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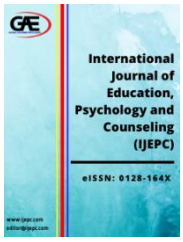

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MENTAL HEALTH LITERACY (MHL) INTERVENTIONS WITH CULTURAL, RELIGIOUS OR SPIRITUAL ADAPTATION: A SYSTEMATIC REVIEW

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Abstract:

Mental health literacy (MHL) interventions are increasingly adapted to reflect the cultural, religious, and spiritual backgrounds of diverse populations, as standard programmes may not adequately address local beliefs, language, stigma, and help-seeking practices. However, evidence on how such adaptations is designed, delivered, and evaluated remains fragmented across different settings and population groups. This systematic review aimed to synthesise current evidence on MHL interventions incorporating cultural, religious, or spiritual adaptation, with particular attention to the nature of adaptation, mechanisms of engagement, and intervention outcomes. The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework. An advanced search was conducted in Scopus and Web of Science using combinations of the keywords "mental health literacy," "intervention," "spiritual," and "cultural." Studies were screened according to predefined inclusion and exclusion criteria, resulting in 21 primary studies included in the final synthesis. The findings were organised into three themes: (1) cultural adaptation centred on content, framing, and conceptual relevance; (2) trust, social infrastructure, and delivery as mechanisms of engagement; and (3) short-term effectiveness, implementation feasibility, and uncertain sustainability. Most interventions adapted existing programmes through language modification, culturally relevant examples, local explanatory models, spiritual or religious framing, and community-specific help-seeking information rather than complete programme redesign.

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Engagement was strengthened through trusted facilitators, faith leaders, community organisations, culturally familiar settings, and accessible digital or face-to-face delivery. The reviewed interventions generally reported improvements in mental health knowledge, confidence, stigma-related attitudes, and helping intentions, although evidence for sustained help-seeking, service use, and long-term behavioural change was limited. Overall, culturally, religiously, and spiritually adapted MHL interventions appear promising for improving relevance, acceptability, and short-term outcomes, but stronger longitudinal studies and clearer reporting of adaptation processes are needed to establish their long-term effectiveness and sustainability.

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Keyword:

Mental Health Literacy; Cultural Adaptation; Religious Adaptation; Spiritual Adaptation; Intervention; Systematic Review

Introduction

Mental health literacy (MHL) refers to knowledge and beliefs that support the recognition, management, and prevention of mental-health problems. It also includes attitudes, stigma, confidence, and help-seeking-related skills that influence whether individuals recognise distress and access suitable support. Although MHL interventions commonly improve knowledge, their relevance and acceptability may be reduced when programme language, explanatory models, examples, or help-seeking pathways do not fit the cultural, religious, or spiritual contexts of the intended population. Cultural and religious beliefs may shape how distress is interpreted, which sources of help are trusted, and whether professional care is considered compatible with community values (Hays & Aranda, 2016; Khatib et al., 2025).

Cultural adaptation therefore involves more than translation. It may include changes to language and literacy level, culturally familiar narratives and metaphors, local explanatory models, faith-based meaning systems, facilitator identity, delivery setting, and referral pathways. Previous work has shown that culturally responsive interventions can retain core evidence-based components while modifying content and delivery to improve conceptual fit and engagement (Barrera & González Castro, 2006; Sorenson & Harrell, 2021). However, evidence on culturally, religiously, and spiritually adapted MHL interventions remains distributed across migrant, Indigenous, faith-based, educational, workplace, refugee, and digital settings. This review therefore synthesised how these interventions were adapted and delivered, the mechanisms used to strengthen engagement, and the evidence reported for effectiveness, feasibility, completion, and sustainability.

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Literature Review

Existing evidence suggests that culturally adapted mental-health education is most consistently associated with short-term improvement in knowledge, recognition, confidence, and selected stigma-related outcomes, while effects on actual help-seeking and service use are less consistent. Adaptation commonly involves changes to terminology, examples, teaching methods, and delivery structures rather than complete redesign of the intervention. For example, school-based and community programmes have retained their central educational aims while modifying examples, references, activities, and implementation procedures to suit local settings (Mansfield et al., 2021). Similarly, culturally adapted interventions for Latino, Nepali, Israeli, migrant, and refugee populations have used simplified language, culturally relevant metaphors, local conceptualisations of distress, and context-specific narratives to improve accessibility and acceptability (Ramos & Alegría, 2014; Ramaiya et al., 2017; Khatib et al., 2025; Schwartz et al., 2022).

Religious and spiritual adaptation adds another level of relevance by linking mental-health information with moral, existential, and communal meaning systems. Faith-based programmes may be particularly useful when religious leaders and institutions are trusted sources of support, but their effectiveness depends on suitable training, clear referral pathways, and collaboration with professional services (Hays & Aranda, 2016; Baheretibeb et al., 2022; Adewuya et al., 2026). Digital delivery can also extend reach, especially for geographically dispersed or underserved populations, although language preference, digital literacy, usability, and cultural relevance continue to shape engagement (Shala et al., 2020; Sit et al., 2020; Stoeckli et al., 2025).

Despite growing interest, several gaps remain. Adaptation processes are often incompletely described, making it difficult to determine which components were retained, modified, added, or removed. Many studies use small samples, uncontrolled designs, short follow-up periods, and heterogeneous outcome measures. Consequently, the study provides stronger evidence for feasibility and immediate changes in knowledge or attitudes than for sustained help-seeking, service use, or behavioural change. A systematic synthesis is therefore needed to distinguish the content of adaptation, the social and delivery mechanisms supporting engagement, and the quality and durability of reported outcomes.

Methodology

Identification

In this study, a systematic review process using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) was employed to identify and retrieve a substantial body of relevant literature. The process began with the identification of key search terms, followed by the exploration of related terms using dictionaries and previous studies. The identified terms were then combined to develop database-specific search strings for Web of Science and Scopus, as presented in Table 1. This initial search yielded a total of 1,681 publications relevant to the study topic across the selected databases.

