PSILOGOS

Research Article

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From Private Coping to Shared Care: A Configuration Study of Religious–Clinical Concordance in Australian Mental Health Services

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ABSTRACT

Religious belief, spiritual practice, congregational support, and contact with religious leaders can shape how culturally and linguistically diverse adults interpret distress and decide where to seek help. Australian mental-health services nevertheless require a precise account of which religious dimensions are suitable for routine clinical attention and which become relevant only when disagreement or mistrust obstructs care. This study asks: which combinations of personal meaning, religious practice, community support, religious leadership, service friction, and endorsement of integrated care identify defensible points of connection between mental-health services and religious life? A Relational Interface Configuration Analysis was applied to a study-by-condition matrix representing 16 Australian empirical investigations and 2,711 participants. Six conditions were coded conservatively from complete study-level findings. Exact contingency analysis, set overlap, leave-one-study-out deletion, and 96 single-cell perturbations examined co-occurrence and stability. Meaning or religious reappraisal and religious practice were each present in 11 investigations, with joint presence in 10 (Jaccard similarity $= 0.833$; Fisher exact $p = 0.0128$). Community support appeared in nine investigations. Service friction appeared in seven; all three investigations that positioned religious leaders as care conduits and all four that explicitly endorsed integrated care also recorded friction. The two most prevalent conditions remained unchanged in every deletion and perturbation trial. The results answer the research question by locating the most widely transferable clinical entry point at voluntary inquiry into personal meaning and practice, while reserving formal religious–clinical coordination for cases where explanatory conflict, mistrust, or incompatible help-seeking preferences are evident. Safe integration therefore depends on consent, non-assumption, role clarity, clinical accountability, and a genuine option to decline religious discussion.

Keywords: culturally and linguistically diverse communities; mental health services; religion; spirituality; configuration analysis; collaborative care; Australia

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– **Published:** 20 November 2024

1. INTRODUCTION

Australia's cultural composition makes mental-health care inseparable from questions of language, migration history, family organization, and religious belonging. The 2021 Census recorded that more than half of Australian residents were born overseas or had at least one overseas-born parent, while millions used a language other than English at home.[1,2] The same census documented a religious landscape in which Christianity remained the largest affiliation, non-affiliation increased substantially, and Islam, Hinduism, and Buddhism formed sizeable and growing communities.[3] These categories do not define an individual's clinical needs, but they demonstrate why a service organized around an implicitly monolingual and culturally uniform patient cannot provide equitable access.

The expression culturally and linguistically diverse (CALD) is useful for service planning, yet it contains people whose migration routes, legal status, education, English proficiency, socioeconomic position, and religious commitments differ markedly. Access difficulties can arise within a universal health system when information, interpretation, referral processes, and continuity are not aligned with the circumstances of migrant and refugee communities.[4] Government estimates have likewise indicated a substantial mental-health burden among first-generation adults while acknowledging limitations in nationally comparable prevalence evidence.[5] Migration itself is not a disorder; distress may instead reflect exposure to violence, family separation, uncertain status, resettlement pressure, discrimination, loss of occupation, or weakened social networks.[6,7] A clinically adequate response must therefore distinguish between cultural difference, ordinary religious commitment, situational distress, and diagnosable illness.

Low use of formal services cannot be explained by language alone. Refugee accounts of Australian health care describe unfamiliar systems, discontinuity, perceived discrimination, and difficulty obtaining culturally appropriate assistance.[8] Somali-Australian women have reported stigma, restricted mental-health knowledge, and religious interpretations that influenced whether professional help appeared acceptable.[9] African women using maternity services have similarly described how expectations formed in another health system affect trust and communication.[10] Earlier service research showed that culturally appropriate rehabilitation requires more than translation because explanatory beliefs, family authority, and expectations of professional roles influence the encounter itself.[11] The practical problem is consequently relational: a person may understand distress through one moral and religious vocabulary while the service responds through another.

Religion and spirituality can operate at several levels that should not be collapsed. They may provide a language of meaning, a repertoire of private practices, a community of material and emotional support, or access to a trusted leader. They may also contribute to shame, supernatural attribution, treatment delay, or disagreement about causation. Muslim Australians from CALD backgrounds have rated religious explanations and Quran recitation differently from Anglo-Caucasian Muslim participants, showing that shared affiliation does not erase cultural variation.[12] Among Middle Eastern migrants, religious identity was associated with psychological well-being partly through social connectedness.[13] Australian Chinese accounts have described prayer, temples, churches, and perspective change as resources for mental-health promotion.[14] Cross-cultural evidence on migrants also indicates that religious-group support may be associated with flourishing without showing an equivalent association with distress.[15] These distinctions matter because an intervention that treats all religious content as inherently therapeutic would be as reductive as one that excludes it from assessment.

