Moving from ‘Complexity’ to Recognizing ‘Humanity’: Exploring the Mental Health Needs of Refugees and Asylum Seekers Through a Recovery Framework

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Portfolio Abstract

Forced migration is a growing global crisis that profoundly impacts the mental health of refugees and asylum seekers (RAS). Many face pre-migration trauma, post-migration stress, and structural barriers that contribute to increased rates of mental health conditions such as post-traumatic stress disorder (PTSD), depression, and anxiety. Despite their heightened vulnerability, RAS populations often experience significant obstacles in accessing appropriate and culturally responsive mental health care. Understanding the psychological needs and experiences of RAS through a recovery framework is essential in addressing these challenges and informing mental health service provision.

This thesis portfolio explores the mental health needs of RAS populations through two interconnected research pieces. The first is a systematic review that synthesizes qualitative research to examine how mental health literacy influences help-seeking behaviours among RAS, providing a theoretical model that highlights key barriers such as cultural perceptions of mental health, social stigma, limited-service awareness, and mistrust of healthcare systems.

The second component is an empirical study that qualitatively explores the meaning of recovery for RAS from the perspectives of healthcare and mental health professionals who support them. The study highlights the necessity of integrating social determinants, trauma-informed care, and culturally responsive approaches into recovery frameworks to better support the mental health of RAS populations.

Collectively, these two research components contribute novel insights into the mental health needs and recovery journeys of RAS. The findings underscore the importance of culturally competent interventions, trust-building in mental healthcare provision, and the need for a more inclusive recovery framework that acknowledges the systemic and contextual factors shaping RAS mental health experiences. This thesis portfolio offers valuable implications for clinical

practice, policy development, and future research, advocating for a paradigm shift from viewing RAS through a lens of complexity to recognizing their resilience and humanity.

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To all the professionals who took part in this project and shared their reflections- thank you for all your work towards making healthcare a more compassionate space and for practicing with humility and humanity. Thank you for trusting me to turn your reflections into this project.

Thank you to my mother and father, who have been steadfast in their support of me and my career and who have watched me grow from the young girl who loved psychology, to now, a Clinical Psychologist. No matter the distance and where we are in the world, know that you are forever in my heart, and I am in yours.

To my partner, Ryad, thank you for being my anchor. Your patience, your humor and your reminders helped me ride the ebbs and flows of this project through video calls and encouraging messages. Distance may have been between us, but you have been the closest person throughout this doctorate.

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Chapter One: Introduction to Thesis Portfolio

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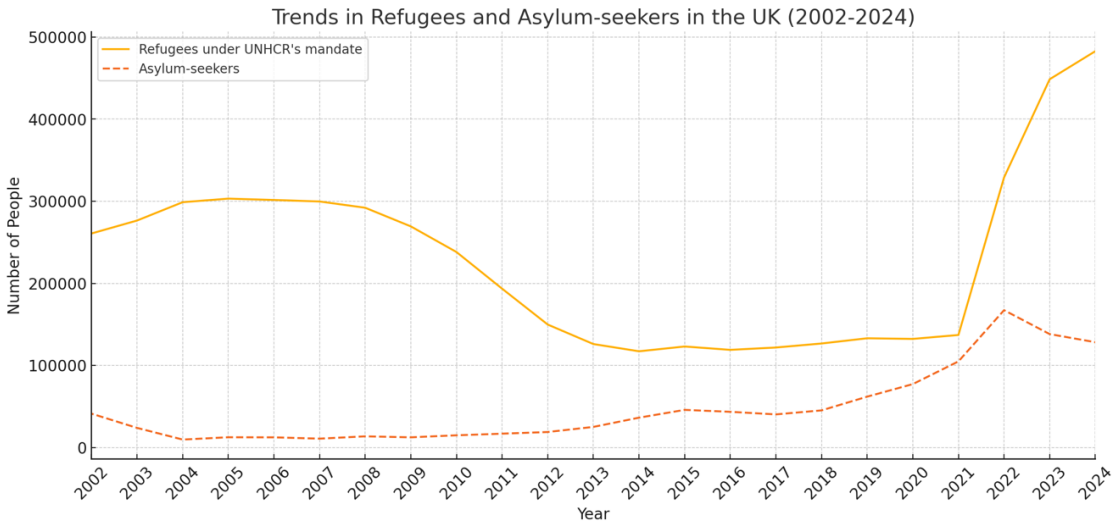
Forced migration has emerged as a significant global crisis, reshaping demographics and placing immense pressure on international humanitarian systems (United Nations High Commissioner for Refugees (UNCHR), 2024a). By mid 2024, the number of forcibly displaced individuals worldwide reached 122.6 million, an increase of 5.3 million from the previous year, reflecting a 12-year trend of rising displacement (UNHCR, 2024a). As of September 2023, the United Kingdom had approximately 175,457 individuals awaiting an initial decision on their asylum applications, representing a 44% increase from the previous year and the highest number recorded since 2010 (UK Government, 2023).

Refugees are individuals who have 'a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion' and as a result have been forced to flee their countries and cross borders (UNHCR, 1951). Asylum seekers are individuals who have arrived in a host country, but who have not yet had their requests for sanctuary processed by the host country (UNHCR, 2023a). In the UK, asylum seekers and refugees are distinguished based on their legal resettlement status, with asylum seekers unable to work while waiting for their claims. Asylum seekers granted refugee status can work, access welfare, and live in the UK (UNHCR, 2023b). This represents a substantial part of the growing global crisis, where forced migration due to persecution, conflict, and human rights violations has reached unprecedented levels with a trend of increasing asylum-seeking and refugee rates in the UK (Figure 1).

Figure 1.

Trend of Refugees and Asylum-Seekers in the UK (Created From Data From UNHCR, 2024b).



The Impact of Forced Migration on Refugee and Asylum Seeker Mental Health

Forced migration is not only a global crisis affecting demographics and political landscapes but also a profound challenge to the mental health of displaced populations. Refugees and asylum seekers (RAS) often face a multitude of stressors across three distinct stages: 1) pre-migration 2) displacement-related stressors 3) post-migration (Fazel & Stein, 2002; Colucci et al., 2015). Asylum seekers entering the UK experience various challenges in their asylum process, with ongoing backlogs of asylum-seeking applications that can sometimes take years to process. These backlogs leave asylum seekers in extended periods of uncertainty around their futures, with their lives "put on hold" until their applications are processed amid fears of being sent back to their home country (Phillimore & Cheung, 2021). Additionally, consistent research has shown that refugees experience higher prevalence rates of mental health problems, including post-traumatic stress disorder, anxiety, and depression when compared to Western and non-refugee migrant populations (Fazel et al., 2005; Steel et al., 2009; Schick et al., 2016). For

example, rates of PTSD among refugee populations are four to ten times greater than in the general population (Silove et al., 2017). Additionally, the experiences that refugees and asylum seekers face upon arriving in their host countries can lead to significant stressors. These stressors include the length of the asylum procedure, insecure visa status, detention in refugee camps, and prohibition from work (Phillimore & Cheung, 2021). Even after securing their visa status, refugees continue to be confronted with social challenges related to communication difficulties, financial austerity, poor accommodation, and inability to secure work. Additionally, experiences of discrimination in the host country and political attitudes towards refugees and asylum seekers all impact psychological distress and the worsening or incidence of mental health disorders (Schick et al., 2016). This indicates that refugee and asylum seeker mental health outcomes are influenced by their social and economic environment, as much as their adverse life experiences.

The Social Determinants of Mental Health (SDMH) model outlines that physical and mental health are determined by both biological and social factors (Compton & Shim, 2015). This model emphasizes that individuals with less access to power, safe environments, appropriate housing, healthcare, employment and resources are at a higher risk for developing mental health disorders (Compton & Shim, 2015). Refugees and asylum seekers (RAS) experience diminished social standing which led to prolonged low socioeconomic status, uncertainty, social isolation, and increasingly poor mental health (Hynie, 2018). These social determinants of health, combined with prior traumatic experiences, have a significant impact on RAS mental health (Hynie, 2018; Phillimore & Cheung, 2021). There are also increasing pressures and obligations for this population to socially integrate into their host society. However, this process of social integration requires a high level of cognitive and interpersonal functioning and agency that RAS with psychological impairments are often unable to achieve

(Schick et al., 2016; Giacco, Laxhman, & Priebe, 2018). The combination of pre-migration and displacement experiences and post-migration social determinants of mental health highlights the need for a more holistic understanding of supporting the mental well-being of RAS within host countries.

Barriers to Appropriate Mental Health Provision for RAS

While there is recognition of the heightened vulnerability of these populations to mental health issues, access to effective and culturally appropriate mental health interventions are often limited (Colucci et al., 2015). The provision of mental health interventions for refugees and asylum seekers is a complex and multifaceted process due to various interrelated factors. Refugees and asylum seekers come from diverse backgrounds and have experienced different traumas, including violence, persecution, and displacement, leading to varied mental health needs that make a one-size-fits-all approach ineffective (Bansal et al., 2022; Silove et al., 2017). For example, a systematic review looking at ethnic inequalities in accessing mental health services (Bansal et al., 2022) revealed that mental health services frequently overlooked the impact of racism, migration-related stress, and complex trauma on individuals' mental well-being. Cultural differences further complicate the delivery of mental health care, as beliefs about mental health such as causation, influence how refugees and asylum seekers perceive and engage with treatment (Kirmayer et al., 2011). Access to mental health services is also hindered by significant barriers, including language difficulties, lack of culturally competent care, social and internalised stigma surrounding mental health, and limited knowledge of available services (Andrade et al., 2014). Additionally, policy and legal challenges play a role; for instance, the legal status of asylum seekers can restrict access to mental health services, as some host countries may have policies that limit healthcare coverage or prioritize basic needs such as housing provision over psychological care (Phillimore & Cheung, 2021).

Current mental health interventions for RAS are typically designed to address trauma-related conditions such as PTSD, depression, and anxiety. In a systematic review by Turrini and colleagues (2025), it was found that various psychosocial interventions for refugees and asylum seekers showed effectiveness over treatment as usual (TAU) in reducing PTSD, depression, and anxiety symptoms. However, confidence in these findings were low due to methodological differences across studies, substantial heterogeneity, and high risk of bias in several studies. Finally, majority of interventions often focus heavily on pre-migration trauma without sufficiently accounting for post-migration stressors such as lengthy asylum processes, insecure legal status, and socio-economic instability (Schick et al., 2016).

The Link Between Mental Health Literacy and Help Seeking Behaviours

In the United Kingdom, RAS can register with a general practice and have the same rights towards accessing National Healthcare Scheme (NHS) services as the general UK population (Century, Leavey, & Payne, 2007). The documented poor mental health of RAS indicates a need to access appropriate specialized mental health care and services (Royal College of Psychiatrists, 2025). However, refugees display low mental health early help-seeking behaviours which can hamper the delivery of preventative or early intervention mental health care (Byrow et al., 2020). It has also been shown that RAS are more likely to present to primary care for concerns around somatization and are more open to physical than mental healthcare interventions (Due et al., 2020). Despite these known trends, there are limited explorations of factors influencing post-migration help-seeking behaviour within host countries (Kirmayer et al., 2011; Schick et al., 2016). One factor hypothesised to influence help-seeking behaviours is mental health literacy, which encompasses an individual's knowledge and beliefs about mental disorders that aid in recognition, management, and prevention (Jorm, 2000). Mental health literacy includes the ability to identify mental health conditions, knowledge about available

treatment options, and attitudes that promote help-seeking behaviour. Research indicates that higher levels of mental health literacy are associated with increased likelihood of seeking professional help and more positive treatment outcomes (Gulliver et al., 2010). Additionally, low mental health literacy can contribute to delays in seeking help, increased psychological distress, and poorer mental health outcomes for refugees and asylum seekers (Gulliver et al., 2010; Colucci et al., 2015). However, little work has been undertaken to understand how health literacy can influence mental health help-seeking behaviours in refugees and asylum seekers. Understanding how mental health literacy impacts help-seeking behaviour in RAS is crucial for developing effective interventions and enhancing access to mental health services (Colucci et al., 2015).

Introducing Personal Recovery

Research indicates that mental health interventions are most effective when they incorporate psychosocial support elements alongside clinical treatments to support both clinical and personal recovery goals from mental ill-health (Silove et al., 2017). Personal recovery is defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles' to live a meaningful and satisfying life despite the limitations brought on by illness or difficult life circumstances (Leamy et al., 2011). Unlike traditional clinical models that focus solely on symptom reduction, the recovery model emphasizes the broader social and personal aspects of well-being, resilience, and social integration (Davidson et al., 2005) and therefore may be a useful lens in which to view refugee and asylum seeker mental health care. One of the prominent theoretical recovery frameworks used in the UK is the CHIME model, which identifies five core components of recovery: Connectedness, Hope and optimism, Identity, Meaning, and Empowerment (Leamy et al., 2011). However, most research examining the recovery framework in mental health has been conducted in Western and English-speaking

populations only (Slade et al, 2012), meaning that recovery services in host countries for RAS, such as the UK, are based on western understanding and conceptualisation of mental health care and personal recovery principles. To date, there has been no research examining the meaning of mental health recovery from the perspectives of refugees and asylum seekers and exploring if RAS, or professionals working with RAS, view personal recovery differently to the current accepted definition and framework. Understanding these perspectives will be essential to UK clinical psychologists and mental health services that support refugees and asylum seekers with their mental health recovery.

Summary of Thesis Portfolio

In order to bridge the gaps in research understanding the unique mental health needs of RAS, this Thesis Portfolio presents two core pieces of work. The first piece is a narrative synthesis review that explores published literature to examine how the mental health literacy of RAS impact on their mental health help seeking behaviours and provides a proposed theoretical framework. The second piece is an empirical study looking at the meaning of personal recovery for RAS from the perspectives of the health and mental health professionals supporting them. Collectively, these two pieces of work will provide greater insight into the psychosocial processes that inform the mental health help seeking behaviours of this population, and a greater understanding into their personal narratives of mental health recovery through the professionals from whom they are seeking help. The insights from this work will help inform the development of future care approaches and psychological interventions for this population, and broader health practice and policy.

Chapter Two: Systematic Review

Understanding the Impact of Mental Health Literacy on Mental Health Help-Seeking Behaviour in Adult Forced Migrants: A Narrative Synthesis Review

Word count (excluding abstract & references): 8,595

Systematic review prepared for submission to Clinical Psychology Review

Author guidelines can be found in Appendix A

Understanding the Impact of Mental Health Literacy on Mental Health Help-Seeking Behaviour in Adult Forced Migrants: A Narrative Synthesis Review

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Abstract

Background. Forced migration due to conflict, persecution, and instability has led to significant mental health challenges among refugees and asylum seekers. Despite high prevalence rates of mental health difficulties in this population, help-seeking behaviours (HSBs) remain disproportionately low. Mental health literacy (MHL) is a key determinant of HSBs. This systematic review explores how MHL influences HSBs among adult forced migrants.

Methods. A systematic review of qualitative studies was conducted, guided by PRISMA methodology. Six electronic databases (PubMed, MEDLINE, PsycINFO, Scopus, Web of Science, and CINAHL) were searched using predefined eligibility criteria. Studies were included if they qualitatively explored mental health literacy and help-seeking in adult forced migrants. A total of 24 studies met the inclusion criteria. Narrative synthesis was used to identify common themes across studies, following the three stages outlined by Popay et al. (2006). Methodological quality was assessed using the Hawker et al. (2002) critical appraisal tool.

Findings. Key findings indicate that cultural interpretations of mental illness significantly shape MHL and HSBs. Religious and community-based support systems play a dominant role in mental health management, often serving as the first line of intervention. Barriers to help-seeking include limited awareness of mental health services, mistrust in healthcare systems, language difficulties, and concerns about confidentiality.

Conclusion. The findings highlight the complex and contextually shaped relationship between mental health literacy, cultural identity, and structural access to care. Interventions aiming to improve mental health outcomes in forced migrant populations must address these barriers

through culturally sensitive approaches, strengthened community collaboration, and improved accessibility of mental health information and services.

Keywords: forced migrant, narrative synthesis, mental health literacy, help seeking behaviors

1. Introduction

According to the United Nations High Commissioner for Refugees (UNHCR) CR (2022), 108.4 million people globally were forcibly displaced due to persecution, conflict, violence, human rights violations, and events seriously disturbing public order by 2022. Compared to the 2021 UHCR statistics, this represented an increase of 19 million people, which is the largest ever increase recorded within a single year (UHCR, 2022). While around 58% of these forcibly displaced individuals represent internally displaced persons, there remains 42% of individuals who are currently living as refugees and asylum seekers in host countries to escape violence and persecution, and are often termed 'forced migrants' (UHCR, 2022). There continues to be a trend of increased forced migration globally due to ongoing and new conflicts around the world. The experience of forced displacement can have profound impacts on individuals' psychological well-being, contributing to a range of mental health challenges (Colucci et al., 2015; Fazel & Stein, 2002).

Adult forced migrants are a particularly vulnerable group facing numerous challenges that can impact their mental health, such as exposure to trauma, displacement, language barriers, and socio-economic instability (Porter & Haslam, 2005). Research has consistently indicated that refugees experience higher prevalence rates of mental health problems, including post-traumatic stress disorder, anxiety, and depression when compared to Western and non-refugee migrant populations (Schick et al., 2016). However, research also shows that while these populations

experience high rates of mental health disorders, their rates of accessing mental health services through voluntary help-seeking remain disproportionately low (Fazel et al., 2005).

Rickwood et al. (2005) describe help-seeking behaviour (HSB) as a process involving firstly problem recognition, the decision to seek help, selecting a source of help, and finally expressing the need for support. Research has shown that barriers to appropriate and timely help-seeking to mental health care through this process include stigma, lack of awareness of where to seek mental health support, cultural beliefs relating to mental health, and limited availability of services, especially in marginalized or underserved populations (Andrade et al., 2014; Corrigan, 2004). These barriers can be particularly pronounced in adult populations where issues such as levels of mental health literacy, fear of judgment, mistrust of healthcare systems, and cultural norms further limit timely engagement with mental health services (Gonzalez et al., 2011; Henderson et al., 2013). The Cultural Determinants of Help-Seeking (CDHS) model (Saint Arnault, 2009) expands on these challenges by conceptualizing help-seeking as an embedded cultural process, where individual distress, the recognition of mental health needs, and subsequent help-seeking behaviours are deeply influenced by cultural norms, social expectations, and structural factors. This model posits that help-seeking is not just a personal decision but is shaped by cultural scripts, social obligations, and the structural accessibility of mental health services. Understanding the factors that influence the help-seeking behaviour of forced migrants, with a focus on mental health literacy, can therefore inform strategies to improve access to care and reduce mental health disparities (Clement et al., 2015; Mohr et al., 2010).

Mental health literacy (MHL) is proposed to be one of the key aspects of help-seeking and psychological health (Sequeira et al., 2022). It is defined as ‘knowledge and beliefs about mental health disorders which aid their recognition, management and prevention' (Jorm et al.,

1997). It is comprised of six components: 1) the ability to recognize different mental health disorders, 2) the knowledge and beliefs around different risk factors and causes of mental health disorders, 3) the knowledge and beliefs around different self-help interventions, 4) the knowledge and beliefs around different avenues of professional help that is available, 5) the attitudes which lead to identification of poor mental health and appropriate help-seeking, and 6) the knowledge of how to seek mental health information (Jorm, 2002). Improving mental health literacy can enable individuals to identify mental health issues early, reduce stigma, and navigate pathways to effective care (Kutcher et al., 2016).

Studies have shown that higher levels of mental health literacy are associated with increased help-seeking intentions and behaviours, particularly through better symptom recognition, knowledge of available services, and positive attitudes toward treatment efficacy (Coles & Coleman, 2010; Reavely & Jorm, 2012; Yap, Wright, & Jorm, 2011). However, these findings have not been systematically reviewed and synthesized for adult forced migrant populations. The systematic review aims to address this gap by deductively synthesizing findings from multiple studies using Jorm's mental health literacy framework (2002) and narrative synthesis.

2. Methodology

2.1. Protocol and Registration

The protocol for this systematic review was registered with PROSPERO on 25th April 2024 (CRD42024520820) [crd.york.ac.uk/PROSPERO/display_record.php?RecordID=520820].

2.2. Design

This systematic review focused on peer-reviewed journal articles that explore the relationship between MHL and HSBs of adult forced migrants through qualitative methods and analysis. Studies were included if they included at least one component of Jorm's framework in addition to exploring help seeking behaviour (Jorm, 2002). The review aimed to qualitatively understand how the MHL of adult forced migrants could be impacting on their mental HSB using Jorm's MHL framework (2002).

Review Process. The articles were retrieved from the following databases: PubMed, MEDLINE, PsycINFO, Scopus, Web of Science, and CINAHL and a full search was conducted on 22nd April 2024. Search terms were identified following a preliminary search on the current literature on adult forced migrants, mental health literacy, and help-seeking behaviours. Final search terms included terms used to describe forced migrants i.e. refugee, asylum seeker, terms to describe mental health literacy, and terms to describe help-seeking behaviours. Only papers written in English were included in the search. Boolean operators 'and' and 'or', wildcards, and truncation symbols '*', were adapted for different databases and used to maximise search results. The full search strategy can be found in Table 1.