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Table 1: The Search String

Scopus (advanced query) Date of Access: July 2026	TITLE-ABS-KEY (("mental health literacy" OR "mental health knowledge" OR "mental health awareness" OR "mental health education" OR "mental illness knowledge" OR "mental health beliefs" OR "mental health attitudes") AND ("cultural adaptation" OR "culturally adapted" OR "culturally tailored" OR "culturally responsive" OR "culturally sensitive" OR "culturally appropriate" OR "culturally relevant" OR "culturally informed" OR "culture-based" OR "cultural competence" OR ethnic* OR indigenous OR "traditional belief*" OR "traditional healing" OR migrant* OR immigrant* OR refugee* OR minorit* OR religion* OR faith* OR "faith-based" OR "faith informed" OR "religiously adapted" OR "religiously integrated" OR spiritual* OR "spiritually adapted" OR "spiritually integrated" OR psychospiritual* OR "psycho-spiritual" OR Islam* OR Muslim* OR Christian* OR Catholic* OR Hindu* OR Buddh* OR Jewish OR Sikh* OR Quran* OR Qur'an* OR Sharia* OR Shari'a* OR fiqh) AND (intervention* OR program* OR programme* OR education* OR training* OR workshop* OR curriculum OR curricula OR module* OR psychoeducation* OR campaign* OR initiative* OR course* OR toolkit* OR resource* OR "mental health promotion")) AND (EXCLUDE (SUBJAREA , "MEDI") OR EXCLUDE (SUBJAREA , "NURS") OR EXCLUDE (SUBJAREA , "NEUR") OR EXCLUDE (SUBJAREA , "COMP") OR EXCLUDE (SUBJAREA , "ENVI") OR EXCLUDE (SUBJAREA , "ENGI") OR EXCLUDE (SUBJAREA , "BIOC") OR EXCLUDE (SUBJAREA , "BUSI") OR EXCLUDE (SUBJAREA , "PHAR") OR EXCLUDE (SUBJAREA , "MATH") OR EXCLUDE (SUBJAREA , "ECON") OR EXCLUDE (SUBJAREA , "DECI") OR EXCLUDE (SUBJAREA , "PHYS") OR EXCLUDE (SUBJAREA , "MATE") OR EXCLUDE (SUBJAREA , "IMMU") OR EXCLUDE (SUBJAREA , "CENG") OR EXCLUDE (SUBJAREA , "AGRI")) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (PUBSTAGE , "final")) AND (LIMIT-TO (DOCTYPE , "ar")) AND (EXCLUDE (OA , "repository") OR EXCLUDE (OA , "publisherfullgold") OR EXCLUDE (OA , "publisherhybridgold")))
Web of Sciences Date of Access: July 2026	("mental health literacy" OR "mental health knowledge" OR "mental health awareness" OR "mental health education" OR "mental illness knowledge" OR "mental health beliefs" OR "mental health attitudes") AND ("cultural adaptation" OR "culturally adapted" OR "culturally tailored" OR "culturally responsive" OR "culturally sensitive" OR "culturally appropriate" OR "culturally relevant" OR "culturally informed" OR "culture-based" OR "cultural competence" OR ethnic* OR indigenous OR "traditional belief*" OR "traditional healing" OR migrant* OR immigrant* OR refugee* OR minorit* OR religion* OR faith* OR "faith-based" OR "faith informed" OR "religiously adapted" OR "religiously integrated" OR spiritual* OR "spiritually adapted" OR "spiritually integrated" OR psychospiritual* OR "psycho-spiritual" OR Islam* OR Muslim* OR Christian* OR Catholic* OR Hindu* OR Buddh* OR Jewish OR Sikh* OR Quran* OR Qur'an* OR Sharia* OR Shari'a* OR fiqh) AND (intervention* OR program* OR programme* OR education* OR training* OR workshop* OR curriculum OR curricula OR module* OR psychoeducation* OR campaign* OR initiative* OR course* OR toolkit* OR resource* OR "mental health promotion") and Open Access and 2026 or 2025 or 2024 (Publication Years) and Article (Document Types) and English (Languages) and Psychiatry or Psychology or Religion or Social Sciences Other Topics or Arts Humanities Other Topics (Research Areas)

Screening

The database search identified 1,681 records, comprising 846 studies from Scopus and 835 studies from Web of Science. A total of 1,131 studies were removed by applying the predetermined database limits, including English-language publication, eligible publication type, and relevant subject areas such as social science, psychology, psychiatry, and humanities. This resulted in 550 studies, consisting of 317 records from Scopus and 233 studies from Web

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of Science. Following the removal of 15 duplicate records, 535 unique records remained to be screened in the eligibility phase.

Eligibility

During the eligibility phase, 535 unique records were assessed through examination of titles, abstracts, and, where available, full texts. Studies were evaluated against four criteria: (1) inclusion of a mental health literacy component; (2) an identifiable cultural, religious, or spiritual adaptation; (3) implementation of an intervention; and (4) an eligible empirical study design, as shown in Table 2. Reviews, protocols, and other non-empirical publications were excluded. In total, 514 records were excluded during eligibility assessment, resulting in 21 studies for the final synthesis as shown in **figure 1**.

Table 2: The Core Criteria of Selection Studies

Criterion	Inclusion	Exclusion
MHL element	Addresses knowledge, recognition, beliefs, attitudes, stigma, prevention, self-help, professional help, or help-seeking relating to mental health	Only measures symptoms or treatment outcomes without an MHL component
Cultural, religious or spiritual adaptation	Intervention is designed, adapted, tailored, informed, delivered, or contextualised according to culture, ethnicity, religion, faith, spirituality, Indigenous knowledge, or a specific cultural population	Culture, religion, or spirituality is only mentioned as participant demographics
Intervention	Evaluates a programme, module, training, workshop, curriculum, campaign, psychoeducation, course, toolkit, or educational resource	Observational study with no implemented intervention
Study type	empirical findings from quantitative, qualitative, or mixed-method research	Review, systematic review, scoping review, meta-analysis, protocol, editorial, commentary, conference abstract, or theoretical paper

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Data Extraction

A structured data-extraction form was developed to ensure consistent collection of information from the 21 included studies. The extracted variables comprised author and year of publication, geographical location, study design, target population, sample size, intervention name, intervention medium, duration and assessment time points, mental health literacy elements, cultural, religious or spiritual adaptation strategies, measurement instruments, effectiveness outcomes, feasibility indicators, and completion or retention rates. Quantitative findings were recorded using the numerical information reported in each study, including means and standard deviations, proportions, regression coefficients, odds ratios, confidence intervals, test statistics, effect sizes, and p values where available. Qualitative and mixed-method findings were also extracted to capture adaptation processes, participant experiences, cultural relevance, acceptability, implementation barriers, and contextual factors. Due to substantial heterogeneity in study designs, target populations, intervention formats, outcome measures, and methods of statistical reporting, a meta-analysis was not considered appropriate. Therefore, the findings were synthesised using descriptive numerical summaries and thematic analysis.

The thematic analysis was conducted through an iterative process of coding, comparison, and refinement. Each study was examined for recurring patterns related to intervention design, adaptation content, delivery setting, implementation process, and reported outcomes. Initial codes were generated from the extracted data and grouped into broader categories according to conceptual similarity. The authors then compared the coded findings across studies and discussed any differences in interpretation until agreement was reached. An audit trail was maintained throughout the analysis to document coding decisions, revisions to theme labels, movement of studies between categories, and the rationale for the final thematic structure. This process resulted in three themes: (1) cultural adaptation centred on content, framing, and conceptual relevance; (2) trust, social infrastructure, and delivery as mechanisms of engagement; and (3) short-term effectiveness, implementation feasibility, and uncertain sustainability. Quantitative summaries were used to complement the thematic findings by describing the distribution of study designs, intervention media, geographical locations, target populations, MHL elements, adaptation strategies, effectiveness outcomes, feasibility indicators, and completion rates.

