religious texts and seeking help from a psychiatrist were the interventions most often rated as helpful, given that these interventions could be seen to be at odds with each other" (Slewa-Younan et al., 2014, p. 5). This demonstrates how different types of mental health supports can be needlessly positioned against one another, often privileging biomedical models. It is also notable as holding religious beliefs and membership in faith communities have been found to promote mental wellbeing for migrants and refugees in the psychiatric and psychological research literature (Copping et al., 2010; Khawaja et al., 2008; Mitha & Adatia, 2016; Russo et al., 2015; Schweitzer et al., 2007).

The focus on biomedical models to address migrant and refugee women's mental health has also been raised as a key factor that affects the utilisation of services. In Markovic et al.'s (2002) study with refugee and migrant women from the former Yugoslavia, the researchers found about one in six participants had accessed the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) service; however, those that had approached the service had often done so for assistance regarding post-migration settlement problems, rather than to address past trauma or mental health symptoms. Participants reported feeling hesitant to access mental health services for various reasons:

“First... women interviewed felt that better financial security would cure their physical and mental problems. Second, women preferred to solve their health problems by relying on their own resources, including informal networks, rather than seeking assistance from health professionals; they felt capable of doing so given that they had applied this survival strategy during the war. Third, some women (professionals) who sought professional assistance considered them somewhat inappropriate [and questioned the usefulness of talking about past-traumas]” (Markovic et al., 2002, p. 9).

Other studies have similarly found that migrants and refugees may not see the value of ‘talk therapies’ as a treatment for mental illness, preferring help that addresses their social and practical needs (Colucci et al., 2014; de Anstiss & Ziaian, 2010). Indeed, there is also evidence that socio-economic conditions influence migrants’ recovery from mental illness (Brijnath, 2015). This demonstrates the importance of addressing the social determinants of mental health as a priority, rather than pathologising migrants and refugees’ experiences of social disadvantage.

More research is needed regarding the gendered factors that affect barriers to help-seeking among refugee and migrant populations. A systematic review of literature relating to refugees’ mental health service utilisation observed that although studies tend to note the *importance* of gender-related factors, such factors have been insufficiently investigated (Colucci et al., 2014). There is also a dearth of intersectional research that explores migrant and refugee women’s experiences of service utilisation from different social locations, such as positions shaped by class, race, disability, age or sexuality. One study highlighted the importance of intersectional analysis for understanding migrant and refugee’s engagement in services:

“[C]onsideration of how broad social categories interact... is essential to understanding health perceptions, behaviours and outcomes of people from CALD backgrounds and thus, to providing effective care. Adoption of a framework such as intersectionality is not intended to diminish the importance of understanding different cultures but serves to increase awareness about the complex range of factors, some of which sit within – and others outside – culture. It is recommended that future research explores the underlying social issues which intersect and impact on people of CALD backgrounds affected by mental health problems by further compounding and perpetuating health inequalities” (Baker et al., 2016, p. 397).

Facilitators

It is clear that interventions need to address the social determinants of mental health on multiple levels beyond that of the mental health system (Delara, 2016). Notwithstanding this, the research suggests or identifies facilitators that may help redress the barriers that migrant and refugee women face when accessing and utilising mental health services:

- In addition to ensuring the availability of effective language services, bilingual community-based advocates or workers are considered to play a key role in guiding people through the health system (Henderson & Kendall, 2011; Karageorge et al., 2018; Willey et al., 2020), including through outreach services (Colucci et al., 2015).
- Community-based or community-engaged initiatives that seek to address mental health are viewed as important (Baker et al., 2016; Colucci et al., 2015; Karageorge et al., 2018; Russo et al., 2015). This involves building trust and relationships with both individuals and communities, and taking a “whole of community” approach (Baker et al., 2016, p. 396). Responses and interventions should also draw upon the strengths and coping resources of both individuals and communities, and avoid deficit approaches (Copping et al., 2010).
- Studies have highlighted the importance of taking a ‘culturally responsive’ or ‘critically conscious’ approach to practice (Kumagai & Lypton, 2009; Verdon, 2020).

- Appropriate and relevant community education and resources need to be developed (Tan & Denson, 2019; Uribe Guajardo et al., 2016).
- Practices that recognise and embed clients' cultural explanatory models of mental health into services and therapeutic models are emphasised. Alternative models of intervention beyond Western biomedical models may be effective (Baker et al., 2016; Cross & Bloomer, 2010; Khawaja & Stein, 2016; Minas et al., 1994). A need for more resources that are based on different cultural approaches to mental health within treatments has also been identified, particularly for those communities living in rural and regional areas (Tan & Denson, 2019).
- Practitioners should recognise the potential impact of stigma and shame experienced by migrants and refugees seeking mental health support (Cross & Bloomer, 2010).
- Interventions that take a trauma-informed (Kaplan et al., 2016), flexible approach to treatment, based on a holistic view of clients' needs (both social/material and psychological) are considered effective (Kartal & Kiroopoulos, 2016; Khawaja & Stein, 2016; Schweitzer et al., 2002).
- Although further research is needed, the effect of gendered inequalities alongside other social inequalities (such as those based on race, class, sexuality and disability) should be considered when designing mental health initiatives with different migrant and refugee communities (Baker et al., 2016; MCWH, 2019).

Finally, it should be noted that despite these recommendations, very few studies identified in this review have evaluated the effectiveness of particular interventions that affect migrant and refugees in the mental health space (Brijnath, 2015; McBride et al., 2016; Verdon, 2020; Willey et al., 2020).

3.5. Specific disorders

Depression

Only a limited number of studies investigated depression in migrant and refugee populations, and most focus on perinatal depression (discussed below). The majority of studies exploring non-perinatal depression also investigated co-occurring symptoms of depression, anxiety and post-traumatic stress. Some research indicates that women experience higher rates of depression (Hamrah et al., 2020; Schweitzer et al., 2006) or depression and anxiety symptoms (Newnham et al., 2019). However, such research has been carried out with refugee populations only. One study investigating the experiences of depressive symptoms among Afghan refugees in Launceston determined that depressive symptoms were higher among women than men (Hamrah et al., 2020). The study found that women's symptoms were associated with formerly having had an occupation before migration, and social factors such as loneliness and boredom (Hamrah et al., 2020).

Several studies explored the meanings and experiences of depression or emotions of sadness within particular populations ([Antoniades et al., 2017](#); [Brijnath & Antoniades, 2018](#); [Fozdar, 2009](#); [Kokanovic et al., 2010](#); [Tilbury, 2007](#)). These studies consistently highlighted the importance of socio-structural factors in shaping participants' experiences, noting the danger of pathologising sadness caused by socio-structural stresses (Fozdar, 2009; Kokanovic et al., 2010; Tilbury, 2007). Kokanovic et al.'s (2010, p. 525) qualitative study with general practitioners working with East Timorese and Vietnamese migrants suffering from depression found that the doctors experienced an "internal struggle to 'fit' their biomedical knowledge with their appreciation of the distressing human stories they encountered", evidencing the "tremendous collision between narratives of traumatised communal and self-identity and the everyday business of clinical problem-solving". A study comparing the beliefs of Sri Lankan migrants and Anglo-Australians regarding aetiologies of depression found that both groups represented the illness in overlapping ways; however, Sri Lankan migrants were more likely to view depression as linked to circumstances, where Anglo-Australians were more likely to employ a biomedical explanatory model (Antoniades et al., 2017). Some studies questioned the efficacy of

biomedical explanatory models of depression for migrants and refugees, in particular where depression was found to arise out of collective experiences, complex traumas and post-migration difficulties (Kokanovic et al., 2010; Tilbury, 2007).

Perinatal depression and anxiety

Perinatal depression/anxiety is the most well-studied aspect of Australian migrant and refugee women's mental health. The majority of studies demonstrate that migrant and refugee women are particularly vulnerable to experiencing perinatal depression and/or anxiety (Alati et al., 2004; Bandyopadhyay et al., 2010; Eastwood et al., 2011, 2012; Hennegan et al., 2015). Australian population-based studies have found that country of birth other than Australia (Eastwood et al., 2011, 2012), migrants from non-English speaking backgrounds (Giallo et al., 2014; Lansakara et al., 2010; Navodani et al., 2019; Yelland et al., 2010), and migrants from CALD backgrounds (Khanlari et al., 2019; Ogbo et al., 2018) are all demographic attributes associated with a greater prevalence of perinatal mental health conditions. Pregnant refugee women have also reported higher rates of major depressive disorder (32.5%) in the antenatal period compared with pregnant Australian-born women (14.5%) (Rees et al., 2019).

The literature suggests that the differences between the experiences of refugee and migrant women and Australian-born women can be explained based on the social determinants of mental health discussed above (section 3.3). Studies consistently confirm the importance of social influences on the emotional wellbeing of migrant and refugee women in the perinatal period, with social isolation and loneliness being key risk factors (Alati et al., 2004; Bandyopadhyay et al., 2010; Hoban & Liamputtong, 2013; Rees et al., 2019; Russo et al., 2015). Factors found to be protective against perinatal mental illness include religiosity, social support networks and access to childcare (Russo et al., 2015). Socioeconomic or financial stresses have also been identified as influencing perinatal mental health (Rees et al., 2019; Shafiei et al., 2018).

Trauma and family violence appear to be associated with perinatal mental ill-health among migrant and refugee women (Rees et al., 2019; Shafiei et al., 2018). This mirrors patterns in the general population which suggest that intimate partner violence during pregnancy is strongly associated with poor perinatal mental health in women generally (Halim et al., 2018; Rose et al., 2010). However, rates of violence experienced during the perinatal period may differ across populations. One study indicated that one in four migrant women experienced intimate partner abuse in the first 12 months postpartum compared with one in six Australian-born women, and that migrant women were more likely to report depressive symptoms (Navodani et al., 2019).

Migrant and refugee women experience similar risk factors to perinatal mental health problems as Australian-born populations, such as isolation, socioeconomic difficulties, lack of social support, marital conflict, physical health problems and baby-related problems (Shafiei et al., 2015, 2018; Small et al., 2003). However, there are also distinctive risk factors associated with migration, such as migrating for marriage, short residency in Australia, uncertain immigration status and lack of social networks (Shafiei et al., 2018; Small et al., 2003).

Other migration-related factors associated with perinatal ill-health is level of English language proficiency and/or being born in a non-English speaking country. One study compared the postnatal experiences of different populations of Australian migrants from non-English speaking countries: one cohort had lower English proficiency (n=184) and one had higher English proficiency (n=460). The authors found that women with lower levels of English experienced more depression than those with higher levels (as well as higher rates compared with the Australian-born population) (Bandyopadhyay et al., 2010). Note that no differences were found between the groups regarding postnatal anxiety

(Bandyopadhyay et al., 2010). Another population-based study found that women born in non-English speaking countries were at increased risk of anxiety as well as comorbid anxiety and depression, compared with both migrant women from English-speaking countries and Australian-born women (Yelland et al., 2010).

Some research has highlighted the importance of being able to perform traditional cultural practices for migrant and refugee women in the postnatal period (Chu, 2005; Hoban & Liamputtong, 2013). However, engaging in cultural practices in hospital is not always supported by health practitioners, which can be distressing for women (e.g. being forced to take a shower) (Chu, 2005). Indeed, studies indicate that migrant and refugee women are more likely to feel excluded from health care decisions and less likely to understand the choices available to them (Hennegan et al., 2015). Shafiei et al. (2018) found that lack of availability of relevant and appropriate care options to be the most significant barrier to migrant accessing perinatal mental health services.

Post-traumatic stress disorder

Rates of PTSD have primarily been investigated among refugee groups and there is considerable variation across regions of origin; however, the overall prevalence appears to be high (Chen, Hall, et al., 2017). Both pre-migration trauma exposure and post-migration stress appear to contribute to the expression of post-traumatic stress symptoms among migrants and refugees (Cooper et al., 2019; Schweitzer et al., 2006).

While some report no gender differences in prevalence rates of PTSD among migrant and refugee communities (Lillee et al., 2015), others have found higher rates among refugee women than men. Liddell et al. (2019) explored the symptom profiles of complex PTSD and PTSD in refugees who had experienced trauma and found that membership in the complex PTSD and PTSD classes was specifically associated with female gender and cumulative experiences of traumatisation. Research has also found interpersonal trauma (such as torture, imprisonment, rape, other forms of sexual violence, and physical assault) to be associated with PTSD and anxiety among women, whereas 'non-interpersonal' trauma (such as lack of food, shelter, isolation) has been linked to poor mental health outcomes in men (Haldane & Nickerson, 2016).

There may also be a relationship between PTSD symptoms and women's age. Vromans et al. (2019) found that refugees over 50 years old who had arrived on the women at risk visa had experienced higher trauma symptom scores than other age groups in the same category and suggested the need for trauma assessments.

Psychotic disorders

The available research regarding migrant and refugees' experiences of psychotic disorders in Australia tends to be quantitative and concerned with prevalence; more qualitative research is needed to explore the experiences and nature of psychotic disorders experienced by refugee and migrant men and women. Some studies have found that migrants experience lower rates of psychotic disorders compared to Australian-born populations (Geros et al., 2020; McGrath et al., 2001). On the other hand, analyses of the 2007 NSMHW survey have found that migrants from non-English-speaking backgrounds are more likely to report at least one psychosis-screening item (Saha et al., 2013; Scott et al., 2006).

There is also a dearth of studies exploring the differences in both the nature and prevalence of psychotic disorders in migrant men and women. One retrospective audit of Australian inpatient unit admissions found that gender was not a risk factor in the development of psychotic disorders among

migrants (Lim & Wong, 2016). This study found that biological risk factors were associated with psychotic disorders among the Australian-born population; however, psychosocial risk factors were more predictive of psychotic disorders among migrants, particularly past experiences of trauma (Lim & Wong, 2016).