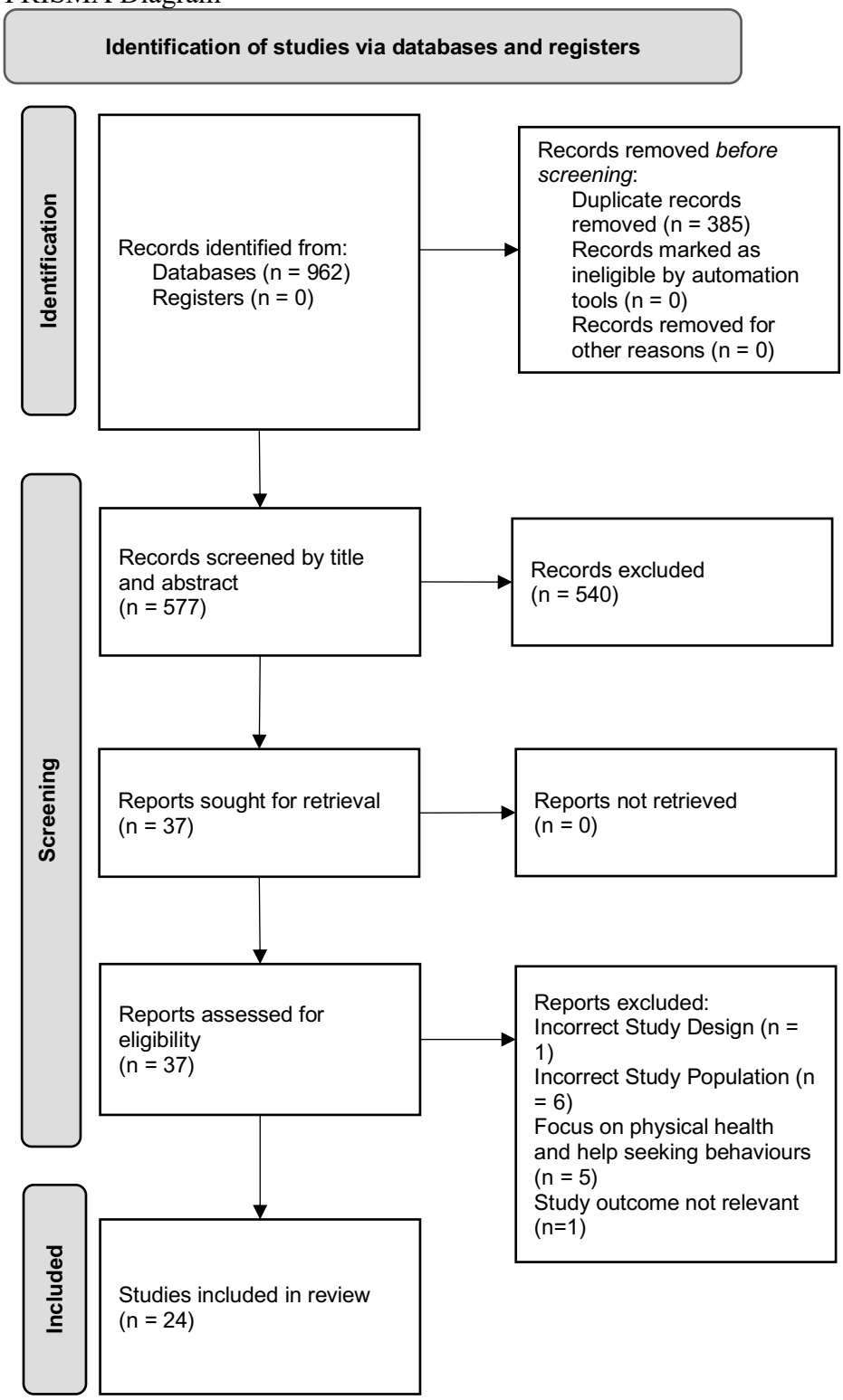
Table 1.
Search Strategy

"Mental Disorder" OR "Mental health" OR "Mental Illness"
AND Literacy OR Know* OR Attitude* or Belief*
AND Refugee* or Asylum seeker* or Forced Migrant* or Displaced Person*
AND Help Seeking or Treatment Seeking or Service Utilization

Search results and screening decisions were documented within a PRISMA diagram (PRISMA, 2020) (Figure 1) and Rayaan was used to remove duplicated papers. All papers were screened against the eligibility criteria (Appendix B).

Critical Appraisal. All included papers were appraised using the Hawker et al. (2002) critical appraisal tool. This tool contains nine questions, each of which can be answered 'good', 'fair', 'poor' or 'very poor'. The tool assesses the following characteristics: abstract and title, introduction and aims, method and data, sampling, data analysis, ethics and bias, results, transferability or generalizability, and implications and usefulness. This tool was chosen due to its versatility in being able to systematically assess papers from across different groups, settings and methodological approaches. To ensure a thorough and consistent quality assessment, both researchers (LO and BT) assessed the quality of the studies using the above tool, and any discrepancies were resolved jointly through supervisory meetings. The final quality assessment for the articles can be found in Appendix C and a copy of the appraisal tool can be found in Appendix D.

Figure 1.
PRISMA Diagram



2.3. Data Extraction and Synthesis

Study characteristics such as the authors, year of study, country of study, methodology, study aims, key findings were extracted by LO. These were then inputted into a table which can be found in Appendix E.

Based on the aim of this systematic review and the eligibility criteria of the studies, a narrative synthesis approach was taken. Narrative synthesis is a qualitative synthesis methodology that involves organizing and summarizing findings from multiple studies in a narrative format. This approach aims to provide a coherent and comprehensive account of the data, often focusing on identifying themes, dimensions, and types within the collected narratives (Llewellyn-Beardsley et al., 2019). While narrative synthesis can utilize the manipulation of statistical data, the main approach is textual in nature which 'tells the story' of findings from included studies (Popay et al., 2006). This synthesis followed the three core stages recommended by Popay et al. (2006): developing a preliminary synthesis, exploring relationships in the data, and assessing the robustness of the synthesis.

The first stage of the narrative synthesis involved developing a preliminary synthesis by systematically organizing the extracted findings using a standardized form. Key themes, participant quotes, and author interpretations were extracted from each study. A thematic grouping approach was used, clustering together studies with similar findings to identify common themes.

Following this, the second stage of the synthesis focused on exploring relationships between the themes across different studies. Line-by-line coding of the qualitative findings was conducted to systematically identify recurrent patterns, which were then grouped into broader thematic categories. Throughout this process, regular supervisory meetings were held between

LO and BT. BT contributed by reviewing coded data and guiding the iterative development and refinement of themes. These discussions helped ensure that the analysis remained grounded in the original data while minimising researcher bias and encouraging reflexivity in theme development. The final themes were continuously cross-referenced with the original study findings to maintain alignment and coherence.

The third and final stage of the synthesis involved assessing the robustness of the findings to ensure methodological transparency and validity. The process was documented systematically, and the findings were considered alongside the quality appraisal results from the Hawker et al. (2002) tool, which allowed for an evaluation of each study's methodological rigor. The final themes were then identified and aligned onto Jorm's (2002) MHL framework (Table 4) and then visualized in a provisional model (Figure 2).

3. Results

24 articles were included in this systemic review, and a full summary of the study characteristics can be found in Appendix E.

While most of the studies were qualitative in nature (n=22), some studies employed mixed methods in their research (n=2). For these studies, only the qualitative methods and results were extracted and summarized. The studies were conducted in different countries including the United States of America (n=7), Australia (n=6), the United Kingdom (n=3), Germany (n=2), Canada (n=1), Netherlands (n=1), Switzerland (n=1), Lebanon (n=1), and Jordan (n=1). One study was conducted in multiple sites across Italy, Bangladesh, and Kenya. The synthesis represented the views of 781 refugees and 137 asylum seekers.

It is important to note that while all studies reflected the voices and perspectives of refugees and asylum seekers from many backgrounds, three studies also reported on the

perspectives of other populations (such as informants, community leaders, and service providers) (Al Laham et al., 2020; Bawadi et al., 2022; Chynoweth et al., 2020).

Due to the focus of the systematic review on the impact of mental health literacy on mental health HSBs, narrative synthesis was used to identify themes of mental health literacy that occurred throughout the paper and understanding how they impact on HSBs and what HSBs look like within this population. Table 4 showcases how each theme identified in this review aligns with the components of mental health literacy identified by Jorm (2002).

Table 4.
Themes and Links to Mental Health Literacy Components.

Theme	**Component of Mental Health Literacy (Jorm, 2002)**
Fears of Ostracization - Cultural Perceptions and Interpretations of Mental Health	Attitudes and Help-Seeking
Spiritual and Social Causes of Poor Mental Health	Knowledge and Beliefs of Causes of Mental Ill-Health
Different Countries, Different Systems Knowledge of Where to Seek Mental Health Treatment	Knowledge and Beliefs of Professional Help; Mental Health Information
Everyday Problems: Recognition of Poor Mental Health	Recognition of Mental Health Problems
The Role of Faith and Family in Help Seeking Behaviours	Knowledge and Beliefs of Self-Help Interventions; Attitudes and Help-Seeking
Fear & Mistrust of Professional Support Systems	Knowledge and Beliefs of Professional Help

3.1. Theme 1: Fears of Ostracization - Cultural Perceptions and Interpretations of Mental Health

Mental Health is for "Crazy People". 15 out of the 24 studies reviewed highlighted participants' understanding of mental health as being linked to significantly pathological states alongside the continual labelling of mental ill-health as being for "crazy people", with an emphasis that someone with poor mental health was violent, destructive, and a danger to others (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Bettmann et al., 2015; Burford-Rice et al., 2022; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2019; Omar et al., 2017; Rae, 2016; Saberi et al., 2021; Shannon et al., 2015; Teunissen et al., 2014; Tonui, 2022; Valibhoy et al., 2017). In one study, this perception was held even by participants who had accessed mental health services themselves (Al Laham et al., 2020).

"If the Somali community knows that you have got a mental health problem (…) they will label you… 'mad person' … 'waali', there's no word between sane or insane." (Somali Male Refugee; Rae, 2016)

"When somebody is mentally ill, I imagine that he is offensive, he is always an ill-tempered person, he cannot communicate" (Eritrean Male Asylum Seeker; Melamed et al., 2019)

Talking About Your Mental Health Is Unhelpful. 14 out of the 24 studies in this review highlighted the view held by participants that talking about their mental health was unhelpful. Unhelpfulness was framed as being a result of two factors: talking about mental health makes them feel worse, and talking about mental health does not lead to any changes (Al Laham et al., 2020; Bettman et al., 2015; Chynoweth et al., 2020; Copolov & Knowles, 2023; Karakas

& du Plooy, 2024; Lechner-Meichsner & Comtesse, 2022; Omar et al., 2017; Quinn, 2014; Rae, 2016; Saberi et al., 2021; Shannon et al., 2015; Soukenik et al., 2017; Teunissen et al., 2014; Valibhoy et al., 2017).

7 out of 24 studies reviewed highlighted the belief held by participants that talking about their mental health would only exacerbate their symptoms and make them worse (Copolov & Knowles, 2023; Karakas & du Plooy, 2024; Omar et al., 2017; Saberi et al., 2021; Shannon et al., 2015; Teunissen et al., 2014; Valibhoy et al., 2017). This belief was held amongst different cultural groups including but not limited to Hazara, Somali, Karen and Oromo refugees.

"Going to psychologists, they are afraid they will ask them very personal questions, about their past which might make them sad. They want to forget everything from the past." (Female Hazara [An ethnic sub-group of Afghanistan] Refugee; Saberi et al., 2021).

7 out of the 24 studies reviewed emphasized that the perception by participants that therapy and mental health services would not lead to any changes in their wellbeing (Al Laham et al., 2020; Copolov & Knowles, 2023; Lechner-Meichsner & Comtesse, 2022; Omar et al., 2017; Shannon et al., 2015; Soukenik et al., 2017; Valibhoy et al., 2017). Six studies highlighted that within this perception was a belief that mental health services were not culturally relevant and felt that professionals were misattributing their symptoms or not appropriately supporting individuals as a result of this (Al Laham et al., 2020; Copolov & Knowles, 2023; Lechner-Meichsner & Comtesse, 2022; Soukenik et al., 2022; Valibhoy et al., 2017; Whittaker et al., 2005).

"I am a bit uncertain regarding these psychologists… For me, the psychologist needs to be familiar with the person's culture, the culture they grew up in, with the traditions regarding grief, and with their life and reality in Germany… when they only know from books, when they

read something or learned something at university, I think it will be the wrong way." (Male Sub-Saharan African Refugee; Lechner-Meichsner & Comtesse, 2022)

"Mental Health" Leads to Ostracism from Community. 16 of the 24 studies in this review identified the perception that acknowledging or speaking about one's mental health can lead to significant consequences to an individual's social standings within their communities (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Branam et al., 2023; Burford-Rice et al., 2022; Chynoweth et al., 2020; Copolov & Knowles, 2023; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Poudel-Tandukar et al., 2019; Quinn, 2014; Saberi et al., 2021; Shannon et al., 2015; Teunissen et al., 2014; Touni, 2022; Valibhoy et al., 2017).

"Openly talking about one's mental health immediately jeopardizes his or her position in the community. …if you talk about mental health, they feel like they are degrad[ed]" (Male Burma Refugee; Kim et al., 2021)

In two studies, participants who had engaged with professional mental health support kept this was hidden from family members or spouses due to fears of ostracization (Al Laham et al., 2020; Bawadi et al., 2022). In the study by Bawadi and colleagues (2022), female refugees feared engaging with services due to their husbands becoming aware of this and either divorcing them or preventing them from seeking further support. In three other studies, individuals who were struggling with their mental health kept this hidden due to fears around its impact on their family members' social standing, including their ability to marry (Burford-Rice et al., 2022; Quinn, 2014; Shannon et al., 2015).

"They don't want to talk about it because if other family members know that I'm mentally ill, my daughter might not get married" (Shannon et al., 2015).

In another study, male refugees who experienced sexual violence faced pressures around masculinity and fears of being perceived as homosexual- these factors discouraged them from seeking mental health support (Chynoweth et al., 2020).

Due to these significant social consequences, 7 studies highlighted a shared belief by participants that mental health difficulties should be endured in silence (Al Laham et al., 2020; Bawadi et al., 2022; Burford-Rice et al., 2022; Copolov & Knowles, 2023; Poudel-Tandukar et al., 2019; Shannon et al., 2015; Teunissen et al., 2014).

"My older sister she's got anxiety …She just can't get out of bed, but she's never been to the doctors to find out what it is because we don't talk about our feelings" (Female Hazara Refugee; Copolov & Knowles, 2023)

3.2. Theme 2: Spiritual and Social Causes of Poor Mental Health

Religious Causes. One prominent cause and risk factor associated with mental health disorders identified from studies was linked to faith and religious beliefs around spiritual possession. This was identified in 18 out of the 24 studies reviewed (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Bettmann et al., 2015; Burford-Rice et al., 2022; Chnoyweth et al., 2020; Copolov & Knowles, 2023; Grupp et al., 2019; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2018; Omar et al., 2017; Rae, 2016; Saberi et al., 2021; Teunissen et al., 2014; Tonui, 2022; Valibhoy et al., 2017; Whittaker et al., 2005). Within the Islamic faith, studies highlighted the belief that God is the bringer of both good and bad health- this included mental health (Bettmann et al., 2015; Lechner-Meichsner & Comtesse, 2022). Participants in 4 studies attributed poor mental health as being a punishment from God or an indicator of a lack of faith (Al Laham et al., 2020; Omar et al., 2017; Tonui, 2022; Whittaker et al., 2005).

"Even mental health cases are due to the weakness of faith… It happens when the person starts to behave abnormally. If the person said bad things about God, he is sure touched by Jinn, because faithful men don't say such things." (Male Syrian Refugee; Al Laham et al., 2020)

Additionally, there was a belief that mental illness was caused by possession from an evil spirit, jinn (spirit), shaytan (demon), or zar (spirit) (Bettmann et al., 2015; Grupp et al., 2019; Rae, 2016; Tonui, 2022; Whittaker et al., 2005).

"There are some people who get possessed, we believe in that. Those people that were crazy, you read Qur'an on them, you do a lot of imam talk, and you pray for them." (Somali Refugee; Bettman et al., 2015)

One study that explored Buddhism also showed similar themes of mental illness being a result of bad karma or being possessed by an evil spirit (Kim et al., 2021).

Loss of Social and Community Connections. The loss of social networks and forms of support that came with transitioning to host countries were also identified as a cause of poor mental health in 8 out of the 24 studies reviewed (Ahmed et al., 2017; Branam et al., 2023; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2019; Poudel-Tandukar et al., 2019; Quinn, 2014; Rae, 2016).

"I am one of those people who left their parents. I lost a lot of my friends. The main reasons [for symptoms of mental illness] are those." (Male Kurdish Refugee; Branam et al., 2023)

Additionally, 5 studies highlighted the sense of isolation and heightened loneliness that the participants felt in their host countries when compared to their country of origin (Ahmed et al., 2017; Branam et al., 2023; Lechner-Meichsner & Comtesse, 2022; Quinn, 2014; Rae, 2016).

". . . because at home you are not alone. You have family, you have brothers, sisters, cousins, the village community or friends who support you. But here, this loneliness, this being alone." (Male Sub-Saharan African Refugee; Lechner-Meichsner & Comtesse, 2022)

Trauma. 10 out of 24 studies in this review highlighted the impact of experiencing traumatic events on mental health (Al Laham et al., 2020; Bettmann et al., 2015; Grupp et al., 2019; Karkas & du Plooy, 2024; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2019; Saberi et al., 2021; Shannon et al., 2015; Teunissen et al., 2014). These traumatic events included those experienced pre-migration in their countries of origin, but also events experienced during and post-migration.

"The thing that causes crazy, let's say that you have a house and your house burns. Something that unexpected happens… Or someone you love, your spouse or children, and all of a sudden, they get killed or you lose them, then your mind changes. Those kinds of things make you crazy." (Male Somali Refugee; Bettmann et al., 2015)

"Our life is very hard. We are not happy with this lifestyle…our mental state is not well. We left our country, we left our jobs, our homes, our people and it is very hard." (Female Syrian Refugee; Al Laham et al., 2020)

Asylum-Seeking Process. All three studies researching asylum seekers highlighted the stressors of waiting for the asylum decision on their mental health (Melamed et al., 2019; Quinn, 2014; Teunissen et al., 2014). These stressors included being placed in difficult living situations, navigating the process of an asylum claim, and constant worry about their unknown future.

"My current situation- it has been almost 2 years here in Switzerland and I don't have any official residence permit, so eventually I'm in a situation where I'm not secure in my future.

This is one of the conditions where you always think and keep worrying, keep your mind worrying." (Male Asylum Seeker; Melamed et al., 2019)

Unemployment & Financial Stressors. Another consistent identified cause was around the effects of unemployment and poor financial standing on mental health- this was reflected in 10 out of the 24 reviewed studies (Al Laham et al., 2020; Branam et al., 2023; Copolov & Knowles, 2023; Karakas & Du Plooy, 2024; Melamed et al., 2019; Omar et al., 2017; Rae, 2016; Saberi et al., 2021; Teunissen et al., 2014; Tonui, 2022). Studies highlighted participants' struggles with employment, either around not being able to find a job or needing to work within environments that did not represent their qualifications from their country of origin (Al Laham et al., 2020; Branam et al., 2023; Karakas & Du Plooy, 2024; Omar et al., 2017; Rae, 2016; Teunissen et al., 2014).

"You spent twenty years getting your college degree and start all over here. Whatever you had in your own country, you will lose it here, for example, your education and your job" (Male Kurdish Refugee; Branam et al., 2023)

For male participants, there was an additional emphasis around the pressures around families' expectations to provide financial support- this also applied to families overseas (Copolov & Knowles, 2023; Saberi et al., 2021).

"I have more responsibilities… to help support my family back in Afghanistan and to cope with my life here. They [family] are going to keep annoying me saying, "Send me money, send me money, send me money." I need the money here as well." (Male Hazara Refugee; Copolov & Knowles; 2023)

3.3. Theme 3: Different Countries, Different Systems - Knowledge of Where to Seek Mental Health Treatment

16 out of 24 studies in this review highlighted the lack of awareness and education in this population around where to seek mental health care and the availability of mental health services (Al Laham et al., 2020; Bettman et al., 2015; Chynoweth et al., 2020; Copolov & Knowles, 2023; Grupp et al., 2019; Karakas & Du Plooy, 2024; Kim et al., 2021; Quinn, 2014; Rae, 2016; Saberi et al., 2021; Shannon et al., 2015; Soukenik et al., 2022; Teunissen et al., 2014; Tonui, 2022; Valibhoy et al., 2017; Whittaker et al., 2005).

"*I grew up in the refugee camp, so definitely, there's no one that takes care of the mental part of health. They do not really know, really see any treatment. … evaluat[ing] you mentally, is not just there. It is just physical health that they do."* (Male Karen Refugee; Kim et al., 2021)

Some studies reported that this knowledge gap was due to mental health services not existing in individuals' countries of origin which in turn impacted their ability to seek these services in their host countries (Kim et al., 2021; Rae, 2016; Saberi et al., 2021; Shannon et al., 2015; Tonui, 2022; Valibhoy et al., 2017).

"*We don't have in our culture like psychologist or something like this*" (Valibhoy et al., 2017)

There was also a unique emphasis on community leaders and representatives being sources of knowledge on where to seek MH support (Karakas & du Plooy, 2024; Kim et al., 2021; Soukenik et al., 2022; Tonui, 2022).

"Many people that do not know that this service exist, you know. Go through the community-based organizations and, uh, inform them, you know, educate them that there are these services. You know, so people can use them." (Male Rwandan Refugee; Tonui, 2022)

Additionally, other studies highlighted that participants did not attribute GPs as providers of mental health treatment (Grupp et al., 2019; Teunissen et al., 2014).

"*Yeah but we didn't knew that you can go to a GP with depression, we didn't know that."* (Filipina Undocumented Migrant; Teunissen et al., 2014)

There were positive insights, however, with studies indicating that increased knowledge and familiarity with healthcare systems, often facilitated by community representatives, organizations, and healthcare providers, improved confidence and subsequent service use and help seeking behaviour (Copolov & Knowles, 2023; Karakas & du Plooy, 2024; Quinn, 2014; Teunissen et al., 2014; Tonui, 2022).

"The best thing I got here, is just, you know, being able to go to the hospital and meeting a mental health worker or mental health specialist who pointed out that I was suffering from PTSD" (Male Rwandan Refugee; Tonui, 2022).

One study in the review explored where refugees and asylum seekers would go to seek mental health information (Quinn, 2014). It highlighted the national Refugee Council, the National Asylum Seekers Support Service, a specialist National Health Service asylum team working with asylum seekers and refugees, the Medical Foundation for Victims of Torture, churches, interpreters, and city-wide community projects.