The literature therefore poses a service-design question rather than a simple argument for or against religion. Routine spiritual-history instruments can prompt useful conversation, but a checklist does not determine when a religious practice should remain a personal coping choice, when a community relationship can be supported, or when a religious leader should enter a clinical pathway. A broad instruction to be culturally sensitive is equally insufficient. Clinicians need a graded account of the conditions that recur across empirical investigations and of the combinations that signal a need for closer coordination.

The institutional setting further shapes whether such conversations are useful. A clinician working through an interpreter may have little time to explore a patient's explanatory language, while electronic records may offer only a tick box for affiliation. Referral systems commonly separate clinical care, settlement support, and pastoral or religious care into different organizations. Even a respectful clinician may therefore be unable to act on a preference that emerges during assessment. Conversely, poorly governed collaboration can expose a patient to unwanted disclosure, community pressure, or contradictory advice. The analytic task must connect interpersonal findings to decisions about consent, documentation, referral, and accountability.

A relational approach is especially important because disagreement can be produced by either party. A patient may attribute distress to a spiritual cause, but a service may also create conflict by dismissing a harmless practice, failing to provide interpretation, or assuming that professional treatment requires abandonment of religious help. The term service friction is used here to capture this two-sided problem. It avoids locating every access difficulty inside the patient or community and directs attention to the point where expectations, language, authority, and treatment preferences meet.

This study addresses that need through a different research question and analytic structure. The empirical

corpus consists of the 16 Australian investigations catalogued in a published article on religion, spirituality, and CALD mental-health care.[16] That article is cited here once to identify corpus provenance; the present unit of analysis is a six-condition study configuration rather than a sequence of review themes. The question is: *which combinations of personal religious meaning, religious practice, community support, religious leadership, service friction, and explicit endorsement of integrated care identify the most defensible points of connection between mental-health services and religious life?* The answer is developed through Relational Interface Configuration Analysis (RICA), exact association tests, deletion trials, and single-cell perturbations. This design retains the heterogeneity of study types while asking whether recurrent relational patterns survive conservative changes to individual coding decisions.

The visual sequence in Fig. 1 establishes the practical distinction at the centre of the question. A clinical consultation and a private community disclosure are not competing depictions of correct care. They are parallel entry points whose relationship depends on the person's consent, the nature of distress, clinical risk, and the trustworthiness of referral arrangements. The paired composition also prevents religious support from being portrayed as a substitute for professional assessment or professional care as a reason to disregard religious commitments.

(a) Clinical consultation **(b)** Community disclosure

Figure 1. Parallel entry points to care.

The contrast in Fig. 1 is intentionally interpersonal rather than diagrammatic. It foregrounds listening, interpretation, privacy, and trust—the features that determine whether a referral becomes a usable connection. The depicted persons are synthetic and are not participants in any investigation. Their inclusion illustrates settings discussed by the evidence without implying that appearance, clothing, or affiliation predicts an individual's preference.

2. MATERIALS AND METHODS

2.1. Evidence corpus and unit of analysis

The corpus comprised 16 empirical investigations conducted in Australia between 2006 and 2022. Eleven used qualitative designs, four used quantitative surveys, and one used mixed methods. Together they represented 2,711 participants, of whom 1,414 were reported as women; five participants had no reported binary sex category. Study populations included African, Middle Eastern, South Asian, East and Southeast Asian, Arabic-speaking, Indian-Australian, Chinese-Australian, Somali-Australian, Sudanese-refugee, and multi-origin migrant groups. Several investigations reported religious affiliation explicitly, while others described religious content without a complete affiliation profile. Study-level analysis was chosen because weighting by participant number would allow one large survey to dominate findings that were often qualitative, context-dependent, and not measured on a common scale.

The unit was the complete study configuration, not an isolated quotation or participant statement. Each investigation contributed one binary value for each of six conditions. A positive value indicated that the relevant findings explicitly supported the condition; absence indicated that the finding was not reported, not that the condition was disproved. This conservative distinction is essential when working with studies that asked different questions and used different instruments.