Some studies have explored psychotic disorders within particular populations of migrants and refugees. Nielssen et al. (2013) investigated the relationship between country of birth and hospital admission into New South Wales public hospitals for psychotic disorders, including schizophrenia and mania, and found that migrants experience the same rates of admissions as people born in Australia. However notably, migrants born in Oceania (including Melanesia, Fiji, Samoa, Tonga and other Polynesian islands, excluding Hawaii and New Zealand) were more likely to be admitted with a diagnosis of schizophrenia or mania compared with the Australian-born population and other migrant populations. O'Donoghue et al. (2020) also explored the risk of experiencing psychotic disorders among different migrant youth populations (aged 15-24) within Australia (n=1220). The authors found that migrants from Central and West Africa and Southern, Eastern Africa and North Africa were all at an increased risk of developing psychotic disorders, whereas migrants from maritime South East Asia and Southern Asia exhibited decreased risk.

Substance use

Overall the available research concerning Australian migrant and refugee populations' substance use and abuse is scant. There is some evidence that women may experience a lower rate of substance-use disorders compared with men (Steel et al., 2002). It also appears that migrant and refugee women are underrepresented in services that address alcohol and drug (AOD) abuse. This may be due to a low prevalence of AOD abuse among migrant and refugee women, or it may be related to barriers to help-seeking. One study based in Perth with newly arrived migrant and refugee women (n=268) found that the majority of participants reportedly did not use alcohol at all (76%), and of those who did only 10 reported consuming dangerous amounts (S. K. Lee et al., 2014). However, the study found that women were concerned about problems associated with AOD even if they did not themselves use substances, such as family violence. One-fifth of respondents reported experiencing distressing incidents associated with other peoples' use of AOD. The authors recommend that newly arrived women be provided with information and support regarding AOD abuse and services, as they may lack knowledge of AOD issues on arrival (S. K. Lee et al., 2014).

Savic et al. (2014) explored whether alcohol-related norms in countries of birth affected the time of help-seeking through analysis of 393 client case files of specialist alcohol and other drug services in Victoria. The authors found that migrants born in countries with high alcohol consumption (such as nations in Europe) experienced more severe alcohol-related problems at the time of intake, and suggest that this indicates that they may have deferred help-seeking. This finding also implies that there are variations in cultural attitudes regarding what is considered a safe or unsafe level of alcohol consumption.

Some research has focussed particularly on the Australian Vietnamese community in light of reports of high levels of AOD abuse (Louie et al., 1998; Reid et al., 2002). Reid et al. (2002) explored the risk factors of substance abuse by Vietnamese Australians and identified a number of important social determinants, including unemployment, poor English language levels, racism, financial difficulties, familial conflicts and acculturation difficulties. The study noted that "there is a need to consider what are described as 'non health orientated interventions' if issues of vulnerability to drug use are to be addressed adequately" (Reid et al., 2002, p. 134). The authors also stressed that discriminatory media reporting and the lack of targeted education and employment programs were factors affecting help-seeking and recovery.

Gambling disorders

Population-based research exploring gambling disorders has found that coming from a non-English speaking background is associated with 'at risk status' for gambling problems among both women and men (Hing et al., 2016).

Several studies have explored gambling and gambling disorders across different populations of migrants and refugees. Scull and Woolcock's (2005) research examined problem gambling among Chinese, Greek and Vietnamese communities in Queensland. Members of Greek and Vietnamese communities reported that while men have traditionally been more likely to experience gambling problems, it is increasingly affecting women. Chinese men however were identified as experiencing more gambling problems than women, particularly married men with families. Lack of recognition of gambling problems was found to be common among both men and women and was a barrier to help-seeking (Scull & Woolcock, 2005). Radermacher et al. (2017) examined the extent to which gambling is stigmatised within the Chinese and Tamil communities in Melbourne. The authors found that a desire to 'save face' due to gambling-related stigma detrimentally affected help-seeking behaviour in both groups. In the research, Tamils experienced stigma regarding all gambling behaviours, whereas Chinese experienced stigma in association with problem gambling only. Other research with Chinese migrants in Sydney has found Mahjong gambling to be problematic for among 3% of players, with men more likely to engage than women (Wu Yi Zheng et al., 2011; Zheng et al., 2010).

Very few studies have specifically explored migrant and refugee women's experiences of gambling disorders. Le and Gilding (2016) interviewed Vietnamese-Australian women imprisoned for drug crimes and found that half (18 of 35 participants) became embroiled in drug crime due to casino gambling debts that they had incurred. The casino was described by participants as a place to find social connection when women felt alienated. Another study exploring migrant Vietnamese women's experiences of problem gambling in Brisbane found that there was a lack of culturally appropriate services available to address the needs of migrant women and their families (Chui, 2008).

There is also evidence that migrant and refugee women suffer mental distress due to the gambling disorders of those close to them. A study exploring the health needs and social problems experienced by Thai migrants in Brisbane found that gambling was a source of conflict between women and their partners (Vatcharavongvan et al., 2014). Women described gambling to be "like a flu" in the community and negatively impacted the gamblers themselves, their families and businesses" (Vatcharavongvan et al., 2014, p. 146). The study highlighted the need for further research examining the barriers and facilitators experienced by Thai migrants to accessing services for gambling disorders.

Gambling disorders are likely to intersect with other mental health concerns. One study found that migrants with gambling disorders were more likely to have alcohol dependence (Pino-Gutiérrez et al., 2017).

Anxiety

Few studies examined anxiety specifically, with many studies exploring anxiety alongside other mental disorders such as depression. There is some evidence that migrant and refugee women experience greater levels of anxiety disorders or symptoms than men (Lumley et al., 2018; Schweitzer et al., 2006; D Silove et al., 1997; Steel et al., 2002). Research with refugees who arrived on women at risk visas determined that almost a third of participants were suffering from anxiety symptoms (Schweitzer et al., 2018). Having children and participant's age were found to each be uniquely associated with anxiety symptoms. However, the effect of age was not linear; women aged 51–60 experienced the

most anxiety, followed by women aged 31–40 years, 18–30 years, 41–50 years respectively, with those in aged 61–70 years experiencing the least anxiety. Notably, unlike other mental disorders, greater proficiency in English was associated with higher levels of anxiety symptoms, and no association was found between post-migration living difficulties and anxiety. Women from regions other than Africa experienced higher anxiety symptoms than those from Africa; however, there was significant variation across locations and the sample sizes from different regions were not representative (Schweitzer et al., 2018).

One study compared the experiences of anxiety and depression among older Chinese migrants with Australian-born people (not living in care) and found that 6% of the Chinese-born participants experienced anxiety symptoms and 10% depression symptoms, which was comparable to that of the Australian-born participants (Xiaoping Lin et al., 2016). However, the Chinese-born participants scored lower on quality of life measures and higher on levels of loneliness compared to the Australian-born participants; indeed 49% of participants from Chinese backgrounds reported that they felt lonely. The authors also note that the difference in the quality of life between the two groups persisted even when socio-demographic factors were controlled for (Xiaoping Lin et al., 2016).

Particular types of anxiety disorders and symptoms have also been investigated such as obsessive-compulsive disorder (OCD) (Mahintorabi et al., 2017), adult separation anxiety (D. Silove et al., 2010), maternal anxiety (Arora et al., 2020), and death anxiety (Johnstone et al., 2016). Arora et al.'s (2020) study comparing the anxiety levels of Indian-born and Australian-born mothers and their children (n=51) reported that the Indian-born mothers were more likely to experience anxiety in relation to child-rearing. Further, the authors found that "adherence to Australian culture" was associated with low levels of maternal and child anxiety in the Indian-born cohort, and suggest that acculturation is of greater importance in predicting anxious behaviours and attitudes in migrants than country of origin (Arora et al., 2020, p. 1763). Mahintorabi et al. (2017) explored Muslim migrant women's experiences of OCD and found that women's faith played a role in both the expression of their condition and their help-seeking behaviours. Participants commonly reported experiencing compulsions, such as rituals before prayer, which they enacted to avoid punishment from God. All the participants in the study had sought assistance from an Imam for their OCD symptoms before seeking professional assistance. The authors recommend awareness-raising initiatives involve Imams to ensure early access to treatment (Mahintorabi et al., 2017).

Eating disorders

There is research which indicates that migrant and refugee women experience eating disorders at similar rates to Australian-born women. One Western Australian study found that overall rates of disordered eating attitudes appeared to be similar among 'Asian' and 'Caucasian' university students (n=240) (Jennings et al., 2006). The authors also found that levels of acculturation did not predict the likelihood of Asian students experiencing eating disorders (Jennings et al., 2006), discrediting findings regarding the influence of acculturation from an earlier, much smaller study (n=42) conducted by the authors. A more recent study investigating the prevalence of eating disorders among Australian adolescents (n=5,191) also found similar prevalence among migrants and non-migrants (the study found an overall prevalence of 22.2%, 12.8% in boys, 32.9% in girls): "There was no effect of socio-economic status or migrant status, confirming that eating disorders do not discriminate on the basis of wealth or origin" (Mitchison et al., 2020, p. 986).

One study examined help-seeking behaviours among adolescents with eating disorders and found that although rates of help-seeking were low across respondents, adolescents born outside Australia were more likely to seek help than Australian-born respondents (Fatt et al., 2020).

Suicidality and self-harm

More research is needed which explores suicidality in migrant and refugee communities in Australia (Bowden et al., 2019). Suicidality among migrant and refugee communities appears to vary significantly across different countries of origin (Anikeeva et al., 2015). Migrant populations from countries with high suicide prevalence are also likely to have high suicide prevalence in Australia; however, suicide rates for migrants in Australia are generally *higher* than the rates in their country of origin (Burvill, 1995). A study examining the trends in Australian migrant mortality rates between 1981 and 2007 found that migrants from New Zealand and Eastern Europe were significantly more likely to commit suicide compared with the Australian-born population, whereas those born in Southern Europe had lower suicide rates than the Australian-born population (Anikeeva et al., 2015). Differences in patterns across countries of origin may also vary by gender. Analysis of suicides committed by Australian migrants between 1974 and 2006 found that women from the UK and Western Europe experienced the highest rates of suicide, whereas men from Eastern, Northern and Western Europe and New Zealand experienced highest rates (Ide et al., 2012). For both men and women, migrants born in North Africa, the Middle East, Southern and Central Asia and South East Asia exhibited the lowest suicidality (Ide et al., 2012).

Various studies concerned with detention have highlighted the prevalence of suicidal ideation and self-harm among detainees. There is evidence that men and women's rates of suicidal behaviours in detention are 41 and 26 times higher respectively than that of the Australian community (Dudley, 2003). Hedrick et al. (2019) examined self-harm among offshore asylum seekers in detention on Nauru and Manus over 12 months and found that rates of self-harm were 200 times the rates of hospital-treated self-harm in the general Australian population (Hedrick et al., 2019). Sobhanian et al. (2006) examined the psychological status of former detainees now living in the Australian community, and found that measures of self-harm and suicidal ideation significantly improved after release. Note that no difference in suicidal ideation and suicidality was identified between male and female former detainees, contrary to the authors' hypothesis that men would report higher levels (Sobhanian et al., 2006).

Indeed, although there is often an assumption that migrant and refugee men experience suicidality and self-harm at greater rates than women, this may not be the case. Correa-Velez' (2011)² research with young people from refugee backgrounds from Africa, the Middle East and South East Asia (n=120) found that 14.8% of women experienced suicidal ideation over the past 12 months, compared with 1.7% of men; and 6.6% of women had attempted suicide in the past year, and no men had (FASST, 2019). Though experiences of past trauma were associated with risk of self-harm, post-migration factors were reported to be more predictive than pre-migration factors, particularly social factors (those with limited family support were more than six times more likely to report self-harm compared with those with support) (FASST, 2019). Other important post-migration factors highlighted were family violence, family problems, loneliness and boredom, mental illness of a family member, suicides within social networks, and academic struggles. Few participants had sought help and those who had generally sought support from people in their social network rather than mental health services (FASST, 2019).

There is evidence of a connection between family violence and suicidality generally, which is likely to extend to migrants and refugees, as observed in Correa-Velez' findings. Research from the US indicates that suicide is seven times more likely among victims of family violence (cited in O'Connor &

² Correa-Velez, I (2011) Self-harm among young people from refugee backgrounds: An investigation of pre- and post-migration risk and protective factors. Brisbane: Queensland Program of Assistance to Survivors of Torture and Trauma – QPASTT. Report unable to be located. Research findings cited in FASST, 2019.

Ibrahim, 2018). O'Connor and Ibrahim (2018) conducted a clinical audit of 84 migrants' psychiatric files who were victims of family violence (56 victims from South Asia and 28 victims from the Middle East). They found that all the women born in the Middle East had experienced suicidal ideation, and almost half (43%) had attempted suicide, and three-quarters of women born in South Asia had experienced suicidal ideation and 17% had attempted suicide. The authors emphasise the importance of considering family violence as a risk factor for self-harm (O'Connor & Ibrahim, 2018).

3.6. Gaps in the literature

There remain many gaps in our understanding of refugee and migrant women's mental health in Australia. Some gaps relate to a history of exclusion or erasure of migrant and refugee populations generally within the broader body of mental health research. In a review of Australian mental health study papers, Minas et al. (2013b, p. 1) found that studies generally neglected migrant and refugee populations in study design as well as in reporting; approximately 10% of studies reviewed actively excluded migrants and refugees from the inclusion criteria, most commonly due to language proficiency concerns, and almost 75% of studies made no mention of migrant or refugee populations present within the sample. This erasure has resulted in a lack of understanding of both the prevalence and nature of mental health conditions experienced in migrant and refugee populations. Further research exploring mental health in Australia needs to account for differences in written literacy, language proficiency and interpretation, rather than simply relying upon unrepresentative sample sizes or excluding migrant and refugee populations altogether.

Mental health research that specifically explores migrant and refugee *women's* mental health is also lacking. We identified several key areas where more evidence is needed:

1. Little is known about the pre-migration and post-migration factors that affect the mental health of **migrants**, including migrant women; most of the available Australian research tends to focus on the experiences of refugees and asylum seekers. For example, future research should consider the stressors experienced by temporary migrants associated with visa status and other factors that may have an impact on mental health.
2. We do not know enough about the **gendered factors and inequalities** that affect migrant and refugee women's mental health. There is also a dearth of research which takes an **intersectional lens** to explore how gendered inequalities intersect with other inequalities, such as those informed by disability, race, class, sexuality and location, to shape migrant and refugee women's mental health outcomes. This research gap extends not only to our understanding of the prevalence and nature of mental health experienced by different populations of migrant and refugee women, but also to the particular barriers they face when accessing and utilising services. Further research is needed that accounts for intersectional, interrelated factors which are shaped by migration, in order to develop a rounded view of the determinants of mental health that is capable of informing policy and practice (Wohler & Dantas, 2017). As Baker et al. (2016, p. 397) stress:

“In order to reduce the impact of depression and anxiety, there is a pressing need for further qualitative research, which explores how individuals from CALD backgrounds want to be engaged to reduce mental ill-health. In advancing this body of knowledge, researchers and practitioners should seek to better understand and address the effects of broader social factors – such as gender, sexuality and socioeconomic status – which intersect and compound health inequities for people from CALD backgrounds.”