3.4. Theme 4: Everyday Problems - Recognition of Poor Mental Health

12 out of 24 studies reviewed highlighted limited recognition of poor mental health within this population (Ahmed et al., 2017; Bawadi et al., 2022; Bettmann et al., 2015; Chynoweth et al., 2020; Copolov & Knowles, 2023; Grupp et al., 2019; Melamed et al., 2019; Poudel-Tandukar et al., 2019; Teunissen et al., 2014; Tonui, 2022; Valibhoy et al., 2017; Whittaker et al., 2005).

Six studies highlighted that symptoms of poor mental health were labelled as being bored, stressed, having difficulties with their partners, “feeling down and lazy”, or “being over-worried" and were not identified as needing treatment (Ahmed et al., 2017; Bawadi et al., 2022; Bettmann et al., 2015; Copolov & Knowles, 2023; Teunissen et al., 2014; Valibhoy et al., 2017).

“I did not think I had a psychological problem ... I did not eat or sleep, I stayed in the room all the time, I did not accept to go out or sit with my family or people in general. I was very tired and if anyone spoke to me, I started crying ... ... My brothers were saying to me that you are young and at the beginning of your life… but neither I nor they knew that I had depression and my case required treatment.” (Male Syrian Refugee; Bawadi et al., 2022)

When it came to participants who had encountered difficult or traumatic life events, there were mixed results around these participants’ ability to identify their own poor mental health and/or the impact of their trauma on their mental health. In one study, participants were able to identify symptoms of Post-Traumatic Stress Disorder within themselves and others (Grupp et al., 2019). Another study showed that almost all their participants were aware of depression as an indicator of poor mental health, with over half able to identify its signs and symptoms (Poudel-Tandukar et al., 2019). On the other hand, a different study found that refugee participants who were survivors of sexual violence struggled to link their distress and poor mental health to their traumatic experiences (Chynoweth et al., 2020).

3.5. Theme 5: The Role of Faith and Family in Help Seeking Behaviours

Religious Support. In 18 out of the 24 studies reviewed, religious or faith-based supports were identified as significant avenues of support when it came to mental health difficulties (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Bettmann et al., 2015; Burford-Rice et al., 2022; Chynoweth et al., 2020; Copolov & Knowles, 2023; Grupp et al., 2019; Kim et

al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2019; Omar et al., 2017; Poudel-Tandukar et al., 2019; Rae, 2016; Saberi et al., 2021; Teunissen et al., 2014; Valibhoy et al., 2017; Whittaker et al., 2005).

"The mind has been set like, there is no cure except religious ones, don't believe in the doctors, because they are not God" (Male Hazara Refugee; Saberi et al., 2021).

The forms of support identified in studies reviewed were as follows: reading the Quran or Bible, completing Hajj or Umrah (a pilgramage within Islam), prayer, meditation , and visiting a sheikh (a religious leader within Islam) (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Bettmann et al., 2015; Burford-Rice et al., 2022; Copolov & Knowles, 2023; Grupp et al., 2019; Kim et al., 2019; Melamed et al., 2019; Omar et al., 2017; Rae, 2016; Teunissen et al., 2014; Valibhoy et al., 2017; Whittaker et al., 2005).

"Every step that you take you have to refer it from the Qur'an and Islam and read chapters.... We believe the, the religious is like a medicine for life." (Female Somali Refugee; Whittaker et al., 2005).

Family and Community Support. 18 out of the 24 studies in this review identified social, family, and community supports as important avenues of mental health support (Ahmed et al., 2017; Al Laham et al., 2020; Bawadi et al., 2022; Bettmann et al., 2015; Branam et al., 2023; Burford-Rice et al., 2022; Chynoweth et al., 2020; Copolov & Knowles, 2023; Grupp et al., 2019; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Melamed et al., 2019; Omar et al., 2017; Poudel-Tandukar et al., 2019; Quinn, 2014; Teunissen et al., 2014; Valibhoy et al., 2017; Whittaker et al., 2005).

"Family members provide love, care, and support that the patient needs. By doing so, they get peace of mind and they feel better. If family member's efforts do not work, we consult

with close relatives and friends to figure out better options." (Female Bhutanese Refugee; Poudel-Tandukar et al., 2019)

There was also a perception in some cultures that emphasized that those who are unwell are not aware of this and that the responsibility to seek help lies in the family or community (Bettmann et al., 2015; Grupp et al., 2019; Melamed et al., 2019).

"You, as an affected person, cannot set yourself off, it's your family that will guide you to (...) as an affected person you don't know immediately how to look out for yourself... and that's why I see the family and the parents as the most important assistance." (Male Eritrean Asylum Seeker; Grupp et al., 2019)

3.6. Theme 6: Fear & Mistrust of Professional Support Systems

Barriers to Professional Support- Lack of Shared Language. 10 out of the 24 studies reviewed identified participants' lack of shared language with health professionals and requiring an interpreter for appointments as being a significant barrier to seeking mental health support and opening up about their mental health (Ahmed et al., 2017; Burford-Rice et al., 2022; Chynoweth et al., 2020; Copolov & Knowles, 2023; Kim et al., 2021; Poudel-Tandukar et al., 2019; Saberi et al., 2021; Soukenik et al., 2022; Tonui, 2022; Whittaker et al., 2005).

"A lot of our population, they don't speak English very well to express themselves fully. So, mostly what we're doing is using translators or interpreters to help communicate. Important things get left behind, like the emotional factor- that really creates, a distrust, a lack of understanding between the counsellor and the client, that fear they won't get the right diagnosis or get the right treatment plan" (Bhutanese Refugee; Soukenik et al., 2022).

Two studies also highlighted an element of not being able to translate the meaning of mental health in participants' language of origin, which showed an additional cultural barrier (Kim et al., 2021; Saberi et al., 2021).

"In Karen language, there is not a word that can translate the meaning mental health." (Male Karen Refugee; Kim et al., 2021)

Barriers to Professional Support- Concerns Over Privacy and Mistrust. 16 out of the 24 studies reviewed identified this populations' concerns around their privacy and confidentiality as being significant barriers towards utilizing professional help for poor MH (Ahmed et al., 2017; Bettman et al., 2015; Chynoweth et al., 2020; Copolov & Knowles, 2023; Karakas & Du Plooy, 2024; Kim et al., 2021; Melamed et al., 2018; Omar et al., 2017; Poudel-Tandukar et al., 2019; Quinn, 2014; Rae, 2016; Shannon et al., 2015; Soukenik et al., 2022; Teunissen et al., 2014; Valibhoy et al., 2017; Whittaker et al., 2005).

"Even if you deep down know that you've got issues you never want to associate yourself with seeing someone [service provider], because no one wants to be known as 'the crazy one' amongst our culture" (Refugee; Valibhoy et al., 2017)

In five studies, these included concerns around interpreters sharing private information with participants' communities or loved ones (Ahmed et al., 2017; Kim et al., 2021; Poudel-Tandukar et al., 2019; Shannon et al., 2015; Soukenik et al., 2022)

"When someone is being referred for counselling, they would hesitate to go. They think if I start going [to] counselling sessions, the local interpreters might share it with my husband or wife. If my wife knows about it- I'm done. I'll be labelled as mad, crazy person throughout my life" (Bhutanese Refugee; Soukenik et al., 2022).

Professional Support as a "Last Resort". Seeking professional help for mental health difficulties were identified as a "last resort" in 10 out of the 24 studies reviewed (Bettmann et al., 2015; Burford-Rice et al., 2022; Copolov & Knowles, 2023; Grupp et al., 2019; Kim et al., 2021; Lechner-Meichsner & Comtesse, 2022; Omar et al., 2017; Quinn, 2014; Rae, 2016; Teunissen et al., 2014).

"If the person has prolonged grief despite having attended the funeral, he cannot do it on his own or others don't understand him... He needs someone to talk to, a therapy, a talking therapy... He really needs help" (Female Cameroonian Refugee; Lechner-Meichsner & Comtesse, 2022)

When professional help was sought, the first line of support was identified to be medical treatment via general practitioners, doctors, and/or hospitals (Bettmann et al., 2015; Burford-Rice et al., 2022; Copolov & Knowles, 2023; Grupp et al., 2019; Melamed et al., 2019; Quinn, 2014; Rae, 2016; Teunissen et al., 2014).

"*The ones that are crazy… you take them there [hospital] and they give them medicine to calm them down, but they stay there … until they are better.*" (Female Somali Refugee; Bettmann et al., 2015)

Generational Differences. Generational differences in utilizing professional support for mental health were observed in 7 out of the 24 studies reviewed- younger individuals appeared more open to seeking professional help for their mental health compared to elders, who leaned towards traditional practices (Burford-Rice et al., 2022; Copolov & Knowles, 2023; Omar et al., 2017; Saberi et al., 2021; Soukenik et al., 2022; Valibhoy et al., 2017).

This shift suggested a gradual change in attitudes toward mental health across generations which three studies attributed to young participants learning about mental health in school and

growing up in Western countries (Burford-Rice et al., 2022; Copolov & Knowles, 2023; Omar et al., 2017).

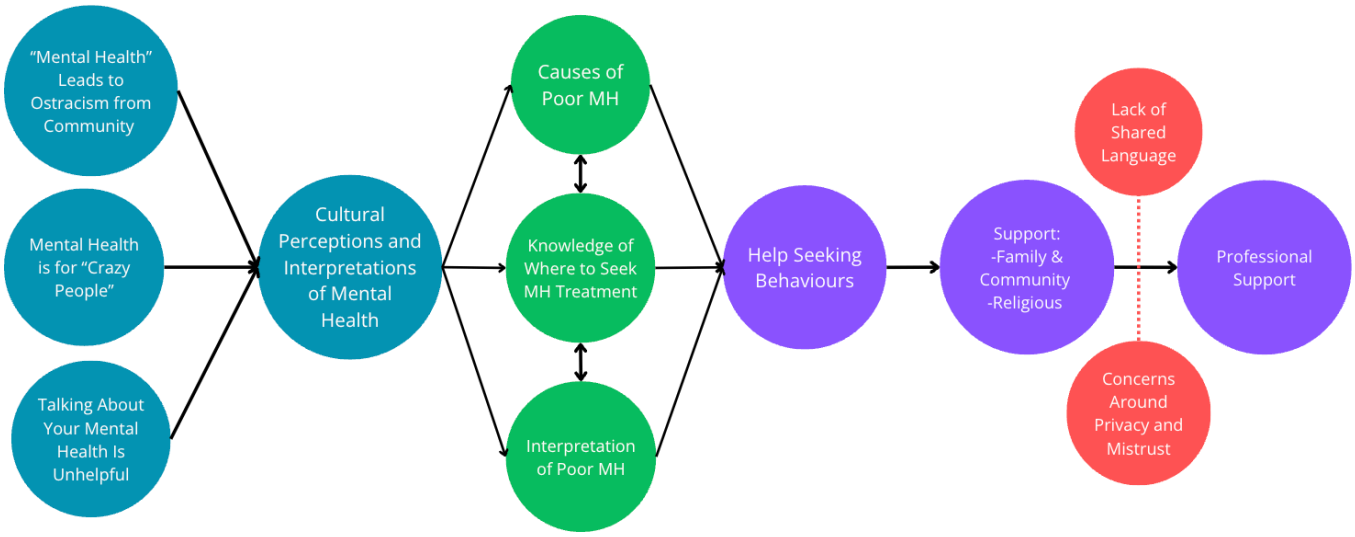
"For our old generation, if someone is sick we quickly invite Sheikh to read Quran on him and I don't think that young people use Quran as a healing … . For them, they believe the hospital, and the [Australian] system that they grew up" (Male Somali Refugee; Omar et al., 2017)

4. Discussion

The aim of this narrative synthesis review was to understand how the mental health literacy of forced migrants impacted their mental health help seeking behaviours using Jorm's (2002) MHL framework. Findings from this review revealed how different components of mental health literacy uniquely and collectively impacted on HSBs among adult forced migrant populations. The review synthesized insights from 24 studies conducted across various countries, including the United States, Australia, European nations, the Middle East, Bangladesh, and Kenya. The final analysis revealed 6 main themes: 'Cultural Perceptions and Interpretations of Mental Health', 'Spiritual and Social Causes of Poor Mental Health', 'Different Countries, Different Systems Knowledge of Where to Seek Mental Health Treatment', 'Everyday Problems - Recognition of Poor Mental Health', 'The Role of Faith and Family in Help Seeking Behaviours', and 'Fear & Mistrust of Professional Support Systems'. Within these themes, various subthemes arose that revealed a process underscored by different layers and complexities involved in understanding the mental health literacy and help seeking behaviours of forced migrants. This process is illustrated in Figure 2 and is framed as a provisional model of understanding how the mental health literacy of forced migrants impacts their help seeking behaviours.

Figure 2.

Visual Representation of Process and Relationship Between Themes



The frequency of themes across the included studies highlighted shared experiences and contextual diversity in how forced migrants understand and respond to mental health. Notably, religious and familial support structures were cited in 18 of the 24 studies, reflecting the central role of informal, culturally familiar systems in shaping both mental health understanding and help-seeking practices. Similarly, fears surrounding mental health-related ostracism (16/24) and concerns around privacy and mistrust of professionals (16/24) were highly prevalent, showcasing the impact of stigma and systemic barriers. Themes such as unemployment and financial stressors (10/24), language difficulties (10/24), and generational differences (7/24), though less consistently reported, further illustrate the layered nature of forced migrants' experiences. The asylum-seeking process emerged in all three studies that focused on it (3/3). A full breakdown of theme frequency can be found in Table 5.

Table 5.
Frequency of Themes and Subthemes Across Included Studies (N = 24)

Theme & Subtheme	No. of Studies (n)	% of Studies
Cultural Perceptions and Interpretations of Mental Health		
MH is for "Crazy" People	15	63%
Talking about MH Does Not Help	14	58%
MH Leads to Ostracism from Community	16	67%
Spiritual and Social Causes of Poor Mental Health		
Religious Causes	18	75%
Loss of Social and Community Connections	8	33%
Trauma	10	42%
Asylum-Seeking Process	3 (of 3 focused studies)	100%
Unemployment and Financial Stressors	10	42%
Knowledge of Where to Seek MH Treatment (Systems Awareness)	16	67%
Recognition of Poor MH in Everyday Problems	12	50%
Role of Faith and Family in Help-Seeking Behaviours		
Religious Support	18	75%
Family and Community Support	18	75%
Fear & Mistrust of Professional Support Systems		
Language Barriers	10	42%
Privacy Concerns and Institutional Mistrust	16	67%
Professional Support as a "Last Resort"	10	42%
Generational Differences	7	29%

Findings from this review highlight the cultural perceptions and interpretations of mental health by forced migrants and provide a more in-depth understanding of the factors shaping mental health literacy as a process experienced by forced migrants. The findings suggest that forced migrants' mental health literacy is shaped both by individual knowledge and by cultural and social dynamics. A key emphasis is the significant fear of social ostracization associated with mental illness, which extends beyond the individual to their family and community. This highlights how attitudes towards help-seeking, a core component of mental health literacy (Jorm,

2002), are influenced by cultural beliefs which were similar despite the different origins of the forced migrants in the study. Research has also shown that the breakdown of social capital, the shared networks and values in communities, within this population results in significant vulnerabilities for individuals (Uzelac et al., 2018). This review supports these findings, showcasing the loss of social and community networks as a key contributor to poor mental health. Further research has shown that forced migrants represent a population where social capital is an indicator of wellbeing (Cheung & Phillimore, 2013; Ziersch et al., 2023). This is supported in a study by Ziersch et al. (2023), who found that social networks and community-based support systems were pivotal to settlement and integration. This aligns with the current review's findings that family, religious figures, and community leaders were frequently cited as primary sources of mental health information and support. This suggests that forced migrants may rely on informal sources of knowledge rather than engaging with formal mental health education or services, shaping their mental health literacy, and in turn, mental health help-seeking behaviours. This finding is also back in the CDHS model, which emphasizes culturally familiar support systems as the primary sources of mental health knowledge (Saint Arnault, 2009).

This reliance on community-based knowledge structures over professional medical advice further contributes to the perception of mental illness as a highly stigmatized, pathological condition in forced migrants. The review found that mental illness is often equated with extreme states of dysfunction ("craziness"), reinforcing fears of exclusion and deterring help-seeking. This reflects a distorted or limited recognition of mental health symptoms, another core component of mental health literacy (Jorm, 2002). As a result, mild to moderate symptoms may not be recognized as requiring treatment, meaning individuals often delay seeking support until

they reach a crisis point. This crisis-driven pattern of help-seeking is problematic, as it leads to a reliance on emergency and crisis medical services and hospital-based interventions rather than early, preventative mental health care. While the review identifies this pattern, there is currently no research on the comparative use of acute and emergency mental health services versus other forms of intervention in forced migrant populations, representing an important gap in understanding how mental health literacy influences service utilization. The perception of mental illness as extreme dysfunction, alongside the significant fear of social ostracization, further reinforces stigma and delays in help-seeking until crisis point, mirroring Saint Arnault's (2009) model stating that cultural interpretations of illness influence service engagement.

Another important finding from this review was the importance of religion, faith, and spirituality for forced migrants when it came to coping with, and seeking help for, their mental health. This finding aligns with the component of mental health literacy that is linked to knowledge and beliefs relating to the causality of mental health problems (Jorm, 2002). In this review, religion was identified as a cause of poor mental health, a significant source of support and one of the main avenues of help seeking for adult forced migrants. This highlights how the interpretation of the cause of poor mental health then informed the help-seeking avenues taken by this population. Research on the use of religious and faith-based coping in forced migrants have shown the positive implications of religious coping for post-traumatic growth and improved integration into the host country (Erashin, 2022; Maier et al., 2022). In the study by Erashin (2022), one potential reason for this was due to religious coping being used by refugees as a positive avenue for meaning making in the face of adverse life events. However, research remains limited on the integration of religion and spirituality into psychology interventions- this is applicable to all populations and not just forced migrants. This brings an important reflection

to understanding how to adapt psychological interventions to become more culturally attuned to this population's spiritual values and needs.

Finally, a significant finding in this review is around the mistrust of health professionals and fears around privacy and confidentiality when it comes to seeking mental health support for forced migrants. Fears around privacy and confidentiality posed as significant barriers to accessing professional support. One fear was around many participants fearing that the interpreters used in sessions would share their private information with their communities. Existing research around the use of interpreters in sessions with forced migrants emphasizes the importance that health professionals acquire specific training alongside contracting, assessing suitability, and trying to maintain consistency in sessions with interpreters (Tribe & Thompson, 2022). There was also a fear held around forced hospitalisations, which was informed by their perception of mental health as reflecting severe pathological states and a lack of understanding of what mental health interventions entail. This finding showcases the importance of providing education around mental health interventions, and the importance of professionals emphasizing privacy and confidentiality protocols within their sessions with forced migrants. It also re-iterates the importance of trust and rapport building when it comes to supporting forced migrants, a finding that is also supported in the existing literature (Peñuela-O'Brien et al., 2023; Sandhu et al., 2013).

It is important to note that, in the context of forced migration, the concept of MHL intersects with displacement-related trauma, cultural idioms of distress, and access barriers in unfamiliar healthcare systems. MHL traditionally emphasizes the recognition, management, and prevention of mental disorders through knowledge and beliefs aligned with biomedical understandings of mental health (Jorm, 2002). However, this review challenges the assumption

that divergence from this dominant model of MHL necessarily reflects a "deficit" in literacy. Rather than indicating poor MHL, many forced migrants demonstrate rich and culturally grounded understandings of mental health that emphasize spiritual, relational, and social forms of healing. Therefore, it is not that MHL is universally lacking, but rather that the types of help prioritized, such as faith-based or family-oriented approaches, may differ from what formal mental health systems expect.

Moreover, the notion of "low MHL" risks placing the burden of help-seeking solely on forced migrants, while overlooking the systemic barriers that constrain access. These include linguistically inaccessible services, lack of culturally attuned care, and institutional distrust rooted in prior experiences of marginalization or trauma. Framing help-seeking as a problem of literacy alone obscures the responsibility of health systems to make information comprehensible, services approachable, and care equitable. True improvements in help-seeking among forced migrants require a shift from individual blame to shared responsibility, recognizing that both knowledge and access must be addressed for equitable mental health support. These findings support the view that MHL is not culturally neutral and that models of MHL must be culturally adapted (Altweck et al., 2015).

4.1. Strengths and Limitations

This systematic review offers a theoretical model of conceptualizing mental health literacy of forced migrants and its impact on their help seeking behaviours. It includes several key strengths that enhance the relevance and applicability of its findings, marking a novel contribution to the limited literature on mental health literacy and help-seeking behaviours among adult forced migrant populations. By synthesizing findings from a diverse range of studies, the review captures common themes and shared experiences and beliefs, despite

geographic, system and cultural differences. Its focus on a highly vulnerable and under-researched population fills a critical gap through promoting a greater understanding of the mental health literacy of forced migrants and its impact on help seeking behaviours for mental health.

The systematic review identified several limitations stemming from the included studies that should be considered when interpreting the findings. One limitation was the variability in sample sizes, with some studies relying on small, non-representative samples that may not accurately reflect the broader experiences of adult forced migrants. Additionally, sampling bias was evident in certain studies that recruited participants through community organizations or healthcare providers, potentially excluding those who are less engaged or encounter more severe barriers to accessing services. There was also inconsistency in the definitions and measurement of mental health literacy across the studies, with some using comprehensive frameworks while others not operationalizing mental health literacy at all, making it challenging to synthesize the results. These limitations highlight the need for caution in generalizing the findings and underscore the importance of future research that addresses these methodological gaps.

Additionally, some of the studies included in the systematic review reported findings from multiple populations, such as community leaders, healthcare providers, and forced migrants themselves which at times made it difficult to separate which findings specifically reflected the views and experiences of adult forced migrants versus those of other groups (Al Laham et al., 2020; Chynoweth et al., 2020; Bawadi et al., 2022). However, the impact of this limitation was reduced by all the studies distinguishing the forced migrant participants from non-forced migrants in their quotations.