2.2. Relational Interface Configuration Analysis

RICA was developed for this study to retain relational combinations that would disappear in a simple theme count. The six conditions were defined as follows:

C1. Meaning/reappraisal (M): religious identity or belief supplied comfort, strength, hope, meaning, resilience, or a constructive reinterpretation of adversity.

C2. Religious practice (P): participants used or endorsed prayer, scripture reading or recitation, chanting, meditation, worship attendance, ritual, or a closely related religious activity for mental well-being.

C3. Community support (C): a congregation or faith community supplied belonging, emotional assistance, material help, safety, or social connection.

C4. Religious leader (L): a religious leader was identified as a trusted first contact, educator, referral partner, counsellor, or care conduit.

C5. Service friction (F): religious explanation, stigma, mistrust, lack of professional understanding, or preference for religious help conflicted with or obstructed mainstream care.

C6. Integrated care (I): findings explicitly endorsed concurrent religious and professional care, collaboration, linkage, or incorporation of chosen religious content into treatment.

The distinction between C4 and C6 is consequential. A leader may be trusted without a study recommending formal coordination, while integrated care may be endorsed without naming a leader. C5 records a relational

problem rather than an individual deficit. It includes discordance created by service practice as well as beliefs held within communities.

2.3. Coding and verification

Coding used the full relevant-findings entry for every investigation. Ambiguous implications were assigned zero. For example, mere reporting of religious affiliation did not qualify for M, and attendance at a religious place did not qualify for C unless social, emotional, material, or belonging-related support was described. Religious counselling did not automatically qualify for L unless a leader or equivalent trusted religious person was identified. General statements that religion was important were not treated as I; integration required an explicit recommendation or endorsement of combined care.

A reverse-order verification pass tested every positive assignment against these rules. The completed audit trail appears in Table 1. Presenting all assignments allows readers to challenge a specific cell and to reproduce the stability tests after changing it. The participant counts provide corpus context only and do not enter the configuration calculations.

Table 1. Study-level configuration matrix.

Investigation	n	Design	M	P	C	L	F	I
Bairami et al. (2021)	182	Quantitative	1	1	0	0	1	0
Brijnath (2015)	58	Qualitative	1	1	0	0	0	0
Chan (2009)	399	Mixed methods	1	1	1	0	0	0
du Plooy et al. (2019)	1,334	Quantitative	0	0	1	0	0	0
Fauk et al. (2022)	20	Qualitative	0	0	0	1	1	1
Hashemi et al. (2020)	382	Quantitative	1	0	1	0	0	0
Hocking (2021)	131	Qualitative	1	1	1	0	0	0
Khawaja et al. (2008)	23	Qualitative	1	1	1	0	0	0
Mitha and Adatia (2016)	11	Qualitative	1	1	1	0	0	0
Omar et al. (2017)	21	Qualitative	1	1	1	0	1	1
Prasad-Ildes and Ramirez (2006)	28	Qualitative	0	0	0	1	1	1
Ridgway (2022)	9	Qualitative	1	1	1	0	0	0
Said et al. (2021)	31	Qualitative	1	1	0	0	1	1
Schweitzer et al. (2007)	13	Qualitative	1	1	1	0	0	0
Stolk et al. (2015)	34	Quantitative	0	0	0	0	1	0
Youssef and Deane (2006)	35	Qualitative	0	1	0	1	1	0

Note. M, meaning/reappraisal; P, religious practice; C, community support; L, religious leader; F, service friction; I, integrated care. A value of 1 indicates explicit support in the reported findings; 0 indicates absence of an explicit report.

The matrix shows why participant weighting would be misleading. The largest investigation contributed evidence about community support, whereas several smaller qualitative investigations supplied the clearest accounts of service friction, leadership, and concurrent care. Treating each investigation as one configuration preserves diversity of evidence type and prevents sample size from being mistaken for conceptual breadth.

2.4. Association and stability analysis

For each pair of conditions, a 2×2 table recorded joint presence, presence of only the first condition, presence of only the second, and joint absence. Jaccard similarity measured overlap among studies containing at least one condition:

$$J(A, B) = \frac{|A \cap B|}{|A \cup B|}. \tag{1}$$

Equation (1) gives zero when two conditions never co-occur and one when their study sets are identical. Two-sided Fisher exact tests and odds ratios were also calculated. These exact tests are descriptive because only 16 investigations were available and the corpus was not a probability sample of all possible studies.