To strengthen the credibility and domain validity of the analysis, the preliminary coding framework, thematic categories, and allocation of the 21 studies were reviewed by two experts with relevant expertise in mental health, psychological intervention, systematic review methodology, or culturally responsive mental health research. The experts assessed the clarity, relevance, distinctiveness, and appropriateness of the proposed themes and examined whether the extracted evidence was accurately represented within each category. Their feedback was used to refine the theme labels, reduce conceptual overlap, and improve consistency between the study findings and the final interpretation. Any discrepancies between the authors and expert reviewers were resolved through discussion and consensus. The data extraction and analysis were guided by the following research questions:

RQ1: How are culturally, religiously, or spiritually responsive mental health literacy interventions designed, adapted, implemented, and evaluated among diverse populations?
RQ2: What cultural, religious, spiritual, linguistic, and contextual elements are incorporated into mental health literacy interventions?

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RQ3: What evidence supports the effectiveness, feasibility, completion, and sustainability of culturally, religiously, or spiritually adapted mental health literacy interventions?

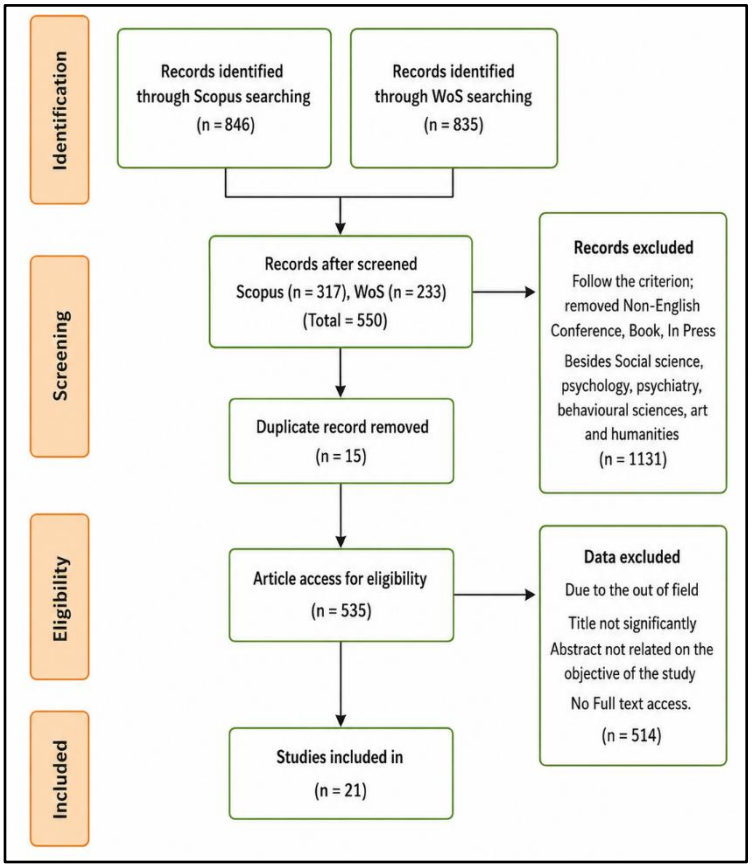

Figure 1. Flow Diagram of The Proposed Searching Study

Result and Discussion

The 21 included studies demonstrated substantial diversity in the types of culturally, religiously, and spiritually adapted mental health literacy interventions, the strategies used to enhance cultural relevance, and the evidence reported regarding intervention outcomes and implementation. To provide a comprehensive synthesis, the findings are presented in two parts which are descriptive analysis and thematic analysis.

Descriptive Analysis

The descriptive analysis first presents the overall characteristics of the 21 studies, including the types of adapted MHL interventions, modes of delivery, geographical distribution, target populations, adaptation elements, outcome measures, effectiveness, feasibility, and completion. This section establishes the main patterns in the evidence base.

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Available Adapted MHL Interventions

Across the 21 included studies, face-to-face delivery remained the most common intervention format. 14 studies (66.7%) used predominantly face-to-face delivery, including workshops, community training, classroom teaching, therapeutic groups, and facilitated psychoeducation (Vang-Kue et al., 2025; Slewa-Younan et al., 2020; Crooks et al., 2018; Day et al., 2021; Wang & Havewala, 2025). Six studies (28.6%) were delivered fully through digital or virtual media, including online training, SMS, interactive theatre, digital animation, online group sessions, and a self-guided website (Yoo et al., 2026; Rushing et al., 2021; Song et al., 2022; Bapolisi et al., 2026; Martinez et al., 2024; Wright et al., 2026). One study (4.8%) used a hybrid format comprising nine face-to-face sessions and one online session (Codjoe et al., 2023). Geographically, the evidence was concentrated in the United States (n = 6, 28.6%), the United Kingdom (n = 5, 23.8%), and Australia (n = 4, 19.0%), while Germany, Ghana, South Africa, Sweden, Canada, and the Democratic Republic of Congo each contributed one study. Consequently, 15 of the 21 studies (71.4%) were undertaken in the United States, United Kingdom, or Australia, indicating that culturally adapted MHL intervention research remains concentrated in high-income Western settings. In terms of participants, most interventions primarily targeted adults (n = 18, 85.7%), including faith leaders, community champions, parents, refugees, migrants, employees, and Indigenous community members, whereas three studies focused substantially on adolescents, young adults, or university students (Rushing et al., 2021; Song et al., 2022; Bantjes et al., 2026). Community and faith-based populations were especially prominent, showing that many interventions relied on trusted local structures rather than conventional clinical services alone.

Several intervention components were repeatedly identified across the studies. Knowledge, awareness, recognition, psychoeducation, or an equivalent MHL construct appeared in 19 studies (90.5%), making informational understanding the most consistent intervention element. Examples included recognition of mental-health problems, knowledge of symptoms and treatments, trauma literacy, dementia knowledge, and understanding of appropriate first-aid responses (Slewa-Younan et al., 2020; Duodu et al., 2026; Bantjes et al., 2026; Bapolisi et al., 2026). Stigma, social distance, attitudes, or willingness to discuss mental health were addressed in approximately 17 studies (81.0%), reflecting a strong emphasis on changing negative beliefs and improving cultural acceptability of mental-health care (Vang-Kue et al., 2025; Stoll et al., 2026; Codjoe et al., 2023; Wang & Havewala, 2025). Help-seeking, referral, service awareness, or engagement with formal support appeared in 14 studies (66.7%), while confidence, self-efficacy, helping skills, or intended helping behaviour appeared in around 10 studies (47.6%) (Yoo et al., 2026; Crooks et al., 2018; Day et al., 2021). Coping, resilience, wellbeing, empowerment, or stress management were less universal but remained important secondary elements, particularly in interventions for Indigenous youth, trauma-affected communities, refugees, and migrant populations (Rushing et al., 2021; Hammad et al., 2020; Ekblad, 2020). Overall, the repeated structure of the interventions involved four linked components: improving knowledge and recognition, reducing stigma, strengthening help-seeking pathways, and increasing confidence to provide support. This pattern suggests that culturally adapted MHL interventions generally move beyond simple information provision by combining educational content with attitudinal, behavioural, and community-level components. *(See Appendix 1)*