While a strength of this review is the diverse range of studies included, it is important to note that the majority of the studies conducted were in Western countries such as the United

States, Canada, Australia, and parts of Europe. This regional concentration may limit the generalizability of the findings, as the experiences of adult forced migrants in these settings could differ significantly from those in non-Western contexts. Forced migrants in host Western countries might have different levels of access to resources, support systems, and healthcare services compared to those in host regions like Central Africa, the Middle East, or parts of Asia, where cultural norms, healthcare infrastructure, and policy frameworks around mental health care may vary widely. Additional research in underrepresented regions would help provide a more comprehensive understanding of these issues across different cultural and socio-economic contexts.

4.2. Conclusion

This systematic review synthesizes the impact of mental health literacy on HSBs among adult forced migrants and provides a theoretical model of understanding how cultural interpretations of mental health inform mental health literacy and thereby the help-seeking behaviours of forced migrants. Across studies, there is a consistent reliance on support systems such as family, community, and religious networks, above formal mental health support, highlighting the cultural and social importance of these structures in shaping mental health responses and help-seeking practices. By identifying these factors, the review offers practitioners and policy makers working to support adult forced migrants with information on how to develop more culturally sensitive mental health interventions that could lead to better engagement with these interventions and encourages better mental health access among refugees and asylum seekers.

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Chapter Three: Bridging Chapter
Word count: 418

The findings of the systematic review provided a theoretical model of understanding the impact of mental health literacy on the help seeking behaviours of forced migrants. This model provides a more in-depth understanding of the mental health literacy and help-seeking of forced migrants as a process, beyond the labelling of "poor" or "low" literacy as outlined in existing literature (Saberi et al., 2021; Bawadi et al., 2022). From the findings of this systematic review, there is a greater understanding of the importance of social capital and community, religion, perceptions of mental health, mistrust of health professionals, and fears around confidentiality for this population. Collectively, these domains give us an insight into what guides the mental help seeking behaviours of this population and the impact of mental health literacy and highlights a need to further understand what mental wellbeing looks like for forced migrants in the context of their changing social circumstances. One potential framework for understanding wellbeing in refugees and asylum seekers is the personal recovery framework, which is defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles' to regain and live a meaningful and satisfying life despite the limitations brought on by illness or difficult life circumstances (Leamy et al., 2011). The meaning of recovery is different for different groups of individuals, with various conceptualisations of personal recovery across different communities (Shanks et al., 2013; Law et al, 2020). To date, however, there has been no research examining the meaning of mental health recovery from the perspective of refugees and asylum seeker care. Understanding how mental health recovery is perceived in this group of people may guide practitioners and services to better support refugees and asylum seekers to identify personal goals for their recovery and adapt or develop avenues of system support such as Refugee-focused recovery college courses or peer-support groups.

Therefore, the following empirical paper is a starting point to understand the meaning of recovery for refugees and asylum seekers from the perspectives of the health professionals supporting them. The aim of the paper is to provide a more comprehensive perspective of wellbeing and recovery for refugees and asylum seekers in the United Kingdom. Where the systematic review aimed to explain the process behind mental health help seeking behaviours through the lens of mental health literacy, the empirical paper aims to understand how personal recovery is conceptualised for refugees and asylum seekers, what facilitates personal recovery in refugees and what may act as a barrier to their recovery.

Chapter Four: Empirical Paper

Making Sense of Recovery: Health Professionals' Perspectives on Supporting the Mental Health of Refugees and Asylum Seekers

Word Count (excluding abstract & references): 7,736

Empirical paper prepared for submission to Clinical Psychology Review

Author guidelines can be found in Appendix A

Making Sense of Recovery: Health Professionals' Perspectives on Supporting the Mental Health of Refugees and Asylum Seekers

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Abstract

Background. Refugees and asylum seekers (RAS) experience significant mental health challenges influenced by both pre-migration trauma and post-migration stressors. Despite growing recognition of the importance of recovery-oriented care, most interventions remain focused on symptom reduction rather than holistic recovery. This study explores healthcare professionals' perspectives on the meaning of recovery for RAS to inform culturally responsive and person-centered care.

Methods. A qualitative design was employed using semi-structured interviews with 11 professionals (six health professionals and five mental health professionals) working with RAS across statutory and third-sector services in the UK. Participants were recruited through purposive and snowball sampling. Interviews were conducted online, audio-recorded, and transcribed verbatim. Data were analysed using reflexive Thematic Analysis, following Braun and Clarke's six-phase framework.

Findings. Six key themes emerged, categorized as facilitators or barriers to recovery. Facilitators included living well with trauma, finding security in the asylum claim, and the power of integration and community. Barriers included carrying the weight of past trauma, struggling against a hostile system, and experiences of isolation and otherness.

Conclusion. Recovery for RAS extends beyond mental health symptom management to include social, legal, and systemic factors. Findings highlight the need for recovery-centered interventions that address both psychological distress and structural inequities is essential for supporting long-term recovery.

Keywords: refugee, asylum seeker, mental health, recovery, health professionals, qualitative

1. Introduction

Forced migration has become a major global crisis, altering population distributions and straining international humanitarian resources (United Nations High Commissioner for Refugees [UNHCR], 2024). In the United Kingdom, 38,761 people were granted refugee status or other forms of protection by September 2023, the highest annual figure recorded since 2002 (UK Government, 2023). By mid-2024, the global number of forcibly displaced individuals had risen to 122.6 million, continuing a 12-year upward trend in displacement (UNHCR, 2024).

Factors that contribute to refugee mental health include both pre-migration as well as post-migration experiences. However, most mental health interventions in host countries focus on psychological impact of pre-migration exposure to trauma (Hynie, 2018). The experiences that asylum seekers face upon arriving in their host countries can lead to significant stressors, and even after securing their visa status, refugees continue to be confronted with challenges (Patanè et al., 2022; Phillimore & Cheung, 2021; Schick et al., 2016). Asylum seekers entering the UK experience various challenges in their asylum process, with ongoing backlogs of asylum-seeking applications that sometimes take years to process. These backlogs leave asylum seekers in extended periods of uncertainty around their futures (Phillimore & Cheung, 2021). Additionally, research has indicated that refugees experience higher prevalence rates of mental health problems, including post-traumatic stress disorder, anxiety, and depression (Patanè et al., 2022; Schick et al., 2016). RAS face heightened risks to their mental health due to social determinants such as prolonged socioeconomic disadvantage, social isolation, and traumatic experiences (Compton & Shim, 2015; Hynie, 2018; Phillimore & Cheung, 2021).

In the United Kingdom, RAS are entitled to register with a general practice and access National Health Service (NHS) care under the same conditions as the general population (Century et al., 2007). Despite their well-documented poor mental health, RAS demonstrate low rates of help-seeking for mental health concerns (Byrow et al., 2020). Instead, they are more likely to seek support from primary care services for somatic symptoms and tend to be more receptive to physical health treatments over mental health interventions (Due et al., 2020). Additionally, healthcare professionals report significant difficulties in addressing the mental health needs of RAS (Peñuela-O'Brien et al., 2023). A systematic review examining professionals' experiences in providing mental healthcare to refugees identified key challenges, including cultural and language barriers, limited training to address the distinct needs of this group, and the complexity of their mental health presentations (Peñuela-O'Brien et al., 2023). Given the multifaceted health challenges faced by forced migrants, understanding healthcare professionals' perspectives on RAS mental health is essential for informing the development of specialized services and improving mental health outcomes in this population.

Research indicates that mental health interventions are most effective when they incorporate psychosocial support elements alongside clinical treatments to support both clinical and personal recovery goals from mental ill-health (Silove et al., 2017). Personal recovery is defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles' to live a meaningful and satisfying life despite the limitations brought on by illness or difficult life circumstances (Leamy et al., 2011). Unlike traditional clinical models that focus solely on symptom reduction, the recovery model emphasizes the broader aspects of well-being, resilience, and social integration (Davidson et al., 2005). The meaning of recovery is different for different groups of individuals, and there have been different conceptualizations of

recovery in research across different communities (Shanks et al., 2013). Additionally, many studies on RAS mental health focus on symptomatology which emphasizes identifying mental health conditions, aligning with biomedical and deficit-focused models (Blackmore et al., 2020; Henkelmann et al., 2020). In contrast, a recovery-based approach prioritizes the unique perspectives and lived experiences of RAS (Leamy et al., 2011; Silove et al., 2017).

Prior research has highlighted significant challenges faced by mental health professionals in understanding and applying recovery principles in practice. Although both clinical and personal recovery are vital components of care, mental health systems often focus on clinical recovery over personal recovery, which centers on the individual's lived experience and pursuit of a meaningful life (Gamieldien et al., 2024; Giusti et al., 2022). Despite growing interest in recovery-oriented approaches, many professionals still report limited familiarity with the recovery model and uncertainty around how to implement it in their daily work (Sreeram et al., 2021; Giusti et al., 2022). These limitations are further complicated when working with RAS populations, where cultural, linguistic, and systemic barriers often challenge professionals' ability to deliver recovery-informed, person-centered care (Peñuela-O'Brien et al., 2023).

Given these complexities, this study explores the perspectives of professionals themselves to understand how they conceptualize and apply recovery principles in the context of forced migration. The lived experiences of healthcare providers supporting RAS offers insights into how recovery is implicitly or explicitly constructed in practice. This study foregrounds their perspectives to uncover how understandings of recovery are shaped, limited, or expanded by cultural context, service constraints, and personal beliefs. Understanding these perspectives is critical for improving the quality of care for RAS and for supporting professionals in navigating the unique challenges of culturally responsive and recovery-oriented mental health practice.

To date, there has been no research examining the conceptualizations of mental health recovery of forced migrants from the perspectives of health professionals working with this population.

1.1. Research Question & Aims

Following the background literature and gaps in understanding and supporting the mental health recovery of RAS, this study aims to answer the following question:

1. From professionals' experiences of supporting RAS, what does personal recovery look like for this population?

2. Methodology

2.1. Ethical Considerations

Ethical approval from the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia was obtained (ETH2324-1747) (Appendix F).

2.2. Participants

Recruitment was conducted through the Advancing Mental Health Equality (AMHE) Refugee and Asylum Seekers Professionals group run by the Royal College of Psychiatrists. This group encompassed a mix of health and mental health professionals working in health and charitable sectors in the East of England to support RAS. To be eligible for this study, participants were required to have at least 6 months of experience professionally supporting RAS and practicing within the East of England. The gatekeeper of this group was contacted to share the study poster with the group (Appendix G). Additionally, snowball sampling was utilised where participants were encouraged to forward the poster to colleagues who are involved in RAS care. Eleven participants were recruited for the study (7 female and 4 male). Out of the 11

participants, 6 worked as health professionals and 5 worked as mental health professionals. The participant demographics can be found in Table 1.

Table 1

Demographics of professionals interviewed ($N = 11$)

		n (%)
Gender		
	Female	7 (64%)
	Male	4 (36%)
Ethnicity		
	White British	7 (64%)
	White European	2 (18%)
	White Other	1 (9%)
	Black African	1 (9%)
Age Range		
	25-34	4 (36%)
	35-44	5 (45%)
	55-64	2 (18%)
Length of Time Supporting RAS		
	6 months – 1 year	4 (36%)
	1 year – 3 years	3 (27%)
	3 – 6 years	1 (9%)
	6+ years	3 (27%)
Type of Professional		
	Health Professional	6 (55%)
	Mental Health Professional	5 (45%)

2.3. Study Procedure & Data Collection

An online participant information sheet and consent form was used to collect consent for the interviews and a copy of both was emailed to all participants (Appendix H & I). Before and during the interview, participants were informed that they could withdraw their participation at any time with no consequences. All data collected was anonymized and stored securely and protected in a password-safe digital OneDrive folder, which can only be accessed by the researcher, in accordance with information governance and data anonymity. Audio recordings of

the interviews were deleted upon transcription. Any identifying information in transcripts were removed.

Online semi-structured individual interviews were conducted by LO. Each of these interviews spanned 60 minutes and participants were compensated with a £10 online voucher. All interviews were recorded via Microsoft Teams and transcribed verbatim. The interview topic guide was collaboratively developed by LO and BT (Appendix J) and informed by conversations with a forced migrant representative of the professional's group.

2.4. Data Analysis

Thematic Analysis (TA) was used to analyze the data, following Braun and Clarke's (2006) six-phase framework. This approach provides a flexible yet rigorous method for identifying, analyzing, and interpreting patterns of meaning across qualitative data. The process involved: (1) familiarisation with the data through repeated reading of transcripts; (2) generating initial codes inductively across the dataset; (3) searching for themes by clustering related codes; (4) reviewing themes in relation to the coded extracts and the full dataset; (5) defining and naming themes; and (6) producing the final report with illustrative quotes. The analysis was primarily inductive and data-driven, aiming to remain grounded in participants' accounts while recognising the active role of the researcher in theme development. An iterative and reflexive approach was maintained throughout the analytic process, involving ongoing critical engagement with the data, the researcher's assumptions, and the broader contextual influences (Naeem et al., 2023). Regular supervisory discussions took place throughout the data analysis stage between BT and LO. BT was actively involved in the analysis by reviewing coded data, discussing emergent themes, and providing critical feedback across the analytic stages. These meetings provided a space to discuss interpretations, explore alternative meanings, and ensure that

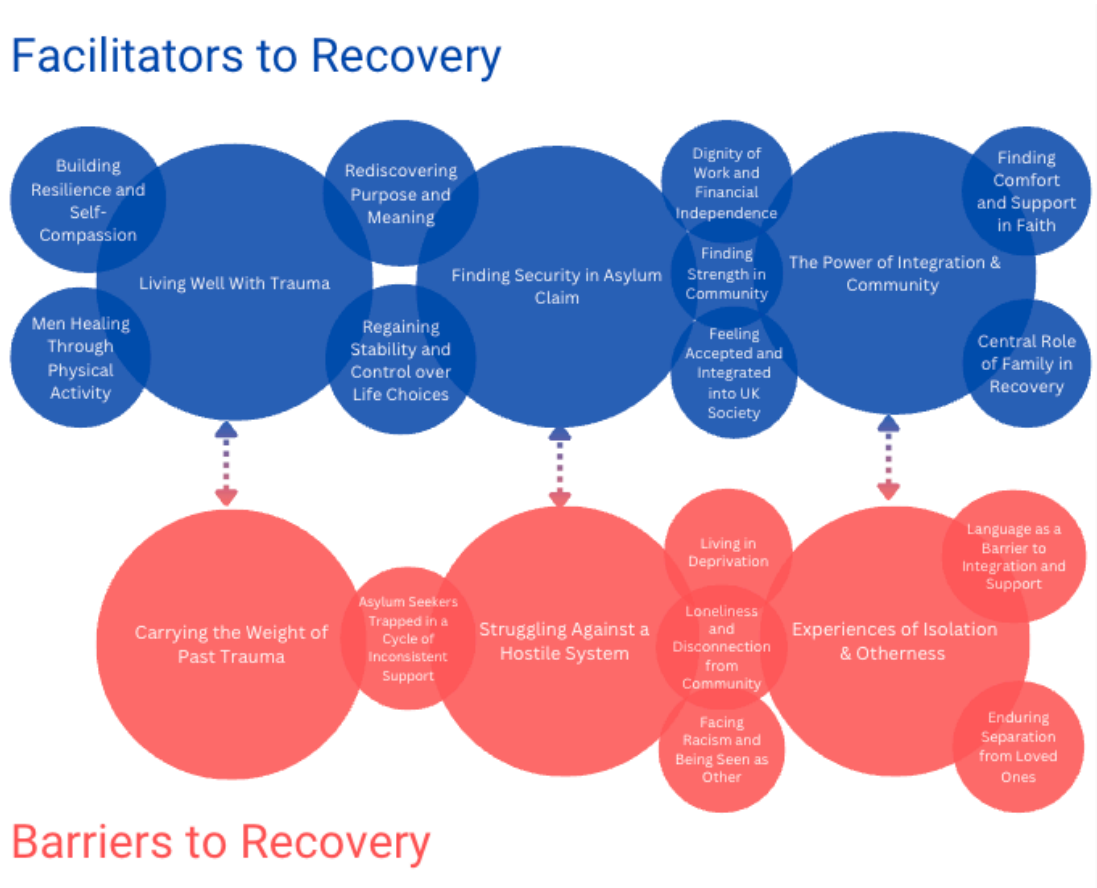
emerging themes remained grounded in participants' narratives (Naeem et al., 2023). NVivo® 14 software was used to manage and organize data.

3. Findings

Six themes were generated from this study and focused on inter-related barriers and facilitators to recovery. Facilitators to recovery included 'living well with trauma', 'finding security in the asylum claim', and 'the power of integration & community'. Barriers to recovery included 'carrying the weight of past trauma', 'struggling against a hostile system', and 'experiences of isolation & otherness'. A visual representation of the themes can be found in Figure 1.

Figure 1.

Themes and Subthemes



3.1. Theme 1: Living Well with Trauma (Facilitator)

This theme illustrates how RAS work toward managing their traumatic experiences and reflects a journey of learning to coexist and live well with their trauma rather than erasing it. This journey is shaped through finding different ways to cope with overwhelming memories, flashbacks, and suicidal thoughts by developing routines and engaging in activities that help stabilize their emotional state. Various subthemes emerged through this theme that outlined the different coping mechanisms and processes that professionals found to be pivotal in this population's journey of living well with their trauma.

"If I were to label a critical aspect of recovery, I would say it's learning how to live with and survive your mental health struggles" (Participant 7, Mental Health Professional)

Men Healing Through Physical Activity. Professionals reflected that activities such as going to the gym, playing sports, and engaging in outdoor group exercises served as vital coping mechanisms for male RAS.

"I do think physical activity is a huge thing for quite a lot of the young men" (Participant 2, Health Professional)

For many men, these activities offered a social component, creating opportunities to build meaningful connections and help foster a sense of routine.

Building Resilience and Self-Compassion. This subtheme highlights the journey of self-discovery and acceptance that RAS undertake as part of their recovery. Mental health professionals in this study highlighted that developing self-compassion was a major component in their work with RAS, as many individuals learnt to recognize that their responses to trauma were both natural and understandable.

"The thought there was something wrong and he was broken and he learned there was absolutely nothing wrong with him whatsoever. And what he was feeling was completely legitimate and understandable" (Participant 9, Mental Health Professional)

By embracing resilience and self-compassion, professionals found that RAS were better equipped to navigate the complexities of their experiences and felt validated in their responses to their experiences.

3.2. Theme 2: Finding Security in Asylum Claim (Facilitator)

Another pivotal aspect of recovery was one's legal status. Professionals emphasized that, for many individuals, securing asylum is the cornerstone upon which many other aspects of

recovery rest. This is partially due to the legal constrictions and lack of autonomous choice and stability that comes with being an asylum seeker in the UK. Achieving asylum offers a sense of safety and permanence, alleviating the constant fear of deportation and providing a foundation to pursue meaningful goals like work, reclaiming autonomy, and integration into UK society.

"I think the main thing and the main priority that people have is their asylum status, like having that certain and a lot for a lot of people it's like "I need that first before I can think about anything else" (Participant 10, Mental Health Professional)

One mental health professional shared their experiences of working with asylum seekers in therapy before and after their asylum claim:

"They've got their leave to remain whilst I've been working with them, which has meant that their presentation drastically improves kind of overnight. That's not to say all their problems are over, they're not, and the acknowledgement of that is important" (Participant 7, Mental Health Professional)

Regaining Stability and Control Over Life Choices. This subtheme highlights the importance of autonomy and routine in the recovery journey of asylum seekers and emphasizes the doors that open after a successful asylum claim. Professionals described that after enduring prolonged instability due to waiting for asylum claims, asylum seekers deeply value the ability to make personal choices about their daily lives. The sense of control is often restored through simple acts of routine, financial independence, and decision-making in areas like housing, employment, and personal activities. Regaining control over these aspects helped individuals provide a foundation of stability, allowing them to rebuild confidence and achieve a sense of normalcy, ultimately supporting long-term recovery.

"In the resettlement context and recovery is you know ultimately and dare I say idealistically, it's about having opportunities to exercise agency to be able to create their own lives" (Participant 6, Mental Health Professional)

The importance of routine was also emphasized by professionals, and RAS having an established routine was an indicator of recovery. It was also seen as allowing individuals to reconnect with the normalcy and humanity of living a day-to-day life.

"And I guess we've seen people like, the people who cope the best and seem to sort of like be- they seem to have improved the most people who have developed a bit of routine for themselves" (Participant 4, Health Professional)

Rediscovering Purpose and Meaning. This subtheme captures the need that RAS have around finding a sense of purpose and rebuilding a sense of direction in their lives. Professionals reported that many found purpose through roles that allowed them to contribute positively to society but also regain their sense of self-worth. These included roles such as volunteering but also reconnecting with parts of their identity that gave them a sense of purpose. For example, one health professional reflected that "for women, it's quite often being able to fulfil their role as a mum" (Participant 5). Rediscovering meaning and purpose helped individuals reframe their experiences and challenges and acted as a motivator.

"Feeling like you've been through all this awful stuff… and now you're at a point where you are allowed to live a positive life with purpose" (Participant 1, Health Professional)

Dignity of Work and Financial Independence. This subtheme underscores how crucial employment and self-sufficiency are for the overall recovery of RAS. Professionals reflected that, for RAS, being able to work leads provides a sense of purpose, routine, and fulfilment that are often lost during displacement. For many, work is a powerful means of reclaiming their

identity, as it allows them to utilize their skills, contribute to the economy, and feel like valued members of society. This sense of dignity and contribution combats feelings of helplessness and dependency that many experience in the asylum process due to legal restrictions around working and limited wages provided for living. Furthermore, financial independence was seen as an avenue for RAS to make choices about their lives that were previously out of reach. This included things like supporting their families, choosing where to live, accessing resources, and engaging in activities that promote their well-being.

