CENTRE FOR MUSLIM WELLBEING

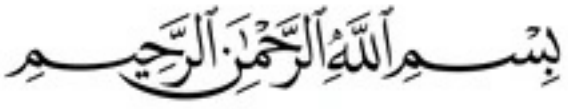
National Mental Health and Suicide Prevention Agreement Review

Submission to the Productivity Commission
By the Centre for Muslim Wellbeing
August 2025

CMW.ORG.AU

Acknowledgement

Centre for Muslim Wellbeing



Bismillah Ar-Rahman Ar-Raheem
In the name of Allah, The Most Compassionate, The Most Merciful

We begin by acknowledging the Traditional Custodians of the lands on which we live, work, and gather—particularly the Wurundjeri Woi Wurrung people of the Kulin Nation—and all First Nations peoples across Victoria. We pay deep respect to Elders past and present, and recognise that sovereignty was never ceded. This always was, and always will be, Aboriginal land.

We stand in solidarity with Aboriginal and Torres Strait Islander communities, whose leadership, knowledge systems, and spiritual connection to Country inspire our shared journey toward justice, healing, and collective wellbeing.

Guided by the Divine names—Ar-Rahman (The Compassionate), Al-Adl (The Just), Ash-Shafee (The Healer), Al-Wasi' (The All-Encompassing), and Al-Hakeem (The All-Wise)—we affirm the sacredness of every life and the right to spiritual, emotional, and cultural wellbeing.

As we reflect on mental health, trauma, and systems reform, we centre lived experience, compassion, and cultural insight. Behind every data point is a person, a family, a story.

This submission is both a call to action and an expression of hope—for a system rooted in equity, dignity, and care.

About Centre for Muslim Wellbeing

Who we are

The Centre for Muslim Wellbeing (CMW) is a not-for-profit, community-led organisation established in 2018, dedicated to improving the mental health, spiritual wellbeing, and social inclusion of Muslim communities in Victoria. Established in response to a critical need for culturally and faith-informed care, CMW is grounded in lived experience, guided by evidence, and driven by community partnership.

We work at the intersection of mental health, community development, and faith-based healing, serving as a trusted bridge between government, services, and communities. Our work honours the diversity of Muslim identities and promotes dignity, resilience, and collective care across generations.

What we do

Through partnerships with primary health networks, services, faith leaders, education providers, and grassroots organisations, CMW has reached thousands of community members — delivering practical impact while championing systemic change.

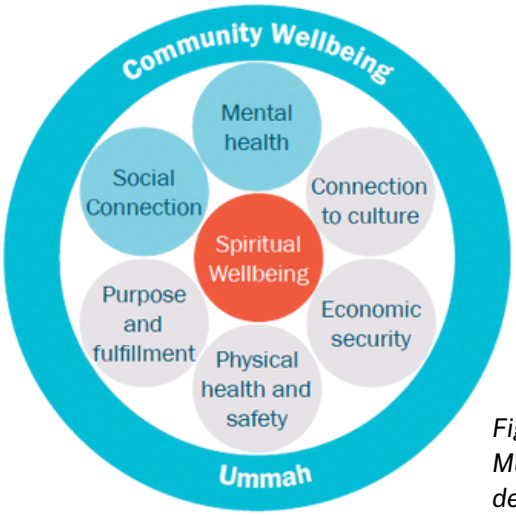


Figure 1: Working Definition of Muslim wellbeing in Australia, developed by CMW

Figure 2: CMW's Guiding Principles

About Centre for Muslim Wellbeing

Centre for Muslim Wellbeing

Key Area	Description	Core Activities
1. Mental Health Education & Suicide Prevention	Addressing stigma, Islamophobia, and gaps in spiritually congruent care through culturally responsive mental health education, suicide postvention, and grief support. Builds community trust and safer pathways to care.	• Mental Health First Aid (MHFA) workshops • Suicide postvention and grief support • Cultural Intelligence and anti-racism training • Community-based mental health literacy initiatives
2. Trauma Recovery & Family Healing	Supporting individuals and families affected by war, displacement, family violence, sexual assault and intergenerational trauma through faith-informed and trauma-sensitive group programs.	• Healing circles and trauma recovery workshops • Bereavement support (Project Zaytouna) • Emotional regulation and spiritual care • Programs for women, carers, children, and men • End to end services support from pre-natal to parenting workshops for families
3. Youth Wellbeing & School Engagement	Supporting Muslim youth through peer-led programs that foster inclusion, identity, and resilience. Addressing racism, bullying, neurodiversity, disengagement, depression, suicide and self-harm through creative and culturally safe approaches.	• Storytelling and movement (Project Nawah) • School-based anti-bullying, wellbeing and resilience programs • Youth mentoring and spiritual development • Emotional literacy and belonging sessions
4. Settlement Services & Community Connection	Holistic support for newly arrived communities facing systemic barriers. Enhancing community capacity, connection, and access to essential services in culturally responsive ways.	• Peer support for migrants and refugees • Outreach for carers, women, and families • Service navigation (employment, health, housing, legal)
5. System Navigation & Crisis Response	Providing culturally and spiritually appropriate responses during times of acute distress — filling a vital gap in crisis care for Muslim communities. Digital information hub to provide key information to community, providers and government	• Crisis intervention and case coordination • Support for suicide risk, family breakdown, and violence • Advocacy and safety planning • Partnerships with crisis and support services (i.e hospitals, emergency, justice) • In-language support and digital resource hub

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1. Executive Summary

Centre for Muslim Wellbeing

The Centre for Muslim Wellbeing (CMW) welcomes the opportunity to contribute to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement. Our submission highlights critical systemic gaps in meeting the mental health needs of Muslim and other culturally and linguistically diverse (CALD) communities — particularly young people, carers, and newly arrived individuals.