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Cultural, Religious, and/or Spiritual Adaptation in MHL Interventions

A quantitative coding of the extracted adaptation descriptions showed that all 21 studies (100%) incorporated at least one culturally or contextually specific modification. Approximately 19 studies (90.5%) adapted intervention content to reflect local beliefs, values, explanatory models, historical experiences, or culturally specific stressors. Examples included Hmong understandings of mental illness, Korean church contexts, refugee trauma and displacement, Indigenous social and emotional wellbeing, colonisation and intergenerational trauma, Asian parenting values, migration and acculturation stress, faith-based explanations, and experiences of racism or discrimination (Vang-Kue et al., 2025; Yoo et al., 2026; Crooks et al., 2018; Day et al., 2021; Wang & Havewala, 2025; Codjoe et al., 2023). Linguistic or literacy-related adaptation was identified in approximately 12 studies (57.1%). These modifications included translation, bilingual delivery, interpreters, simplified terminology, one-language groups, low-literacy materials, culturally familiar metaphors, and the replacement of examples or references that were unsuitable for the intended population (Slewa-Younan et al., 2020; Martinez et al., 2024; Wright et al., 2026; Morse et al., 2024; Mansfield et al., 2021; Ekblad, 2020). Contextual tailoring to migration, conflict, trauma, workplace culture, school systems, discrimination, or structural barriers was evident in 19 studies (90.5%), indicating that adaptation usually extended beyond language translation to address the social conditions influencing mental-health understanding and help-seeking. *(see Appendix 2).*

Effectiveness, Feasibility, and Completion of Adapted MHL Interventions

Across the 21 studies, 16 studies (76.2%) reported at least one quantitative effectiveness result, while five studies (23.8%) relied mainly on qualitative, process, or service-evaluation evidence. Significant improvements were most frequently reported for mental-health knowledge, recognition, confidence, stigma-related attitudes, help-seeking intentions, and first-aid behaviour. However, the evidence was not consistently positive across all outcomes. Several studies reported non-significant changes in overall help-seeking, cultural identity, resilience, or selected stigma outcomes. Only nine studies (42.9%) included follow-up beyond the immediate post-intervention assessment, with follow-up periods ranging from approximately four weeks to eight months. This indicates that most available evidence concerns short-term rather than sustained intervention effects. All 21 studies reported some evidence related to feasibility, acceptability, usability, engagement, or implementation. Numerical participation and completion data were available for most studies, although the indicators differed and included intervention attendance, post-intervention response, complete-case analysis, interview participation, and follow-up retention. Completion rates varied substantially across interventions. For example, the Arabic-speaking religious and community leaders' workshop retained 52 of 54 participants (96.3%), whereas T4W/Juntos retained 68 of 131 participants at follow-up (51.9%). Higher completion was generally observed in brief, community-based, and culturally matched interventions, while retention tended to decline when participants were required to complete longer programmes or repeated follow-up assessments. In the Hmong church-leader programme, 36 of 41 participants completed the pre–post assessment (87.8%), but only 31 of 41 completed the six-week follow-up (75.6%). In the culturally adapted Youth Mental Health First Aid trial, 99 of 109 participants were retained at one month (90.8%), decreasing to 64 of 109 at four months (58.7%). A similar pattern was observed in The Working Mind, where 94 of 118 participants completed the immediate post-assessment (79.7%), but only approximately 75–76 participants remained at six months (63.6%–64.4%). This pattern

was evident across both face-to-face and digital interventions, suggesting that completion was influenced not only by delivery format but also by assessment burden, programme duration, and participant circumstances. Overall, feasibility appeared to be strengthened by trusted community settings, culturally relevant facilitators, accessible language, flexible delivery, and programme formats that reduced participation barriers. (see Appendix 3).

Additionally, community participation was another prominent feature, although it was less consistently documented than content modification. Seven studies (33.3%) explicitly reported co-production, co-design, participatory consultation, or formal target-group input during intervention development or adaptation (Duodu et al., 2026; Mantovani et al., 2017; Hammad et al., 2020; Stoll et al., 2026; Wright et al., 2026; Morse et al., 2024; Codjoe et al., 2023). Several additional studies drew on community organisations, cultural experts, local facilitators, or Indigenous instructors without clearly describing a formal co-design process. In total, approximately 15 studies (71.4%) used trusted community structures, culturally matched facilitators, faith organisations, Indigenous instructors, lay champions, interpreters, or community-based delivery to strengthen engagement. Religion or spirituality was explicitly incorporated in around nine studies (42.9%), particularly through churches, faith leaders, spiritual meaning-making, Indigenous worldviews, and discussions of religious explanations for mental distress (Vang-Kue et al., 2025; Yoo et al., 2026; Slewa-Younan et al., 2020; Hammad et al., 2020; Codjoe et al., 2023). These patterns suggest that adaptation extended beyond changing educational materials. It also involved modifying who delivered the intervention, where it was delivered, how mental-health concepts were framed, and how referral pathways were connected to culturally trusted sources of support.

Thematic Analysis

The descriptive findings indicated that the included interventions varied primarily in three interconnected areas: the depth and form of cultural adaptation, the mechanisms used to establish trust and facilitate engagement, and the strength of evidence regarding effectiveness and implementation. Based on these patterns, three themes were developed: (1) cultural adaptation centred on content, framing, and conceptual relevance; (2) trust, social infrastructure, and delivery as mechanisms of engagement; and (3) short-term effectiveness, implementation feasibility, and uncertain sustainability. This structure moves beyond categorising interventions by format and instead explains how adaptation was operationalised, how participation was facilitated, and what outcomes were supported by the available evidence.

Theme 1: Cultural Adaptation Centred on Content, Framing, and Conceptual Relevance

Across the 21 included studies, cultural, religious, and spiritual adaptation was most commonly achieved through selective modification of intervention content, language, examples, and explanatory framing rather than complete redesign. This pattern was evident in structured programmes such as Mental Health First Aid, Youth Mental Health First Aid, Psychological First Aid, The Working Mind, and The Guide, where the core educational structure was retained while terminology, case scenarios, family roles, cultural beliefs, and referral information were adjusted for the target population (Crooks et al., 2018; Day et al., 2021; Mansfield et al., 2021; Stoll et al., 2026; Wang & Havewala, 2025). Similar approaches were used in interventions for Hmong, Korean American, Arabic-speaking, Filipino migrant, and Black faith communities,

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where local beliefs, language, community roles, and help-seeking pathways were incorporated to improve relevance and comprehension (Vang-Kue et al., 2025; Yoo et al., 2026; Slewa-Younan et al., 2020; Martinez et al., 2024; Codjoe et al., 2023). This pattern is consistent with Barrera and González Castro's recommendation that adaptation should be selective and directed toward areas of cultural mismatch while preserving core intervention mechanisms.