"I think that sense of occupation having your kind of own finances is quite empowering" (Participant 3, Health Professional)

"He was very clear on what he wanted, he said. "Look, I don't think I'm asking for much… I want to work and that's it." (Participant 5, Health Professional)

3.3. Theme 3: Integration and Community (Facilitator)

Throughout all the interviews, participants strongly emphasised the importance of integration and finding community when it came to the recovery of RAS. Different factors were highlighted that helped with feeling integrated and building community- these factors are discussed below.

Feeling Accepted and Integrated into UK Society. This subtheme captures the significance of social inclusion and integration on the recovery of RAS. Professionals emphasized that feeling welcomed and accepted within UK society played a critical role in RAS sense of belonging, which was essential for their emotional well-being. While a successful asylum claim was significant in promoting integration and feeling accepted into UK society, the process of integration was also important throughout the asylum-seeking process.

"I would hope that the recovery would be that they feel like anybody else in England" (Participant 2, Health Professional)

Actions that contributed to feelings of integration in RAS varied in magnitude- they could be passive like being around other members of UK society or active such as volunteering or joining community initiatives. Learning English was repeatedly referenced by professionals as a significant driver in helping RAS feel integrated into UK society. While most appointments with professionals involved the use of interpreters, some RAS used these appointments to practice their English.

"I am another person that they can practice small amounts of English with" (Participant 8, Mental Health Professional)

Central Role of Family in Recovery. This subtheme reflects that family connections are foundational to the recovery journey for RAS. They consistently highlighted that family reunification, or knowing that loved ones are safe, provided a sense of emotional stability and hope for RAS. Professionals also noted that family acted as both a source of motivation and a core element of identity. One professional reflected that men valued both being reunited with their family and being able to provide for them:

"Being reunited with family, and if they don't have a family, being able to start one" (Participant 5, Health Professional)

Professionals recognized that the absence of family often compounded the challenges of trauma and displacement, while the presence of family offered an anchor, allowing RAS to feel supported, connected, and capable of building a future in their new environment.

Finding Comfort and Support in Faith. This subtheme reflects the significant role of faith and spirituality in the recovery of RAS. They observed that religious practices, such as

prayer, worship, and participation in faith-based communities helped individuals cope with the psychological impact of displacement and trauma.

"When you speak to someone about what will help them with their mental health, one of the things we see quite frequently is an individual saying "actually probably the most beneficial thing I do is go and worship, go and pray"" (Participant 3, Health Professional)

Additionally, being able to engage in faith-based practices was seen as an important part of preserving one's identity and autonomy.

"To maintain a sense of pride in who they are, you know, as what their cultural identity or their religious identity is because that's the big thing as well" (Participant 5, Health Professional)

Finally, professionals reflected that faith-based communities served as informal support networks, providing emotional, social, and sometimes practical assistance. One health professional emphasized the need to collaborate with faith leaders and religious communities to ensure culturally sensitive care:

"Religious leaders probably have a better understanding of what is going on with their community than we do as a health service looking in, so we need to have that voice." (Participant 3, Health Professional)

Finding Strength in Community. This subtheme reflects the role that community connections play in the recovery of RAS. They noted that engaging with communities provided a sense of belonging and solidarity, which was particularly meaningful for individuals who experienced isolation and displacement. Many emphasized that community activities, whether through shared cultural, religious, or recreational spaces, allowed individuals to rebuild their social networks, foster friendships, and develop a sense of purpose.

"I felt like some of the community interventions are the most important- people connecting to others forming and forming some sense of cohesion within the community… and finding a sense of purpose... there was a lot of healing that could go on through that." (Participant 1, Health Professional)

Community connections also enabled access to informal support systems, which helped address both emotional and practical needs. For example, community groups often provided opportunities for shared experiences, mutual aid, and access to resources such as English classes, employment opportunities, or social events. These interactions reduced loneliness and helped individuals feel accepted and valued, contributing to their sense of identity and stability.

"I've noticed that it's really helpful when the client has some community who are able to gauge in like cost-effective ways with, you know, sharing food and eating well, going to the outdoor gym together or helping each other get bicycles and cycle around" (Participant 7, Mental Health Professional)

There was also a unique emphasis on RAS communities coming together and supporting each other through the challenges that the asylum and resettlement process bring. RAS communities brought another level of understanding and hope to others who may be struggling with the process:

"They provide a huge amount of hope in the way that us as health professionals can't. I can say "it will get better" but they can really show them and say "look, it gets better"" (Participant 5, Health Professional)

3.4 Theme 4: Carrying the Weight of Past Trauma (Barrier)

This theme reflects professionals' recognition of how unresolved trauma can impact the recovery of RAS. Professionals reflected that that many clients arrived with significant psychological scars from their journeys:

"They just survived these really incredible journeys and then got to the UK and... there was nothing, no sense of purpose, they would feel trapped, and I think that's when the PTSD is more prominent." (Participant 1, Health Professional)

Professionals also observed that trauma impacted both emotional well-being and cognitive functions such as memory, concentration, and decision-making, making it harder for clients to engage with support systems.

"We're dealing with clients that are holding severe trauma and this affects cognition, processing memory… it's very frustrating for a lot of clients because even though the opportunities are there, because of the effects of trauma, clients are getting frustrated with themselves... and give up early on." (Participant 6, Mental Health Professional)

This trauma was often manifested as intrusive thoughts, flashbacks, dissociation, and difficulties in forming relationships, which created barriers to rebuilding their lives.

"People that were much more unwell where you're actually talking about just managing very suicidal thoughts or where people are unable to make any relationships because they're too traumatized and too distressed and got too many active symptoms of post-traumatic stress." (Participant 1, Health Professional)

Finally, professionals highlighted that trauma is often compounded by the stressors of the asylum process, even for individuals who have had their asylum status approved.

"Clients have come back to me and said "but I'm still having the intrusive thoughts, still having the flashbacks… the trauma of having gone through the asylum process, it is a deeply traumatic experience." (Participant 7, Mental Health Professional)

Asylum Seekers Trapped in an Inconsistent Cycle of Support. This subtheme reflects the fragmented mental health services that fail to provide consistent care for RAS. They reflected that clients are often "bounced" between different services without receiving the comprehensive, long-term support they need.

"Being bounced, referring into secondary mental health services because you felt that they were pretty complex and then being either bounced to Wellbeing, who would then do an assessment and then say actually, yeah, you're too complex and bouncing back" (Participant 5, Health Professional)

Professionals highlight that systemic barriers, including rigid eligibility criteria and insufficient resources, contribute to this inconsistency. Asylum seekers were often deemed "too complex" for some services but "not unwell enough" for others, leaving them in a liminal space.

"One of the service users that I was seeing ended up coming back [from being discharged from the CMHT] because the team were like "No, they don't meet the criteria, send them to Wellbeing" and then Wellbeing was like, "No, they're too complex"" (Participant 10, Mental Health Professional)

Other factors such as language barriers or relocations by the Home Office further disrupted their ability to establish stable care plans.

"With asylum seekers, they quite often will not read. So, when you're sent a letter to attend or to be available for phone call, they DNA (do not attend), and then they're removed from that service" (Participant 2, Health Professional)

3.5. Theme 5: Struggling Against a Hostile System (Barrier)

This theme highlights professionals' concerns about the barriers created by systemic hostility in the asylum process and its impact on RAS recovery. They observed that the legal and social systems designed to manage immigration often exacerbated the trauma and distress experienced by their clients. Prolonged uncertainty, restrictive policies, and inhumane living conditions, such as detention centres, overcrowded accommodations, or forced isolation, created a sense of instability and reinforced feelings of dehumanization.

"*It highlights that this client group are operating within a system that constantly denies their humanity."* (Participant 7, Mental Health Professional)

When speaking about the conditions within an asylum site, one professional described:

"Housing somebody in incredibly remote locations without any services nearby, no means of getting like no public transport or paths, in an environment that's going to be very retraumatizing with like security guards and barbed wire and things- that feels like a prison" (Participant 4, Health Professional)

Professionals emphasized that the hostile environment within the system often compounded existing psychological wounds, leading to heightened anxiety, depression, and suicidal ideation among their clients.

"The whole system is just incredibly cruel and retraumatizing and creates a lot of distress and unnecessarily unnecessary mental health problems" (Participant 1, Health Professional)

Additionally, professionals note that this systemic hostility undermines recovery efforts:

"There's just so many things within that system to hold back them from even starting to think about recovery- the whole of the system seems to be designed to not aid recovery" (Participant 4, Health Professional)

Professionals advocated for more compassionate, stable, and supportive systems, recognizing that without these changes, RAS remained trapped in a cycle of re-traumatization and disempowerment that hindered their ability to rebuild their lives.

"*[the asylum process] causes a number of PTSD symptoms that many people wouldn't experience if they came into the country and it was immediately supportive and they're immediately supported to find work and set up… you know if our system was fairer and kinder"* (Participant 1, Health Professional)

Living in Deprivation. This subtheme reflects how poverty and a lack of basic resources significantly hinder the recovery of RAS. Professionals report that many individuals are forced to live in inappropriate housing, with minimal financial support and limited access to essential services.

"We were hearing about people that were receiving £30 a month and practically who can live with £30? That will affect one's mental health" (Participant 11, Mental Health Professional)

They also noted that inadequate financial support often restricted individuals' ability to engage in meaningful activities, such as learning new skills, attending language classes, or participating in community life.

"In the existing system, there's so many limitations without having the right to work and not actually huge meaningful opportunities around volunteering and integration into the local community and ability to learn English" (Participant 6, Mental Health Professional)

For professionals, addressing deprivation was not just a social or economic concern but a critical mental health issue. They recognized that without meeting basic needs, it was challenging to engage clients in therapeutic work or support their long-term recovery.

"The medication can only do so much, all the therapy can only do so much when they are living in poverty … I'd say, you know, on a very human level, recovery is very hard for them because of the conditions they live in." (Participant 5, Health Professional)

3.6. Theme 6: Isolation and Otherness (Barrier)

This theme illustrates the impact that isolation from community and core family systems and the pervasive feelings of otherness had on the recovery journey of RAS.

Facing Racism and Being Seen as Other. This subtheme reflects the impact of discrimination and marginalization on the recovery of RAS.

Professionals reported on different experiences that clients had with both overt and covert racism. They also observed how negative societal attitudes and stereotypes limited opportunities for integration, further entrenching a cycle of exclusion and marginalization.

"The attitudes of our society and the lack of compassion and lack of understanding and kindness- it's quite hard to keep being othered all the time. [Asylum Seeker Client] was having panic attacks in the street… he was seeing the people across the road when they saw him because of his colour" (Participant 9, Mental Health Professional)

Language as a Barrier to Integration and Support. This subtheme highlights the impact that language barriers have on the recovery journey of RAS. Professionals reflected that limited proficiency in English often isolated individuals, preventing them from accessing essential services, building community connections, or participating in daily activities that foster integration. Professionals note that language difficulties can make clients hesitant to engage with support systems.

"When we've talked about community, a lot of the time, what they'll say is… "oh but I don't speak English, so how am I going to go to that place or that service or that community"" (Participant 10, Mental Health Professional)

In healthcare and mental health settings, language barriers presented additional challenges. While interpreters could help bridge this gap, professionals highlighted that they sometimes were unsure about the accuracy of interpretations and that some clients are reluctant to use them. This resulted in miscommunication and unmet needs, particularly when discussing complex mental health issues that required deep understanding and trust.

"The other group that is very hard is those that have got a level of English proficiency, but not fluent, because they may decline an interpreter. Their level of English proficiency is OK for kind of more physical, straightforward things… but for more subtle, really trying to grasp their mental health- that's trickier" (Participant 5, Health Professional)

Professionals also observed that language proficiency was closely linked to clients' sense of autonomy, empowerment, and self-expression. For many, learning English represented a practical necessity and a pathway to greater self-sufficiency, integration, and confidence.

"People who speak are able to speak some English who learn some English it- that's quite transformative for them usually" (Participant 4, Health Professional)

Loneliness and Disconnection from Community. This subtheme reflects how isolation and a lack of community affected the recovery of RAS. Professionals highlighted that disconnection from community was a significant indicator that individuals were struggling with poor mental health.

"People that were suffering with PTSD, you could see they were isolated, not able to concentrate on anything… and so they weren't forming new friendships. You could sort of get a

sense of where people were in terms of whether they managed to start to get a support network locally." (Participant 1, Health Professional)

However, professionals also observed that loneliness was exacerbated by systemic factors, such as being housed in remote locations with few resources or community networks. This meant that being isolated from a community was the norm rather than an exception.

"Individuals who say "I'm really struggling with my mental health, my moods quite low, I feel really isolated" and when you go into what their daily activities are, they say "well, the system has broken me. All I have to do is sit in my room watching videos either on my phone or the TV. I don't have anyone to talk to and I only leave my room to go and eat"" (Participant 3, Health Professional)

Even when opportunities for community engagement are available, fear, stigma, or a lack of familiarity with local services discouraged individuals from participating.

"The [asylum] site is very isolated; we're not allowed to go on to the site to deliver services. After quite a lot of negotiating, the Home Office put on some buses to bring people to our sessions- but they've cancelled all of those buses now… the time when we were setting up was around the Rwanda announcements and people were getting detained after getting on buses- so people were quite scared about getting on like buses to get off the site." (Participant 4, Health Professional)

Enduring Separation from Loved Ones. This subtheme captures the emotional toll that family separation has on RAS recovery.

Being separated from family members often created a persistent source of distress, anxiety, and longing. For many clients, the uncertainty surrounding their loved ones' safety and well-being in their home countries or during the migration process prevented them from fully

engaging in their recovery or focusing on their own needs. For some, this left them with a sense of "survivor's guilt". Additionally, the desire to reunite with family or bring them to safety frequently became a dominant focus, overshadowing other aspects of recovery.

"Survivor's guilt- "my community is still there, there are still killings happening, I'm still getting updates all the time about the killings", so there is that which creates enormous amounts of distress" (Participant 6, Mental Health Professional)

"I think if you come on your own and you still have a lot of family left behind, I think it's very hard to really move forward but before you know that family is safe or if you have this constant anxiety about your loved ones wellbeing and safety" (Participant 1, Health Professional)

Professionals noted that for clients who viewed family as a central source of emotional support, the absence of loved ones left a significant void. Additionally, the desire to reunite with family or bring them to safety could at times take a dominant focus.

"*We spoke about his mother, who he spoke on the phone to and every day. And the fact that that was really hard for him [to be away from her]"* (Participant 9, Mental Health Professional)

"*Often you would be drawn into something like: "Oh I really need my wife to come over, I've been working hard for my wife to come over. We're not getting anywhere" and they're distressed because of it"* (Participant 1, Health Professional)

4. Discussion & Conclusion

This study provides an in-depth exploration of the meaning of recovery for RAS through the lens of health and mental health professionals that have been supporting RAS within the East of England. It is the first study of its kind that conceptualizes the mental health needs of RAS through a recovery framework and through the perspectives of the professionals supporting this population. The following six key themes emerged from this study: 'living well with trauma',

‘finding security in the asylum claim’, ‘the power of integration & community’, ‘carrying the weight of past trauma’, ‘struggling against a hostile system’, and ‘experiences of isolation & otherness’.

The themes of Living Well with Trauma and Carrying the Weight of Past Trauma captured the dual realities faced by RAS as they navigated their recovery journeys alongside their unresolved traumas- both pre-migration and post-migration. These findings align with research showing high prevalence of significant psychological difficulties within this population, and the impact that trauma has on the cognitive functioning of RAS (Schick et al., 2016; Yoon & Fisseha, 2019; Taylor et al., 2024). It also aligns with research highlighting difficulties that RAS face when accessing mental health services (Salvo et al., 2017; Peñuela-O’Brien et al., 2023). Despite the impact of these unresolved traumas, professionals noted that recovery involved learning to coexist with these traumas rather than erasing them. Research on resilience is prominent in the field of RAS mental health, with many studies showed that despite the hardship endured by RAS, many individuals go on to thrive in their new host countries (Yoon & Fisseha, 2019; Lindert et al., 2023).

The themes of Finding Security in the Asylum Claim and. Struggling Against a Hostile System highlighted the pivotal role of the asylum process in shaping the recovery trajectories of RAS. This finding maps on to research showing that post-migration stressors experienced by RAS can have a significant impact on their wellbeing- these include experiences of unemployment, financial difficulties, insecure housing, and perceived discrimination from others (Shick et al., 2016; Li et al., 2016; Salove et al., 2017; Phillimore & Cheung, 2021; Feyissa et al., 2022). The professionals in this study also highlighted that securing legal status provided individuals with a sense of stability and safety, of integration into UK society, and the right to

work and develop financial independence, all of which contributed to the recovery of RAS. A systematic review by Li and colleagues (2023) further highlights the positive impact that employment, social connectedness and integration have on the development of resilience within RAS.

Finally, the themes of The Power of Integration and Community and Experiences of Isolation and Otherness reflected the importance of social connectedness and community on the recovery of RAS. Experiences of isolation, exacerbated by language barriers, separation from loved ones, and systemic discrimination, often left RAS feeling marginalized and disconnected from their host society. The impact of language barriers is supported by a study by Salvo and colleagues (2017) which found that closing the language barrier led to greater feelings of autonomy and achievement while low levels of language competence led to feelings of dependence and distress. Other studies also highlighted the impact of lack of integration, separation from family and social factors such as discrimination has on the emotional wellbeing of RAS (Li et al., 2016; Schick et al., 2016; Taylor et al., 2024). The findings also showed that social alienation not only amplified psychological distress but also hindered access to essential services and support systems. This is highlighted by a systematic review by Alemi and colleagues (2014) that found that language conflicts alongside feelings of alienation were significant contributors to low mental health care utilization for Afghan refugees (Alemi et al., 2014). In contrast, professionals reflected that integration was achieved through RAS finding comfort and support in their faith, being able to reunite with or establish new family networks and finding strength within community groups. Many studies have highlighted the positive impact that engaging in faith practices and religion has on the wellbeing of RAS (Brijnath, 2015; Lindert et al., 2023; Taylor et al., 2024).

Additionally, these findings align with the CHIME model (Leamy et al., 2011) of personal recovery, providing a greater understanding of recovery processes in RAS populations. The themes of The Power of Integration and Community and Experiences of Isolation and Otherness particularly resonate with the Connectedness component, as participants highlighted the crucial role of social relationships, community belonging, and integration in their recovery process. Similarly, Finding Security in the Asylum Claim reflects Hope and Optimism, where securing legal status and financial independence offered RAS a renewed sense of future possibilities. Identity was rooted within Carrying the Weight of Past Trauma, as unresolved trauma shaped participants' sense of self and belonging. Additionally, Meaning in recovery emerged through coping strategies identified in Living Well with Trauma, such as rediscovering purpose, engaging in faith, and developing resilience despite ongoing psychological distress. Finally, the Empowerment aspect of CHIME was reflected in the emphasis on regaining autonomy over life choices, whether through employment, language acquisition, or community engagement. While CHIME provides a useful framework for understanding recovery, this study extends existing research by emphasizing the impact of structural barriers on refugees and asylum seekers (RAS) on their personal recovery journey. The findings highlight how immigration policies, the asylum process, and systemic discrimination shape RAS's recovery. Themes such as Finding Security in the Asylum Claim and Struggling Against a Hostile System illustrate how legal status, housing, and financial security are critical to recovery. Finally, this study expands CHIME's Connectedness dimension, showing that integration goes beyond relationships to include navigating systemic obstacles, and finding support through faith, peer networks, and cultural communities.

4.1. Strengths and Limitations

The study provides unique contributions to the field of RAS mental health. It addresses an under-researched area by exploring personal recovery through the lens of health and mental health professionals who are supporting RAS, offering valuable insights into the recovery needs of this population.

One strength of this study is the recruitment of a diverse group of professionals that are working within different services, professions, and locations across the East of England. Balancing the perspectives of both health and mental health professionals allowed for a more nuanced understanding of recovery perspectives as different professions are supporting RAS at different capacities. Additionally, including both health and mental health professionals in a topic that focuses on wellbeing acknowledges the research that shows that RAS are more likely to present to primary care for their concerns (Due et al., 2020). Another strength in this study was the use of online semi-structured interviews with the professionals being recruited. This allowed for the interview to be accessible to professionals working across the East of England, adding to the diversity of professionals who were then recruited for the study. Additionally, the semi-structured nature of the interviews allowed for a balance between structure and giving the participants the space to guide the conversation and share their unique perspectives (Ruslin et al., 2022). Thematic Analysis was well suited to the aims of this study, offering a structured yet adaptable framework for capturing nuanced professional perspectives on recovery. The method's transparency and emphasis on reflexivity enhanced the credibility and dependability of the findings, aligning with trustworthiness standards in qualitative research (Nowell et al., 2017).

However, the study also has limitations that should be acknowledged. One limitation is around the lack of perspectives of RAS themselves. This overlooks the lived experiences and

personal recovery narratives of RAS, as their narratives are interpreted through the lens of a healthcare professional. Another limitation comes from the way that recruitment was undertaken, which was through the Advancing Mental Health Equality (AMHE) Refugee and Asylum Seekers Professionals group run by the Royal College of Psychiatrists. This potentially represents a group of professionals who are likely to have similar opinions about the field of RAS wellbeing and health provision as they work in the same health and social care system. This may limit the generalizability of the findings and its applicability to a wider population of health and mental health professionals, and future research would benefit from recruiting professionals from more than one group. Finally, while the sample of participants are occupationally diverse, they are limited in ethnic diversity with most participants identifying as White British. When considering the ethnic and cultural diversity of RAS populations, this may have impacted on the perspectives of recovery as shared by the professionals.

4.2. Clinical Implications

The findings of this study highlight important considerations when it comes to the mental health care of RAS and offers a perspective to the conceptualisation of recovery for RAS. It emphasizes a recovery-based approach to conceptualizing the unique mental health needs of RAS, and the implications that this approach has on their care.