As a Muslim-led, community-based organisation, CMW brings qualified, evidence-based insight grounded in cultural, spiritual, and lived experience. We specialise in culturally responsive, trauma-informed, and faith-sensitive care. Our work spans service delivery, trauma recovery, workforce development, research, and policy reform — bridging gaps between systems and communities to improve mental health outcomes.

Muslim Australians — over 813,000 nationally and 273,000 in Victoria — are among the youngest and most diverse populations in the country. Yet they remain largely absent from national mental health policy, data, and funding. Islamophobia, stigma, structural exclusion, and a lack of culturally safe services continue to erode wellbeing and access.

The estimated economic cost of mental ill-health among Victorian Muslims is $232–$285 million annually. Community-led models like CMW's offer cost-effective, scalable solutions for prevention and recovery.

To build a fair and inclusive mental health system, national reforms must embed cultural safety, intersectionality, and community leadership across all levels of design, governance, and delivery.

Terms of Reference & Key Recommendations

We propose twenty-nine bold but necessary recommendations. These are not just technical tweaks; they are calls for a reorientation of mental health policy toward equity, co-ownership, and lived experience leadership.

Each recommendation is rooted in frontline insights and backed by a growing body of research that shows the effectiveness of community-led approaches.

A. Impact on Wellbeing and Productivity

1. A national Muslim Mental Health and Wellbeing Strategy should be developed in partnership with community leaders, researchers, youth advocates, and faith-based mental health professionals.
2. Suicide prevention programs must be locally tailored, trauma-informed, and co-designed with Muslim youth and families to address specific drivers of distress.
3. All Productivity Commission and Treasury-led economic modelling should integrate disaggregated data on the mental health outcomes of CALD communities to better assess productivity impacts.

1. Executive Summary

Centre for Muslim Wellbeing

Terms of Reference & Key Recommendations (continued)

B. Effectiveness of Reforms Across Populations

4. The National Mental Health Commission should fund a comprehensive research program into Muslim mental health and wellbeing, including suicide prevalence, service gaps, and protective factors.
5. Reform outcomes should be evaluated using culturally appropriate indicators developed in collaboration with Muslim communities.
6. Accountability mechanisms — such as KPIs for engagement with priority populations — should be embedded into all funded programs under the Agreement.

C. Best Practice and Productivity Improvement Opportunities

7. Establish a National Centre for Cultural and Faith-Based Mental Health Innovation to incubate best practice models, train practitioners, and scale community-led interventions.
8. Reform funding models to prioritise partnerships with Muslim-led organisations and local faith networks.
9. Invest in digital inclusion strategies tailored for faith-based communities, including telehealth, app development, and digital literacy campaigns.

D. System Preparedness and Responsiveness to Emerging Priorities

10. Establish a National Muslim and CALD Crisis Mental Health Preparedness Framework to enable rapid investment in culturally and faith-informed responses to global or domestic events impacting priority populations.
11. Mandate community horizon scanning by funding organisations like CMW to regularly identify and report emerging mental health risks among Muslim and CALD communities.
12. Introduce a responsive funding stream within the Agreement to allow timely commissioning of community-led mental health initiatives during crises or periods of heightened community distress.

E. Unintended Consequences: Cost Shifting and Inequity

13. Require Primary Health Networks (PHNs) to allocate at least 15% of mental health funding to CALD- and Muslim-led organisations through long-term, non-competitive grants.
14. Embed enforceable equity and cultural responsiveness measures in bilateral agreements, with financial consequences for non-compliance.
15. Establish a national infrastructure fund to build the capacity of CALD and Muslim community organisations, supporting their long-term sustainability and reducing reliance on unpaid labour.

1. Executive Summary

Centre for Muslim Wellbeing

Terms of Reference & Key Recommendations (continued)

F. Effectiveness of Administration and Bilateral Schedules

16. Require all jurisdictions to report annually on mental health funding directed to CALD and Muslim-led organisations, including clear metrics on cultural safety and workforce diversity.
17. Develop and implement national cultural responsiveness standards for mental health service design, delivery, and evaluation across all states and territories.
18. Mandate the inclusion of CALD and Muslim-led organisations in mental health governance and planning bodies, with a minimum target of 30% representation.

G. Governance, Reporting and Evaluation Frameworks

19. Introduce a mandatory cultural accountability framework embedded within all bilateral and national evaluations, which includes metrics aligned with CALD and faith community wellbeing.
20. Require disaggregated data collection by religious affiliation, ethnicity, and migration background across all PHNs and funded services, ensuring transparency in reporting.
21. Establish national and state-level CALD governance advisory panels, with equal representation from Muslim mental health professionals, carers, and lived experience advocates, to oversee implementation and evaluations.

H. Roles and Responsibilities of Government and Service Providers

22. Mandate clear delineation of responsibilities between Commonwealth and state actors for engaging CALD and Muslim-led services, including streamlined commissioning pathways.
23. Introduce minimum cultural capability standards for all contracted service providers, monitored through independent audits and client experience data.
24. Provide sustainable funding and workforce development for community leaders and peer supporters in Muslim communities, recognising their role as cultural brokers in the mental health ecosystem.
25. Require joint commissioning models between PHNs and states that prioritise the integration of CALD and Muslim-specific services.

I. Lived Experience and Cultural Inclusion

26. Redesign lived experience structures to include culturally grounded peer roles and pathways, ensuring faith-based and intergenerational mental health knowledge is formally recognised.
27. Establish dedicated Muslim Lived Experience Panels at national and state levels, co-funded and co-led with community organisations.
28. Fund long-term capacity-building programs to train and support Muslim carers, youth, and elders to participate in mental health system governance and reform.
29. Shift from tokenistic cultural inclusion to structural co-leadership models with Muslim mental health professionals and scholars embedded in policymaking bodies.