Findings from related cultural adaptation studies are consistent with this pattern. The Lighthouse Parenting Programme was adapted for Chile through changes to terminology, materials, literacy level, and facilitator preparation while preserving its mentalization-based framework (Costa-Cordella et al., 2025). START NOW incorporated culturally relatable characters, narratives, and migration-related stressors for Persian and Afghan populations without changing its foundational structure (Schwartz et al., 2022). Other interventions used culturally familiar metaphors, proverbs, visual materials, spiritual perspectives, and simplified language to improve accessibility among Latino, Dutch, Israeli, and Nepali populations (Ramos & Alegría, 2014; van Nieuw Amerongen et al., 2024; Khatib et al., 2025; Ramaiya et al., 2017). Comparable strategies appeared in BRAVE, Indigenous MHFA programmes, Hand of Hope, Tara, Usap Tayo! and Arabic-language refugee interventions, where established intervention components were reframed through Indigenous narratives, colonial history, faith-based meaning-making, migration experiences, and culturally familiar understandings of distress (Rushing et al., 2021; Crooks et al., 2018; Day et al., 2021; Hammad et al., 2020; Martinez et al., 2024; Slewa-Younan et al., 2020).

Overall, the evidence suggests that content and framing adaptations can enhance cultural resonance, feasibility, and scalability while maintaining fidelity to established intervention principles. This aligns with Sorenson and Harrell's cultural context and content domain, which includes language, values, explanatory models, spirituality, literacy, and sociopolitical context. However, many studies described the final adapted materials more clearly than the decision-making process behind them. Few explicitly identified which components were considered core, which were peripheral, how fidelity was protected, or whether adapted content improved outcomes beyond the non-adapted version. Future studies should therefore document the rationale for each modification, distinguish surface adaptations from deeper conceptual changes, and test whether culturally adapted framing improves engagement, knowledge, stigma, help-seeking, and behavioural outcomes.

Theme 2: Trust, Social Infrastructure, and Delivery as Mechanisms of Engagement

The descriptive findings showed that participation depended not only on adapted content but also on whether the intervention was delivered through trusted people, familiar settings, and socially legitimate institutions. Across the included studies, faith leaders, community champions, culturally matched facilitators, Indigenous instructors, interpreters, schools, workplaces, refugee services, and community organisations were used to reduce social distance and increase credibility. This was particularly evident in programmes involving Hmong and Korean American church leaders, Arabic-speaking religious leaders, African and African Caribbean community champions, Muslim communities affected by the Grenfell Tower fire, and Black faith organisations (Vang-Kue et al., 2025; Yoo et al., 2026; Slewa-Younan et al., 2020; Mantovani et al., 2017; Hammad et al., 2020; Codjoe et al., 2023). In these interventions, trusted facilitators did more than deliver information: they legitimised discussion of mental

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health, translated professional concepts into culturally acceptable language, and linked participants with formal or community-based support.

Previous research on culturally adapted interventions provides similar evidence whereby reinforces the importance of cultural legitimacy and social infrastructure. Religious and spiritual beliefs can shape how distress is understood, where help is sought, and which forms of intervention are considered acceptable (Abe, 2013; Jerome et al., 2023; Haidar et al., 2023). The MeHPriC initiative in Lagos demonstrated that churches and mosques could serve as effective platforms for improving knowledge, reducing stigma, and strengthening referral behaviour when facilitators and materials were culturally and religiously congruent (Adewuya et al., 2026). Similarly, consultative workshops between psychiatrists and religious healers in Ethiopia showed that respectful engagement with spiritual explanatory models could strengthen collaboration between biomedical and traditional systems of care (Baheretibeb et al., 2022). Within the 21 studies, the Hmong and Korean American church-leader programmes improved knowledge, confidence, behavioural intentions, and referral planning, while Arabic-speaking leader programmes improved recognition, treatment knowledge, social distance, and professional help-seeking responses (Vang-Kue et al., 2025; Yoo et al., 2026; Slewa-Younan et al., 2020). These findings indicate that engagement was strengthened when interventions were embedded within trusted community relationships rather than delivered solely through unfamiliar clinical systems.

Delivery format also operated as an access mechanism, although cultural fit remained more important than technology alone. Most included studies used face-to-face delivery, while others employed virtual training, SMS, websites, digital storytelling, and animated video (Rushing et al., 2021; Yoo et al., 2026; Song et al., 2022; Bapolisi et al., 2026; Martinez et al., 2024; Wright et al., 2026). Digital formats offered flexibility, privacy, and broader geographical reach, but engagement still depended on language, digital literacy, usability, and cultural relevance. BRAVE used Indigenous strengths and resilience-oriented messages within an SMS format, while Bapolisi et al. (2026) used culturally resonant stories and characters to improve trauma knowledge and attitudes. Comparable evidence from the Sui app, Step-by-Step, and Hap-pas-Hapi demonstrates that participatory and culturally contextualised digital adaptation is more likely to support engagement than simple translation or technological access alone (Stoeckli et al., 2025; Sit et al., 2020; Shala et al., 2020). However, reliance on community gatekeepers or digital platforms also creates risks when referral pathways are weak, facilitators are insufficiently trained, or structural barriers remain unresolved. Future interventions should therefore evaluate not only reach and satisfaction, but also referral quality, service uptake, facilitator burden, digital exclusion, and the durability of partnerships between community and professional care systems.

Theme 3: Short-Term Effectiveness, Implementation Feasibility, and Uncertain Sustainability

The evidence across the 21 studies was strongest for immediate or short-term improvements in mental health knowledge, problem recognition, confidence, stigma-related attitudes, coping, and intended helping behaviour. Significant gains were reported following culturally adapted interventions for Hmong and Korean American church leaders, Arabic-speaking community leaders and refugees, Ghanaian participants, South African university staff, Indigenous communities, and users of digital or media-based interventions (Vang-Kue et al., 2025; Yoo et

al., 2026; Slewa-Younan et al., 2020; Duodu et al., 2026; Bantjes et al., 2026; Rushing et al., 2021; Bapolisi et al., 2026). Mental Health First Aid First Nations showed immediate improvements in knowledge, self-efficacy, stigma-related outcomes, and cultural acceptability (Crooks et al., 2018), while ON TRAC reported favourable changes in knowledge, prejudice, tolerance, disclosure, and help-seeking among Black faith communities (Codjoe et al., 2023). These results are consistent with related evidence showing that culturally adapted MHL interventions are generally effective in improving knowledge and attitudes in the short term, particularly when they address familiar barriers such as stigma, language, and culturally specific explanatory models (Adewuya et al., 2026; Lee et al., 2026).