3. Initiatives that seek to address the mental health of migrant and refugee women need to be **evaluated** to build evidence about what is effective, in what contexts and for whom. Such research needs to avoid homogenising approaches towards migrant and refugee populations. More evidence is needed to better inform interventions at the service level, but also the **policy level**. Our findings are confirmed by others: a systematic review which explored the available research surrounding CALD women's mental health disorders in Australia found that overall there is insufficient evidence available to inform policy (Wohler & Dantas, 2017).
4. There is a lack of research that takes a **community-based participatory approach** to explore migrant and refugee women's experiences of mental health and their mental health needs. Indeed, despite many research articles noting the importance of engaging community in mental health initiatives, community members have largely been excluded from the research process. Research that takes a community-based participatory approach is necessary to better understand migrant and refugee women's priorities and needs in the mental health and wellbeing space.

3.7. Australian interventions and services for migrant and refugee mental health

Our grey literature search and peer literature review garnered some evidence surrounding specific Australian interventions and initiatives that have sought to address and prevent mental health conditions in migrant and refugee communities, which we outline below. However, it should be noted that our results did not provide a comprehensive review of the Australia-wide available services and programs.

Response interventions and services

Psychological

Studies have explored the experiences and effectiveness of numerous psychological therapies for migrants and refugee communities Australia, including animal-assisted therapy (Every et al., 2017), art therapy (Fitzpatrick, 2002), 'cultural relaxation methods' (Somasundaram, 2010), neurofeedback (Askovic et al., 2017), self-disclosure therapy (D Silove et al., 1995), relationship and family therapies (Bradley et al., 2006; Karageorge et al., 2018), and cognitive-behavioural therapy (Choi et al., 2012; Kayrouz et al., 2015, 2020; Ooi et al., 2016). Evaluation evidence tends to concern cognitive behavioural therapy and varies from case studies to randomised controlled trials. Evidence regarding the effectiveness of cognitive behavioural therapy with migrant and refugee populations is inconclusive. Several trials have demonstrated its effectiveness in reducing mental health symptoms (Choi et al., 2012; Kayrouz et al., 2015, 2020), while one randomised control trial demonstrated its effectiveness for depressive symptoms only (Ooi et al., 2016). Choi et al (2012), and Kayrouz et al. (2020) both confirmed the efficacy of delivering treatment online for users who were not born in Australia. Note that the benefits and effects of interventions in these studies were not disaggregated by gender.

Medical

The impacts of medical interventions upon migrant and refugee women's mental health have not been adequately explored. We identified one study exploring the meanings and experiences associated with Indian Australians and Anglo-Australians' antidepressant use (Brijnath & Antoniadis, 2017). Similar themes were found across the Anglo-Australian and Indian Australian experiences, such as modification of antidepressant use and dosage to meet changing daily needs without medical supervision and feelings of ambivalence towards antidepressant medication. Anglo-Australian participants commonly reported combining anti-depressants with other drugs and alcohol to manage

their symptoms; however, no Indian-Australians reported such measures (Brijnath & Antoniadis, 2017).

Alternative

The benefits of several alternative interventions to address migrant and refugee populations' mental health have been explored. Complementary therapies include music and singing (Faulkner, 2011, 2017; J. Lee & Davidson, 2017; Lenette et al., 2016), Capoeira Angola (Momartin et al., 2019; Radicchi et al., 2019), physical activity (Hartley et al., 2017; Hashimoto-Govindasamy & Rose, 2011), and support programs (Liamputtong et al., 2015; Taft et al., 2011; Walker et al., 2015; Wollersheim et al., 2013). Four main alternative interventions targeted to refugee and migrant women have been identified in the literature: (1) Groups employing music and other creative components (2) Support groups, (3) Mobile-phone based peer mentoring, (4) Female-led social enterprises.

1. Music and creative group therapy

We identified two interventions that incorporated components of music or creativity to heal trauma among refugee women. The Bosnian Women's Choir, based in New South Wales, seeks to create a space for women to express emotions, overcome isolation, share culture, and heal from experiences of war and trauma. Women in the choir have reported therapeutic and healing benefits, including increased happiness and confidence (Carter, 2000). While no formal evaluation of the choir has been conducted, the benefits of music and singing activities have been demonstrated in other studies with Australian refugees and asylum seekers (Faulkner, 2011, 2017; J. Lee & Davidson, 2017; Lenette et al., 2016).

Reconnection and Healing after Trauma after Trauma and Transition (RAHATT) is a STARTTS initiated group involving mature aged Arabic speaking refugee women who have directly or indirectly been victims of violence and other human rights violations. The objective of the group is to assist women to reflect upon traumas through means such as drawing and music. In a "Tree of Life" activity, for example, women are encouraged to draw trees to symbolise their healing process and to discuss their lives in order to reduce the impact of grief and trauma. Though no evaluation has been conducted, reported benefits of the group include social inclusion and recovery for post-traumatic stress symptoms (Kozaki, 2018).

2. Support groups and mentor programs

The Sisters of Mercy run a community support program for Sudanese refugee women to support them in resettlement through promoting awareness of potential coping, resilience and growth strategies. The support group also involves awareness-raising about the benefits of exercise to address post-resettlement lifestyle factors that negatively impact on health. A qualitative evaluation revealed the respite offered by the program alleviated the burden of childcare and provided an opportunity for participants to focus on their wellbeing (Hashimoto-Govindasamy & Rose, 2011).

A non-professional mentor mother support program has been developed to support culturally linguistically diverse women who were pregnant or had children under five and had been abused or were symptomatic of abuse (Taft et al., 2011). The program involved both migrant and non-migrant women. The intervention aimed to reduce intimate partner violence and improve participants' mental and physical health. It is also important to note that women were ineligible to participate if they lacked English proficiency capable of providing informed consent (except for Vietnamese women). An evaluation of the program demonstrated a reduction in IPV experienced by participants; however, a similar reduction in depression or improvement in wellbeing was not found. It should be noted that the sample size was small and so effects may have been undetected. Further, only a third of the evaluation sample were born overseas.

3. Mobile phone-based peer mentoring

A mobile phone-based peer mentoring program aimed to facilitate social connectedness and enhance psychosocial health and wellbeing has been evaluated in adult South Sudanese, Afghan, and Burmese refugee women in Australia (Liamputtong et al., 2015; Walker et al., 2015; Wollersheim et al., 2013). The evaluations found reduced social isolation and increased wellbeing in participants (Liamputtong et al., 2015).

4. Female-led social enterprises

There are several female-led social enterprise initiatives directed towards refugee and migrant women in Australia. These initiatives claim to offer supportive education environments and economic empowerment opportunities to refugee and migrant women facing post-settlement stressors associated with poorer mental health, such as racism, lack of social connectedness and unemployment. They hope to provide an opportunity for women to develop their confidence and self-esteem and encourage greater social participation. Examples of social enterprise initiatives include *Angkor Flowers and Crafts* and *The Social Outfit* in New South Wales and *Sorghum Sisters*, *Second Stitch* and *SisterWorks* in Victoria. These social enterprises have not been evaluated for their impact on health and wellbeing.

Prevention and early interventions and initiatives

While some prevention and early intervention programs have been evaluated with respect to their efficacy for refugee and migrant populations, their effects have not been disaggregated by gender and few were targeted specifically towards women. We identified two prevention programs that demonstrated effectiveness in refugee and migrant women.

The effectiveness of the FRIENDS program, a validated Anglo-Australian anxiety-prevention program, has been evaluated in adolescent former-Yugoslavian refugee women in a small pilot study (Barrett et al., 2000). While data trends demonstrated a reduction of anxiety symptoms post-intervention, these findings were not statistically significant as the sample size was small. It is important to note, the intervention was not culturally adapted. Participants in qualitative feedback suggested the examples and activities in the program needed to incorporate cultural and migration issues to best cater to the needs of specific groups.

The Gambling Awareness Project (GAP) was funded by the Victorian Responsible Gambling Foundation (VRFG) and worked in partnership with six organisations to share information about gambling harm and in-language support services to migrant groups in Victoria (MCWH, n.d.). Multicultural Centre for Women's Health (MCWH) was one of the partner organisations and focussed on targeting gambling harm experienced by migrant and refugee women. MCWH reached over 3,000 women from both established and newly arrived communities across Victoria through community education sessions, prevention activities and support programs. These activities and programs were evaluated for their impact on participants' mental health and wellbeing.

Many organisations engage in advocacy-based strategies to promote the mental health of migrants, refugees and people from culturally and linguistically diverse backgrounds in Australia, such as the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) and FASSTT member organisations such as the Victorian Foundation for Survivors of Torture (Foundation House), enliven's Refugee and Asylum Seeker Health Alliance, the Ethnic Communities' Council of Victoria, Queensland Transcultural Mental Health Centre and Mental Health Australia's Embrace Multicultural Mental Health.

Perinatal mental health initiatives

There was some evidence in the peer-reviewed literature regarding the efficacy of particular interventions which sought to address the perinatal mental health of migrant and refugee women.

One study evaluated a perinatal mental health screening program for women from refugee backgrounds that was codesigned by maternal health service stakeholders, a community-based refugee health and wellbeing service, NGOs and community members at Monash Health in Melbourne. This program forms part of a dedicated refugee antenatal clinic (Willey et al., 2020). The clinic employs bicultural workers and refugee health nurse liaisons from the community-based refugee health and wellbeing service, and introduced the use of the Edinburgh Postnatal Depression Scale (EPDS) tool (alongside the usual psychosocial assessment), as well as codesigned comprehensive referral pathway information. An evaluation of the program from the perspective of health professionals found the project had been received positively by staff and was determined by the evaluators to be acceptable and feasible (Willey et al., 2020). Midwives considered that completing the EPDS tool facilitated conversations about mental health and early referrals. Some concerns were raised by health professionals about women's misinterpretation of the EPDS questions and communication barriers, as well as the time involved. One respondent noted:

“if they scored high, which they keep doing and then I'll question the things they've scored high and then once they've answered they're like, oh no ... maybe they were actually a bit confused. And then it's taking more time, because then you're going through the same stuff again” (Willey et al., 2020, p. 249).

This confirms concerns raised by health professionals in previous studies considering the appropriateness of the EPDS screening in this context (Nithianandan et al., 2016). Health professionals also raised concerns about the completion of the screening by women's husbands, particularly when interpreters were not available, but felt there was little choice in such circumstances (Willey et al., 2020). Unfortunately, the evaluation did not involve the views of women who had used the service.

A community-based antenatal service specialising in maternity care for women from CALD backgrounds has also been developed in Perth and involves a midwifery model of care at a local health centre (Owens et al., 2016). In an evaluation of the model, Owens et al. (2016) found that the service provided a much needed form of social support to women that was not necessarily available through their personal networks. The model also enabled clients to ask questions and receive assistance in relation to pregnancy as well as non-pregnancy related issues, taking a holistic view of their needs: “Since migrant CaLD women may have other issues which impact on their pregnancy care, a social model of care which considers holistic needs is more appropriate” (Owens et al., 2016, p. 134).

3.8. Resources

We identified four resources aimed at health practitioners working with migrant and refugee women:

- *Women: A guide for health professionals* (n.d.) was developed with the assistance of community groups and health care providers and provides an overview of cultural and health issues of concern to women within Queensland ethnic minority groups. The guide seeks to raise health practitioner awareness various psychosocial stressors such as culture shock, racism, unemployment, gender-related violence, and social isolation. The guide focusses on health generally, with minimal focus on mental health.
- *Overcoming barriers: A toolkit to improve responses to CALD women and children who have experienced family violence* (NIFVS, n.d.) is an online resource aimed to enhance the response of practitioners working with women and children from CALD backgrounds who have experienced family violence. While the primary focus of the toolkit is on family violence, it

covers aspects of trauma-informed care. The resource encourages practitioners to contemplate the systemic barriers that their clients may be facing.