2. Centring Muslim Wellbeing in Australia

Centre for Muslim Wellbeing

Systemic Inequities and Emerging Challenges Facing Muslim Communities

Despite the profound social contributions and deep-rooted resilience of Muslim communities across Australia, CMW's extensive engagement and frontline service delivery continue to expose a range of structural and interrelated barriers that compromise mental health and wellbeing outcomes. These challenges are systemic — embedded within service design, policy architecture, and broader societal attitudes.

Exclusion from Mainstream Systems of Care

Muslim individuals and families are consistently underrepresented in mainstream mental health and social services, not due to a lack of need, but because these systems fail to meet cultural and spiritual expectations of care. CMW's consultations reveal entrenched distrust in formal services, especially among newly arrived migrants, men, and youth — groups who frequently cite experiences of erasure, othering, and bureaucratic gatekeeping.

Islamophobia and Structural Discrimination as Social Determinants of Health

Islamophobia — both overt and institutional — remains a significant driver of psychological distress. The exponential rise in reports of targeted abuse, particularly impacting visibly Muslim women, is producing cycles of trauma, hypervigilance, and alienation. This trauma is compounded by the perceived inaction of institutions tasked with protecting community safety and upholding rights.

Cultural Stigma and the Silencing of Distress

Mental ill-health remains heavily stigmatised within parts of the Muslim community, particularly among older generations and men. However, CMW's peer-led initiatives — including storytelling, dialogue spaces, and culturally anchored education — have demonstrated that stigma can be disrupted when mental health is framed through a faith-informed, collectivist lens.

Barriers to Access and System Navigation

For many migrants, refugees, and asylum seekers, mental health care remains inaccessible or unresponsive. Language, visa precarity, and unfamiliar service models create insurmountable obstacles. CMW continues to receive high volumes of referrals seeking bilingual advocates and cultural liaison support, signalling a service delivery model ill-suited to the lived realities of CALD communities.

2. Centring Muslim Wellbeing in Australia

Centre for Muslim Wellbeing

Systemic Inequities and Emerging Challenges Facing Muslim Communities (continued)

Vicarious Trauma from Global Crises

The mental health impacts of international conflict, forced displacement, and racialised political discourse are not abstract. They are lived. Events such as the war in Gaza have generated waves of grief, fear, and retraumatisation across communities — particularly among youth, carers, and those with lived refugee experience. CMW has recorded a marked increase in distress-related presentations directly linked to global events and political rhetoric.

Disenfranchisement and the Emotional Labour of Community Care

CMW's ongoing engagement reveals an intensifying sense of disenfranchisement among:

i. Young Muslims, whose political disillusionment, identity conflict, and exposure to hostile media narratives have created widespread cynicism and disengagement from public life.

ii. Community leaders and informal service navigators, who are increasingly burdened by the emotional labour of care, often in the absence of adequate resourcing, clinical support, or systemic recognition.

iii. Muslim men, whose help-seeking behaviours are declining, resulting in a 'silent epidemic' of social isolation and suppressed distress. CMW's targeted initiatives — including men's healing circles, embodied wellbeing practices, and intergenerational dialogues — are beginning to offer support.

What is clear from these insights is that piecemeal reform will not suffice.
A transformative, trauma-informed, and spiritually inclusive reimagining of mental health policy and investment is urgently required. There is now an unprecedented opportunity — and responsibility — to partner with organisations like CMW to co-create models of care that are community-led, culturally safe, and capable of restoring trust and dignity in mental health systems.

3. Mental Health and Suicide Prevention Agreement Review: Recommendations & Case Studies

Centre for Muslim Wellbeing

A. Impact on Wellbeing and Productivity

The mental health and wellbeing of Australia's Muslim communities remain critically underserved. While significant investments have been made to strengthen mental health systems nationally, the framing and implementation of the National Mental Health and Suicide Prevention Agreement have not sufficiently accounted for the diverse realities and structural barriers experienced by faith-based and culturally diverse populations — particularly Muslims. This omission is not simply a matter of equity; it carries profound economic, social, and national productivity consequences.

Muslim communities in Australia are growing and highly diverse, comprising over 813,000 individuals as of the 2021 Census. Systemic marginalisation — including Islamophobia, racial profiling, and media vilification — has created a heightened psychosocial burden for these communities. This lived reality intersects with existing service gaps, leading to underutilisation of mental health services, delayed help-seeking, and a continued cycle of distress and exclusion.

Despite mental ill-health being a leading cause of productivity loss in Australia, current mental health reforms have not comprehensively addressed the economic cost of structural exclusion for minority communities. The Treasury's Intergenerational Reports and Productivity Commission findings make clear that the future of Australia’s economy depends on the full participation of its diverse population. When entire communities face systemic barriers to wellbeing — such as culturally unsafe care, religious stigma, or linguistic inaccessibility — national productivity is hindered. Unaddressed mental health challenges limit workforce participation, interrupt education and training pathways, and erode social cohesion.

Centre for Muslim Wellbeing

A. Impact on Wellbeing and Productivity (Continued)

The situation is especially urgent when it comes to suicide prevention. Although national suicide data disaggregated by religion is not systematically collected, community-led research, coroner's reports, and local service providers confirm a growing concern around suicide and self-harm in Muslim communities, particularly among young people. The mental health challenges faced by young Muslims are not merely individual — they are sociopolitical and structural. For example, being subject to targeted counter-terrorism policy, discriminatory policing, or xenophobic media narratives compounds psychological distress. These experiences are often pathologised when encountered in clinical settings, further alienating individuals from care.