Firstly, community-based interventions are highlighted by the findings as being valuable facilitators of recovery. Interventions that foster social connectedness and promote the active participation of RAS in their local communities can mitigate feelings of isolation and otherness. This aspect of recovery is conceptualized as “social recovery” and has become increasingly more recognized in the literature (Norton & Swords, 2021). Similarly, interventions should not only focus on pre-migration trauma but also address the post-migration stressors identified in this

study, such as socio-economic insecurity, discrimination, and restricted access to meaningful community integration.

Crucially, these findings call for health professionals to adopt a compassionate and curious stance when working with RAS. Rather than relying on pre-defined recovery goals or assumptions about mental health needs, professionals are encouraged to engage openly and reflexively with each individual's cultural worldview and recovery journey. Research has underscored the importance of cultural humility, the willingness to acknowledge what we do not know about another person's cultural background, and to position ourselves as learners in the therapeutic relationship (Lekas et al., 2020). This contrasts with traditional notions of cultural competence, shifting the focus from expertise to relational curiosity and respect.

Finally, addressing systemic barriers is critical as the mental health of RAS cannot be considered without recognizing the harmful psychological impact of the asylum system. The Equality and Human Rights Commission's (2019) report emphasizes a human rights-based approach to healthcare for asylum seekers, advocating for equitable access. It highlights the importance of cross-sector collaboration between healthcare providers, NGOs, and community organizations to create integrated support networks. Additionally, the report underscores the need to educate asylum seekers on their healthcare rights and navigate systemic barriers such as unclear eligibility criteria or documentation issues. By adopting these practices, healthcare services can better meet the complex needs of asylum seekers and ensure inclusive and equitable care.

4.3. Recommendations for Future Research & Conclusion

Future research should prioritize capturing the lived experiences of RAS to complement and expand on the perspectives provided by healthcare professionals. While the current study

highlights valuable insights from professionals working with RAS, it remains crucial to understand how RAS themselves conceptualize recovery and navigate the barriers they encounter. Additionally, there are different barriers and stigmas that can get in the way of RAS expressing their recovery narratives to the professionals that are supporting them. These can include language barriers, power imbalances, cultural beliefs around sharing personal information, restricted appointment times, and RAS own understanding around the nature of their appointments with these professionals (Kiselev et al., 2020; Penuela-O'Brien et al., 2022). Moreover, involving RAS in participatory research methods, such as co-designing studies or engaging in collaborative data interpretation, can empower them as active contributors to the knowledge base.

Overall, this study highlighted the growing field of recovery-based frameworks of mental health and adds a novel exploration of RAS recovery needs from the perspectives of their health and mental health providers. The findings emphasized the importance of addressing structural inequities, such as the adversities of the asylum process and inconsistent mental health support, while fostering community integration and empowerment as key components of recovery.

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Chapter Five: Extended Methodology

Word count: 4,273

The extended methods chapter of this portfolio outlines the developmental underpinnings of the empirical study and the process of utilizing thematic analysis in the project. Additionally, reflections throughout the duration of the empirical study are provided. This section hopes to outline the details behind the research process for the study through understanding the analysis method chosen, the research paradigm followed throughout the study, and the reflexivity behind the project.

Thematic Analysis

Thematic Analysis (TA) was used to analyse the interview data, drawing on Braun and Clarke's (2006) reflexive approach. This approach is grounded in a contextualist and interpretivist epistemology, which assumes that knowledge is situated, socially constructed, and shaped by the contexts in which it is produced. Rather than seeking an objective "truth" within the data, reflexive TA recognises the active role of the researcher in generating meaning through ongoing interpretation. This orientation aligned with the aims of the current study, which sought to explore how professionals working with refugees and asylum seekers (RAS) understand the concept of recovery, a value-laden construct that is shaped by personal, cultural, and systemic influences. Reflexive TA was chosen for its compatibility with experiential and meaning-focused research. The study did not aim to test a pre-existing theory, but rather to illuminate diverse understandings of recovery from the perspective of professionals embedded in various service contexts. TA's flexible yet rigorous structure provided the tools to explore these understandings inductively, while its interpretivist roots supported engagement with the sociopolitical and relational dynamics that inform participants' accounts. As Braun and Clarke (2022) highlight, reflexive TA facilitates the development of conceptual insights rather than simply descriptive themes, which was consistent with the study's objective to inform recovery-oriented and culturally responsive practices in RAS mental health care.

Research Paradigm

The empirical study adopted Critical Realism (CR) as its guiding research paradigm, a framework originally developed by Bhaskar (1975) that is increasingly recognized for its suitability in healthcare research (Danermark et al., 2002; Waring et al., 2019). CR posits that reality exists independently of human perception but that our understanding of this reality is shaped by social and cultural contexts. This distinction between ontological realism (an independent reality) and epistemological relativism (our knowledge of reality) provides a balanced lens through which to investigate the complex dynamics of mental health recovery among refugees and asylum seekers.

Ontological and Epistemological Foundations

CR distinguishes between three levels of reality: the empirical, actual, and real. The empirical level refers to what is observed and experienced, while the actual level encompasses events that occur whether or not they are observed. The real level consists of the deep, underlying structures and mechanisms that generate events (Bhaskar, 1975). This stratified ontology allows for the identification of both the observable phenomena in mental health recovery (e.g., health professionals' perspectives) and the deeper, often unobserved, causal mechanisms (e.g., structural inequalities, systemic barriers) that influence these phenomena (Wainwright & Forbes, 2000; Fletcher, 2017).

This approach is particularly valuable in studying healthcare systems, where social, cultural, and institutional structures play significant roles in shaping individual experiences (Archer et al., 2013). By employing CR, this study seeks to move beyond surface-level observations of health professionals' views on recovery to uncover the broader systemic and contextual factors that shape these perspectives, such as immigration policies, healthcare access, and socio-economic challenges faced by refugees and asylum seekers (Karadzhov, 2021).

Suitability of Critical Realism for the Study

CR is well-suited for research in healthcare, particularly in contexts involving marginalized or vulnerable populations such as refugees and asylum seekers (Waring et al., 2019). Its emphasis on both structure and agency, acknowledging that individuals' actions are shaped by broader social structures while still allowing room for personal agency, aligns well with the study's focus on mental health recovery. CR allows the researcher to explore how macro-level forces (such as healthcare policies and immigration laws) interact with micro-level experiences (such as individual resilience and healthcare professionals' interventions), providing a more comprehensive understanding of the recovery process (Danermark et al., 2002; Karadzhov, 2021).

In healthcare research, CR has been noted for its ability to uncover the causal mechanisms that influence health disparities, particularly among vulnerable groups (Houston, 2001). Refugees and asylum seekers face unique challenges that are not always visible in empirical observations, such as structural discrimination, trauma histories, and barriers to accessing mental health services. By using CR, this research can investigate not only the observable outcomes but also the deeper social, cultural, and institutional factors that affect mental health recovery (Fletcher, 2017; Archer et al., 2013).

Moreover, CR's commitment to understanding the real level of causality makes it a powerful tool for identifying how health professionals' perceptions of recovery are shaped by the broader social and institutional context in which they operate (Wainwright & Forbes, 2000). This is critical for developing a nuanced understanding of how recovery is conceptualized and facilitated, and how systemic barriers can be addressed to improve care for RAS.

Method

Patient and Public Involvement

The initial iteration of the empirical study involved a current refugee service user of mental health services (particularly Recovery College within the UK). Their involvement in services was the primary driver around choosing to focus on understanding the meaning of recovery for refugees and asylum seekers due to their unique experiences of utilizing Recovery College. Unfortunately, shortly after beginning the project, this service user disengaged from the project due to suddenly leaving the United Kingdom. As a result, I was not able to incorporate the service user's important perspective as a current refugee throughout the duration of the study. Following the service user's disengagement, a key systems stakeholder who is involved in different sectors and aspects of refugee care was sought for professional involvement and co-production. I met with this professional, who provided advice and helped inform the framing of the study. Additionally, in the early stages of the project I attended one of the monthly meetings ran by the Advancing Mental Health Equality (AMHE) Refugee and Asylum Seekers Professionals group to introduce myself and the project.

Developing the Topic Guide

The topic guide was collaboratively developed with BT (the primary supervisor) during thesis supervisor meetings and underwent different iterations. It was informed by empirical literature on recovery and on the utilization of primary health and mental health services by RAS. Additionally, based on the recommendations by Creswell and Cresswell (2018) and to ensure that the guide upheld its semi-structured nature, 8 central questions were explored during the interviews.

The topic guide was divided into two sections. The first section encompassed 4 questions and focused on professionals' experiences of working with RAS- this emphasis was included in

the beginning stages of the interview to understand the context under which professionals were supporting RAS. The second section also included 4 questions and were around introducing the concept of recovery to professionals and understanding their perceptions around recovery for this population. The definition of recovery by Leamy et al. (2011) was provided to professionals to help operationalize the concept that we were exploring in interviews. Despite a definition being provided, professionals were also encouraged to provide perspectives on recovery that may not fully align with the definition provided if they felt it reflected their work with RAS.

Interview Design

Online interviews were chosen for this study to promote its accessibility and to show sensitivity to professionals' busy schedules, saving them travel time. As recruitment took place across a vast region of the United Kingdom (East of England), it was important to capture multiple perspectives from practitioners across the region.

Analysis

The thematic analysis approach encompasses six stages: 1) familiarisation with the data; (2) generating initial codes; (3) constructing candidate themes; (4) reviewing and refining themes; (5) defining and naming themes; and (6) producing the final analytic narrative with illustrative quotes (Braun & Clarke, 2006). The stages are recursive and iterative rather than linear, allowing for ongoing movement between phases as understanding deepens.

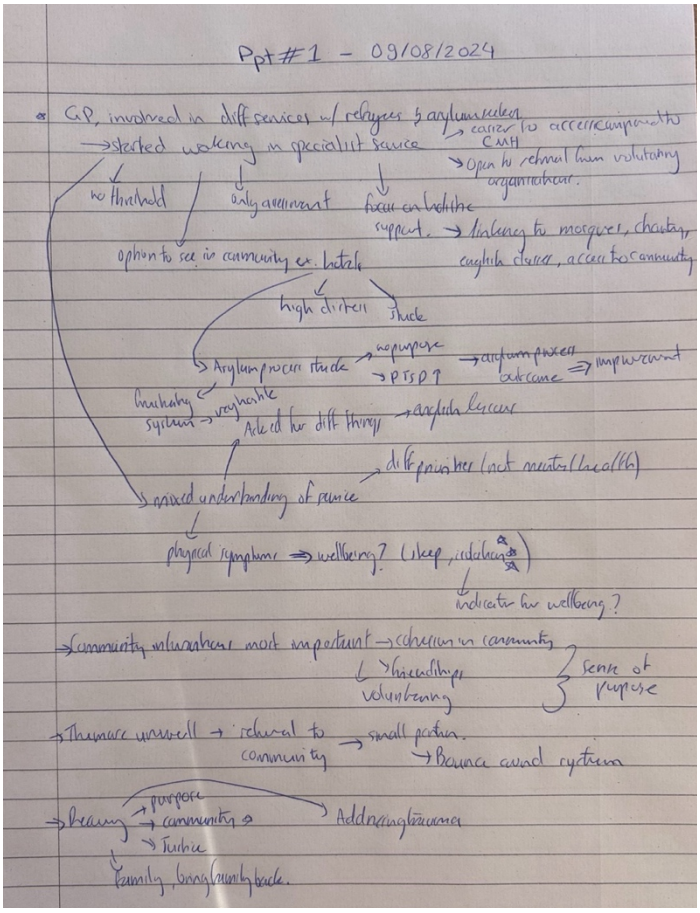
Familiarisation with the Data

The familiarisation phase involved being immersed in the data to develop a holistic sense of each participant's narrative before formal coding began (Braun & Clarke, 2022). All interviews were transcribed verbatim by the researcher (LO), allowing for early engagement with the tone, rhythm, and emotional nuances of each conversation. Transcribing the data firsthand facilitated a closer connection to participants' language, hesitations, and emphasis, which helped shape early

analytic impressions. Following transcription, the researcher read each transcript multiple times in its entirety. During this phase, the researcher began writing informal memos to capture initial observations, patterns, and questions (Figure 1). This groundwork laid the foundation for more formal coding in the next phase and supported the development of a deeper interpretative engagement with the data from the outset.

Figure 1.

Participant 1 Interview Memos

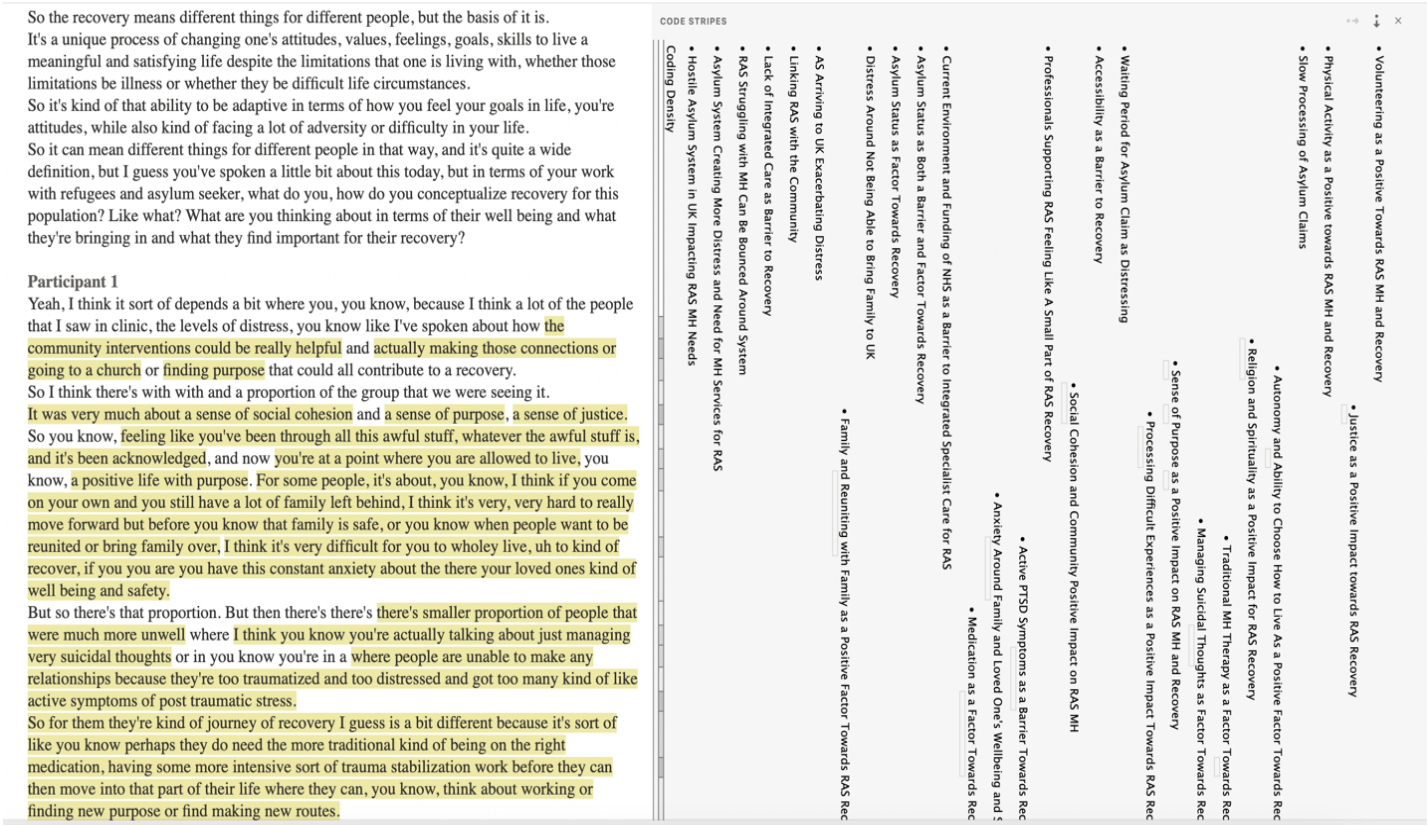


Generating Initial Codes

Once familiarisation was complete, the second phase involved systematically generating initial codes across the entire dataset. Coding was conducted inductively, meaning that codes were developed directly from the data rather than being shaped by a pre-existing theoretical framework. This allowed the analysis to remain grounded in participants' language and experiences, while still shaped by the researcher's interpretative lens (Braun & Clarke, 2022). Coding was carried out using NVivo software, which helped to organise the data and track analytic decisions. Each transcript was coded line-by-line, with attention paid to both semantic content (what was said) and initial interpretative insights (what might be meant). Codes captured aspects of meaning relevant to the research question. During this phase, codes were intentionally kept close to the data and numerous, reflecting the complexity of the dataset. The coding process was iterative, with the researcher revisiting and revising earlier transcripts as new codes were developed. Coding decisions and reflections were documented through analytic memos, which supported transparency and laid the groundwork for theme development. An example of this can be seen in Figure 2, showcasing a portion of Participant 1's line by line coding in NVivo. There was a total of 330 codes generated across all 11 participant interviews at this stage.

Figure 2.

Participant 1 Nvivo Line-by-Line Coding



Constructing Candidate Themes

After initial coding was completed across all transcripts, the next phase involved examining the full set of codes to begin constructing candidate themes. This process entailed clustering related codes together and exploring their conceptual connections. Codes were categorised by shared meaning, interpretative resonance, and relevance to the research question (Braun & Clarke, 2022). Candidate themes were initially broad and overlapping, reflecting the richness and complexity of the data. This stage involved moving back and forth between codes, data extracts, and initial memos to refine the boundaries of candidate themes. Regular discussions with the supervisor (BT) provided a space to critically reflect on the coherence and relevance of candidate themes and to check that they remained grounded in participants' accounts.

Reviewing and Refining Themes

The fourth phase involved critically reviewing and refining the candidate themes to ensure they were analytically robust, coherent, and clearly distinct from one another. This was an iterative process in which themes were assessed both in relation to the coded data and the dataset as a whole (Braun & Clarke, 2006). The goal at this stage was to engage in deeper analytic thinking to determine whether each theme captured a meaningful and defensible pattern of shared meaning relevant to the research question. Each candidate theme was examined for internal coherence, ensuring the codes within a theme were conceptually aligned, and for external differentiation, ensuring each theme offered a distinct contribution to the overall narrative. This involved revisiting original data extracts, re-reading full transcripts, and mapping the relationships between themes. Refinement also involved articulating the "central organising concept" of each theme, that is, the specific idea that bound together the varied meanings within the theme (Braun & Clarke, 2022). Attention was paid to how themes worked together to tell a coherent analytic story about professionals' understandings of recovery. Throughout this process, regular supervisory discussions were used to interrogate early interpretations, surface implicit assumptions, and challenge conceptual overlap. These dialogues helped ensure the developing themes remained grounded in the data while supporting analytic complexity. Examples of this can be found in Figures 3 & 4, which represent the categories of 'Poverty and Lack of Finances as a Barrier to Recovery' (Figure 3) and 'Religion and Spirituality as a Positive Impact for RAS Recovery' (Figure 4). During this stage of coding, there were around 34 codes related to barriers to recovery, and 57 codes related to facilitators to recovery.

Figure 3.
Formation of 'Poverty and Lack of Finances as a Barrier to Recovery'

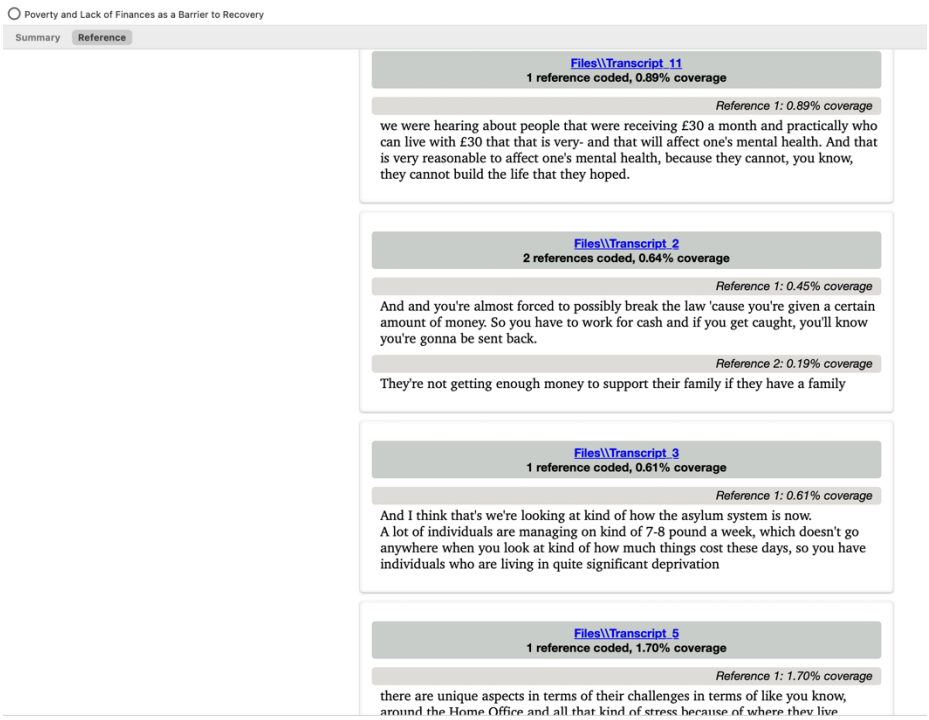
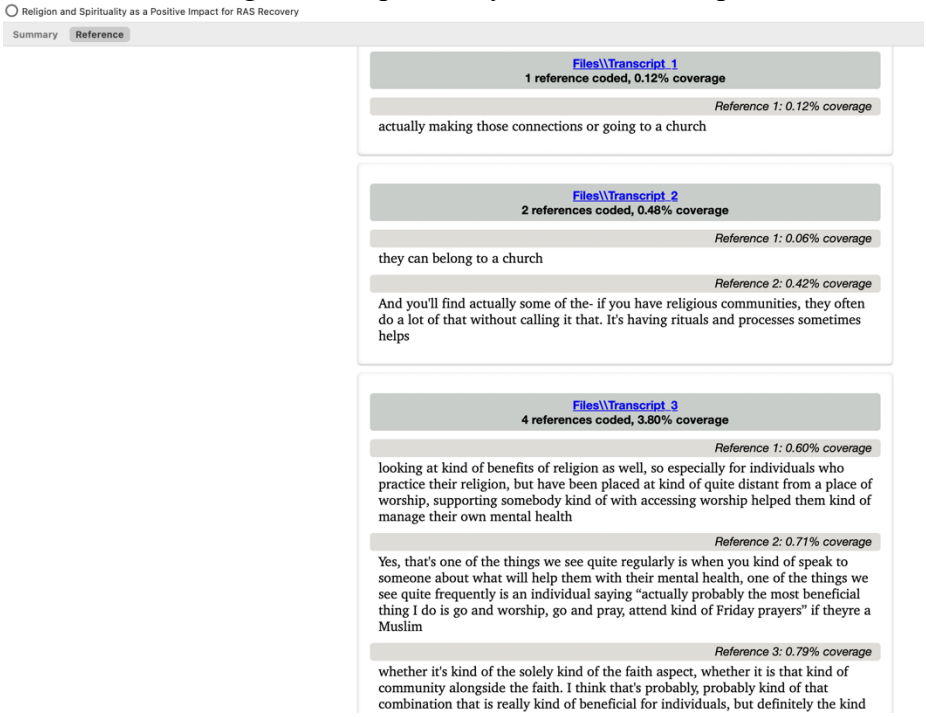


Figure 4.
Formation of ‘Religion and Spirituality as a Positive Impact for RAS Recovery’



Defining and Naming Themes

In this phase, the focus shifted to clearly defining what each theme was about and how it contributed to answering the research question. This stage of the analysis moved from the use of NVivo 14 to Microsoft Word as I felt that it was useful to my analysis to transfer the core categories into a different interface while keeping the "skeleton" of the analysis intact. This stage involved deeper conceptual work through pinpointing the central organising concept of each theme and articulating its boundaries and internal structure (Braun & Clarke, 2022). Each theme was examined in detail to identify its specific contribution to the overall analytic narrative. Themes were understood as interpretative stories that captured something significant about how recovery was constructed and understood in the context of refugee and asylum seeker mental health care. Theme definitions were developed inductively, through a close engagement with the data, codes, and prior analytic memos. Theme definitions and names were refined collaboratively through discussion with the supervisor (BT), who provided feedback on clarity, distinctiveness, and alignment with the dataset. This ensured that the final thematic structure was both conceptually robust and accessible to the intended audience of practitioners and researchers working in refugee mental health. An example of this process can be seen in Figure 6, where text in black indicated a theme I outlined, while the red reflected comments made by BT. During this stage of coding, 16 core categories were identified, with 9 being related to facilitators to recovery and 6 being related to barriers to recovery.