Stability was examined in two ways. First, every investigation was removed once, generating 16 leave-one-study-out matrices. Each deletion tested whether M and P remained the two most prevalent conditions and whether the subset relations $L \subseteq F$ and $I \subseteq F$ remained intact. Second, each of the 96 binary cells was flipped once. These single-cell perturbations represented the strongest local challenge to a disputed coding decision: a reported presence became absence, or an absence became presence. The analysis recorded preservation of the two most prevalent conditions, preservation of each subset relation, and the range of $J(M, P)$.

All calculations used unweighted binary values. No imputation was performed. The analysis file, coding matrix, and executable script are included in the accompanying project so that every numerical statement can be reproduced.

2.5. Ethical and interpretive boundaries

No new human participants were recruited, and no identifiable participant record was accessed. Formal ethics review was therefore not required. The analysis concerns what investigations reported, not the prevalence of beliefs among all CALD Australians. CALD status was never treated as a proxy for religiosity, and religious affiliation was never treated as a proxy for treatment preference. The photographic panels are conceptual illustrations composed with synthetic people; they are not empirical observations and are not used in any calculation.

3. RESULTS

3.1. Corpus composition

The 16 investigations spanned clinical and non-clinical populations, including people experiencing depression or psychosis, refugees and asylum seekers, migrant women, youth, and community participants. The evidence was methodologically asymmetric: qualitative investigations supplied detailed accounts of practices,

meanings, and help-seeking relationships, while quantitative investigations examined selected associations or group differences. The studies also differed in reporting of country of birth, ethnicity, language, and religious affiliation. This heterogeneity precluded pooled symptom estimation but was compatible with study-level configuration analysis.

Design type affected what could become visible in the matrix. Surveys were well suited to group differences, associations, or the stated importance of religion, but their fixed response categories rarely described how a referral unfolded. Qualitative interviews captured private interpretation, community dynamics, and trust, yet did not estimate how common those experiences were. Mixed-method evidence connected some of these levels but appeared in only one investigation. The matrix does not erase these differences: it uses them to compare the presence of relational conditions while leaving claims about magnitude within the design that produced them.

The participant distribution was also highly uneven. One online survey accounted for nearly half of all participants, whereas six qualitative investigations contained fewer than 30 participants each. A participant-weighted count would consequently convert the measurement priorities of the largest survey into the apparent priorities of the entire corpus. Equal study contribution yielded a different and more defensible question: how many independent investigations, regardless of size, explicitly documented a given relation? The answer does not describe national prevalence, but it is appropriate for identifying recurrent care interfaces.

Several investigations illustrate the relational distinctions used in coding. Somali and Horn of Africa accounts described Quran recitation, congregational prayer, resilience, and the possibility of combining religious and professional responses.[17] Narratives of asylum seeking identified prayer, religious counselling, community belonging, and belief as buffers against hopelessness.[18] Sudanese refugees described prayer, surrender, reappraisal, and church-based support.[19] Ismaili Muslim youth described meaning, chanting, meditation, service, and congregational connection.[20] Migrant women used religious belief to reinterpret divorce and rebuild continuity after marital loss,[21] while Sudanese refugee narratives linked faith, prayer, meaning, and material community support.[22] These findings support M, P, or C without necessarily implying formal service coordination.

Other investigations concentrated on the interface with care. CALD consumers in Brisbane identified limited professional understanding of religion and recommended education and linkage with religious leaders.[23] Arabic-speaking communities in Sydney described religious leaders as trusted initial contacts and discussed religious healing practices.[24] African migrants and service providers in South Australia connected divergent understandings of mental illness with access difficulty and supported leader education and service involvement.[25]

Table 2. Prevalence of relational conditions.

Condition	Studies	Percentage	Direct implication
Meaning/reappraisal	11	68.8	Ask whether belief affects meaning, hope, endurance, or interpretation.
Religious practice	11	68.8	Identify chosen practices that the person already uses or wishes to retain.
Community support	9	56.3	Consider belonging, emotional help, and material assistance beyond the clinic.
Religious leader	3	18.8	Involve a leader only when trusted, competent, and requested.
Service friction	7	43.8	Examine disagreement, stigma, mistrust, and poor professional understanding.
Integrated care	4	25.0	Coordinate roles when parallel systems would otherwise remain disconnected.