- *Improving responses to refugees with backgrounds of multiple trauma: Pointers for practitioners in domestic and family violence, sexual assault and settlement services* (Zannettino et al., 2013) is a practice monograph with various contributors. It contains a chapter devoted to: “Best practice considerations when responding to people from CALD backgrounds, including refugees, with mental health issues and experiences of domestic and sexual violence”. The best practice considerations for health practitioners outlined include:
 - Recognising diverse worldviews and individual experiences;
 - Reflecting on the practitioner’s own cultural positioning, core values and beliefs, as well as their past experiences;
 - Recognition that clients’ previous experiences with services and institutions may lead to concerns about engaging with practitioners;
 - Understanding the clients’ level of literacy;
 - Using clear and simple language;
 - Determining the safety risks for the client;
 - Determining the emotional wellbeing of the client; and
 - Addressing safety risks. E.g. Check with client before sending mail to their home address.
- *Common Threads Best Practice Guide* (Hach, 2012) was produced by MCWH to promote a ‘gendered cross-cultural understanding and practice’ in the delivery of health services for migrant and refugee women. The guide highlights the limitations of the concept of ‘culturally competency’ and criticises one-size-fits-all approaches and the stereotyping of culture. Four principles which are key to gendered cross-cultural understanding and practice are set out:
 1. Women's empowerment
 2. Cultural and linguistic appropriateness
 3. Access and equity
 4. Collaboration

Citations

- ABS. (2008). *National Survey of Mental Health and Wellbeing: Summary of Results* (4326.0). Australian Bureau of Statistics. <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0>
- ABS. (2020, April 28). *Migration, Australia, 2018-19*. Australian Bureau of Statistics. <https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release>
- AIHW. (2018). *Australia's health 2018* (Australia's Health Series No. 16). Australian Institute of Health and Welfare.
- AIHW. (2020, July 23). *Australia's health 2020: Stress and trauma*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/australias-health/stress-and-trauma>
- Alati, R., Najman, J., & Williams, G. (2004). The Mental Health of Filipino-Born Women 5 and 14 Years after they have given Birth in Australia: A Longitudinal Study. *Health Sociology Review, 13*(2), 145–156. <https://doi.org/10.5172/hesr.13.2.145>
- Allotey, P. (1999). Travelling with “Excess Baggage”: Health Problems of Refugee Women in Western Australia. *Women & Health, 28*(1), 63–81. https://doi.org/10.1300/J013v28n01_05
- Anikeeva, O., Bi, P., Hiller, J. E., Ryan, P., Roder, D., & Han, G.-S. (2015). Trends in migrant mortality rates in Australia 1981–2007: A focus on the National Health Priority Areas other than cancer. *Ethnicity & Health, 20*(1), 29–48. <https://doi.org/10.1080/13557858.2014.883368>
- Antoniades, J., Mazza, D., & Brijnath, B. (2017). Becoming a patient-illness representations of depression of Anglo-Australian and Sri Lankan patients through the lens of Leventhal's illness representational model. *International Journal of Social Psychiatry, 63*(7), 569–579. <https://doi.org/10.1177/0020764017723669>
- Apostolidou, Z. (2018). Australian asylum discourses permeating therapeutic work with asylum seekers: A thematic analysis of specialist practitioners' experiences. *Psychotherapy and Politics International, 16*(1), e1434. <https://doi.org/10.1002/ppi.1434>
- Arora, A., Baker, J. R., & Tay, A. K. (2020). Parenting and Child Anxiety: The Role of Country of Birth and Acculturation in Indian-born Migrants to Australia Relative to Native-born Australians. *Journal of Child and Family Studies, 29*(6), 1757–1770. <https://doi.org/10.1007/s10826-019-01633-z>
- Askovic, M., Watters, A. J., Aroche, J., & Harris, A. W. F. (2017). Neurofeedback as an adjunct therapy for treatment of chronic posttraumatic stress disorder related to refugee trauma and torture experiences: Two case studies. *Australasian Psychiatry, 25*(4), 358–363. <https://doi.org/10.1177/1039856217715988>
- Babatunde-Sowole, O. O., DiGiacomo, M., Power, T., Davidson, P. M., & Jackson, D. (2020). Resilience of African migrant women: Implications for mental health practice. *International Journal of Mental Health Nursing, 29*(1), 92–101. <https://doi.org/10.1111/inm.12663>
- Baker, A. E. Z., Procter, N. G., & Ferguson, M. S. (2016). Engaging with culturally and linguistically diverse communities to reduce the impact of depression and anxiety: A narrative review. *Health and Social Care in the Community, 24*(4), 386–398. Scopus. <https://doi.org/10.1111/hsc.12241>
- Bandyopadhyay, M., Small, R., Watson, L. F., & Brown, S. (2010). Life with a new baby: How do immigrant and Australian-born women's experiences compare? *Australian and New Zealand Journal of Public Health, 34*(4), 412–421. <https://doi.org/10.1111/j.1753-6405.2010.00575.x>
- Barrett, P. M., Moore, A. F., & Sonderegger, R. (2000). The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. *Behaviour Change, 17*(3), 124–133.
- Barrett, P. M., Sonderegger, R., & Sonderegger, N. L. (2002). Assessment of child and adolescent migrants to Australia: A crosscultural comparison. *Behaviour Change, 19*(4), 220–235. Scopus. <https://doi.org/10.1375/bech.19.4.220>
- Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J. D., Kirkbride, J., Moussaoui, D., Nazroo, J., Qureshi, A., Stompe, T., & Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry, 9*.

- Blignault, I., Ponzio, V., Rong, Y., & Eisenbruch, M. (2008). A Qualitative Study of Barriers to Mental Health Services Utilisation Among Migrants From Mainland China in South-East Sydney. *International Journal of Social Psychiatry*, 54(2), 180–190. <https://doi.org/10.1177/0020764007085872>
- Bowden, M., McCoy, A., & Reavley, N. (2019). Suicidality and suicide prevention in culturally and linguistically diverse (CALD) communities: A systematic review. *International Journal of Mental Health*, 1–28.
- Bradley, G. M., Couchman D Psych, G. M., Perlesz, A., Nguyen, A. T., Singh, B., & Riess, C. (2006). Multiple-family group treatment for English-and Vietnamese-speaking families living with schizophrenia. *Psychiatric Services*, 57(4), 521–530.
- Brijnath, B. (2015). Applying the CHIME recovery framework in two culturally diverse Australian communities: Qualitative results. *International Journal of Social Psychiatry*, 61(7), 660–667. <https://doi.org/10.1177/0020764015573084>
- Brijnath, B., & Antoniadou, J. (2017). Playing With Antidepressants: Perspectives From Indian Australians and Anglo-Australians Living With Depression. *Qualitative Health Research*, 27(13), 1970–1981. <https://doi.org/10.1177/1049732316651404>
- Brijnath, B., & Antoniadou, J. (2018). Beyond patient culture: Filtering cultural presentations of depression through structural terms. *Critical Public Health*, 28(2), 237–247. <https://doi.org/10.1080/09581596.2017.1344771>
- Brough, M., Gorman, D., Ramirez, E., & Westoby, P. (2003). Young Refugees Talk About Well-Being: A Qualitative Analysis of Refugee Youth Mental Health from Three States. *Australian Journal of Social Issues*, 38(2), 193–208. <https://doi.org/10.1002/j.1839-4655.2003.tb01142.x>
- Buchanan, Z. E., Abu-Rayya, H. M., Kashima, E., Paxton, S. J., & Sam, D. L. (2018). Perceived discrimination, language proficiencies, and adaptation: Comparisons between refugee and non-refugee immigrant youth in Australia. *International Journal of Intercultural Relations*, 63, 105–112. <https://doi.org/10.1016/j.ijintrel.2017.10.006>
- Bull, M., Schindeler, E., Berkeman, D., & Ransley, J. (2013). A Demography and Taxonomy of Long-term Immigration Detention in Australia. *International Journal for Crime, Justice and Social Democracy*, 2(1). <https://www.crimejusticejournal.com/article/view>
- Bull, M., Schindeler, E., Berkman, D., & Ransley, J. (2013). Sickness in the System of Long-term Immigration Detention. *Journal of Refugee Studies*, 26(1), 47–68. <https://doi.org/10.1093/jrs/fes017>
- Burford-Rice, R., Augoustinos, M., & Due, C. (2020). ‘That’s what they say in our language: One onion, all smell’: the impact of racism on the resettlement experiences of South Sudanese women in Australia. *Language and Intercultural Communication*, 20(2), 95–109. <https://doi.org/10.1080/14708477.2020.1722146>
- Burvill, P. W. (1995). Suicide in the multiethnic elderly population of Australia, 1979–1990. *International Psychogeriatrics*, 7(2), 319–333.
- Campbell, E. J., & Steel, E. J. (2015). Mental distress and human rights of asylum seekers. *Journal of Public Mental Health*, 14(2), 43–55. <https://doi.org/10.1108/JPMH-06-2013-0040>
- Carter, N. (2000). *Singing for the soul: The Blue river choir, Transitions*. STARTTS.
- Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: Findings from the first wave data of the BNLA cohort study. *The Lancet Psychiatry*, 4(3), 218–229. [https://doi.org/10.1016/S2215-0366\(17\)30032-9](https://doi.org/10.1016/S2215-0366(17)30032-9)
- Chen, W., Ling, L., & Renzaho, A. M. N. (2017). Building a new life in Australia: An analysis of the first wave of the longitudinal study of humanitarian migrants in Australia to assess the association between social integration and self-rated health. *BMJ Open*, 7(3), e014313. <https://doi.org/10.1136/bmjopen-2016-014313>
- Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., Andrews, G., & Hunt, C. (2012). Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders*, 136(3), 459–468.

- Chu, C. M. Y. (2005). Postnatal experience and health needs of Chinese migrant women in Brisbane, Australia. *Ethnicity & Health, 10*(1), 33–56. <https://doi.org/10.1080/1355785052000323029>
- Chui, W. H. (2008). True Stories: Migrant Vietnamese Women With Problem Gambling in Brisbane, Queensland. *Journal of Social Work Practice in the Addictions, 8*(2), 276–280. <https://doi.org/10.1080/15332560802157214>
- Coffey, G. J., Kaplan, I., Sampson, R. C., & Tucci, M. M. (2010). The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Social Science & Medicine, 70*(12), 2070–2079. <https://doi.org/10.1016/j.socscimed.2010.02.042>
- Colic-Peisker, V., & Walker, I. (2003). Human capital, acculturation and social identity: Bosnian refugees in Australia. *Journal of Community & Applied Social Psychology, 13*(5), 337–360. <https://doi.org/10.1002/casp.743>
- Colucci, E., Minas, H., Szwarc, J., Guerra, C., & Paxton, G. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. *Transcultural Psychiatry, 52*(6), 766–790. <https://doi.org/10.1177/1363461515571624>
- Colucci, E., Szwarc, J., Minas, H., Paxton, G., & Guerra, C. (2014). The utilisation of mental health services by children and young people from a refugee background: A systematic literature review. *International Journal of Culture and Mental Health, 7*(1), 86–108. <https://doi.org/10.1080/17542863.2012.713371>
- Cooper, S., Enticott, J. C., Shawyer, F., & Meadows, G. (2019). Determinants of Mental Illness Among Humanitarian Migrants: Longitudinal Analysis of Findings From the First Three Waves of a Large Cohort Study. *Frontiers in Psychiatry, 10*. <https://doi.org/10.3389/fpsy.2019.00545>
- Copolov, C., Knowles, A., & Meyer, D. (2018). Exploring the predictors and mediators of personal wellbeing for young Hazaras with refugee backgrounds in Australia. *Australian Journal of Psychology, 70*(2), 122–130. <https://doi.org/10.1111/ajpy.12171>
- Copping, A., Shakespeare-Finch, J., & Paton, D. (2010). Towards a Culturally Appropriate Mental Health System: Sudanese-Australians' Experiences with Trauma. *Journal of Pacific Rim Psychology, 4*(1), 53–60. <https://doi.org/10.1375/prp.4.1.53>
- Correa-Velez, I., Gifford, S. M., & Barnett, A. G. (2010). Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science & Medicine, 71*(8), 1399–1408. <https://doi.org/10.1016/j.socscimed.2010.07.018>
- Correa-Velez, I., Green, A., Murray, K., Schweitzer, R. D., Vromans, L., Lenette, C., & Brough, M. (2020). Social Context Matters: Predictors of Quality of Life among Recently Arrived Refugee Women-at-Risk Living in Australia. *Journal of Immigrant & Refugee Studies, 0*(0), 1–17. <https://doi.org/10.1080/15562948.2020.1734893>
- Costa, D. (2007). Health care of refugee women. *Australian Family Physician, 36*(3), 151.
- Cross, W. M., & Bloomer, M. J. (2010). Extending boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *International Journal of Mental Health Nursing, 19*(4), 268–277. <https://doi.org/10.1111/j.1447-0349.2010.00667.x>
- Dahlen, H. G., Munoz, A. M., Schmied, V., & Thornton, C. (2018). The relationship between intimate partner violence reported at the first antenatal booking visit and obstetric and perinatal outcomes in an ethnically diverse group of Australian pregnant women: A population-based study over 10 years. *BMJ Open, 8*(4). <https://doi.org/10.1136/bmjopen-2017-019566>
- de Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation. *Australian Psychologist, 45*(1), 29–37. <https://doi.org/10.1080/00050060903262387>
- Delara, M. (2016, March 7). *Social Determinants of Immigrant Women's Mental Health* [Review Article]. *Advances in Public Health*; Hindawi. <https://doi.org/10.1155/2016/9730162>
- Dowling, A., Enticott, J., Kunin, M., & Russell, G. (2019). The association of migration experiences on the self-rated health status among adult humanitarian refugees to Australia: An analysis of a longitudinal

- cohort study. *International Journal for Equity in Health*, 18(1), 130. <https://doi.org/10.1186/s12939-019-1033-z>
- Dowling, A., Kunin, M., & Russell, G. (2020). The impact of migration upon the perceived health of adult refugees resettling in Australia: A phenomenological study. *Journal of Ethnic and Migration Studies*, 0(0), 1–18. <https://doi.org/10.1080/1369183X.2020.1771173>
- du Plooy, D. R., Lyons, A., & Kashima, E. S. (2019). Predictors of Flourishing and Psychological Distress Among Migrants to Australia: A Dual Continuum Approach. *Journal of Happiness Studies*, 20(2), 561–578. <https://doi.org/10.1007/s10902-018-9961-7>
- Dudley, M. (2003). Contradictory Australian national policies on self-harm and suicide: The case of asylum seekers in mandatory detention. *Australasian Psychiatry*, 11(1_suppl), S102–S108.
- Eastwood, J. G., Jalaludin, B. B., Kemp, L. A., Phung, H. N., & Barnett, B. E. (2012). Relationship of postnatal depressive symptoms to infant temperament, maternal expectations, social support and other potential risk factors: Findings from a large Australian cross-sectional study. *BMC Pregnancy and Childbirth*, 12(1), 148. <https://doi.org/10.1186/1471-2393-12-148>
- Eastwood, J. G., Phung, H., & Barnett, B. (2011). Postnatal depression and socio-demographic risk: Factors associated with Edinburgh Depression Scale scores in a metropolitan area of New South Wales, Australia. *Australian & New Zealand Journal of Psychiatry*, 45(12), 1040–1046. <https://doi.org/10.3109/00048674.2011.619160>
- ECCV. (2018). *Submission to Victoria's Mental Health Royal Commission*. Ethnic Communities' Council of Victoria Inc.
- Edwards, B., Smart, D., De Maio, J., Silbert, M., & Jenkinson, R. (2018). Cohort Profile: Building a New Life in Australia (BNLA): the longitudinal study of humanitarian migrants. *International Journal of Epidemiology*, 47(1), 20–20h. <https://doi.org/10.1093/ije/dyx218>
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, 371(9619), 1165–1172. [https://doi.org/10.1016/S0140-6736\(08\)60522-X](https://doi.org/10.1016/S0140-6736(08)60522-X)
- Every, D., Smith, K., Smith, B., Trigg, J., & Thompson, K. (2017). How can a donkey fly on the plane? The benefits and limits of animal therapy with refugees. *Clinical Psychologist*, 21(1), 44–53. <https://doi.org/10.1111/cp.12071>
- FASST. (2019). *Submission to the Productivity Commission Inquiry into the Social and Economic Benefits to Improving Mental Health*. Forum of Australian Services for Survivors of Torture and Trauma (FASST).
- Fatt, S. J., Mond, J., Bussey, K., Griffiths, S., Murray, S. B., Lonergan, A., Hay, P., Trompeter, N., & Mitchison, D. (2020). Help-seeking for body image problems among adolescents with eating disorders: Findings from the EveryBODY study. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, 25(5), 1267–1275. <https://doi.org/10.1007/s40519-019-00759-9>
- Faulkner, S. (2011). DRUMBEAT: In search of belonging. *Youth Studies Australia*, 30(2), 9.
- Faulkner, S. (2017). Rhythm2Recovery: A model of practice combining rhythmic music with cognitive reflection for social and emotional health within trauma recovery. *Australian and New Zealand Journal of Family Therapy*, 38(4), 627–636.
- FECCA, NEDA, RCOA, & Settlement Council of Australia. (2019). *Barriers and exclusions: The support needs of newly arrived refugees with a disability*. Federation of Ethnic Communities Council of Australia, the National Ethnic Disability Alliance, the Refugee Council of Australia, and the Settlement Council of Australia.
- Ferdinand, A. S., Paradies, Y., & Kelaher, M. (2015). Mental health impacts of racial discrimination in Australian culturally and linguistically diverse communities: A cross-sectional survey. *BMC Public Health*, 15(1), 401. <https://doi.org/10.1186/s12889-015-1661-1>