Figure 6.
Defining and Naming Emerging Themes

Men Healing Through Physical Activity (Emphasize the use of physical activity by men to betther their recovery)	Ppt 1: • whether that be through football Ppt 2: • just a sports hall or clubs Ppt 3: • So exercise comes up quite frequently Ppt 4: • I guess we've seen people like, the people who cope the best and seem to sort of like be- they seem to have imporved the most people who have developed a bit of routine for themselves and like the using the gym Ppt 5: • I do think physical activity is a huge thing for quite a lot of the young men. Ppt 7: • So you know, and it's really helped I've noticed that it's really helpful when, like the client has some community who are able to gauge in like cost effective ways with, you know, sharing food and eating well. Going to like the outdoor gym together or helping each other get bicycles and cycle around Ppt 9: • So connecting with other people, so he built relationships within his own community and he was sharing a flat with people, he was doing salsa dancing. He was cooking, he wanted to be a chef. He had aspirations and and vision and hope, and he had a very active gym life. He was a member of a gym and he used to go there, I think daily and he was learning English. In fact, one day I couldn't, I think this is like halfway through the sessions, I couldn't get the interpreter online, so I went downstairs to collect him and sort of tried to sort of and explain that we haven't gotten interpreter and he said “don't worry, [NAME] confidence is key.”

Producing the Final Analytic Narrative

The final phase of Thematic Analysis involved weaving the refined themes into a coherent and compelling analytic narrative that addressed the research question and reflected the complexity of the dataset. The aim was to situate each theme within the broader sociocultural and systemic context in which participants were embedded. Quotes were chosen for their clarity, relevance, and ability to reflect both shared understandings and points of divergence across participants. Attention was paid to maintaining the integrity of participants’ accounts and avoiding decontextualisation. Where appropriate, quotes were lightly edited for readability, with ellipses indicating omissions and square brackets used for clarification. Pseudonyms were assigned to protect confidentiality. The narrative was structured to reflect the interrelated nature of the themes, highlighting how professional understandings of recovery were shaped by values, cultural contexts, systemic barriers, and relational processes. Reflexivity was embedded in the write-up, with the researcher acknowledging their interpretative role and the influence of their clinical and research background on the construction of the analytic account. In this stage, the

two final categories of barriers and facilitators to recovery were solidified, alongside the six core themes that emerged from the data. Upon reflection and discussion during supervision meetings with BT, within the six themes, there appeared to be three continuums within which the themes were operating. While these continuums were not explicitly discussed in the empirical study, I felt that it was important to represent them visually in the diagram of the themes. I felt that the visual representation of the themes was important in telling the story of the data. As a result, many iterations of this visual representation were attempted including placing the different themes on a wall (Figure 7) and designing the visual on a graphic design platform (Figure 8).

Figure 7.
Themes Grouped Together on Wall

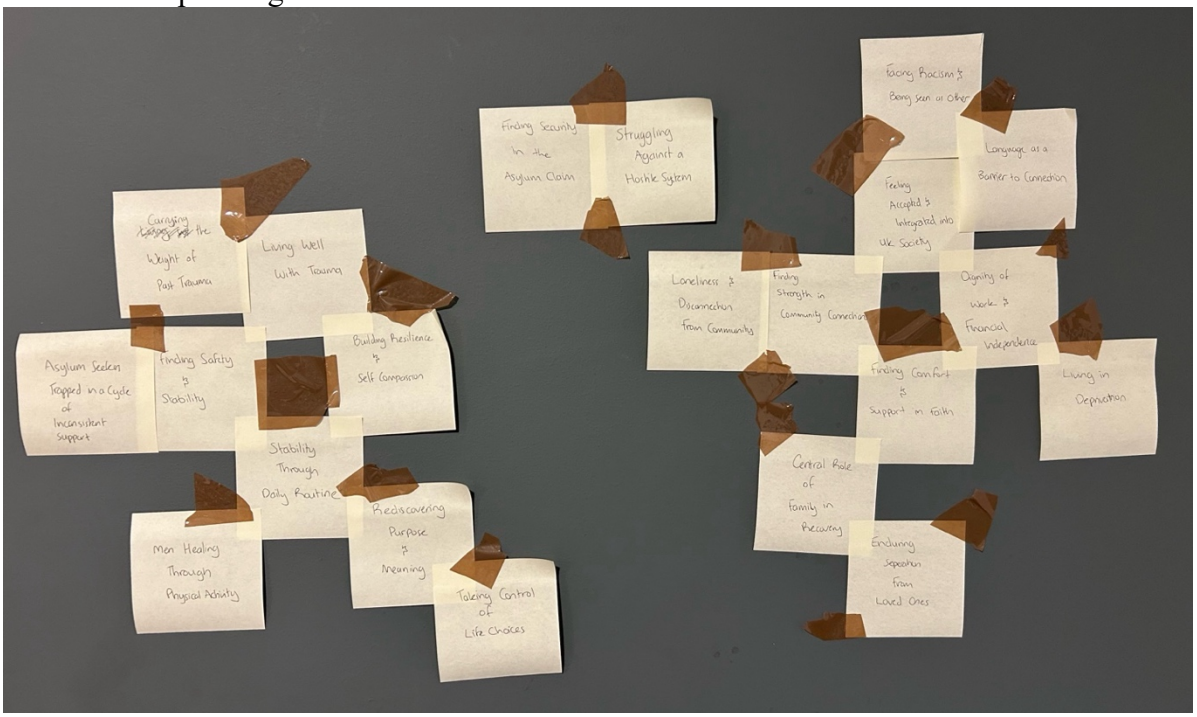
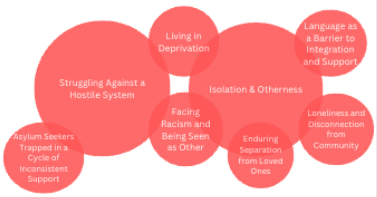


Figure 8.
Graphic Design of Visual Representation

Facilitators to Recovery

Barriers to Recovery



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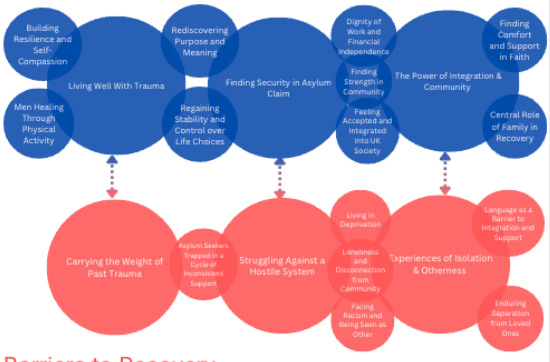
Facilitators to Recovery



Barriers to Recovery

Reflexivity

Reflexivity is integral in qualitative research and reflects the researcher's ability to explore their own thoughts and feelings around the research at the beginning, middle, and end of their projects (Shaw, 2010). In qualitative research, reflexivity is woven into the process to enhance the research's quality and validity. Researchers engage in self-awareness, acknowledging and mitigating their own biases and preconceptions (Denzin & Lincoln, 2018). They consider their positionality, recognizing social context and power dynamics that might affect the research (Hammersley & Atkinson, 2007). Transparency is key, with researchers openly disclosing their personal biases, affiliations, and conflicts of interest (Denzin & Lincoln, 2018). Consistent with reflexive TA, I approached the data as an active meaning-maker situated within particular cultural and disciplinary contexts (Braun & Clarke, 2022).

Researcher's Position

An important part of this empirical study is the acknowledgement of my positionality as a researcher- this is a pivotal aspect of qualitative research as it can impact the analysis and interpretation of data (Berger, 2015).

I am a White European and Arab woman, the daughter of a first-generation Syrian/Romanian immigrant family where both my parents uprooted their lives to provide a better future for their children. Due to my family structure, I was raised Arab and Muslim and grew up in the United Arab Emirates, where my parents immigrated in 1990. Growing up, I spent my summers in Syria with my extended family and my last summer in Syria was in 2010, one year before the civil war. Witnessing the journeys of many Syrian asylum seekers and refugees has had a substantial impact on me. It has forced me to reflect on my privilege of being a part of an immigrant family that had a choice to leave their home. To this day, being an immigrant remains a strong part of my identity, as I have had my own personal journey of

uprooting and travelling to Canada and the United Kingdom to further my education and career as psychologist. My personal identity and experiences profoundly shaped my approach to the interviews and allowed me to be sensitive to and tuned in with the many difficulties faced by RAS. They provided me with a contextual understanding that enabled me to engage with participants' narratives with both sensitivity and genuine curiosity. This background allowed me to navigate complex topics with empathy, while maintaining an inquisitive stance that fostered deeper exploration of their perspectives. I was not approaching these conversations as an outsider; rather, my understanding of displacement, belonging, and cultural identity enriched the dialogue, allowing for more authentic and meaningful exchanges.

I must also acknowledge my current standing as a mental health professional in training, and that the combination of my identity and my training as a clinical psychologist shape my understanding of recovery. I was mindful during interviews to not impose my own framing as I was aware that not all professionals have the same exposure to this concept. I felt that the richness of the data would be compromised if I had been biased towards my own understanding, and so I made sure to hold an attitude of curiosity and openness during instances where participants disagreed with the concept of recovery.

Finally, in between my identity and my profession lies my passion for advocacy and social justice, particularly concerning the human rights of migrants. This passion is not separate from my work as a clinical psychologist in training but deeply intertwined with how I view mental health, recovery, and the systemic factors that shape individual well-being. Advocacy for me goes beyond policy or activism, it is embedded in how I approach my work, whether through amplifying the voices of marginalized communities, challenging narratives that dehumanize refugees and asylum seekers, or fostering spaces where individuals feel seen, heard, and valued.

This drive for social justice also influenced how I conducted my research. I approached interviews not just as a data collection process but as an opportunity to bear witness to the experiences of professionals supporting RAS within challenging and often hostile systems. I was mindful of the ethical responsibility this carried, to ensure that the narratives I gathered were represented with integrity, nuance, and respect. At the heart of this research is a commitment to humanizing the discourse around migration and mental health, shifting the focus from 'complex cases' to the recognition of resilience, dignity, and shared humanity.

Maintaining Reflexivity

My reflexivity was maintained throughout the project in the form of keeping a reflexive journal where I documented my thoughts and feelings that arose throughout my research. The diary also contained accounts of what decisions were made throughout the project, as well as the reasoning behind them.

Throughout the study, two Arabic words pivotal to the experiences of migration resonated deeply with me, enriching my understanding of recovery. The first, *al-ghorba* (الغربة), encapsulates the profound sense of displacement and longing for one's homeland, a sentiment that surfaced in participants' narratives about RAS enduring the psychological impact of forced migration. The second, *istiqraar* (إستِقرَار), meaning settled-ness or stability, reflects the aspirational journey towards a sense of belonging and emotional security. These concepts allowed me to engage with participants' descriptions of the different losses experienced by RAS and their process of recovery through both a culturally sensitive and academically critical lens, shaping my reflections on how recovery is navigated in contexts marked by displacement and systemic uncertainty.

While preparing for and conducting interviews, I also remained mindful of the evolving political landscape surrounding refugees and asylum seekers (RAS) in the UK, particularly the

government's Rwanda policy and the subsequent protests following the devastating Southport murders in 2024. The UK's Rwanda policy and the Southport riots both reflected complex and often divisive public and political attitudes towards refugees and asylum seekers, revealing themes of hostility, deterrence, fear, and resistance alongside solidarity and opposition to government policies. While these events reflected increasing hostility towards RAS in public and political discourse, it was equally important to recognize the strong presence of individuals, organizations, and communities actively fighting for the rights and compassionate treatment of refugees and asylum seekers. This duality of systemic hostility and resilient advocacy was reflected in my participant interviews, with many expressing feelings of helplessness within a hostile system while simultaneously demonstrating steadfast commitment to providing compassionate care. Reflecting on these dynamics allowed me to engage with participants more thoughtfully, acknowledging the broader socio-political forces that shaped both their work and the recovery journeys of the RAS they supported. An example of this was during my interview with Participant 1, who shared the following with me:

"I think early on in the clinic I had a real sense of like, hopelessness and also I'm not doing anything. I can't do anything. The system's too big.… I think through that work I've been able to just realize the importance of being somebody that has time to listen … even if you are just what you're offering is an hour where you are there you are supportive of them, trying to listen and understand where they're at in terms of their own kind of journey and that that in itself is valuable"

Similarly with Participant 7:

"The client has been very vocal about what he has got from our sessions is an acknowledgement of his humanity… he has told me that that was a reminder that he is human

and is worth care and is worthy of people who want to give that … it kind of highlights that this client group are operating within a system that constantly denies their humanity. You know, like they're constantly butting up against processes that make them feel like they're a number or make them feel like they're statistic. And so is quite radical for them to sit with someone who's like "No, no. You're a person and I'm here with and that's enough.""

These participant reflections left a profound impact on me, particularly when they spoke about the transformative power of simply being heard. For instance, Participant 1 shared feelings of hopelessness in the face of systemic barriers but highlighted the significance of offering 'an hour where you are there, you are supportive of them, trying to listen and understand.' Similarly, Participant 7 described how acknowledging a client's humanity within a system that often strips it away was not just therapeutic but radical. This insight was captured in a journal entry on August 30, 2024:

'When something as simple as listening and being present with someone is enough to give them back their humanity, you have to sit back and think just how inhumane one must feel… these acts are ones we might all take advantage of, to be listened to, to be understood and heard and validated. Sometimes it feels too big to face and fight back against, this asylum system, but one thing that should not be taken lightly is our shared humanity.'

Engaging with these narratives often left me reflecting on the emotional labour involved in holding space for stories marked by systemic injustice. This emotional engagement, while challenging, enriched my understanding of recovery as being a process that is embedded in human connection, dignity, and the simple act of being seen and heard. Additionally, participant 7's reflections on restoring a client's sense of humanity made me acutely aware of the ethical responsibility I held as a researcher. I was engaging in conversations that held emotional weight

for both myself and my participants. This emotional weight was observed in many of my participants as they described their work with RAS. This realization reinforced the importance of conducting interviews with care, empathy, and a commitment to ethical integrity.

Chapter Six: Discussion & Critical Evaluation

Word count: 3,973

In this final chapter of this portfolio, an overview of the narrative synthesis review, and empirical study findings are provided. These findings are considered within the wider scope of existing research within the field of refugee and asylum seeker (RAS) mental health and their theoretical and clinical implications. Additionally, a critical appraisal of both the studies are provided. The chapter ends with an overall conclusion of the portfolio.

Overview of Findings

The systematic review explored how the mental health literacy of forced migrants (an umbrella term for RAS) impacts their mental health help seeking behaviours. Through the narrative synthesis of 24 studies the following themes were identified: 'fears of ostracization - cultural perceptions and interpretations of mental health', 'spiritual and social causes of poor mental health', 'different countries, different systems: knowledge of where to seek mental health treatment', 'everyday problems: recognition of poor mental health', 'the role of faith and family in help seeking behaviours', and 'fear & mistrust of professional support systems'. Findings from the review highlighted the cultural perceptions and interpretations of mental health by forced migrants and provided a more in-depth understanding to what is informing mental health literacy. It also revealed the unique ways that forced migrants do seek initial mental health support, which was found to be predominantly through their faith and their families and communities. Finally, it showcased the significant barriers to professional help seeking behaviours in this population related to fears around privacy and mistrust of health professionals.

Where the systematic review aimed to explain the process behind mental health help seeking behaviours through the lens of mental health literacy, the empirical paper aimed to understand how personal recovery is conceptualised for RAS, what facilitates personal recovery in refugees and what may act as a barrier to their recovery. The thematic analysis qualitative study provided an in-depth exploration of the meaning of recovery for RAS through the lens of

11 health and mental health professionals that have been supporting RAS within the East of England. It was the first study of its kind that conceptualized the mental health needs of RAS through a recovery framework and through the perspectives of the professionals supporting this population. Six key themes were generated from this study that informed barriers and facilitators to personal recovery. Facilitators to recovery included 'living well with trauma', 'finding security in the asylum claim', and 'the power of integration & community'. Barriers to recovery included 'carrying the weight of past trauma', 'struggling against a hostile system', and 'experiences of isolation & otherness'.

The themes of 'Living Well with Trauma' and 'Carrying the Weight of Past Trauma' illustrate the dual challenges faced by RAS as they navigate recovery while still grappling with trauma. Unresolved traumas from both pre-migration and post-migration experiences significantly affect their emotional well-being and cognitive functioning, with inconsistent support from mental health services further intensifying these struggles. Similarly, 'Finding Security in the Asylum Claim' and 'Struggling Against a Hostile System' highlight the critical role of the asylum process in shaping recovery outcomes. The prolonged uncertainty, restrictive policies, and systemic hostility of the asylum system leave many trapped in limbo, exacerbating helplessness and psychological distress. These challenges are further aggravated by financial hardship, exposure to racism, and feelings of being 'othered' within their new environment. Finally, 'The Power of Integration and Community' and 'Experiences of Isolation and Otherness' emphasize the importance of social connectedness in the recovery of RAS. Language barriers, separation from loved ones, and systemic discrimination frequently contribute to social isolation, leaving many RAS feeling marginalized and disconnected from their host communities.

Findings Contextualized in the Current Research

When it comes to the field of RAS mental health provision and unique mental health needs of this population, the systematic review introduces a potential model for conceptualizing the mental health literacy of RAS and its impact on the mental health help seeking behaviours for this population. It highlights the role of cultural perceptions and interpretations of mental health and their roles in informing mental health literacy and in turn mental health help-seeking behaviours. In addition to this model, the findings of the empirical paper argue for the incorporation of a recovery framework in both understanding and supporting RAS wellbeing and provides a preliminary framework for understanding the meaning of recovery for RAS. The findings of this portfolio align with and extend existing literature on mental health literacy, help-seeking behaviours, and recovery-oriented approaches for refugees and asylum seekers (RAS).

The systematic review conducted in this research showcases the role of cultural perceptions and interpretations of mental health as significantly informing the mental health help seeking behaviours among RAS. This is consistent with broader evidence indicating that ethnic minority groups face substantial challenges in accessing mental health support due to stigma, cultural beliefs, and structural barriers (Colucci et al., 2015; Silove et al., 2017). In a systematic review, Misra et al. (2021) further highlight the role of public, structural, and self-stigma in shaping mental health attitudes among racial and ethnic minority groups, reinforcing the notion that stigma manifests across multiple levels, from individual perceptions to systemic discrimination. Similarly, Prajapati and Liebling (2021) emphasize the cultural dissonance experienced by South Asian service users in the UK, particularly regarding trust in mental health services. Their meta-ethnography describes a “dilemma of trust”, where service users remain distanced from available care due to concerns over cultural misalignment, a finding that mirrors

the challenges identified in this study. This dilemma aligns with our review's findings around the lack of trust towards health professionals acting as a significant barrier to mental health help seeking and service utilisation in forced migrants.

Beyond barriers to help-seeking, the empirical study in this research contributes to the understanding of recovery-oriented care for RAS and argues for the incorporation of a recovery framework in both understanding and supporting RAS wellbeing. In a systematic review by Pouille et al. (2022), this is further emphasized by the introduction of recovery capital- personal, social, and community-based resources that facilitate recovery, as a critical framework for understanding the recovery experiences of migrants and ethnic minorities (MEM). The empirical study in this research also emphasizes the role of social and community support in fostering recovery, with professionals identifying faith, cultural belonging, and stable relationships as fundamental to well-being. These findings align with Pouille et al. (2022), who stress the need for culturally and trauma-sensitive relational support, particularly in community-driven and faith-based recovery interventions. Additionally, the systematic review's emphasis on stigma and mistrust of services resonates with Pouille et al.'s argument that migration-related stressors, including perceived and structural discrimination, limit access to recovery capital.