Policy responses have generally framed Muslim wellbeing through a deficit lens — either as a community 'at risk' of radicalisation or as culturally 'hard to reach'. This framing is not only inaccurate, but counterproductive. It fails to recognise the strengths, resilience, and innovations emerging from within Muslim communities themselves — including peer support models, spiritual care frameworks, community-based healing practices, and youth-led mental health initiatives.

The strategic imperative, therefore, is to integrate Muslim mental health equity into mainstream national planning, funding, and service design. This includes resourcing Muslim-led organisations to co-design culturally responsive mental health strategies, embedding religious literacy into clinical workforce development, and funding community-specific mental health research.

Recommendations

1. A national Muslim Mental Health and Wellbeing Strategy should be developed in partnership with community leaders, researchers, youth advocates, and faith-based mental health professionals.
2. Suicide prevention programs must be locally tailored, trauma-informed, and co-designed with Muslim youth and families to address specific drivers of distress.
3. All Productivity Commission and Treasury-led economic modelling should integrate disaggregated data on the mental health outcomes of CALD communities to better assess productivity impacts.

A. Impact on Wellbeing and Productivity (Continued)

"The Emotional Toll of Being a Muslim Carer
"As a Muslim carer, I often feel like services don't understand our cultural or religious needs. I have to explain things that should be basic constantly. It's exhausting and isolating."
- Carer

On Client Mistrust of Services
"Many of my clients fear engaging with mainstream services because of previous harm, racism, or dismissal of their faith. We need to rebuild trust from the ground up."
- Practitioner

Need for faith-based and peer-led alternatives
"What helps the most is being around other Muslim carers who get it. We need more safe spaces where we can share our stories without judgement." - Carer

Invisibility in the System
"Carers like me aren't seen — we're just expected to manage at home. There's no check-in, no emotional support. Just silence until there's a crisis."

"We carry the emotional and spiritual weight of care, but the system only sees us when something goes wrong. Prevention and support are completely missing." - Carer

Isolation Within the System
"It felt like I had to strip parts of my identity just to get help. I couldn't talk about faith, about my family, about racism. I just played along to get the session over with."
- Consumer

On Cultural Safety and the System
"We're constantly working in systems that weren't built for our communities. It's like translating between two worlds while trying not to burn out." - Practitioner

Figure 3: Muslim Communities Voices

B. Effectiveness of Reforms Across Populations

Australia's Mental Health and Suicide Prevention reforms have advanced national coordination, funding clarity, and service integration. However, their effectiveness across culturally and linguistically diverse (CALD) and faith-based populations remains highly uneven — and, in some cases, harmful.

One of the most glaring omissions is the lack of national data on the mental health needs, experiences, and outcomes of Muslim Australians. Without comprehensive research and disaggregated data, policy cannot be evidence-based. This data gap leads to misinformed assumptions, inappropriate service models, and a continuing cycle of policy invisibility. Mental health needs are not monolithic across the Muslim population, which includes over 160 ethnic and linguistic groups. Intersectional experiences — migration status, racialisation, gender, disability, socio-economic precarity — are often ignored by one-size-fits-all reforms. The presumption of universality in mental health reform limits its effectiveness. For example, while mainstream services have adopted digital mental health platforms, Muslim youth may encounter additional barriers — such as culturally inappropriate content, mistrust of institutional systems, or privacy concerns rooted in fear of surveillance. Reforms that have proven effective for the broader population may require fundamental redesign for specific communities.

Further, many reforms presume high levels of mental health literacy. Yet this literacy may not be accessible or meaningful in communities where spiritual or religious concepts are central to understanding mental distress. If reform measures are to be effective across populations, they must move beyond translation into true cultural and spiritual adaptation. This means integrating imams, female religious leaders, and community elders into prevention and care models — not as optional extras, but as essential co-providers of support.

The crisis is also exacerbated by lack of targeted investment. While funding allocations under the Agreement are meant to reflect priority populations, Muslim communities are rarely explicitly included — even though they often intersect with multiple 'priority' categories such as multicultural, refugee, youth, or low-income groups. The absence of targeted reform efforts fuels a perception of neglect and further deters help-seeking.

Despite this, Muslim communities have innovated. Youth groups have created peer support circles; mosques have begun delivering mental health awareness sermons; and grassroots services are being developed on shoestring budgets. These initiatives are promising but remain under-resourced and disconnected from formal policy infrastructure.

Recommendations

4. The National Mental Health Commission should fund a comprehensive research program into Muslim mental health and wellbeing, including suicide prevalence, service gaps, and protective factors.
5. Reform outcomes should be evaluated using culturally appropriate indicators developed in collaboration with Muslim communities.
6. Accountability mechanisms — such as KPIs for engagement with priority populations — should be embedded into all funded programs under the Agreement.

C. Best Practice and Productivity Improvement Opportunities

There is no single blueprint for best practice in mental health — but there is ample evidence that place-based, community-led, and culturally anchored approaches lead to better outcomes. For Muslim communities in Australia, improving mental health care delivery is not only about adapting existing services — it is about co-creating new pathways for healing, resilience, and recovery.

Best practice begins with recognising the limitations of Eurocentric mental health models. While diagnostic and treatment frameworks remain important, they are insufficient in isolation. In Muslim-majority contexts, mental wellbeing is often understood holistically — linked to faith, family, community responsibility, and moral conduct. Healing is relational, not transactional. Productivity is communal, not individualised. Ignoring these cultural logics creates services that alienate rather than empower.

Some promising practices already exist. For example, cross-sector collaborations between primary health networks, Muslim-led organisations, and local mosques have produced culturally safe referral pathways and early intervention programs. Mental health training for imams and community leaders has shown measurable improvements in trust and engagement. In some states, bilingual counsellors and trauma-informed therapists from Muslim backgrounds are working in schools and community hubs. These are pockets of innovation, not yet mainstream practice.