- Fisher, C. (2013). Changed and changing gender and family roles and domestic violence in African refugee background communities post-settlement in Perth, Australia. *Violence against Women, 19*(7), 833–847.
- Fitzpatrick, F. (2002). A Search for Home: The Role of Art Therapy in Understanding the Experiences of Bosnian Refugees in Western Australia. *Art Therapy, 19*(4), 151–158.
<https://doi.org/10.1080/07421656.2002.10129680>
- Fox, S. D., Griffin, R. H., & Pachankis, J. E. (2020). Minority stress, social integration, and the mental health needs of LGBTQ asylum seekers in North America. *Social Science & Medicine, 246*, 112727.
- Fozdar, F. (2009). 'The Golden Country': Ex-Yugoslav and African Refugee Experiences of Settlement and 'Depression'. *Journal of Ethnic and Migration Studies, 35*(8), 1335–1352.
<https://doi.org/10.1080/13691830903123120>
- Fozdar, F., & Hartley, L. (2013). Refugee Resettlement in Australia: What We Know and Need to Know. *Refugee Survey Quarterly, 32*(3), 23–51. <https://doi.org/10.1093/rsq/hdt009>
- Fraser, C., Judd, F., Jackson, H., Murray, G., Humphreys, J., & Hodgins, G. A. (2002). Does One Size Really Fit All? Why the Mental Health of Rural Australians Requires Further Research. *Australian Journal of Rural Health, 10*(6), 288–295. <https://doi.org/10.1046/j.1440-1584.2002.00463.x>
- Geros, H., Sizer, H., Mifsud, N., Reynolds, S., Kim, D. J., Eaton, S., McGorry, P., Nelson, B., & O'Donoghue, B. (2020). Migrant status and identification as ultra-high risk for psychosis and transitioning to a psychotic disorder. *Acta Psychiatrica Scandinavica, 141*(1), 52–59.
<https://doi.org/10.1111/acps.13099>
- Giallo, R., Cooklin, A., & Nicholson, J. M. (2014). Risk factors associated with trajectories of mothers' depressive symptoms across the early parenting period: An Australian population-based longitudinal study. *Archives of Women's Mental Health, 17*(2), 115–125. <https://doi.org/10.1007/s00737-014-0411-1>
- Gorman, D., Brough, M., & Ramirez, E. (2003). How young people from culturally and linguistically diverse backgrounds experience mental health: Some insights for mental health nurses. *International Journal of Mental Health Nursing, 12*(3), 194–202. <https://doi.org/10.1046/j.1440-0979.2003.00289.x>
- Green, J. P., & Eagar, K. (2010). The health of people in Australian immigration detention centres. *Medical Journal of Australia, 192*(2), 65–70. <https://doi.org/10.5694/j.1326-5377.2010.tb03419.x>
- Hach, M. (2012). *CommonThreads Best Practice Guide*. Multicultural Centre for Women's Health.
- Haldane, J., & Nickerson, A. (2016). The Impact of Interpersonal and Noninterpersonal Trauma on Psychological Symptoms in Refugees: The Moderating Role of Gender and Trauma Type. *Journal of Traumatic Stress, 29*(5), 457–465. <https://doi.org/10.1002/jts.22132>
- Halim, N., Beard, J., Mesic, A., Patel, A., Henderson, D., & Hibberd, P. (2018). Intimate partner violence during pregnancy and perinatal mental disorders in low and lower middle income countries: A systematic review of literature, 1990–2017. *Clinical Psychology Review, 66*, 117–135.
<https://doi.org/10.1016/j.cpr.2017.11.004>
- Hamrah, M. S., Hoang, H., Mond, J., Pahlavanzade, B., Charkazi, A., & Auckland, S. (2020). Occurrence and correlates of depressive symptoms among the resettled Afghan refugees in a regional area of Australia. *Early Intervention in Psychiatry*. <https://doi.org/10.1111/eip.12957>
- Haralambous, B., Dow, B., Goh, A., Pachana, N. A., Bryant, C., LoGiudice, D., & Lin, X. (2016). 'Depression is not an illness. It's up to you to make yourself happy': Perceptions of Chinese health professionals and community workers about older Chinese immigrants' experiences of depression and anxiety. *Australasian Journal on Ageing, 35*(4), 249–254. Scopus. <https://doi.org/10.1111/ajag.12306>
- Hart, J. (2002). Journey of Resilience and Adaptation: Counselling Vietnamese People. *Australian and New Zealand Journal of Family Therapy, 23*(1), 20–28. <https://doi.org/10.1002/j.1467-8438.2002.tb00481.x>

- Hartley, L., Fleay, C., & Tye, M. E. (2017). Exploring physical activity engagement and barriers for asylum seekers in Australia coping with prolonged uncertainty and no right to work. *Health & Social Care in the Community, 25*(3), 1190–1198.
- Hashimoto-Govindasamy, L. S., & Rose, V. (2011). An ethnographic process evaluation of a community support program with Sudanese refugee women in western Sydney. *Health Promotion Journal of Australia, 22*(2), 107–112.
- Heaven, P. C. L., & Goldstein, M. (2001). Parental influences and mental health among some Australian youth. *Australian Journal of Psychology, 53*(3), 170–175. <https://doi.org/10.1080/00049530108255141>
- Hedrick, K., Armstrong, G., & Borschmann, R. (2019). Self-harm among asylum seekers in Australian immigration detention. *The Lancet Public Health, 4*(12), e604. [https://doi.org/10.1016/S2468-2667\(19\)30221-X](https://doi.org/10.1016/S2468-2667(19)30221-X)
- Henderson, S., & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: Exploring the need for improvement in health service delivery. *Australian Journal of Primary Health, 17*(2), 195–201. <https://doi.org/10.1071/PY10065>
- Hennegan, J., Redshaw, M., & Kruske, S. (2015). Another country, another language and a new baby: A quantitative study of the postnatal experiences of migrant women in Australia. *Women and Birth, 28*(4), e124–e133. <https://doi.org/10.1016/j.wombi.2015.07.001>
- Herrman, H., Kaplan, I., & Szwarc, J. (2010). Post-migration and mental health: The Australian experience. In D. Bhugra, T. Craig, & K. Bhui (Eds.), *Mental Health of Refugees and Asylum Seekers*. OUP Oxford.
- Hing, N., Russell, A., Tolchard, B., & Nower, L. (2016). Risk Factors for Gambling Problems: An Analysis by Gender. *Journal of Gambling Studies, 32*(2), 511–534. <https://doi.org/10.1007/s10899-015-9548-8>
- Hoban, E., & Liamputtong, P. (2013). Cambodian migrant women's postpartum experiences in Victoria, Australia. *Midwifery, 29*(7), 772–778. <https://doi.org/10.1016/j.midw.2012.06.021>
- Hocking, D. C., Kennedy, G. A., & Sundram, S. (2015). Mental disorders in asylum seekers: The role of the refugee determination process and employment. *Journal of Nervous and Mental Disease, 203*(1), 28–32. Scopus. <https://doi.org/10.1097/NMD.0000000000000230>
- Honey, A., Emerson, E., & Llewellyn, G. (2011). The mental health of young people with disabilities: Impact of social conditions. *Social Psychiatry and Psychiatric Epidemiology, 46*(1), 1–10. <https://doi.org/10.1007/s00127-009-0161-y>
- Hopkinson, R. A., Keatley, E., Glaeser, E., Erickson-Schroth, L., Fattal, O., & Sullivan, M. N. (2017). Persecution Experiences and Mental Health of LGBT Asylum Seekers. *Journal of Homosexuality, 64*(12), 1650–1666. <https://doi.org/10.1080/00918369.2016.1253392>
- Hugman, R., Bartolomei, L., & Pittaway, E. (2004). It is part of your life until you die: Older refugees in Australia. *Australasian Journal on Ageing, 23*(3), 147–149. <https://doi.org/10.1111/j.1741-6612.2004.00037.x>
- Ide, N., Kolves, K., Cassaniti, M., & De Leo, D. (2012). Suicide of first-generation immigrants in Australia, 1974–2006. *Social Psychiatry and Psychiatric Epidemiology, 47*(12), 1917–1927.
- Jarallah, Y., & Baxter, J. (2019). Gender disparities and psychological distress among humanitarian migrants in Australia: A moderating role of migration pathway? *Conflict and Health, 13*, 13.
- Jatrana, S., Richardson, K., & Pasupuleti, S. S. R. (2018). Investigating the Dynamics of Migration and Health in Australia: A Longitudinal Study. *European Journal of Population, 34*(4), 519–565. <https://doi.org/10.1007/s10680-017-9439-z>
- Jennings, P. S., Forbes, D., McDermott, B., & Hulse, G. (2006). Acculturation and eating disorders in Asian and Caucasian Australian university students. *Eating Behaviors, 7*(3), 214–219. <https://doi.org/10.1016/j.eatbeh.2005.08.006>
- Jirojwong, S., & Manderson, L. (2001). Feelings of Sadness: Migration and Subjective Assessment of Mental Health among Thai Women in Brisbane, Australia. *Transcultural Psychiatry, 38*(2), 167–186. <https://doi.org/10.1177/136346150103800202>

- Joffe, H. I., Joffe, C. F., & Brodaty, H. (1996). Ageing Jewish holocaust survivors: Anxieties in dealing with health professionals. *Medical Journal of Australia*, *165*(9), 517–520. Scopus. <https://doi.org/10.5694/j.1326-5377.1996.tb138622.x>
- Johnstone, M.-J., Hutchinson, A. M., Rawson, H., & Redley, B. (2016). Assuaging death anxiety in older overseas-born Australians of culturally and linguistically diverse backgrounds hospitalised for end-of-life care. *Contemporary Nurse*, *52*(2–3), 269–285. Scopus. <https://doi.org/10.1080/10376178.2016.1192953>
- Kaplan, I., Stow, H. D., & Szwarc, J. (2016). Responding to the Challenges of Providing Mental Health Services to Refugees: An Australian Case Report. *Journal of Health Care for the Poor and Underserved*, *27*(3).
- Karageorge, A., Rhodes, P., & Gray, R. (2018). Relationship and Family Therapy for Newly Resettled Refugees: An Interpretive Description of Staff Experiences. *Australian and New Zealand Journal of Family Therapy*, *39*(3), 303–319. <https://doi.org/10.1002/anzf.1325>
- Kartal, D., & Kiropoulos, L. (2016). Effects of acculturative stress on PTSD, depressive, and anxiety symptoms among refugees resettled in Australia and Austria. *European Journal of Psychotraumatology*, *7*. Scopus. <https://doi.org/10.3402/ejpt.v7.28711>
- Kavanagh, A. M., Aitken, Z., Krnjacki, L., LaMontagne, A. D., Bentley, R., & Milner, A. (2015). Mental Health Following Acquisition of Disability in Adulthood—The Impact of Wealth. *PLOS ONE*, *10*(10), e0139708. <https://doi.org/10.1371/journal.pone.0139708>
- Kayrouz, R., Dear, B. F., Johnston, L., Gandy, M., Fogliati, V. J., Sheehan, J., & Titov, N. (2015). A feasibility open trial of guided Internet-delivered cognitive behavioural therapy for anxiety and depression amongst Arab Australians. *Internet Interventions*, *2*(1), 32–38.
- Kayrouz, R., Karin, E., Staples, L. G., Niessen, O., Dear, B. F., & Titov, N. (2020). A comparison of the characteristics and treatment outcomes of migrant and Australian-born users of a national digital mental health service. *BMC Psychiatry*, *20*(1). Scopus. <https://doi.org/10.1186/s12888-020-02486-3>
- Kelagher, M. A., Ferdinand, A. S., & Paradies, Y. (2014). Experiencing racism in health care: The mental health impacts for Victorian Aboriginal communities. *Medical Journal of Australia*, *201*(1), 44–47. <https://doi.org/10.5694/mja13.10503>
- Kennedy, S., & McDonald, J. T. (2006). Immigrant Mental Health and Unemployment. *Economic Record*, *82*(259), 445–459. <https://doi.org/10.1111/j.1475-4932.2006.00358.x>
- Kenyon, G. (2017). Illnesses of isolation: Detention of asylum seekers. *The Lancet Infectious Diseases*, *17*(10), 1028–1029. [https://doi.org/10.1016/S1473-3099\(17\)30529-7](https://doi.org/10.1016/S1473-3099(17)30529-7)
- Khanlari, S., Eastwood, J., Barnett, B., Naz, S., & Ogbo, F. A. (2019). Psychosocial and obstetric determinants of women signalling distress during Edinburgh Postnatal Depression Scale (EPDS) screening in Sydney, Australia. *BMC Pregnancy and Childbirth*, *19*(1), 407. <https://doi.org/10.1186/s12884-019-2565-3>
- Khawaja, N. (2007). An Investigation of the Psychological Distress of Muslim Migrants in Australia. *Journal of Muslim Mental Health*, *2*(1), 39–56. <https://doi.org/10.1080/15564900701238526>
- Khawaja, N., & Mason, L. (2008). Predictors of Psychological Distress in South African Immigrants to Australia. *South African Journal of Psychology*, *38*(1), 225–246. <https://doi.org/10.1177/008124630803800112>
- Khawaja, N., & Stein, G. (2016). Psychological Services for Asylum Seekers in the Community: Challenges and Solutions. *Australian Psychologist*, *51*(6), 463–471. <https://doi.org/10.1111/ap.12149>
- Khawaja, N., White, K. M., Schweitzer, R., & Greenslade, J. (2008). Difficulties and Coping Strategies of Sudanese Refugees: A Qualitative Approach. *Transcultural Psychiatry*, *45*(3), 489–512. <https://doi.org/10.1177/1363461508094678>
- Khawaja, N., Yang, S., & Cockshaw, W. (2016). Taiwanese Migrants in Australia: An Investigation of Their Acculturation and Wellbeing. *Journal of Pacific Rim Psychology*, *10*. <https://doi.org/10.1017/prp.2016.1>
- Khoo, S.-E. (2010). Health and Humanitarian Migrants' Economic Participation. *Journal of Immigrant and Minority Health*, *12*(3), 327–339. <https://doi.org/10.1007/s10903-007-9098-y>