However, changes in knowledge and attitudes did not consistently translate into sustained help-seeking, service use, or behavioural outcomes. Only a minority of studies assessed outcomes beyond the immediate post-intervention period, and maintenance of effects was inconsistent. Moreover, the limited number of participants retained at later assessments reduced confidence in determining whether observed benefits were sustained over time. In the German adaptation of The Working Mind, strong immediate improvements in MHL reduced to a medium and non-significant effect at six months, while stigma-related changes were limited (Stoll et al., 2026). The Arabic-speaking refugee intervention-maintained reductions in psychological distress, but most MHL outcomes showed little sustained change apart from stigma (Slewa-Younan et al., 2020). BRAVE improved health, resilience, coping, self-efficacy, and self-esteem but did not significantly improve overall help-seeking or cultural identity (Rushing et al., 2021). Similarly, ON TRAC reported positive mean changes based on a small pilot sample without long-term follow-up (Codjoe et al., 2023). The existing studies reports comparable uncertainty, as culturally adapted cognitive-behavioural and behavioural interventions may show stronger immediate outcomes than standard approaches, yet their durability varies across populations, contexts, and adaptation depth (Gkintoni & Nikolaou, 2026; Ramaiya et al., 2017; Ramos & Alegría, 2014).

Implementation feasibility and acceptability were reported more consistently than long-term effectiveness. Many interventions achieved favourable attendance, satisfaction, cultural relevance, or willingness to recommend the programme, particularly at immediate post-intervention assessment. However, retention often declined over time. For example, completion decreased from 87.8% at post-intervention to 75.6% at six weeks in the Hmong church-leader programme, from 90.8% at one month to 58.7% at four months in the culturally adapted Youth Mental Health First Aid trial, and from 79.7% immediately after training to approximately 63.6%–64.4% at six months in The Working Mind (Vang-Kue et al., 2025; Wang & Havewala, 2025; Stoll et al., 2026). Lower completion was also reported in the Korean American church-leader programme and T4W/Juntos (Yoo et al., 2026; Wright et al., 2026). These patterns suggest that sustained participation was influenced by repeated assessments, programme duration, and participant circumstances rather than delivery format alone. The evidence base was also limited by small samples, uncontrolled designs, brief follow-up, heterogeneous measures, and inconsistent reporting of adaptation fidelity. Future studies should therefore use longer follow-up periods, stronger comparative designs, behavioural and service-use outcomes, and clearer reporting of adaptation processes and stakeholder involvement.

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Conclusion

Culturally, religiously, and spiritually adapted mental health literacy interventions have become increasingly important for improving the relevance and accessibility of mental health education among diverse populations. The reviewed studies showed that most interventions adapted existing programmes through changes in language, examples, cultural beliefs, spiritual values, and local help-seeking practices rather than developing entirely new interventions. Their effectiveness was also influenced by trusted facilitators, faith leaders, community organisations, and culturally familiar settings, while digital delivery was useful only when it remained accessible and culturally appropriate. Overall, the interventions were effective in improving short-term mental health knowledge, confidence, stigma-related attitudes, and helping intentions. However, evidence for long-term help-seeking, service use, behavioural change, and sustained outcomes remains limited. Successful implementation therefore depends on meaningful cultural adaptation, community involvement, appropriate delivery methods, and strong links with formal mental health services. These interventions provide a useful framework for developing more inclusive and responsive mental health literacy programmes, but future research should examine their long-term effectiveness, sustainability, and impact on actual help-seeking behaviour.

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Appendices

Appendix 1: Details Of Included Studies

No	Authors, Year	Study Design	MHL Elements / Condition of Interest	The Intervention	Medium of Intervention	Geographical Location	Target Group
1	Vang-Kue, et al. (2025)	Quality-improvement pretest-posttest study with 6-week follow-up	Mental-health knowledge; stigma reduction; confidence; awareness; recognition and response skills	Mental Health First Aid (MHFA) for Hmong church leaders	Face-to-face training	Faith-based/church setting, Detroit, United States	Hmong adult church leaders recruited from three Detroit churches; Adults; Hmong American
2	Yoo, et al. (2026)	Mixed-method pre-post evaluation with fixed-effects panel regression	Mental-health knowledge; behavioural intentions/action; confidence; referral planning	Virtual MHL gatekeeper training for Korean American church leaders	Virtual/online	Korean American churches; online	Korean American church leaders from two cohorts; Adults; Korean American
3	Slewa-Younan, et al. (2020)	Uncontrolled pre-post study	PTSD recognition; treatment knowledge; stigma/social distance; professional help-seeking	Arabic culturally sensitive MHL training workshop	Face-to-face workshop in Arabic; PowerPoint, video and group discussion	Community/religious leadership, South Western Sydney, Australia	Arabic-speaking religious and community leaders; Adults; Arabic-speaking leaders serving refugee communities

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4	Duodu, et al (2026)	Participatory multi-method pre-post workshop evaluation	Dementia knowledge; caregiver understanding; attitudes; stigma reduction; community action	Dementia knowledge dissemination and co-creation workshop	Face-to-face participatory workshop	Participatory stakeholder workshop, Kumasi, Ghana	People living with dementia, carers, health professionals, policy actors, faith leaders and community advocates; Adults; Ghanaian stakeholders
5	Rushing, et al (2021)	Randomized controlled trial	Mental wellness; resilience; coping; self-efficacy; self-esteem; help-seeking	BRAVE	SMS text messaging with linked multimedia	Nationwide digital recruitment, United States	American Indian and Alaska Native teenagers and young adults; 15-24 years; American Indian and Alaska Native
6	Mantovani, et al (2017)	Qualitative participatory evaluation	Mental-health awareness; early recognition; stigma reduction; referral and community helping	Community and Well-being Champions pilot outreach intervention	Face-to-face training and community outreach	Faith and community organisations, South London	Community and well-being champions; Adults; African and African Caribbean
7	Hammad, et al (2020)	Mixed-method service evaluation of two pilot groups	Attitudes toward therapy; stigma; service engagement; coping; resilience; wellbeing	Hand of Hope	Face-to-face therapeutic group	Community/NHS post-disaster service, London	Bereaved British MENA Muslim women and families affected by Grenfell; Adults; British Middle Eastern and North African Muslim communities
8	Stoll et al (2026)	Quasi-experimental sequential explanatory mixed-methods study	Mental-health literacy; workplace stigma; resilience; openness and support-seeking	The Working Mind (TWM), German adaptation	Small-group face-to-face workshops	University workplace, Germany	University managers and employees; Adults; German university workforce

9	Song et al (2022)	Qualitative programme evaluation using thematic analysis	Mental-health education; stigma discussion; connectedness; resilience; early help-seeking	Compassionate Home, Action Together (CHATogether)	Virtual/digital; interactive theatre and storytelling	Virtual community programme, United States	AAPI teens, young adults, parents and mental-health professionals; Adolescents and adults; Asian American and Pacific Islander
10	Bantjes, et al (2026)	Mixed-method pre-post intervention evaluation	Psychological literacy; PFA knowledge; help-seeking attitudes; crisis response confidence	Psychological First Aid (PFA) course module	University course module; facilitated teaching	Medical school/university, South Africa	Medical students; University students; South African medical students
11	Bapolisi. et al (2026)	Community-based quasi-experimental pre-post pilot	Trauma recognition; knowledge; attitudes; empathy; help-seeking communication	Culturally adapted animated trauma-awareness video	Digital animated video	Community, South Kivu	Community members in South Kivu; Adults; Conflict-affected residents of eastern Democratic Republic of Congo
12	Martinez et al (2024)	Mixed-method non-randomized single-group pilot	Mental-health literacy; help-seeking attitudes and propensity; stigma discussion	Tara, Usap Tayo! (C'mon, Let's Talk)	Online group sessions	Community-based online programme, United Kingdom	Filipino migrant domestic workers in the UK; Adults; Filipino migrants
13	Crooks et al (2018)	Mixed-method feasibility trial	Recognition; knowledge; stigma reduction; self-efficacy; first-aid skills; community support	Mental Health First Aid First Nations (MHFAFN)	Face-to-face community training	10 community groups in First Nations and urban Indigenous	First Nations community members and facilitators; Adults; First Nations communities across four Canadian provinces