Vietnamese-Australian participants with psychosis more often rated religion or spirituality as important and sometimes attributed illness to supernatural causes, yet did not report consulting traditional healers.[26] The last example demonstrates why an attribution cannot be treated automatically as religious help seeking.

3.2. Prevalence of conditions

Meaning/reappraisal and religious practice each appeared in 11 investigations (68.8%). Community support appeared in nine (56.3%), service friction in seven (43.8%), explicit integrated care in four (25.0%), and a religious-leader conduit in three (18.8%). Table 2 reports the full distribution.

The distribution separates routine inquiry from intensive coordination. Personal meaning and practice recur often enough to justify a voluntary question in ordinary assessment. Leader involvement and formal integration are much less frequent and should not be assumed. Their lower prevalence does not make them unimportant; it indicates that they are targeted responses to a narrower set of relational conditions.

3.3. Co-occurrence and configuration structure

Meaning/reappraisal and practice co-occurred in 10 investigations. Only one investigation contained M without P, and one contained P without M; four contained neither. Their Jaccard similarity was 0.833, and the exact association was strong (odds ratio $= 40.0$, $p = 0.0128$). Eight of nine community-support investigations also contained M, although the small corpus left the Fisher test uncertain ($p = 0.1058$). Seven contained both P and C.

Service friction occupied a different position. Every investigation containing L also contained F, and every investigation containing I also contained F. The I–F relation was exact at the observed level (four joint presences, no I-only configuration) and produced $p = 0.0192$. Two investigations contained both L and I. Table 3 provides the full pairwise results.

The pairwise structure supports a two-level interpreta-

Table 3. Pairwise configuration results.

Pair	Joint	First only	Second only	J	Fisher p
M–P	10	1	1	0.833	0.0128
M–C	8	3	1	0.667	0.1058
P–C	7	4	2	0.538	0.5962
L–F	3	0	4	0.429	0.0625
I–F	4	0	3	0.571	0.0192
L–I	2	1	2	0.400	0.1357

J, Jaccard similarity. Exact p values are descriptive and are not adjusted for multiple comparisons.

tion. M, P, and C describe resources that can exist without a documented conflict with services. L and I, by contrast, are concentrated within investigations where friction is visible. The analysis therefore does not support routine referral to a religious leader for every religious patient. It supports escalation from respectful inquiry to negotiated coordination when ordinary care and the person's religious world are not aligning.

Ten distinct six-bit configurations occurred. The most frequent was $MPC\bar{L}\bar{F}\bar{I}$, present in six investigations. Two investigations shared $M\bar{P}\bar{C}LFI$. Every other configuration appeared once. This concentration is substantively important. The dominant pattern joins private meaning, practice, and community support without reported friction or formal integration; the smaller repeated pattern joins leader involvement and integration specifically with friction.

The three settings in Fig. 2 translate the dominant personal and community conditions into recognisable contexts. Quiet prayer or sacred reading represents P and may also support M; a community circle represents C; seated breathing or meditation represents a low-language practice that some people may experience as religious or spiritual. None of these activities is presumed to be treatment, and none should be assigned because of ethnicity or clothing.

(a) Quiet reflection **(b)** Shared support **(c)** Embodied practice

Figure 2. Personal and communal resources.

The changing viewpoint across Fig. 2 also reflects a clinical distinction. Private practices are controlled primarily by the individual; community resources depend on relationships and safety; an embodied practice may reduce language demands but still requires preference-sensitive screening. The recurring M–P overlap does not authorize clinicians to prescribe religious acts. It shows that meaning and practice are frequently connected and should not be separated mechanically when a patient chooses to discuss them.

3.4. Stability tests

All 16 deletion trials preserved M and P as the two most prevalent conditions. Every deletion also preserved $L \subseteq F$ and $I \subseteq F$. Across 96 single-cell perturbations, M and P remained the leading pair in every trial. Their Jaccard similarity ranged from 0.750 to 0.917. The leader subset relation survived 84 trials (87.5%), the integration subset relation survived 83 (86.5%), and both survived together in 73 (76.0%).

The stability trials distinguish a highly durable prevalence result from more coding-sensitive subset relations. The leading position of M and P cannot be overturned by any single study deletion or any single cell reversal. The association of leadership and integration with friction is also stable to every deletion, although a deliberately adverse cell reversal can break it. This is the expected behaviour of a targeted interface finding supported by only three or four investigations.