- Killedar, A., & Harris, P. (2017). Australia's refugee policies and their health impact: A review of the evidence and recommendations for the Australian Government. *Australian and New Zealand Journal of Public Health, 41*(4), 335–337. <https://doi.org/10.1111/1753-6405.12663>
- Klimidis, S., Stuart, G., Minas, H., & Ata, A. W. (1994). Immigrant status and gender effects on psychopathology and self-concept in adolescents: A test of the migration-morbidity hypothesis. *Comprehensive Psychiatry, 35*(5), 393–404. Scopus. [https://doi.org/10.1016/0010-440X\(94\)90281-X](https://doi.org/10.1016/0010-440X(94)90281-X)
- Kokanovic, R., May, C., Dowrick, C., Furler, J., Newton, D., & Gunn, J. (2010). Negotiations of distress between East Timorese and Vietnamese refugees and their family doctors in Melbourne. *Sociology of Health & Illness, 32*(4), 511–527. <https://doi.org/10.1111/j.1467-9566.2009.01228.x>
- Koopowitz, L. F., & Abhary, S. (2004). Psychiatric aspects of detention: Illustrative case studies. *Australian & New Zealand Journal of Psychiatry, 38*(7), 495–500. <https://doi.org/10.1080/j.1440-1614.2004.01402.x>
- Kozaki, D. (2018, March 11). Syrian refugees singing to soothe the trauma of war. *ABC News*. <https://www.abc.net.au/news/2018-03-11/music-therapy-helps-syrian-refugees-deal-with-trauma/9535040>
- Kumagai, A. K., & Lypson, M. L. (2009). Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education. *Academic Medicine, 84*(6), 782–787. <https://doi.org/10.1097/ACM.0b013e3181a42398>
- Lansakara, N., Brown, S. J., & Gartland, D. (2010). Birth Outcomes, Postpartum Health and Primary Care Contacts of Immigrant Mothers in an Australian Nulliparous Pregnancy Cohort Study. *Maternal and Child Health Journal, 14*(5), 807–816. <https://doi.org/10.1007/s10995-009-0514-x>
- Le, R., & Gilding, M. (2016). Gambling and drugs: The role of gambling among Vietnamese women incarcerated for drug crimes in Australia. *Australian & New Zealand Journal of Criminology, 49*(1), 134–151. <https://doi.org/10.1177/0004865814554307>
- Lee, J., & Davidson, J. W. (2017). Music's Role in Facilitating the Process of Healing—A Thematic Analysis. *Religions, 8*(9), 184.
- Lee, S. K., Sulaiman-Hill, C. M. R., & Thompson, S. C. (2013). Providing health information for culturally and linguistically diverse women: Priorities and preferences of new migrants and refugees. *Health Promotion Journal of Australia, 24*(2), 98–103. <https://doi.org/10.1071/HE12919>
- Lee, S. K., Sulaiman-Hill, C. M. R., & Thompson, S. C. (2014). Alcohol Experiences and Concerns of Newly Arrived Migrant Women. *SAGE Open, 4*(2), 2158244014530727. <https://doi.org/10.1177/2158244014530727>
- Leite da Silva, A., & Dawson, M. T. (2004). The impact of international migration on the health of Brazilian women living in Australia. *Texto & Contexto - Enfermagem, 13*(3), 339–350. <https://doi.org/10.1590/S0104-07072004000300002>
- Lenette, C., Brough, M., & Cox, L. (2013). Everyday resilience: Narratives of single refugee women with children. *Qualitative Social Work, 12*(5), 637–653. <https://doi.org/10.1177/1473325012449684>
- Lenette, C., Weston, D., Wise, P., Sunderland, N., & Bristed, H. (2016). Where words fail, music speaks: The impact of participatory music on the mental health and wellbeing of asylum seekers. *Arts & Health, 8*(2), 125–139.
- Liamputtong, P., Koh, L., Wollersheim, D., & Walker, R. (2015). Peer support groups, mobile phones and refugee women in Melbourne. *Health Promotion International, 31*(3), 715–724.
- Liddell, B. J., Chey, T., Silove, D., Phan, T. T. B., Giao, N. M., & Steel, Z. (2013). Patterns of risk for anxiety-depression amongst Vietnamese-immigrants: A comparison with source and host populations. *BMC Psychiatry, 13*(1), 329. <https://doi.org/10.1186/1471-244X-13-329>
- Liddell, B. J., Nickerson, A., Sartor, L., Ivancic, L., & Bryant, R. A. (2016). The generational gap: Mental disorder prevalence and disability amongst first and second generation immigrants in Australia. *Journal of Psychiatric Research, 83*, 103–111. Scopus. <https://doi.org/10.1016/j.jpsychires.2016.08.011>

- Lillee, A., Thambiran, A., & Laugharne, J. (2015). Evaluating the mental health of recently arrived refugee adults in Western Australia. *Journal of Public Mental Health, 14*(2), 56–68. <https://doi.org/10.1108/JPMH-05-2013-0033>
- Lim, G. Y., & Wong, M. T. (2016). Migration and psychosis in acute inpatient psychiatry. *Australasian Psychiatry, 24*(6), 548–552. <https://doi.org/10.1177/1039856216649772>
- Lin, X., Haralambous, B., Pachana, N. A., Bryant, C., Logiudice, D., Goh, A., & Dow, B. (2016). Screening for depression and anxiety among older Chinese immigrants living in Western countries: The use of the Geriatric Depression Scale (GDS) and the Geriatric Anxiety Inventory (GAI). *Asia-Pacific Psychiatry, 8*(1), 32–43. Scopus. <https://doi.org/10.1111/appy.12191>
- Lin, Xiaoping, Bryant, C., Boldero, J., & Dow, B. (2016). Psychological well-being of older Chinese immigrants living in Australia: A comparison with older Caucasians. *International Psychogeriatrics, 28*(10), 1671–1679. <https://doi.org/10.1017/S1041610216001010>
- Louie, R., Krouskos, D., Gonzalez, M., & Crofts, N. (1998). Vietnamese-speaking injecting drug users in Melbourne: The need for harm reduction programs. *Australian and New Zealand Journal of Public Health, 22*(4), 481–484. <https://doi.org/10.1111/j.1467-842X.1998.tb01418.x>
- Lumley, M., Katsikitis, M., & Statham, D. (2018). Depression, Anxiety, and Acculturative Stress Among Resettled Bhutanese Refugees in Australia. *Journal of Cross-Cultural Psychology, 49*(8), 1269–1282. <https://doi.org/10.1177/0022022118786458>
- Mahintorabi, S., Jones, M. K., & Harris, L. M. (2017). Exploring Professional Help Seeking in Practicing Muslim Women with Obsessive Compulsive Disorder Washing Subtype in Australia. *Religions, 8*(8), 137. <https://doi.org/10.3390/rel8080137>
- Mansouri, F., & Cauchi, S. (2007). A Psychological Perspective on Australia's Asylum Policies¹. *International Migration, 45*(1), 123–150. <https://doi.org/10.1111/j.1468-2435.2007.00398.x>
- Mares, S. (2016). The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australian human rights commission data set. *Health and Human Rights, 18*(2), 219–232. Scopus.
- Mares, S., & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention—Clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health, 28*(6), 520–526. Scopus. <https://doi.org/10.1111/j.1467-842X.2004.tb00041.x>
- Markovic, M., Manderson, L., & Kelaheer, M. (2002). The Health of Immigrant Women: Queensland Women from the Former Yugoslavia. *Journal of Immigrant Health, 4*(1), 11.
- McBride, J., Russo, A., & Block, A. (2016). The Refugee Health Nurse Liaison: A nurse led initiative to improve healthcare for asylum seekers and refugees. *Contemporary Nurse, 52*(6), 710–721. <https://doi.org/10.1080/10376178.2016.1238774>
- McEvoy, P. M., Grove, R., & Slade, T. (2011). Epidemiology of anxiety disorders in the Australian general population: Findings of the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry, 45*(11), 957–967. <https://doi.org/10.3109/00048674.2011.624083>
- McGorry, P. (2002). Asylum seeking and mandatory detention: The psychological consequences. *Australian Family Physician, 31*(3), 275.
- McGrath, J., El-Saadi, O., Cardy, S., Chapple, B., Chant, D., & Mowry, B. (2001). Urban birth and migrant status as risk factors for psychosis: An Australian case-control study. *Social Psychiatry and Psychiatric Epidemiology, 36*(11), 533–536. <https://doi.org/10.1007/s001270170003>
- McKelvey, R. S., Sang, D. L., Baldassar, L., Davies, L., Roberts, L., & Cutler, N. (2002). The prevalence of psychiatric disorders among Vietnamese children and adolescents. *Medical Journal of Australia, 177*(8), 410–417. <https://doi.org/10.5694/j.1326-5377.2002.tb04880.x>
- McNair, R., Szalacha, L. A., & Hughes, T. L. (2011). Health status, health service use, and satisfaction according to sexual identity of young Australian women. *Women's Health Issues, 21*(1), 40–47.

- MCWH. (n.d.). *Gambling harm* [Multicultural Centre For Women's Health]. Retrieved 25 September 2020, from <https://www.mcwh.com.au/project/gambling-awareness-project-gap-2/>
- MCWH. (2019). *Submission to the Royal Commission into Victoria's Mental Health Services*. Multicultural Centre for Women's Health.
- MHCS. (2018). *Mental Health Literacy Project – Indian Women*. NSW Multicultural Health Communication Service (MHCS).
- Milner, A., LaMontagne, A. D., Aitken, Z., Bentley, R., & Kavanagh, A. M. (2014). Employment status and mental health among persons with and without a disability: Evidence from an Australian cohort study. *J Epidemiol Community Health, 68*(11), 1064–1071. <https://doi.org/10.1136/jech-2014-204147>
- Milner, K., & Khawaja, N. (2010). Sudanese Refugees in Australia: The Impact of Acculturation Stress. *Journal of Pacific Rim Psychology, 4*(1), 19–29. <https://doi.org/10.1375/prp.4.1.19>
- Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013a). *Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion*. Mental Health in Multicultural Australia.
- Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013b). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems, 7*, 23. <https://doi.org/10.1186/1752-4458-7-23>
- Minas, H., Klimidis, S., Ranieri, N., & Stuart, G. W. (2008). Relative prevalence of psychological morbidity in older immigrants. *International Journal of Culture and Mental Health, 1*(1), 58–72. <https://doi.org/10.1080/17542860802149845>
- Minas, H., Klimidis, S., & Tuncer, C. (2007). Illness causal beliefs in Turkish immigrants. *BMC Psychiatry, 7*(1), 34. <https://doi.org/10.1186/1471-244X-7-34>
- Minas, H., & Sawyer, S. M. (2002). The mental health of immigrant and refugee children and adolescents: A case of public policy confusion. *Medical Journal of Australia, 177*(8), 404–405. Scopus. <https://doi.org/10.5694/j.1326-5377.2002.tb04875.x>
- Minas, H., Stuart, G. W., & Klimidis, S. (1994). Language, culture and psychiatric services: A survey of Victorian clinical staff. *Australian and New Zealand Journal of Psychiatry, 28*(2), 250–258. <https://doi.org/10.1080/00048679409075636>
- Misev, A., & Phillips, C. B. (2019). Dangerous sadness: Nervoza among first and second generation Macedonian immigrants to Australia. *Ethnicity & Health, 24*(3), 301–311. <https://doi.org/10.1080/13557858.2017.1332757>
- Mitchison, D., Mond, J., Bussey, K., Griffiths, S., Trompeter, N., Lonergan, A., Pike, K. M., Murray, S. B., & Hay, P. (2020). DSM-5 full syndrome, other specified, and unspecified eating disorders in Australian adolescents: Prevalence and clinical significance. *Psychological Medicine, 50*(6), 981–990. <https://doi.org/10.1017/S0033291719000898>
- Mitha, K., & Adatia, S. (2016). The faith community and mental health resilience amongst Australian Ismaili Muslim youth. *Mental Health, Religion & Culture, 19*(2), 192–207. <https://doi.org/10.1080/13674676.2016.1144732>
- Momartin, S., Coello, M., Pittaway, E., Downham, R., & Aroche, J. (2019). Capoeira Angola: An alternative intervention program for traumatized adolescent refugees from war-torn countries. *Journal on Rehabilitation of Torture Victims and Prevention of Torture, 29*(1), 85.
- Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D. M., & Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *The Medical Journal of Australia, 185*(7), 357–361.
- Mulé, N., & Gamble, K. (2018). Haven or precarity? The mental health of LGBT asylum seekers and refugees in Canada. In N. Nicol, A. Jjuuko, R. Lusimbo, N. Mulé, S. Ursel, A. Wahab, & P. Waugh (Eds.), *Envisioning Global LGBT Human Rights(Neo)colonialism, Neoliberalism, Resistance and Hope* (p. 205).