To achieve system-wide change, the Agreement should reframe productivity as more than employment outcomes — it should reflect belonging, access to care, and capacity for communities to flourish. This requires funding reform. Current commissioning structures often disadvantage smaller community-led organisations who lack the infrastructure to compete for large contracts. Shifting to partnership models that build capacity and share risk would enable more authentic engagement.

Workforce development is also key. Training clinicians in cultural humility, anti-racist practice, and spiritual literacy should be mandated in all federally funded mental health education. Further, pathways should be created for Muslim Australians to enter and lead in the mental health sector — not just as service users, but as researchers, practitioners, and policymakers.

C. Best Practice and Productivity Improvement Opportunities (continued)

Finally, digital mental health services represent a significant productivity opportunity — if designed inclusively. Culturally adapted telehealth models, multilingual apps, and peer-moderated online forums can dramatically improve access for Muslim youth, women, and regional communities.

Recommendations

7. Establish a National Centre for Cultural and Faith-Based Mental Health Innovation to incubate best practice models, train practitioners, and scale community-led interventions.
8. Reform funding models to prioritise partnerships with Muslim-led organisations and local faith networks.
9. Invest in digital inclusion strategies tailored for faith-based communities, including telehealth, app development, and digital literacy campaigns.

Case Study 1

Embedding Emotional Resilience in Islamic Senior Schools

Youth Wellbeing at Schools

Embedding Emotional Resilience in Islamic Senior Schools
Program: Unshakeable Resilience – School Edition
Location: Victoria
Led by: Centre for Muslim Wellbeing (CMW)

Focus: *Mental health literacy, emotional resilience, and early intervention for Muslim students in Years 10–12*

In response to growing mental health concerns among Muslim youth — particularly around anxiety, academic pressure, stigma, and belonging — the Centre for Muslim Wellbeing (CMW) launched Unshakeable Resilience, a tailored emotional resilience program for senior secondary students in Islamic schools.

Co-designed with Muslim psychologists, educators, and youth workers, the program blends evidence-based psychological tools with Islamic concepts such as sabr (patience), shukr (gratitude), and tawakkul (trust in God). This faith-aligned, trauma-informed approach creates a safe and culturally meaningful space for students to explore mental well-being.

Delivered through interactive workshops, the program covers:

- Emotional literacy and self-regulation
- Managing stress, anxiety, and academic expectations
- Faith-based coping strategies and spiritual grounding
- Help-seeking, stigma reduction, and peer support

Facilitated by Muslim mental health professionals — many with lived experience — the program has resonated deeply with students, teachers, and families.

"This program opened up conversations we'd been struggling to have for years. It gave our students the tools and language to talk about what they're going through."
— Wellbeing Coordinator, Senior Islamic School

Case Study 1

Embedding Emotional Resilience in Islamic Senior Schools (continued)

Youth Wellbeing at Schools

Impact

- Delivered across 10 Islamic schools, reaching over 500 senior students
- Students reported increased confidence in managing stress and knowing where to seek help
- Strengthened wellbeing frameworks within schools, with some developing internal referral pathways and culturally informed wellbeing teams
- Created ripple effects, with improved engagement from parents, staff, and school leadership

Challenges

Despite strong demand, the program faces challenges in scalability due to:

- Short-term funding cycles that limit continuity
- Lack of targeted commissioning streams for CALD, faith-based, and preventative mental health programs
- Limited capacity among small community organisations to compete for large government tenders

This case study illustrates how community-led, faith-aligned mental health education embedded in trusted settings can dramatically improve outcomes for young people.
To sustain and scale such initiatives, government reform is needed to:

- Fund preventative, culturally responsive programs in schools
- Support community–school partnerships through long-term investment
- Recognise faith-based frameworks as legitimate foundations for healing and resilience
- Enable smaller organisations like CMW to lead and deliver place-based intervention

D. System Preparedness and Responsiveness to Emerging Priorities

The current National Mental Health and Suicide Prevention Agreement (the Agreement) lacks the operational flexibility necessary to respond to the rapidly evolving mental health landscape, particularly in relation to Muslim and culturally and linguistically diverse (CALD) communities. CMW has observed that despite increasing awareness of social, economic, and cultural determinants of mental ill-health, the system remains unprepared and ill-equipped to address emergent needs, including faith-based mental health stressors, racialised trauma, and Islamophobia-induced distress.

While the Agreement purports to deliver "joined-up care" and system integration, it has failed to embed the structures required for anticipatory governance — particularly for communities who experience marginalisation across multiple policy fronts. For example, in times of socio-political upheaval, such as the escalation of international conflicts affecting Muslim-majority nations (e.g., Palestine, Sudan, Afghanistan), Muslim Australians often experience heightened racial profiling, surveillance, and community grief. Yet, the Agreement has no mechanism for rapidly funding community-designed psychosocial responses to these events, despite clear evidence linking these episodes to increased psychological distress among Australian Muslims.

Moreover, the system lacks a faith-and culturally-informed mental health emergency response protocol. Mainstream mental health services have little to no capacity to support communities facing collective trauma. The response from the mental health system was, at best, symbolic — limited to generic public statements rather than any operational or funding recalibration. This reflects a dangerous rigidity in the current agreement's design.

Additionally, there is no framework for horizon scanning in mental health policy that integrates community-generated data and insights. Muslim organisations like CMW, despite having unparalleled proximity to community need, are excluded from formal advisory roles in forecasting mental health risks. This exclusion not only undermines effectiveness but also contravenes the Agreement's stated principle of "lived experience-led policy design."

Without dedicated mechanisms for cultural intelligence, strategic foresight, and agile investment, system preparedness will remain a bureaucratic exercise rather than a community-centred reality. The result is a reactive system that fails to prevent crises or mitigate emerging harms — particularly for communities who are politically, culturally, and socially misrepresented.