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						contexts, Canada	
14	Slewa-Younan et al (2020)	Uncontrolled pre-post-follow-up intervention trial	Mental-health literacy; stigma; help-seeking intentions; psychological distress	Culturally tailored Arabic-language mental-health promotion programme	Face-to-face group sessions delivered in Arabic	Community refugee mental-health promotion, Australia	Arabic-speaking refugees resettled in South Western Sydney; Adults; Arabic-speaking refugees
15	Wright et al (2026)	Pilot subanalysis with baseline and 4–6-week follow-up surveys	Psychoeducation; service/resource awareness; engagement; access to mental-health information	Together for Wellness/Juntos Por Nuestro Bienestar (T4W/Juntos)	Web-based, self-guided digital resource	Statewide digital mental-health prevention resource, California, United States	Latino/a/x adults with internet access who could use English or Spanish; Adults aged 18 years and older; Latino/a/x adults in California
16	Day et al(2021)	Mixed-method uncontrolled pre-post-follow-up evaluation	Recognition; knowledge; confidence; stigma; intended helping behaviour; cultural understanding	Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA), Version 3	Face-to-face community training	Community training, Australia	Adults attending 21 courses across two Australian states; Adults; Aboriginal and Torres Strait Islander participants and people working with these communities
17	Wang C.; Havewala M. (2025)	Blocked randomized waitlist-control trial	Mental-health literacy; stigma; professional help-seeking attitudes;	Culturally adapted Youth Mental Health First	Face-to-face one-day training	School/community parent training, United States	Asian American parents; Mean age 46.24 years (SD 6.80); Asian American

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			confidence; first-aid behaviour	Aid (YMHFA)			
18	Morse et al (2024)	Mixed qualitative and quantitative programme evaluation	Mental-health awareness; confidence; stigma reduction; community education; empowerment	My Mind, My Voice (MMMV)	Training workshops, story crafting, community events and presentations	Community mental-health promotion, Australian Capital Territory	CALD organisation/community members who attended training, presented or attended events; Adults; Culturally and linguistically diverse communities
19	Mansfield et al (2021)	Qualitative process evaluation within a feasibility study	Mental-health knowledge; stigma reduction; student empowerment; curriculum implementation	The Guide, adapted from Canada to England	Teacher-delivered classroom curriculum	Secondary schools in South East England	School staff responsible for planning/implementation; Adults; English school staff
20	Ekblad S. (2020)	Community case study; mixed-method participatory pre-post evaluation	Mental-health literacy; stress/anxiety management; empowerment; sense of coherence; human rights	Tailor-made group health-promotion intervention	Face-to-face small groups, lectures, discussion and interpreters	Five municipalities in Sweden; community health promotion	Arabic- or Somali-speaking newcomer mothers with war experience; Mean age 40 years; Arabic- and Somali-speaking newcomers in Sweden
21	Codjoe et al (2023)	Mixed-method pre-post pilot	Mental-health knowledge; stigma; social distance; disclosure; help-seeking; faith-community capacity	ON TRAC	Nine face-to-face sessions and one online session	Black faith communities/ community centre, South London	Black African and Black Caribbean faith-community members; 35-49: 4; 50-64: 10; 65+: 3; Black African and Black Caribbean

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Appendix 2: Integrated Coding of Cultural, Linguistic, Contextual, Community, and Religious or Spiritual Adaptations

No.	Author (Year)	Cultural or conceptual adaptation	Linguistic or literacy adaptation	Contextual adaptation	Formal co-production or co-design	Trusted community or culturally matched delivery	Religious or spiritual integration	Main adaptation and implementation features
1	Vang-Kue et al. (2025)	✓	—	✓	—	✓	✓	Addressed Hmong beliefs about mental illness, stigma, church-based support, and culturally relevant examples.
2	Yoo et al. (2026)	✓	✓	✓	—	✓	✓	Adapted for Korean American church leaders through culturally relevant terminology, congregation-based examples, and referral planning.

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3	Slewa-Younan et al. (2020)	✓	✓	✓	—	✓	✓	Used Arabic-language delivery, refugee-relevant vignettes, and the gatekeeping roles of religious and community leaders.
4	Duodu et al. (2026)	✓	—	—	✓	—	—	Used stakeholder consultation and co-creation involving carers, professionals, faith leaders, and community advocates.
5	Rushing et al. (2021)	✓	—	✓	—	✓	—	Incorporated Indigenous identity, Native role models, resilience, family values, and community support within an SMS intervention.
6	Mantovani et al. (2017)	✓	—	✓	✓	✓	✓	Co-produced with African and African Caribbean communities and delivered through community champions and faith organisations.
7	Hammad et al. (2020)	✓	✓	✓	✓	✓	✓	Combined Islamic meaning-making, Arabic and English delivery, trauma-informed content, and trusted Muslim community partnerships.

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8	Stoll et al. (2026)	✓	✓	✓	✓	—	—	Revised terminology, examples, and materials for the German university and workplace context through target-group input.
9	Song et al. (2022)	✓	—	✓	—	✓	—	Used culturally relevant storytelling to address Asian American family relationships, intergenerational conflict, identity, stigma, and racism.
10	Bantjes et al. (2026)	—	—	✓	—	—	—	Tailored Psychological First Aid training to the South African medical education and student-support environment.
11	Bapolisi et al. (2026)	✓	✓	✓	—	✓	—	Used simplified language, locally recognisable characters, conflict-related trauma experiences, and culturally relevant resilience messages.
12	Martinez et al. (2024)	✓	✓	✓	—	✓	—	Adapted language, communication style, migrant experiences, cultural beliefs, and help-seeking barriers for Filipino domestic workers.

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13	Crooks et al. (2018)	✓	✓	✓	—	✓	✓	Integrated Indigenous wellness, colonial history, spirituality, community support, and a culturally revised action plan.
14	Slewa-Younan et al. (2020), refugee programme	✓	✓	✓	—	✓	✓	Used Arabic-language delivery and adapted content to refugee trauma, displacement, stigma, religious beliefs, and service navigation.
15	Wright et al. (2026)	—	✓	✓	✓	✓	—	Co-designed multilingual resources with community organisations and addressed migration, language, and structural access barriers.
16	Day et al. (2021)	✓	—	✓	—	✓	✓	Incorporated Indigenous social and emotional wellbeing, colonisation, intergenerational trauma, cultural values, and Indigenous instructors.
17	Wang and Havewala (2025)	✓	—	✓	—	—	—	Included Asian parenting values, family expectations, migration, acculturation stress, and culturally familiar examples.