- Murdolo, A. (2008). Living in Harmony With Your Contradictions': Lesbian health in a multicultural context. *Gay and Lesbian Issues and Psychology, 4*(1), 68.
- Nahas, V., & Amasheh, N. (1999). Culture Care Meanings and Experiences of Postpartum Depression among Jordanian Australian Women: A Transcultural Study. *Journal of Transcultural Nursing, 10*(1), 37–45. <https://doi.org/10.1177/104365969901000113>
- Navodani, T., Gartland, D., Brown, S. J., Riggs, E., & Yelland, J. (2019). Common maternal health problems among Australian-born and migrant women: A prospective cohort study. *PLoS ONE, 14*(2), 1–12. <https://doi.org/10.1371/journal.pone.0211685>
- Newman, L. K., Procter, N. G., & Dudley, M. J. (2011). Suicide and self-harm in immigration detention. *Medical Journal of Australia, 195*(6), 310–311. <https://doi.org/10.5694/mja11.10993>
- Newnham, E. A., Pearman, A., Olinga-Shannon, S., & Nickerson, A. (2019). The mental health effects of visa insecurity for refugees and people seeking asylum: A latent class analysis. *International Journal of Public Health, 64*(5), 763–772. <https://doi.org/10.1007/s00038-019-01249-6>
- Nguyen, T., Dennis, S., An, H., Vagholkar, S., & Liaw, S. T. (2016). Psychological distress among Vietnamese adults attending Vietnamese-speaking general practices in South Western Sydney: Prevalence and associations. *Australian Journal of Primary Health, 22*(4), 354–359. Scopus. <https://doi.org/10.1071/PY14145>
- Nickerson, A., Byrow, Y., O'Donnell, M., Mau, V., McMahon, T., Pajak, R., Li, S., Hamilton, A., Minihan, S., Liu, C., Bryant, R. A., Berle, D., & Liddell, B. J. (2019). The association between visa insecurity and mental health, disability and social engagement in refugees living in Australia. *European Journal of Psychotraumatology, 10*(1). <https://doi.org/10.1080/20008198.2019.1688129>
- Nickerson, A., Hadzi-Pavlovic, D., Edwards, B., O'Donnell, M., Creamer, M., Felmingham, K. L., Forbes, D., McFarlane, A. C., Silove, D., Steel, Z., van Hoof, M., & Bryant, R. A. (2019). Identifying distinctive psychological symptom profiles among a nationally representative sample of refugees resettled in Australia. *Australian and New Zealand Journal of Psychiatry, 53*(9), 908–919. Scopus. <https://doi.org/10.1177/0004867419846403>
- Nickerson, A., Liddell, B. J., Keegan, D., Edwards, B., Felmingham, K. L., Forbes, D., Hadzi-Pavlovic, D., McFarlane, A. C., O'Donnell, M., Silove, D., Steel, Z., Van Hooff, M., & Bryant, R. A. (2019). Longitudinal association between trust, psychological symptoms and community engagement in resettled refugees. *Psychological Medicine, 49*(10), 1661–1669. Scopus. <https://doi.org/10.1017/S0033291718002246>
- Nielssen, O., Sara, G., Lim, Y., & Large, M. (2013). Country of birth and hospital treatment for psychosis in New South Wales. *Social Psychiatry and Psychiatric Epidemiology, 48*(4), 613–620. <https://doi.org/10.1007/s00127-012-0577-7>
- NIFVS. (n.d.). *A toolkit to improve responses to CALD women and children who have experienced family violence*. Northern Integrated Family Violence Services Partnership.
- Nithianandan, N., Gibson-Helm, M., McBride, J., Binny, A., Gray, K. M., East, C., & Boyle, J. A. (2016). Factors affecting implementation of perinatal mental health screening in women of refugee background. *Implementation Science, 11*(1), 150. <https://doi.org/10.1186/s13012-016-0515-2>
- O'Connor, M., & Colucci, E. (2016). Exploring domestic violence and social distress in Australian-Indian migrants through community theater. *Transcultural Psychiatry, 53*(1), 24–44. <https://doi.org/10.1177/1363461515599327>
- O'Connor, M., & Ibrahim, S. (2018). Suicidality and family violence in Australian immigrant women presenting to out-patient mental health settings. *Australasian Psychiatry, 26*(2), 224–225. <https://doi.org/10.1177/1039856217737884>
- O'Donoghue, B., Downey, L., Eaton, S., Mifsud, N., Kirkbride, J. B., & McGorry, P. (2020). Risk of psychotic disorders in migrants to Australia. *Psychological Medicine, 1*–9. <https://doi.org/10.1017/S0033291719004100>

- Ogbo, F. A., Eastwood, J., Hendry, A., Jalaludin, B., Agho, K. E., Barnett, B., & Page, A. (2018). Determinants of antenatal depression and postnatal depression in Australia. *BMC Psychiatry, 18*(1), 49. <https://doi.org/10.1186/s12888-018-1598-x>
- Omeri, A., Lennings, C., & Raymond, L. (2006). Beyond Asylum: Implications for Nursing and Health Care Delivery for Afghan Refugees in Australia. *Journal of Transcultural Nursing, 17*(1), 30–39. <https://doi.org/10.1177/1043659605281973>
- Ooi, C. S., Rooney, R. M., Roberts, C., Kane, R. T., Wright, B., & Chatzisarantis, N. (2016). The efficacy of a group cognitive behavioral therapy for war-affected young migrants living in Australia: A cluster randomized controlled trial. *Frontiers in Psychology, 7*, 1641.
- Outram, S., Mishra, G. D., & Schofield, M. J. (2004). Sociodemographic and Health Related Factors Associated with Poor Mental Health in Midlife Australian Women. *Women & Health, 39*(4), 97–115. https://doi.org/10.1300/J013v39n04_06
- Owens, C., Dandy, J., & Hancock, P. (2016). Perceptions of pregnancy experiences when using a community-based antenatal service: A qualitative study of refugee and migrant women in Perth, Western Australia. *Women and Birth, 29*(2), 128–137. <https://doi.org/10.1016/j.wombi.2015.09.003>
- Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE, 10*(9), 1–48. <https://doi.org/10.1371/journal.pone.0138511>
- Pino-Gutiérrez, A. del, Fernández-Aranda, F., Granero, R., Tárrega, S., Valdepérez, A., Agüera, Z., Håkansson, A., Sauvaget, A., Aymamí, N., Gómez-Peña, M., Moragas, L., Baño, M., Honrubia, M., Menchón, J. M., & Jiménez-Murcia, S. (2017). Impact of alcohol consumption on clinical aspects of gambling disorder. *International Journal of Mental Health Nursing, 26*(2), 121–128. <https://doi.org/10.1111/inm.12221>
- Radermacher, H., Dickins, M., Anderson, C., & Feldman, S. (2017). Perceptions of Gambling in Tamil and Chinese Communities in Australia: The Role of Saving Face in Perpetuating Gambling Stigma and Hindering Help Seeking. *Journal of Gambling Issues, 34*(0), Article 0. <https://doi.org/10.4309/jgi.2016.34.5>
- Radicchi, M. R., Papertalk, L., & Thompson, S. (2019). “It made me feel Brazilian!”: Addressing prejudice through Capoeira classes in a school in Western Australia. *Health Promotion Journal of Australia, 30*(3), 299–302.
- Raphael, B., Taylor, M., & McAndrew, V. (2008). Women, Catastrophe and Mental Health. *Australian & New Zealand Journal of Psychiatry, 42*(1), 13–23. <https://doi.org/10.1080/00048670701732707>
- Rees, S. (2003). Refugees and Remote Populations Refuge or retrauma? The impact of asylum seeker status on the wellbeing of East Timorese women asylum seekers residing in the Australian community. *Australasian Psychiatry, 11*, S96. <https://doi.org/10.1046/j.1038-5282.2003.02022.x>
- Rees, S. (2004). East Timorese women asylum seekers in Australia: Extrapolating a case for resettlement services. *Australian Social Work, 57*(3), 259–272. <https://doi.org/10.1111/j.1447-0748.2004.00148.x>
- Rees, S., Fisher, J. R., Steel, Z., Mohsin, M., Nadar, N., Moussa, B., Hassoun, F., Yousif, M., Krishna, Y., Khalil, B., Mugo, J., Tay, A. K., Klein, L., & Silove, D. (2019). Prevalence and Risk Factors of Major Depressive Disorder Among Women at Public Antenatal Clinics From Refugee, Conflict-Affected, and Australian-Born Backgrounds. *JAMA Network Open, 2*(5), e193442–e193442. <https://doi.org/10.1001/jamanetworkopen.2019.3442>
- Rees, S., & Pease, B. (2006). *Refugee Settlement, Safety and Wellbeing: Exploring Domestic and Family Violence in Refugee Communities* (Violence Against Women Community Attitudes Project No. 4). Immigrant Women’s Domestic Violence Service.
- Rees, S., & Pease, B. (2007). Domestic Violence in Refugee Families in Australia. *Journal of Immigrant & Refugee Studies, 5*(2), 1–19. https://doi.org/10.1300/J500v05n02_01
- Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., Teesson, M., Bryant, R., McFarlane, A. C., Mills, K. L., Slade, T., Carragher, N., O’Donnell, M., & Forbes, D. (2011). Lifetime Prevalence of Gender-Based

- Violence in Women and the Relationship With Mental Disorders and Psychosocial Function. *JAMA*, 306(5), 513–521. <https://doi.org/10.1001/jama.2011.1098>
- Rees, S., Silove, D., & Kareth, M. (2009). Dua Sakit (Double Sick): Trauma and the Settlement Experiences of West Papuan Refugees Living in North Queensland. *Australasian Psychiatry*, 17(1_suppl), S128–S132. <https://doi.org/10.1080/10398560902948399>
- Reid, G., Higgs, P., Beyer, L., & Crofts, N. (2002). Vulnerability among Vietnamese illicit drug users in Australia: Challenges for change. *International Journal of Drug Policy*, 13(2), 127–136. [https://doi.org/10.1016/S0955-3959\(02\)00012-9](https://doi.org/10.1016/S0955-3959(02)00012-9)
- Rintoul, A. (2010). *Understanding the mental health and wellbeing of Afghan women in South East Melbourne*. Monash University, Foundation House.
- Rivas, L., & Bull, M. (2018). Gender and Risk: An Empirical Examination of the Experiences of Women Held in Long-Term Immigration Detention in Australia. *Refugee Survey Quarterly*, 37(3), 307–327. <https://doi.org/10.1093/rsq/hdy006>
- Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *British Journal of Psychiatry*, 194(4), 306–312. Scopus. <https://doi.org/10.1192/bjp.bp.108.053223>
- Rose, L., Alhusen, J., Bhandari, S., Soeken, K., Marcantonio, K., Bullock, L., & Sharps, P. (2010). Impact of Intimate Partner Violence on Pregnant Women’s Mental Health: Mental Distress and Mental Strength. *Issues in Mental Health Nursing*, 31(2), 103–111. <https://doi.org/10.3109/01612840903254834>
- Russo, A., Lewis, B., Joyce, A., Crockett, B., & Luchters, S. (2015). A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia. *BMC Pregnancy and Childbirth*, 15(1), 197. <https://doi.org/10.1186/s12884-015-0631-z>
- Saha, S., Scott, J. G., Varghese, D., & McGrath, J. J. (2013). Socio-Economic Disadvantage and Delusional-Like Experiences: A Nationwide Population-Based Study. *European Psychiatry*, 28(1), 59–63. <https://doi.org/10.1016/j.eurpsy.2011.09.004>
- Savic, M., Barker, S. F., Best, D., & Lubman, D. I. (2014). Alcohol problems among migrants in substance use treatment: The role of drinking patterns in countries of birth. *Australian Journal of Primary Health*, 20(3), 220–221. <https://doi.org/10.1071/PY14028>
- Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. (2013). Separation from family and its impact on the mental health of Sudanese refugees in Australia: A qualitative study. *Australian and New Zealand Journal of Public Health*, 37(4), 383–388. <https://doi.org/10.1111/1753-6405.12088>
- Schweitzer, R., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental Health of Newly Arrived Burmese Refugees in Australia: Contributions of Pre-Migration and Post-Migration Experience. *Australian & New Zealand Journal of Psychiatry*, 45(4), 299–307. <https://doi.org/10.3109/00048674.2010.543412>
- Schweitzer, R., Buckley, L., & Rossi, D. (2002). The psychological treatment of refugees and asylum seekers: What does the literature tell us? *Mots Pluriels*, 21. <http://motspluriels.arts.uwa.edu.au/MP2102sbr.html>
- Schweitzer, R., Greenslade, J., & Kagee, A. (2007). Coping and Resilience in Refugees from the Sudan: A Narrative Account. *Australian & New Zealand Journal of Psychiatry*, 41(3), 282–288. <https://doi.org/10.1080/00048670601172780>
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, Post-Migration Living Difficulties, and Social Support as Predictors of Psychological Adjustment in Resettled Sudanese Refugees. *Australian & New Zealand Journal of Psychiatry*, 40(2), 179–187. <https://doi.org/10.1080/j.1440-1614.2006.01766.x>
- Schweitzer, R., Vromans, L., Brough, M., Asic-Kobe, M., Correa-Velez, I., Murray, K., & Lenette, C. (2018). Recently resettled refugee women-at-risk in Australia evidence high levels of psychiatric symptoms: Individual, trauma and post-migration factors predict outcomes. *BMC Medicine*, 16(1), 149. <https://doi.org/10.1186/s12916-018-1143-2>