4. DISCUSSION

4.1. Direct answer to the research question

The research question asked which combinations identify defensible points of connection between mental-health services and religious life. The answer has two parts. First, the most transferable point is voluntary, person-specific inquiry into meaning and practice. M and P were the most prevalent conditions, co-occurred in 10 investigations, and retained their leading position under every robustness trial. Second, formal coordination is not a universal next step. L and I appeared only in the presence of documented friction. A religious leader or shared care arrangement is therefore most defensible when explanatory conflict, mistrust, stigma, incompatible help-seeking preference, or deficient professional understanding is obstructing care and when the person explicitly wants such involvement.

This answer is narrower than a general call to integrate spirituality. It identifies a sequence of increasing relational intensity. A clinician can ask whether faith or spirituality affects coping without endorsing a theological claim. Chosen practices can be supported without turning them into clinician-controlled techniques. Community contact can be discussed without assuming that a congregation is safe. Formal involvement of a leader requires consent, competence, confidentiality, and agreement about clinical responsibility.

4.2. Meaning and practice as the routine entry point

The strong M–P overlap suggests that belief and action frequently work together. Religious ideas may reframe loss, locate suffering within a larger narrative, preserve hope, or reduce isolation; prayer, recitation, chanting, meditation, and worship can embody those meanings. Faith-adapted psychotherapy has shown potential for depression and anxiety when religious content is congruent

Table 4. Stability of central findings.

Finding challenged	Preserved	Trials
M and P remain the two most prevalent conditions, deletion	16	16
$L \subseteq F$, deletion	16	16
$I \subseteq F$, deletion	16	16
M and P remain the two most prevalent conditions, cell flip	96	96
$L \subseteq F$, cell flip	84	96
$I \subseteq F$, cell flip	83	96
Both subset relations, cell flip	73	96

with the recipient's beliefs.[27,28] Clinical trials of Quran recitation have reported anxiety or depression benefits in selected Muslim samples,[29] while broader syntheses have found that yoga can reduce depressive symptoms in people with mental disorders.[30] These findings justify careful discussion of patient-chosen practices, not blanket treatment claims.

Research with Somali communities outside Australia similarly shows that Quran reading and negotiation of spiritual explanations can coexist with complex decisions about biomedical help.[31] Mantra meditation evidence points to possible mental-health effects but also to variation in design and study quality.[32] Earlier work on rhythmic Quranic recitation and later work on Surah Al-Rehman reported reductions in depressive symptoms in particular samples.[33,34] The clinically relevant principle is concordance: the practice must be acceptable, safe, and meaningful to the individual, and any claimed benefit must be proportionate to evidence for that population and condition.

Routine inquiry should consequently be brief and permissive. Suitable questions include whether religious or spiritual beliefs affect the way the person understands the problem, whether any practice is helping or causing distress, and whether there is anyone from a faith community whom the person wants involved. The person must be able to answer that religion is irrelevant, private, harmful, uncertain, or unwelcome. Documentation should record the individual's words and preferences rather than a clinician's inference from surname, dress, language, or country of birth.

4.3. Community connection is distinct from individual religiosity

Community support appeared in nine investigations and overlapped with meaning in eight. A congregation can provide friendship, meals, transport, housing assistance, childcare, interpretation, and continuity after migration. It can also reproduce stigma, gendered control, family surveillance, exclusion, or pressure to use only religious healing. For that reason, a social connection assessment should ask about the quality and safety of relationships, not merely attendance.

Young CALD Australians have described religious belonging as one component of strength alongside family and peer relationships.[35] Studies of culturally appropriate chronic-disease care likewise show that community participation, communication, and service accessibility interact rather than operate separately.[36] Palliative-care accounts indicate that patients and caregivers may negotiate cultural expectations in ways that are not visible to clinicians,[37] while Sri Lankan Tamil refugee narratives demonstrate how past experience and local service encounters shape help seeking.[38] These adjacent literatures reinforce the need to ask how community relations function for a particular person.

Religious community support should not be recorded as a substitute for housing, income, language access, medication, psychotherapy, or crisis care. It is one part of a wider social ecology. The large quantitative investigation in the corpus associated religious-group support with flourishing but not distress, illustrating that a positive social resource and symptom relief are not identical outcomes. Services should therefore preserve beneficial connections while retaining direct responsibility for assessment and evidence-based care.