Centre for Muslim Wellbeing

D. System Preparedness and Responsiveness to Emerging Priorities (continued)

Recommendations

10. Establish a National Muslim and CALD Crisis Mental Health Preparedness Framework to enable rapid investment in culturally and faith-informed responses to global or domestic events impacting priority populations.
11. Mandate community horizon scanning by funding organisations like CMW to regularly identify and report emerging mental health risks among Muslim and CALD communities.
12. Introduce a responsive funding stream within the Agreement to allow timely commissioning of community-led mental health initiatives during crises or periods of heightened community distress.

Case Study 2

Responding to Rising Islamophobia

Filling the gap

In recent years, the Centre for Muslim Wellbeing (CMW) has observed sharp spikes in community distress during periods of heightened Islamophobia — particularly following international conflicts, divisive political commentary, or media coverage that fuels racialised narratives. These moments trigger widespread fear, emotional exhaustion, and re-traumatisation within Muslim communities.

Common experiences reported to CMW include:

- Women in hijab are being harassed in public
- Muslim students feeling unsafe or silenced in schools
- Community grief and collective distress, particularly during global crises such as the war in Gaza or the fall of Afghanistan

While public figures may issue anti-racism statements, the mental health system remains symbolically reactive. There are no formal pathways to support those experiencing racialised trauma or Islamophobia-induced distress.

In the absence of a system-led response, CMW stepped in to fill the gap, providing:

- Rapid referrals to Muslim-identifying or culturally informed counsellors and psychologists
- Psychoeducation resources on managing trauma and navigating racialised harm
- Group support sessions and healing spaces, co-facilitated by trauma-informed practitioners with lived experience
- Collaboration with schools, councils, and legal services to respond to discrimination and its psychological impacts

Despite the clear need, this work was carried out with no designated funding, formal recognition, or systemic support.

"We don't have surge funding. We respond to Islamophobia the same way we do everything else: with community effort, unpaid hours, and a deep sense of responsibility. But it's not sustainable."
— Program officer, Centre for Muslim Wellbeing (CMW)

Case Study 2

Responding to Rising Islamophobia (continued)

Filling the gap

Key Issues Highlighted

- The mental health system lacks culturally and faith-informed protocols for addressing Islamophobia and racialised trauma
- Communities are left to carry the emotional and operational burden without support
- Community-led organisations like CMW are best positioned to respond, but face ongoing structural and funding barriers

This case underscores the urgent need for a National Muslim and CALD Crisis Mental Health Preparedness Framework, including:

- Responsive and flexible funding mechanisms for times of acute community distress
- Formal integration of Muslim-led organisations like CMW in the design and delivery of rapid psychosocial responses

E. Unintended Consequences: Cost Shifting and Inequity

The Agreement has led to several unintended outcomes that disproportionately burden Muslim communities and entrench inequity. Chief among them is the misapplication of PHN commissioning powers, which has resulted in cost shifting from government to underfunded community organisations without the requisite structural support. The current reliance on short-term competitive grants, rather than strategic long-term partnerships, disadvantages CALD-led organisations who lack grant-writing infrastructure and political capital. This practice perpetuates funding inequity.

This funding logic assumes parity in organisational capacity, but fails to acknowledge the barriers faced by Muslim service providers, including Islamophobia, governance racism, and financial precarity. Such a model reinforces a market logic that prizes scale over cultural fidelity, forcing small culturally responsive organisations to compete with mainstream incumbents who lack cultural expertise but benefit from historic funding advantages.

Furthermore, a perverse incentive structure has emerged, where state and federal actors displace responsibility for equitable service provision onto local entities such as PHNs, without mandating accountability metrics that prioritise equity. The result is a fragmented and opaque commissioning landscape where Muslim and CALD voices are sidelined in favour of politically neutral providers.

This model has also shifted the burden of mental health care provision onto families and communities, particularly for Muslim communities whose youth experience heightened stigma and disengagement from clinical services. Without culturally appropriate access pathways, the responsibility of care defaults to families, who are often unsupported, under-resourced, and traumatised themselves.

Critically, this exacerbates intergenerational harm: unmet mental health needs among young Muslims are often pathologised as behavioural problems or extremism risk factors in other systems (e.g., schools, police). This framing criminalises rather than supports affected individuals and represents a systemic failure to address structural mental health inequities.

Recommendations

13. Require Primary Health Networks (PHNs) to allocate at least 15% of mental health funding to CALD-and Muslim-led organisations through long-term, non-competitive grants.
14. Embed enforceable equity and cultural responsiveness measures in bilateral agreements, with financial consequences for non-compliance.
15. Establish a national infrastructure fund to build the capacity of CALD and Muslim community organisations, supporting their long-term sustainability and reducing reliance on unpaid labour.

Case Study 3

Financial Hardship in Muslim-Led Mental Health Service

Financial Hardship

The Centre for Muslim Wellbeing (CMW), like many Muslim-led organisations, plays a vital role in delivering culturally responsive mental health support — filling gaps where mainstream services fail to reach. Yet, despite its impact, CMW has faced ongoing financial hardship due to systemic underfunding, short-term grants, and structural exclusion from mainstream commissioning processes.

In 2023, CMW was operating multiple programs, including:

- Community-based resilience and trauma workshops
- Faith-informed group sessions for newly arrived refugees
- Emotional wellbeing sessions in Islamic schools
- Crisis response following international events affecting Muslim communities

These services were in high demand, especially among communities experiencing stigma, collective grief, and racism. However, the organisation was funded through a patchwork of short-term, competitive grants, each with different reporting requirements, limited timelines, and no allowance for infrastructure, governance development, or workforce wellbeing.