- Scott, J., Chant, D., Andrews, G., & McGRATH, J. (2006). Psychotic-like experiences in the general community: The correlates of CIDI psychosis screen items in an Australian sample. *Psychological Medicine*, *36*(2), 231–238. <https://doi.org/10.1017/S0033291705006392>
- Scull, S., & Woolcock, G. (2005). Problem Gambling in Non-English Speaking Background Communities in Queensland, Australia: A Qualitative Exploration. *International Gambling Studies*, *5*(1), 29–44. <https://doi.org/10.1080/14459790500097939>
- Severino, G. A., & Haynes, W. D. G. (2010). Development of an Italian version of the Depression Anxiety Stress Scales. *Psychology, Health and Medicine*, *15*(5), 607–621. Scopus. <https://doi.org/10.1080/13548506.2010.498889>
- Shafiei, T., Flood, M., & Bee, J. (2018). *Identifying the perinatal mental health needs of immigrant and refugee women*. Judith Lumley Centre, La Trobe University.
- Shafiei, T., Small, R., & McLachlan, H. (2015). Immigrant Afghan women's emotional well-being after birth and use of health services in Melbourne, Australia. *Midwifery*, *31*(7), 671–677. <https://doi.org/10.1016/j.midw.2015.03.011>
- Sharma, S. (2012). Psychological distress among Australians and immigrants: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Advances in Mental Health*, *10*(2), 106–116. <https://doi.org/10.5172/jamh.2011.10.2.106>
- Silove, D., Chang, R., & Manicavasagar, V. (1995). Impact of recounting trauma stories on the emotional state of Cambodian refugees. *Psychiatric Services*.
- Silove, D., Momartin, S., Marnane, C., Steel, Z., & Manicavasagar, V. (2010). Adult separation anxiety disorder among war-affected Bosnian refugees: Comorbidity with PTSD and associations with dimensions of trauma. *Journal of Traumatic Stress*, *23*(1), 169–172. Scopus. <https://doi.org/10.1002/jts.20490>
- Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry*, *170*(4), 351–357. <https://doi.org/10.1192/bjp.170.4.351>
- Silove, Derrick, Austin, P., & Steel, Z. (2007). No Refuge from Terror: The Impact of Detention on the Mental Health of Trauma-affected Refugees Seeking Asylum in Australia. *Transcultural Psychiatry*, *44*(3), 359–393. <https://doi.org/10.1177/1363461507081637>
- Silove, Derrick, & Steel, Z. (1998). *The Mental Health & Well-Being of On-Shore Asylum Seekers in Australia*. Psychiatry Research and Teaching Unit, University of NSW.
- Silove, Derrick, Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: Comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica*, *97*, 175–181.
- Slewa-Younan, S., Mond, J., Bussion, E., Mohammad, Y., Uribe Guajardo, M. G., Smith, M., Milosevic, D., Lujic, S., & Jorm, A. F. (2014). Mental health literacy of resettled Iraqi refugees in Australia: Knowledge about posttraumatic stress disorder and beliefs about helpfulness of interventions. *BMC Psychiatry*, *14*(1). <https://doi.org/10.1186/s12888-014-0320-x>
- Slewa-Younan, S., Mond, J. M., Bussion, E., Melkonian, M., Mohammad, Y., Dover, H., Smith, M., Milosevic, D., & Jorm, A. F. (2015). Psychological trauma and help seeking behaviour amongst resettled Iraqi refugees in attending English tuition classes in Australia. *International Journal of Mental Health Systems*, *9*(1). Scopus. <https://doi.org/10.1186/1752-4458-9-5>
- Small, R., Lumley, J., & Yelland, J. (2003). Cross-cultural experiences of maternal depression: Associations and contributing factors for Vietnamese, Turkish and Filipino immigrant women in Victoria, Australia. *Ethnicity & Health*, *8*(3), 189–206. <https://doi.org/10.1080/1355785032000136416>
- Smith, L. (2015). *The Health Outcomes of Migrants: A Literature Review*. Migration Council Australia.
- Sobhanian, F., Boyle, G. J., Bahr, M., & Fallo, T. (2006). Psychological Status of Former Refugee Detainees From the Woomera Detention Centre Now Living in the Australian Community. *Psychiatry, Psychology and Law*, *13*(2), 151–159. <https://doi.org/10.1375/pplt.13.2.151>

- Somasundaram, D. (2010). Using cultural relaxation methods in post-trauma care among refugees in Australia. *International Journal of Culture and Mental Health*, 3(1), 16–24. Scopus.
<https://doi.org/10.1080/17542860903411615>
- Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D. M., Everson, N., Roy, K., Dudley, M., Newman, L., Blick, B., & Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health*, 28(6), 527–536. <https://doi.org/10.1111/j.1467-842X.2004.tb00042.x>
- Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine* (1982), 72(7), 1149–1156. <https://doi.org/10.1016/j.socscimed.2011.02.007>
- Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *The British Journal of Psychiatry*, 188(1), 58–64. <https://doi.org/10.1192/bjp.bp.104.007864>
- Steel, Z., Silove, D., Giao, N. M., Phan, T. T. B., Chey, T., Whelan, A., Bauman, A., & Bryant, R. A. (2009). International and indigenous diagnoses of mental disorder among Vietnamese living in Vietnam and Australia. *The British Journal of Psychiatry*, 194(4), 326–333.
<https://doi.org/10.1192/bjp.bp.108.050906>
- Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *The Lancet*, 360(9339), 1056–1062. [https://doi.org/10.1016/S0140-6736\(02\)11142-1](https://doi.org/10.1016/S0140-6736(02)11142-1)
- Straiton, M., Grant, J. F., Winefield, H. R., & Taylor, A. (2014). Mental health in immigrant men and women in Australia: The North West Adelaide health study. *BMC Public Health*, 14(1).
<https://doi.org/10.1186/1471-2458-14-1111>
- Sultan, A., & O’Sullivan, K. (2001). Psychological disturbances in asylum seekers held in long term detention: A participant–observer account. *Medical Journal of Australia*, 175(11–12), 593–596.
<https://doi.org/10.5694/j.1326-5377.2001.tb143740.x>
- Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers’ AdvocateS In the Community (MOSAIC)-non-professional mentor support to reduce intimate partner violence and depression in mothers: A cluster randomised trial in primary care. *BMC Public Health*, 11(1), 178.
- Tan, L. L., & Denson, L. (2019). Bilingual and Multilingual Psychologists Practising in Australia: An Exploratory Study of Their Skills, Training Needs and Experiences. *Australian Psychologist*, 54(1), 13–25.
<https://doi.org/10.1111/ap.12355>
- Tang, G. W.-G., Dennis, S., Comino, E., & Zwar, N. (2009). Anxiety and Depression in Chinese Patients Attending an Australian GP Clinic. *Australian Family Physician*, 38(7), 552.
- Thompson, S., Manderson, L., Woelz-Stirling, N., Cahill, A., & Kelaher, M. (2002). The social and cultural context of the mental health of Filipinas in Queensland. *Australian & New Zealand Journal of Psychiatry*, 36(5), 681–687. <https://doi.org/10.1046/j.1440-1614.2002.01071.x>
- Tilbury, F. (2007). “I Feel I Am a Bird Without Wings”: Discourses of Sadness and Loss Among East Africans in Western Australia. *Identities*, 14(4), 433–458. <https://doi.org/10.1080/10702890701578464>
- Tilbury, F., & Rapley, M. (2004). ‘There are orphans in Africa still looking for my hands’: African women refugees and the sources of emotional distress. *Health Sociology Review*, 13(1), 54–64.
<https://doi.org/10.5172/hesr.13.1.54>
- Uribe Guajardo, M. G., Slewa-Younan, S., Smith, M., Eagar, S., & Stone, G. (2016). Psychological distress is influenced by length of stay in resettled Iraqi refugees in Australia. *International Journal of Mental Health Systems*, 10(1), 4. <https://doi.org/10.1186/s13033-016-0036-z>
- Valibhoy, M. C., Kaplan, I., & Szwarc, J. (2017). “It comes down to just how human someone can be”: A qualitative study with young people from refugee backgrounds about their experiences of Australian mental health services. *Transcultural Psychiatry*, 54(1), 23–45.
<https://doi.org/10.1177/1363461516662810>

- Vatcharavongvan, P., Hepworth, J., Lim, J., & Marley, J. (2014). What are the Health Needs, Familial and Social Problems of Thai Migrants in a Local Community in Australia? A Focus Group Study. *Journal of Immigrant and Minority Health, 16*(1), 143–149. <https://doi.org/10.1007/s10903-012-9725-0>
- Vaughan, C., Chen, J., Block, K., Sullivan, C., Suha, M., Sandhu, M., Hourani, J., Khaw, S., Jarallah, Y., Zannettino, L., Gregoric, C., Murray, L., & Murdolo, A. (2020). *Multicultural and Settlement services Supporting women experiencing violence*: (No. 11/2020; Research Report, p. 112). ANROWS.
- Vaughan, C., Davis, E., Murdolo, A., Chen, J., Murray, L., Quiazon, R., Block, K., & Warr, D. (2016). *Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia. The ASPIRE Project: Research report* (No. 07/2016; ANROWS Horizons). Australia's National Research Organisation for Women's Safety.
- Verdon, S. (2020). Awakening a critical consciousness among multidisciplinary professionals supporting culturally and linguistically diverse families: A pilot study on the impact of professional development. *Child Care in Practice, 26*(1), 4–21. <https://doi.org/10.1080/13575279.2018.1516626>
- Vos, T., Astbury, J., Piers, L. S., Magnus, A., Heenan, M., Stanley, L., Walker, L., & Webster, K. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization, 84*, 739–744. <https://doi.org/10.1590/S0042-96862006000900017>
- Vromans, L., Schweitzer, R. D., Brough, M., Correa-Velez, I., Murray, K., & Lenette, C. (2019). Psychometric Properties of the Multidimensional Loss Scale with Refugee Women-at-Risk Recently Arrived in Australia. *Journal of Immigrant and Minority Health, 21*(2), 271–277. <https://doi.org/10.1007/s10903-018-0750-5>
- Wagner, R., Manicavasagar, V., Silove, D., Marnane, C., & Tran, V. T. (2006). Characteristics of Vietnamese Patients Attending an Anxiety Clinic in Australia and Perceptions of the Wider Vietnamese Community about Anxiety. *Transcultural Psychiatry, 43*(2), 259–274. <https://doi.org/10.1177/1363461506064863>
- Walker, R., Koh, L., Wollersheim, D., & Liamputtong, P. (2015). Social connectedness and mobile phone use among refugee women in Australia. *Health & Social Care in the Community, 23*(3), 325–336.
- Watson, N., & Wooden, M. (2002). *Assessing the Quality of the HILDA Survey Wave 1 Data* (Hilda Project Technical Paper Series No. 4/02; p. 40). Melbourne Institute of Applied Economic and Social Research, the University of Melbourne.
- WHO. (2018, March 30). *Mental health: Strengthening our response*. World Health Organisation. <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>
- WHO. (2019, November 28). *Mental disorders*. World Health Organisation. <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>
- Willey, S. M., Gibson-Helm, M. E., Finch, T. L., East, C. E., Khan, N. N., Boyd, L. M., & Boyle, J. A. (2020). Implementing innovative evidence-based perinatal mental health screening for women of refugee background. *Women and Birth, 33*(3), e245–e255. <https://doi.org/10.1016/j.wombi.2019.05.007>
- Wilmsen, B. (2013). Family separation and the impacts on refugee settlement in Australia. *Australian Journal of Social Issues, 48*(2), 241–262. Scopus. <https://doi.org/10.1002/j.1839-4655.2013.tb00280.x>
- Wohler, Y., & Dantas, J. A. (2017). Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications. *Journal of Immigrant and Minority Health, 19*(3), 697–701. <https://doi.org/10.1007/s10903-016-0402-6>
- Wollersheim, D., Koh, L., Walker, R., & Liamputtong, P. (2013). Constant connections: Piloting a mobile phone-based peer support program for Nuer (southern Sudanese) women. *Australian Journal of Primary Health, 19*(1), 7–13.
- Women: A Guide for Health Professionals*. (n.d.).
- Wong, D. F. K., Lam, A. Y. K., Poon, A., & Chow, A. Y. M. (2012). Gender differences in mental health literacy among Chinese-speaking Australians in Melbourne, Australia. *International Journal of Social Psychiatry, 58*(2), 178–185. <https://doi.org/10.1177/0020764010390431>
- Wood, N., Charlwood, G., Zecchin, C., Hansen, V., Douglas, M., & Pit, S. W. (2019). Qualitative exploration of the impact of employment and volunteering upon the health and wellbeing of African refugees

- settled in regional Australia: A refugee perspective. *BMC Public Health*, 19(1), 143.
<https://doi.org/10.1186/s12889-018-6328-2>
- Wu Yi Zheng, Walker, M., & Blaszczynski, A. (2011). Mahjong and Problem Gambling in Sydney: An Exploratory Study with Chinese Australians. *Journal of Gambling Issues*, 25, 24–35.
<https://doi.org/10.4309/jgi.2011.25.3>
- Yelland, J., Sutherland, G., & Brown, S. J. (2010). Postpartum anxiety, depression and social health: Findings from a population-based survey of Australian women. *BMC Public Health*, 10(1), 771.
<https://doi.org/10.1186/1471-2458-10-771>
- Young, P., & Gordon, M. S. (2016). Mental health screening in immigration detention: A fresh look at Australian government data. *Australasian Psychiatry*, 24(1), 19–22.
<https://doi.org/10.1177/1039856215624247>
- Zannettino, L., Pittaway, E., Eckert, R., Bartolomei, L., Ostapiej-Piatkowski, B., Allimant, A., & Parris, J. (2013). *Improving responses to refugees with backgrounds of multiple trauma*: (p. 40). Australian Domestic and Family Violence Clearinghouse.
- Zheng, W. Y., Walker, M., & Blaszczynski, A. (2010). Mahjong gambling in the Chinese-Australian community in Sydney: A prevalence study. *Journal of Gambling Studies*, 26(3), 441–454.
- Ziersch, A., Gallaher, G., Baum, F., & Bentley, M. (2011). Racism, social resources and mental health for Aboriginal people living in Adelaide. *Australian and New Zealand Journal of Public Health*, 35(3), 231–237. <https://doi.org/10.1111/j.1753-6405.2011.00681.x>