4.4. Why friction changes the role of religious leaders

The subset relations are the most distinctive result. All leader-conduit and integrated-care configurations also contained service friction. This pattern suggests that leaders become clinically salient not simply because a person is religious, but because the ordinary route into care is failing or because religious and clinical explanations are not meeting productively. In such circumstances, a trusted leader may explain services, reduce stigma, accompany a referral, or help the clinician understand a practice. The leader may also discourage care, breach confidentiality, or lack competence in risk recognition. Trust must therefore be assessed, not presumed.

Prior work with families facing cancer, dementia, and caregiving shows that religious coping can be interwoven with family responsibility and service use.[39,40] Trauma care for Arab women also requires attention to gender, safety, migration, and religious meaning without reducing the person to any single identity.[41] Australian health workers have described the difficulty of turning cultural

competence into day-to-day practice, especially where organizational routines do not support reflective communication.[42] These findings help explain why leader collaboration cannot be implemented by maintaining an informal contact list alone.

The two-panel sequence in Fig. 3 presents collaboration as negotiated work. Joint planning requires the client, clinician, bilingual practitioner, and religious-care practitioner to share relevant information only with consent. A warm handover requires continuity at the boundary between settings. Neither arrangement transfers diagnostic or risk responsibility to a leader, and neither allows a clinician to dictate religious practice.

(a) Joint planning **(b)** Warm handover

Figure 3. Collaborative service bridge.

The practical value of Fig. 3 lies in its role boundaries. The client remains the decision maker; the clinician retains clinical accountability; the bilingual practitioner supports accurate communication; and the religious-care practitioner contributes only the role requested and agreed. Written consent, a defined purpose, a review date, and a direct route back to clinical care convert goodwill into a safer working relationship.

4.5. A graded clinical sequence

The results support four stages of care. The first is *permission*: ask whether religion or spirituality is relevant and accept a refusal without penalty. The second is *clarification*: identify meanings, practices, community relationships, and any religious concern that increases distress. The third is *accommodation*: where safe and feasible, preserve chosen practices, interpreter access, dietary or scheduling needs, privacy, and supportive community contact. The fourth is *coordination*: when friction is present and the person requests it, establish a time-limited connection with a competent religious-care practitioner or community leader.

This sequence is not a rigid protocol. Urgent risk, psychosis, coercion, abuse, or severe functional decline may require immediate clinical action while religious concerns are addressed concurrently. Conversely, a stable person may need only recognition of a private practice and no further action. The sequence is valuable because it prevents two common errors: excluding religion until conflict becomes acute, and escalating every mention of religion into a formal referral.

Accommodation also requires content-specific safety review. Fasting may affect medication timing or physical health; prolonged breath retention may be unsuitable for some conditions; intensive meditation may worsen dissociation or distress in some people; group disclosure may compromise privacy; and recitation or prayer can be supportive for one person but guilt-inducing for another. Clinicians should assess the actual practice, frequency, meaning, and effects rather than judging a broad religious category.

4.6. Safeguards against stereotyping and coercion

The corpus demonstrates heterogeneity within and across affiliations. CALD Muslim participants differed from Anglo-Caucasian Muslim participants; Somali-Australian views varied by generation; Vietnamese-Australian participants could hold supernatural attributions without consulting a traditional healer. A service that equates ethnicity with religious treatment preference would therefore contradict the evidence it claims to respect.

Consent must be specific. Agreement to discuss religion is not agreement to contact a leader. Agreement to contact a leader is not permission to share the clinical record. Agreement to use prayer is not refusal of medication or psychotherapy. A patient must be able to change a decision, request a different representative, use an interpreter independent of the religious community, or exclude family members. Where community leadership is male-dominated or closely connected to family networks, services should offer confidential alternatives.

Competence requirements should apply on both sides. Clinicians need skill in eliciting religious concerns, distinguishing culturally shared belief from psychopathology, recognizing spiritual struggle, and documenting preference without judgment. Religious-care practitioners involved in referrals need basic knowledge of crisis signs, suicide risk, safeguarding, privacy, and the limits of their role. Joint education can establish shared vocabulary, but competence should be demonstrated through observable practice and supervision rather than assumed from title or affiliation.

Governance is equally important. Services should record who initiated contact, what information may be exchanged, who manages medication and risk, how disagreement will be resolved, and when the arrangement will be reviewed. Referral directories should include multiple traditions and nonreligious options. Complaints processes must be accessible in relevant languages. Payment or volunteer status should not determine whose religious representation becomes available.