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18	Morse et al. (2024)	✓	✓	—	✓	✓	—	Used community co-design, culturally safe storytelling, language sensitivity, and lived-experience narratives.
19	Mansfield et al. (2021)	✓	✓	✓	—	—	—	Revised terminology, examples, references, and teaching activities for English school settings.
20	Ekblad (2020)	✓	✓	✓	—	—	—	Used interpreters, one-language groups, low-literacy materials, and content relevant to war-affected newcomer mothers.
21	Codjoe et al. (2023)	✓	—	✓	✓	✓	✓	Co-produced with Black faith communities and addressed spirituality, stigma, mistrust, discrimination, and referral pathways.
	Total, n (%)	19 (90.5%)	12 (57.1%)	19 (90.5%)	7 (33.3%)	15 (71.4%)	9 (42.9%)	

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Appendix 3: Effectiveness, Feasibility, Follow-Up, and Completion of Adapted MHL Interventions

No.	Author (Year)	Effectiveness evidence	Follow-up	Feasibility or acceptability	Completion or retention
1	Vang-Kue et al. (2025)	Significant improvement in MHL; mean increase of 11.03 points, $p < .001$; 91.7% improved	Six-week follow-up	Training was acceptable and relevant to Hmong community needs	41 attended training; 36 completed pre–post assessments (87.8%); 31 completed six-week follow-up (75.6%).
2	Yoo et al. (2026)	Significant improvements in knowledge, behavioural intentions, and confidence, all $p < .001$	Immediate post-training	Virtual delivery was feasible for Korean American church leaders	79 completed baseline; 48 completed post-training assessment (60.8%); 46 were included as complete cases (58.2%).
3	Slewa-Younan et al. (2020)	Significant improvements in recognition, medication knowledge, social distance, and professional help-seeking	Immediate post-workshop	Culturally and linguistically appropriate workshop was well accepted	52 (96.3%)
4	Duodu et al. (2026)	Significant improvements in dementia knowledge and attitudes	Immediate post-workshop	Co-creation workshop was feasible and positively received	71 participated pre-workshop; 69 participated in focus-group discussions; 22 contributed complete quantitative cases. Clarify which denominator was used for the effectiveness analysis.

5	Rushing et al. (2021)	Significant improvements in health, resilience, coping, self-efficacy, and self-esteem; no overall improvement in help-seeking or cultural identity	Repeated follow-up included	SMS delivery supported flexible participation	1,044 enrolled; 833 included in analysis (79.8%).
6	Mantovani et al. (2017)	Mainly qualitative evidence of improved knowledge, relationships, and referral activity	Process evaluation	Community champion model was acceptable, although some champions felt underprepared	13 community champions participated in interviews; this represents qualitative participation rather than intervention retention.
7	Hammad et al. (2020)	Mainly qualitative and service-evaluation evidence	Not clearly reported	Strong acceptability through culturally and religiously congruent delivery	Group 1: 20 individuals (100%); 10 complete cases; 7 focus group; 3 verbal feedback Group 2: 6 complete cases; 5 focus group; 1 verbal feedback
8	Stoll et al. (2026)	Large immediate improvement in MHL; effects reduced and became non-significant at six months	Six months	Programme was implementable in the university workplace context	T1: 118 participants; 69 intervention; 49 control. T2: 94 complete surveys; 52 intervention; 42 control. T3: 75 complete surveys; 39 intervention; 37 control.

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9	Song et al. (2022)	Mainly qualitative evidence concerning engagement and family dialogue	Not clearly reported	Digital storytelling was considered culturally relevant and acceptable	20 participants in the programme; 17 participated in the focus group (85.0%).
10	Bantjes et al. (2026)	Significant improvements in PFA knowledge, attitudes, help-seeking, and confidence; some outcomes were non-significant	Immediate post-training	Training was feasible within the medical education setting	285 invited; 166 completed pre–post assessments (58.2%).
11	Bapolisi et al. (2026)	Significant improvements in trauma perceptions, knowledge, and attitudes	Immediate post-intervention	Animated storytelling achieved high reported empathy and willingness to share	239 participants completed the immediate pre–post evaluation.
12	Martinez et al. (2024)	Improvements in MHL and help-seeking-related outcomes were reported	Immediate post-programme	Programme was highly acceptable to Filipino migrant domestic workers	21 complete cases, approximately 97%; 21 also participated in the focus group.
13	Crooks et al. (2018)	Immediate improvements in knowledge, self-efficacy, and stigma-related outcomes	Short-term assessment	Strong cultural acceptability and positive participant feedback	91 survey participants, 89 participant interviews, nine facilitator interviews, and 24 implementation surveys. These are different data sources, not a single completion rate.
14	Slewa-Younan et al. (2020)	Stigma and psychological distress improved; several	Follow-up included	Arabic-language delivery was acceptable to refugee participants	33 completed the intervention; 31 completed post-test (93.9%); 29

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		MHL outcomes were non-significant			completed three-month follow-up (87.9%).
15	Wright et al. (2026)	Comfort, perceived relevance, and resource use were associated with language and user experience	Follow-up included	Multilingual digital resources were usable, although engagement differed by language preference	131 at baseline; 68 completed follow-up (51.9%).
16	Day et al. (2021)	Preliminary positive outcomes and strong acceptability	Immediate or short-term assessment	69.0% rated it organised, 70.9% well prepared, 70.3% reported learning, and 79.5% would recommend it	Measure-specific paired samples up to 223; avoid describing 98.6% feeling safe as a completion rate because it is an acceptability outcome.
17	Wang and Havewala (2025)	Significant improvements in MHL, stigma, help-seeking attitudes, confidence, and first-aid behaviour	Four-month follow-up	Culturally adapted YMHFA was feasible and acceptable	T1: 109; T2: 99 (90.8%); T3: 64 (58.7%).
18	Morse et al. (2024)	Mainly qualitative and process evidence	Not clearly reported	Community co-design supported cultural safety and acceptability	32 survey respondents and nine interview participants.
19	Mansfield et al. (2021)	Mainly process and implementation evidence; limited evidence of student-level effectiveness	Not clearly reported	Adaptation was feasible within English school settings	11 staff members across three schools participated in the process evaluation. The current T3 data copied from Wang and Havewala must be removed.

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20	Ekblad (2020)	Stress and anxiety decreased from 56% to 42%; self-rated health improved from 52% to 68%, $p < .001$	Follow-up included	Tailored language groups and interpreters supported participation	51
21	Codjoe et al. (2023)	Positive changes in knowledge, prejudice, tolerance, disclosure, and help-seeking scores	Immediate post-intervention	Pilot intervention was feasible and acceptable in Black faith communities	17 participated in the pilot; 11 had paired pre–post data. The completion rate for paired analysis was therefore 64.7%.