As a result, CMW was forced to:

- Turn away clients due to limited staff capacity
- Rely on unpaid or underpaid practitioners and volunteers
- Operate without certainty of continuity for high-impact programs

Meanwhile, mainstream organisations with little cultural expertise continued to receive long-term core funding, sometimes subcontracting culturally specific components to smaller organisations like CMW — without genuine partnership, power-sharing, or resourcing.

This funding model effectively outsources responsibility for equity to the very communities most impacted by systemic disadvantage, without building their capacity or supporting sustainability.

Case Study 3

Financial Hardship in Muslim-Led Mental Health Service (continued)

Financial Hardship

Key Issues Highlighted

- Short-term, competitive grants undermine the stability and sustainability of Muslim-led mental health services
- CALD and Muslim organisations are excluded from long-term funding streams, despite strong evidence of impact
- The burden of care shifts to underpaid staff and unpaid volunteers, reinforcing structural inequity
- Without predictable funding, community organisations cannot plan, evaluate, or grow their services

This case illustrates the urgent need to shift from a transactional, competitive funding model to one that prioritises partnership, equity, and long-term investment. Muslim and CALD-led organisations must be resourced proportionately and sustainably to continue their essential role in delivering culturally safe mental health care.

F. Effectiveness of Administration and Bilateral Schedules

The administrative architecture of the Agreement, including its bilateral schedules, has failed to deliver clarity, consistency, or culturally safe service outcomes. The lack of uniform cultural responsiveness standards across jurisdictions leads to a postcode lottery for CALD and Muslim communities. This has enabled states and territories to define "priority populations" inconsistently, leaving many Muslim Australians functionally invisible in local reform plans.

Bilateral schedules, as they currently stand, do not include enforceable obligations around cultural safety, disaggregated data collection, or governance inclusion. They remain bureaucratic instruments focused on administrative compliance rather than system transformation. This results in siloed implementation, inconsistent reporting, and ineffective coordination — contradicting the Agreement's core principle of national coherence.

Furthermore, the bilateral schedules have failed to secure Muslim representation in co-design processes, planning bodies, or governance forums. Despite the prominence of Muslim communities in Victoria, NSW, and WA, Muslim-led organisations remain excluded from core reform processes. This structural exclusion compromises the legitimacy and cultural relevance of reform implementation.

The use of generic "CALD" language in administrative schedules masks the diversity of needs and experiences within multicultural communities, particularly those shaped by faith-based stigma, ethno-religious profiling, and the legacy of the War on Terror. Treating Muslims as a subcategory of "CALD" erases their distinct policy needs and obstructs meaningful representation.

From an administrative perspective, there is no accountability framework for evaluating the cultural responsiveness of bilateral reform outcomes. Governments are not required to track funding flows to CALD-led services, nor assess the cultural safety of programs funded under bilateral agreements. This absence of accountability entrenches invisibility and permits structural neglect.

Recommendations

16. Require all jurisdictions to report annually on mental health funding directed to CALD and Muslim-led organisations, including clear metrics on cultural safety and workforce diversity.
17. Develop and implement national cultural responsiveness standards for mental health service design, delivery, and evaluation across all states and territories.
18. Mandate the inclusion of CALD and Muslim-led organisations in mental health governance and planning bodies, with a minimum target of 30% representation

G. Governance, Reporting and Evaluation Frameworks

Governance and evaluation frameworks under the Agreement remain insufficiently robust to ensure equitable accountability or culturally responsive metrics for priority populations, including culturally and linguistically diverse (CALD) and Muslim communities.

First, the Agreement has inherited a predominantly biomedical and Western-centric evaluative framework, which narrowly emphasises service throughput and clinical symptomatology. Such frameworks systematically devalue community-defined markers of recovery, social and spiritual wellbeing, and collective care — particularly vital to Muslim communities where mental health is often interwoven with family, faith, and community cohesion. Consequently, lived outcomes for Muslim clients are rendered invisible in reporting systems that do not adequately account for intersectional and culturally shaped determinants of wellbeing.

Second, data disaggregation across the governance chain remains a persistent issue. National datasets, such as those held by the Australian Institute of Health and Welfare, fail to disaggregate by religion, cultural background, or migration experience in a manner that enables meaningful policy evaluation for Muslim populations. The absence of fine-grained, culturally disaggregated data not only obscures health inequities but perpetuates the invisibilisation of Muslim Australians from key accountability frameworks. The failure to generate community-relevant evidence reflects an institutional blind spot that undermines both system learning and reform.

Third, evaluation committees tend to lack both diversity and cultural capability, resulting in tokenistic consultation and limited uptake of alternative knowledge systems. Despite decades of evidence showing the importance of participatory governance in mental health (Muir et al., 2021), Muslim and CALD community leaders are seldom involved as equal partners in monitoring or co-design.

Recommendations

19. Introduce a mandatory cultural accountability framework embedded within all bilateral and national evaluations, which includes metrics aligned with CALD and faith community wellbeing.
20. Require disaggregated data collection by religious affiliation, ethnicity, and migration background across all PHNs and funded services, ensuring transparency in reporting.
21. Establish national and state-level CALD governance advisory panels, with equal representation from Muslim mental health professionals, carers, and lived experience advocates, to oversee implementation and evaluations.

H. Roles and Responsibilities of Government and Service Providers

Critical Analysis

A central weakness of the Agreement lies in its ambiguous delineation of roles between Commonwealth and state/territory governments, especially when addressing the needs of structurally marginalised groups. The resulting fragmentation is most acutely experienced by small CALD-led service providers, particularly Muslim-run organisations, who face exclusion from funding and decision-making processes due to lack of system integration and institutional recognition.