4.7. Organizational implementation and evaluation

The graded sequence requires organizational support if it is to survive beyond individual clinician interest. Intake forms should contain an optional free-text field for religious or spiritual concerns rather than a compulsory affiliation category. Interpreter booking should occur be-

fore sensitive discussion, and services should avoid using relatives or community representatives as interpreters when privacy or coercion is possible. Clinical records should separate the patient's own account, the agreed accommodation, consent for external contact, and the identity and role of any person contacted.

Referral arrangements should be bilateral and reviewable. Mental-health services can define minimum expectations for religious-care practitioners who accept referrals, including confidentiality, safeguarding, crisis escalation, and respect for the patient's right to use clinical treatment. Religious organizations can identify what their practitioners can and cannot provide, how complaints are handled, and whether an alternative practitioner is available. A written memorandum can clarify institutional responsibilities, but every patient-level contact still requires specific consent.

Evaluation should distinguish acceptability from clinical effectiveness. A service can begin by recording the proportion of patients offered an optional inquiry, the proportion who choose discussion, interpreter availability, referral completion, time to contact, and withdrawals of consent. Patient-reported measures should examine respect, explanatory agreement, trust, and whether care accommodated or burdened the person's beliefs. Clinical outcomes, adverse events, crisis escalation, and continuity should be analyzed separately. Improvement in willingness to attend does not by itself demonstrate symptom benefit, just as unchanged symptoms do not mean that respectful access lacks value.

Equity review is necessary because availability may differ by tradition, geography, gender, and community size. A metropolitan service may have several trained partners, whereas a regional service may depend on remote consultation. Smaller faiths and nonreligious patients must not receive fewer options. Services should examine who is offered collaboration, who declines, whose referral is completed, and whether any group is overrepresented in coercive or delayed pathways. These checks keep the graded sequence centred on individual preference rather than institutional enthusiasm for partnership.

Training should be tested through practice rather than attendance alone. Clinicians can be assessed using structured consultations that require permission, nonassumptive questioning, use of an interpreter, and a response to disagreement. Religious-care practitioners can demonstrate risk recognition, referral communication, and confidentiality decisions. Joint case review can then focus on boundary problems, including pressure from relatives, conflict between practitioners, withdrawal of consent, and urgent risk. This organizational layer is what allows a respectful conversation to become reliable care.

4.8. Interpretation of robustness

The deletion and perturbation trials strengthen the central conclusion without erasing uncertainty. The prevalence of M and P is unusually stable: no single investigation or coding reversal displaced them. That stability supports routine, low-burden inquiry. The subset relations survived all study deletions but fewer cell reversals because they rely on small counts. Their practical implication should therefore be treated as a targeted proposition for service testing, not a universal law.

The Jaccard range of 0.750–0.917 under every one-cell reversal shows that the M–P connection is not an artefact of a single ambiguous assignment. By contrast, a new investigation documenting leader involvement without friction would directly refine the L–F relation. This sensitivity is useful: the method identifies exactly what future evidence could change the clinical interpretation.

Future empirical work should recruit participants from defined communities rather than use CALD as a single analytic category. It should compare voluntary spiritual inquiry with ordinary assessment, record who declines, distinguish private practice from organized religion, and measure access, alliance, symptom change, adverse events, and continuity separately. Collaborative models should report leader selection, training, confidentiality, referral completion, and responsibility for risk. Such studies would test whether the graded sequence improves care without increasing stereotyping or coercion.

5. CONCLUSION

The paper asked which combinations of religious and service conditions identify defensible connections between Australian mental-health services and the religious lives of CALD adults. The configuration analysis gives a specific answer. Personal meaning/reappraisal and religious practice are the broadest and most stable entry points: each appeared in 11 of 16 investigations, they co-occurred in 10, and no deletion or single-cell reversal displaced them as the two leading conditions. Community support is also common but must be assessed for quality and safety. Formal leader involvement and integrated care are narrower responses; in this corpus they appeared only where service friction was documented.

Accordingly, equitable practice should begin with permission-based inquiry, proceed to clarification and safe accommodation, and move to religious–clinical coordination only when the person requests it and a defined access problem justifies it. This conclusion rejects both exclusion and automatic inclusion. Religion should neither be omitted when it shapes distress nor assigned clinical authority because a patient belongs to a CALD community. Consent, non-assumption, role clarity, confidentiality, interpreter independence, safeguarding, and continuing clinical accountability are the conditions that convert religious recognition into responsible care.

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