PHNs and state mental health agencies operate under different commissioning logics and priorities, which create duplications in some areas and critical gaps in others. For example, while some PHNs fund short-term, low-intensity multicultural mental health programs, state-run services often lack formal referral pathways to these supports, leading to confusion and discontinuity in care. Furthermore, few Muslim-specific services have been formally commissioned at the state level despite demonstrated community need.

The Agreement has also failed to require cultural capability standards within service provider contracts or licensing arrangements. This omission allows mainstream providers to deliver culturally unsafe care — often relying on superficial cultural awareness training without institutionalising cultural responsiveness at all service levels. Muslim clients frequently report feeling misunderstood, pathologised, or compelled to suppress religious or identity-based expressions of distress in clinical settings. This results in low service uptake and premature disengagement, especially among youth and refugee-background populations.

Another overlooked dimension is the pressure on community and faith-based leaders to act as informal crisis responders in the absence of culturally safe mental health services. These individuals operate in a vacuum — unfunded, unsupported, and untrained — shouldering disproportionate responsibility for community mental wellbeing. Without recognition of their roles within the formal mental health system, both community trust and service delivery outcomes suffer.

Recommendations

22. Mandate clear delineation of responsibilities between Commonwealth and state actors for engaging CALD and Muslim-led services, including streamlined commissioning pathways.
23. Introduce minimum cultural capability standards for all contracted service providers, monitored through independent audits and client experience data.
24. Provide sustainable funding and workforce development for community leaders and peer supporters in Muslim communities, recognising their role as cultural brokers in the mental health ecosystem.
25. Require joint commissioning models between PHNs and states that prioritise the integration of CALD and Muslim-specific services.

I. Lived Experience and Cultural Inclusion

The Agreement's stated commitment to lived experience is commendable in principle but lacking in execution for CALD and Muslim communities. The prevailing model of lived experience is predicated on a secular, individualised, and largely Anglo-centric framework that often marginalises non-Western understandings of healing, trauma, and mental illness.

Muslim communities have long reported stigma, misdiagnosis, and systemic alienation in their interactions with mental health services. Yet, most lived experience roles (such as advisory councils, peer support workers, and service co-design consultants) are drawn from existing mental health cohorts that do not reflect the religious, cultural, or linguistic realities of Muslim Australians. As a result, the perspectives shaping reform are incomplete and culturally unrepresentative.

Furthermore, the tokenisation of CALD voices persists. Community members are often invited into decision-making spaces too late, with no ability to shape agendas or challenge epistemic assumptions. This form of 'consultative extraction' undermines genuine co-production and breeds distrust. Meaningful inclusion requires both procedural and epistemic justice — that is, fair processes and the validation of diverse worldviews.

The Agreement also fails to provide adequate funding or infrastructure to build the capacity of Muslim lived experience advocates. This is particularly critical for groups such as women, carers, and young people, whose insights into intergenerational trauma, racism, and systemic harm are often excluded from formal policy channels.

Finally, cultural inclusion remains misinterpreted as cultural awareness training or the occasional translation of resources, rather than a fundamental rethinking of how systems recognise and centre diverse knowledge systems, practices of care, and community sovereignty.

Recommendations

26. Redesign lived experience structures to include culturally grounded peer roles and pathways, ensuring faith-based and intergenerational mental health knowledge is formally recognised.
27. Establish dedicated Muslim Lived Experience Panels at national and state levels, co-funded and co-led with community organisations.
28. Fund long-term capacity-building programs to train and support Muslim carers, youth, and elders to participate in mental health system governance and reform.
29. Shift from tokenistic cultural inclusion to structural co-leadership models with Muslim mental health professionals and scholars embedded in policymaking bodies

Case Study 4

CMW Lived Experience Driving Services and Strategic Direction

Lived Experience

Since its founding, the Centre for Muslim Wellbeing (CMW) has embedded lived experience at the core of its operations — not as a symbolic gesture, but as a structural and strategic foundation. CMW was established in direct response to the longstanding exclusion of Muslim voices from mental health policy, service design, and research. From its governance model to frontline programming, CMW centres faith-informed, community-grounded lived experience.

The organisation's board, staff, and advisory networks include practitioners, carers, and community leaders with lived experience of navigating the mental health system as Muslims — many of whom have faced stigma, misdiagnosis, and disengagement from mainstream services. This insight has shaped the design of:

- Faith-aligned resilience programs for Muslim youth
- Trauma-informed support spaces for community
- Healing circles led by community members trained in culturally safe facilitation
- Peer support networks grounded in shared values of care, spirituality, and mutual responsibility

Beyond service delivery, CMW has actively advocated for policy reform, engaging with state and federal governments to raise issues of structural exclusion, cultural erasure, and epistemic injustice in the mental health system.

CMW has also co-designed and delivered training for mainstream services, helping them move beyond "cultural awareness" toward practices of cultural intelligence.

However, this work has been conducted with no dedicated funding for lived experience infrastructure, and with limited inclusion in formal government advisory bodies. CMW's attempts to create peer worker pathways and leadership pipelines for Muslim youth and carers have been constrained by the absence of national frameworks or resourced models for culturally grounded peer roles.

4. Conclusion

Centre for Muslim Wellbeing

The Agreement tends to adopt an individualised, clinical model of mental health, assuming that wellbeing is best achieved through access to formal, institutional services. Yet for many Muslim communities, wellbeing is relational, spiritual, and collective. Failure to embed these alternative epistemologies undermines the effectiveness of reforms. For instance, programs that overlook Islamophobia or ignore religious healing practices often generate low trust and disengagement.

The Agreement's impact indicators must therefore expand to include community-defined measures of wellbeing, such as spiritual resilience, safety from discrimination, and access to culturally embedded supports.

CENTRE FOR MUSLIM WELLBEING

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