A key contribution of this research is its examination of structural barriers that impede mental health recovery among RAS. Both Bansal et al. (2022) and Prajapati & Liebling (2021) argue that institutional racism, restrictive asylum policies, and financial deprivation systematically disadvantage ethnic minorities in accessing mental health services. This aligns with findings from the empirical study, where professionals identified the hostile migration environment as a direct impediment to recovery, and is reinforced by Pouille et al. (2022)'s argument that recovery capital is inextricably linked to socio-political conditions. Furthermore,

Pouille et al. (2022) highlight that social capital, relationships that facilitate recovery, can be both a facilitator and a barrier, as some cultural expectations discourage open discussions about mental health and recovery. This dual role of community influence is also reflected in the systematic review, which notes that RAS often rely on informal networks and faith-based coping strategies while simultaneously facing cultural stigma surrounding mental illness.

Another key thread that runs through both the systematic review and the empirical study is the movement through different internalized and externalized stages experienced by RAS before, during, and beyond mental health care. The systematic review highlights how forced migrants navigate cultural understandings of mental health before even engaging with formal mental health systems. This includes the internalized processes of stigma, fear of ostracization, and reliance on community or faith-based coping mechanisms as primary sources of support. The empirical study then explores how forced migrants move through recovery and what facilitates or impedes that process. Both papers, therefore, contribute to a broader conceptualization of mental health care engagement as a journey rather than a static decision or outcome. The systematic review identifies barriers and facilitators to help-seeking, demonstrating that forced migrants often undergo an extended period of internal meaning-making before they engage with formal mental health services, if they do at all. These internalized processes, shaped by cultural beliefs, fear of professional systems, and uncertainty about where to seek help, create a form of psychological limbo (Saint Arnault, 2018). The empirical study, on the other hand, illustrates how forced migrants are in a process of continually navigating systemic obstacles, community integration, and the dual realities of trauma and resilience in their recovery journey. The hostile migration environment, characterized by prolonged asylum processes and systemic

discrimination, further exacerbates mental health challenges (Phillimore & Cheung, 2021; Bansal et al., 2022).

This shared theme of process aligns with theoretical models of recovery that emphasize non-linear progress (Leamy et al., 2011), reinforcing that mental health support is not a one-time intervention but an ongoing process that is deeply intertwined with personal, social, and systemic factors. The empirical study's framework of living well with trauma directly connects to the systematic review's findings that many forced migrants do not necessarily conceptualize mental health distress in biomedical terms but rather as everyday struggles that require collective coping strategies (Byrow et al., 2020). Similarly, the systematic review's emphasis on mistrust of services as a barrier to help-seeking is reflected in the empirical study's theme of struggling against a hostile system, where even those who access mental health care remain vulnerable to re-traumatization due to structural barriers (Pouille et al., 2022).

Theoretical & Clinical Implications

Theoretical Implications

The findings of the Portfolio align with the Social Determinants of Mental Health (SDMH) model, which emphasizes how structural and social factors shape mental health outcomes (Compton & Shim, 2015). Within the empirical paper, the barriers to recovery identified in this study, such as prolonged asylum processes, systemic hostility, financial deprivation, unstable housing, social exclusion, and discrimination, reflect key social determinants that contribute to distress and poor mental health among refugees and asylum seekers (Compton & Shim, 2015; Hynie, 2018; Phillimore & Cheung, 2021). At the same time, the study highlights facilitators of recovery, including social integration, stable housing and employment, and access to supportive communities, which align with SDMH's emphasis on social connectedness and economic security as protective factors for mental well-being (Li et al.,

2016; Lindert et al., 2023). The study also highlights the interplay between pre-migration trauma and post-migration stressors, reinforcing the argument that social conditions in host countries significantly influence long-term mental health outcomes (Schick et al., 2016; Hynie, 2018; Patanè et al., 2022). Additionally, findings from the systematic review showed that the loss of social and community networks among forced migrants contributed to poor mental health, reinforcing the model's emphasis on social support as a key determinant (Compton & Shim; 2015).

Additionally, the findings of the systematic review align with the Cultural Determinants of Help-Seeking (CDHS) model by demonstrating how cultural beliefs, social networks, and structural barriers shape help-seeking behaviours among adult forced migrants (Saint Arnault, 2009). The review highlights that forced migrants' cultural models of distress often conceptualize mental health issues through religious or social frameworks, leading to reliance on faith-based or community support rather than professionals. This aligns with the CDHS model's emphasis on how cultural ideologies shape perception and labelling of distress and subsequent help-seeking pathways (Saint Arnault, 2009). The review also shows that social context plays a critical role in help-seeking, as fears of stigma, ostracization, and loss of social standing discourage engagement with formal mental health services. In line with the CDHS model's recognition of exchange rules and social obligations (Saint Arnault, 2009), studies in the review highlighted that family and community expectations dictated whether professional help was deemed acceptable, with help-seeking often framed as a last resort. Additionally, the review highlights the impact of structural barriers, such as language difficulties, lack of mental health literacy, and mistrust of healthcare systems, which interact with cultural determinants to limit access to care. These findings align with the CDHS model's emphasis on structural influences,

reinforcing that cultural meanings of distress must be considered alongside systemic barriers when examining help-seeking behaviours to (Saint Arnault, 2018).

Clinical Implications

The findings from this portfolio highlight the emerging need for mental health professionals to adopt a recovery-oriented, culturally responsive, and system-aware approach when working with RAS, which recognizes the impact of post-migration experiences alongside pre-migration beliefs. Traditional biomedical models that focus primarily on symptom reduction are insufficient in addressing the complex and multi-layered experiences of RAS. Instead, services should incorporate strength-based interventions that emphasize resilience, autonomy, and social integration as central components of recovery (Davidson et al., 2005; Leamy et al., 2011; Silove et al., 2017). Unlike conventional Western models of mental health, recovery for RAS is deeply intertwined with structural, legal, and socio-cultural factors, requiring clinicians to move beyond individual-level interventions and engage in broader systemic advocacy (Compton & Shim, 2015; Hynie, 2018; Phillimore & Cheung, 2021). Furthermore, to practice a recovery-based approach for this population, research emphasizes the value of curiosity and the ability for professionals to explore culture, ethnicity, and race within their care (Naz et al., 2019). This can involve training mental health professionals to develop their cultural competence with respect to RAS populations (Lau & Rodgers, 2021). Another branch of research emphasizes a shift towards “cultural humility”- the humility of not knowing or understanding another’s cultural perspective and engaging in learning from service users about their experiences and their expertise on the social and cultural context of their lives (Lekas et al., 2020). This is particularly relevant for RAS populations that are ethnically and culturally diverse.

The systematic review examined the conceptualisations and language of mental health literacy (MHL) in terms of help-seeking in RAS. It revealed how the MHL of RAS is shaped by

cultural beliefs, stigma, and a lack of awareness of available services. It also highlighted how RAS populations conceptualize mental distress through somatic symptoms, spiritual frameworks, or everyday stressors rather than psychiatric diagnoses. This divergence in mental health conceptualization can lead to misalignment between service providers and RAS clients, reducing engagement with available mental health care (Blackmore et al., 2020; Byrow et al., 2020). This conceptualization also highlights that an integrated care approach to mental health care provision for RAS would likely lead to better engagement with services and allow for earlier identification of poor mental health in this population (Suhaiban et al., 2019; Satinsky et al., 2019).

Additionally, the review showed that stigma surrounding mental health remains a significant barrier, as acknowledging psychological distress may lead to ostracization within communities, negative social consequences, or fears of being perceived as ‘crazy'. These challenges emphasize the need for mental health services to integrate culturally tailored psychoeducation and community-based outreach programs, working in collaboration with faith leaders, cultural organizations, and informal community networks to improve awareness and reduce stigma (Colucci et al., 2015; Peñuela-O’Brien et al., 2023). Finally, the findings highlight the central role of social integration and community belonging in mental health recovery for RAS. Social isolation has been identified in this portfolio as both a symptom and a contributor to mental health deterioration in this population, with many RAS facing significant barriers to establishing social connections due to language difficulties, discrimination, and exclusion from local communities. Community-based interventions, including peer support networks, volunteer opportunities, and culturally specific support groups, have been found to enhance social cohesion and provide meaningful pathways to integration and recovery (Davidson et al., 2005; Best & de Alwis, 2017). Mental health professionals can play a pivotal role in facilitating access to these

social resources by working alongside community organizations, providing mental health psychoeducation training to community leaders and peer support workers, and promoting psychosocial interventions that align with the lived experiences of RAS (Colucci et al., 2015; Valibhoy et al., 2017).

Critical Appraisal of Research

Critical Appraisal of Systematic Review

The systematic review presented in this portfolio has several key strengths that enhance the relevance and applicability of its findings, offering a novel contribution to the limited research on mental health literacy and help-seeking behaviours among adult forced migrants. By synthesizing data from a broad range of studies, the review identifies common themes and shared experiences across diverse cultural and geographic settings. Its focus on a highly vulnerable and under-researched population helps bridge a critical gap in understanding how mental health literacy influences help-seeking in forced migrants.

Despite these strengths, several limitations must be considered when interpreting the findings. One issue is the variation in sample sizes across studies, with some relying on small, non-representative samples that may not fully capture the experiences of adult forced migrants. Additionally, sampling bias was evident in studies that recruited participants through community organizations or healthcare services, potentially excluding individuals who face greater barriers to accessing care. Another limitation was the inconsistency in defining and measuring mental health literacy, as some studies employed comprehensive frameworks, while others focused on narrower aspects, making it more difficult to integrate the findings. These methodological constraints highlight the need for caution in generalizing the results and emphasize the importance of future research that addresses these gaps.

Furthermore, some studies in the review included perspectives from multiple groups, such as community leaders, healthcare professionals, and forced migrants, which made it challenging to distinguish findings that specifically reflected the experiences of forced migrants (Bawadi et al., 2022; Al Laham et al., 2020; Chynoweth et al., 2020). However, this limitation was mitigated by studies clearly differentiating forced migrant participants from others in their reported quotations.

Although a key strength of this review is its diverse range of included studies, most were conducted in Western countries such as the United States, Canada, Australia, and parts of Europe. This geographical concentration may limit the generalizability of findings, as forced migrants' experiences in these settings could differ significantly from those in non-Western contexts. Differences in resource availability, healthcare infrastructure, cultural norms, and policy frameworks may shape mental health literacy and access to care in ways not fully captured by Western-focused research. Expanding studies to underrepresented regions, including Africa, the Middle East, and parts of Asia, would provide a more comprehensive understanding of mental health literacy and help-seeking behaviours across different socio-cultural and economic contexts.

Critical Appraisal of Empirical Paper

To assess the methodological rigor of the empirical study, Braun and Clarke's (2022) criteria for good practice in reflexive Thematic Analysis (TA) were used. These criteria emphasize conceptual coherence, analytic transparency, and reflexive engagement.These criteria include credibility, originality, resonance, usefulness, methodological rigor, fit with grounded theory, and empirical grounding.

This study employed reflexive Thematic Analysis (TA) (Braun & Clarke, 2006) to explore professionals' understandings of recovery in the context of refugee and asylum seeker mental health. The analytic approach was clearly stated and consistently applied throughout the research. Reflexive TA was selected due to its conceptual compatibility with a critical realist epistemology, which acknowledges the existence of a reality independent of individual perception, while also recognising that knowledge is shaped by socio-cultural, linguistic, and personal interpretative frameworks. This stance allowed for attunement to both the content and the context of participants' narratives, constructing themes that reflected shared patterns of meaning rather than surface-level categories.

The six phases of Braun and Clarke's (2006) framework were carried out in an iterative and recursive manner. Familiarisation with the data involved repeated readings of transcripts and memo-writing to capture early impressions. Codes were generated inductively, with attention to both explicit and latent meanings across the dataset. The process of constructing, reviewing, and refining themes was marked by close engagement with the data and reflexive consideration of how initial codes clustered into coherent patterns. Themes were developed as interpretive, analytic outputs. Their central organising concepts were continually tested and adjusted through supervision, reflective journaling, and repeated immersion in the data. The final analytic narrative was structured to highlight both convergence and divergence in professional perspectives, supported by illustrative quotes embedded in a cohesive and interpretative account.

Reflexivity was an integral part of the study and was enacted through both individual and relational processes. The researcher acknowledged their positionality as a trainee clinical psychologist and the impact of her culture and experiences, as well as the potential influence of

their clinical training and academic frameworks on the interpretation of data. Reflexive memos were used throughout to document analytic decisions, while regular supervisory meetings created a space for discussion about theme development, researcher assumptions, and emerging interpretations. These practices supported transparency, theoretical coherence, and the engagement necessary to maintain analytic rigor in reflexive TA. Power dynamics and relational influences within the interview context were also considered, with attention to how participants might shape their responses based on perceived shared values, professional identity, or authority.

The final write-up aimed to balance the researcher's analytic voice with participants' illustrative quotes, ensuring that themes were situated within both the empirical data and the broader literature on recovery and forced migration. The analytic narrative was conceptually rich, clearly defined, and situated within relevant theoretical frameworks (e.g., CHIME, social determinants of health). Throughout, the analysis was approached as an active, interpretive process. Taken together, the study demonstrates strong alignment with Braun and Clarke's (2023) criteria for good reflexive Thematic Analysis, including clear specification of method, theoretical and conceptual coherence, reflexive engagement, analytic transparency, and interpretative depth.

Future Research

Based on the findings of the systematic review and empirical study, should further explore the interplay between systemic, cultural, and psychological factors that shape the mental health recovery journey and help-seeking behaviours of refugees and asylum seekers (RAS). Adding onto the empirical study, future research should prioritize capturing the lived experiences of refugees and asylum seekers (RAS) to complement and expand on the perspectives provided by healthcare professionals. RAS voices can provide unique, firsthand accounts of the

challenges and facilitators of recovery, offering a deeper understanding of their mental health needs and the systemic and cultural factors that shape their recovery journeys. Moreover, involving RAS in participatory research methods, such as co-designing studies or engaging in collaborative data interpretation, can empower them as active contributors to the knowledge base. By centering RAS voices in future research, the field can move closer to developing recovery models, interventions, and policies that truly reflect the lived realities of forced migration.

Additionally, following the findings from both the empirical study and systematic review, future research on the effectiveness of culturally adapted intervention for RAS would be beneficial to explore. These interventions could include community-led psychoeducation programs or the use of peer interventions for this population and could involve comparisons with non-culturally adapted interventions.

Conclusion

This thesis portfolio aimed to provide greater insight into the processes that inform the mental health help seeking behaviours of RAS and understanding into their personal narratives of recovery through the professionals that they are seeking help from. Findings from the systematic review highlighted the cultural perceptions and interpretations of mental health held by forced migrants and provided a more in-depth understanding to what is informing mental health literacy. It also revealed the unique ways that forced migrants do seek mental health support, which was found to be predominantly through their faith and their families and communities. Finally, it showcased the significant barriers to professional help seeking behaviours in this population related to fears around privacy and mistrust of health professionals. Findings from the empirical study showcase key facilitators of recovery, such as fostering community connections, securing asylum status, and living well with trauma, while also

acknowledging barriers, including experiences of isolation, trying to navigate a hostile system, and the impacts of trauma.

Together, these findings emphasize the importance of incorporating holistic, recovery-oriented mental health approaches that consider both individual experiences and broader systemic influences on RAS well-being.

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Appendices

Appendix A- Author Guidelines for Clinical Psychology Review

Abstract

You are required to provide a concise and factual abstract which does not exceed 250 words. The abstract should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:

- Abstracts must be able to stand alone as abstracts are often presented separately from the article.
- Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
- Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

For full details, please see Science Direct website:
https://www.sciencedirect.com/journal/clinical-psychology-review/publish/guide-for-authors

Appendix B- Eligibility Criteria for Systematic Review

Criteria	Specification
Population	Include: Studies where the target population are participants aged 18 years old and above who were identified as forced migrants (refugees, asylum seekers, or undocumented migrants) when researched. Exclude: Studies where the target population are participants identified as internally displaced.
Outcomes	Include: Studies that include themes or aspects of participant mental health literacy Studies that include themes around mental health help-seeking behaviours or service utilization of participants Exclude: Studies looking at perspectives of participants who are not adult forced migrants.
Study Design	Include: Primary qualitative research studies reporting primary or first order data perspectives of the participants along with second order data (authors interpretation). Methodology of the studies can include interviews, focus groups, community groups and/or surveys' open comment boxes. For studies with mixed methodology, only qualitative findings will be extracted. Exclude: Quantitative studies, systematic reviews, books, and non-peer reviewed articles.
Country, language	Include: Studies written in English

Appendix C- Quality Appraisal of Systematic Review Articles

	Abstract and title	Intro and aims	Method and data	Samp-ling	Data analysis	Ethics and bias	Results	Transfer-ability	Implications and usefulness
Branam et al. (2023)	Good	Fair	Fair	Poor	Poor	Fair	Fair	Poor	Fair
Melamed et al. (2019)	Good	Good	Good	Good	Fair	Fair	Fair	Fair	Good
Tonui (2022)	Good	Fair	Poor	Poor	Fair	Very Poor	Fair	Poor	Fair
Lechner-Meichsner & Comtesse (2022)	Good	Fair	Fair	Poor	Poor	Very Poor	Fair	Poor	Poor
Poudel-Tandukar et al. (2019)	Good	Fair	Good	Poor	Fair	Fair	Good	Fair	Fair
Saberi et al. (2021)	Good	Fair	Fair	Poor	Poor	Very Poor	Fair	Poor	Fair
Al Laham et al. (2020)	Good	Fair	Fair	Poor	Fair	Fair	Fair	Poor	Fair
Copolov & Knowles (2023)	Good	Good	Fair	Fair	Fair	Fair	Good	Fair	Good
Bettmann et al. (2015)	Good	Good	Good	Fair	Fair	Fair	Fair	Fair	Good
Grupp et al. (2019)	Good	Fair	Good	Fair	Fair	Poor	Fair	Fair	Fair

Ahmed et al. (2017)	Good	Good	Good	Fair	Good	Poor	Good	Poor	Good
Burford-Rice et al. (2022)	Good	Good	Fair	Poor	Poor	Poor	Fair	Poor	Fair
Teunissen et al. (2014)	Good	Fair	Fair	Fair	Fair	Poor	Fair	Poor	Fair
Karakas & Du Plooy (2024)	Good	Fair	Fair	Poor	Fair	Fair	Fair	Poor	Fair
Chynoweth et al. (2020)	Good	Good	Good	Fair	Good	Good	Fair	Poor	Poor
Quinn (2014)	Good	Fair	Good	Fair	Poor	Fair	Fair	Poor	Poor
Shannon et al. (2015)	Fair	Fair	Good	Fair	Good	Fair	Fair	Fair	Fair
Bawadi et al. (2022)	Good	Fair	Fair	Poor	Poor	Poor	Fair	Poor	Fair
Rae (2016)	Good	Good	Fair	Fair	Poor	Good	Good	Fair	Fair
Omar et al. (2017)	Good	Fair	Fair	Good	Fair	Poor	Fair	Fair	Good
Valibhoy et al. (2017)	Good	Fair	Fair	Good	Good	Poor	Good	Fair	Good
Kim et al. (2021)	Good	Fair	Poor	Poor	Poor	Poor	Fair	Poor	Fair
Soukenik et al. (2021)	Good	Fair	Good	Good	Fair	Fair	Good	Fair	Fair

Whittaker et al. (2005)	Good	Poor	Fair	Poor	Fair	Poor	Fair	Poor	Fair

Appendix D- Copy of Hawker et al. (2002) Appraisal Tool

1. Abstract and title: Did they provide a clear description of the study?
   - Good: Structured abstract with full information and clear title.
   - Fair: Abstract with most of the information.
   - Poor: Inadequate abstract.
   - Very Poor: No abstract.
2. Introduction and aims: Was there a good background and clear statement of the aims of the research?
   - Good: Full but concise background to discussion/study containing up-to-date literature review and highlighting gaps in knowledge.
     Clear statement of aim AND objectives including research questions.
   - Fair: Some background and literature review.
     Research questions outlined.
   - Poor: Some background but no aim/objectives/questions, OR
     Aims/objectives but inadequate background.
   - Very Poor: No mention of aims/objectives.
     No background or literature review.
3. Method and data: Is the method appropriate and clearly explained?
   - Good: Method is appropriate and described clearly (e.g., questionnaires included).
     Clear details of the data collection and recording.
   - Fair: Method appropriate, description could be better.
     Data described.
   - Poor: Questionable whether method is appropriate.
     Method described inadequately.
     Little description of data.
   - Very Poor: No mention of method, AND/OR
     Method inappropriate, AND/OR
     No details of data.
4. Sampling: Was the sampling strategy appropriate to address the aims?
   - Good: Details (age/gender/race/context) of who was studied and how they were recruited.
     Why this group was targeted.
     The sample size was justified for the study.
     Response rates shown and explained.
   - Fair: Sample size justified.
     Most information given, but some missing.
   - Poor: Sampling mentioned but few descriptive details.
   - Very Poor: No details of sample.
5. Data analysis: Was the description of the data analysis sufficiently rigorous?
   - Good: Clear description of how analysis was done.
     Qualitative studies: Description of how themes derived/respondent validation or triangulation.
     Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.
   - Fair: Qualitative: Descriptive discussion of analysis.
     Quantitative.
   - Poor: Minimal details about analysis.
   - Very Poor: No discussion of analysis.

6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

Good	Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias.
Fair	Lip service was paid to above (i.e., these issues were acknowledged).
Poor	Brief mention of issues.
Very Poor	No mention of issues.

7. Results: Is there a clear statement of the findings?

Good	Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.
Fair	Findings mentioned but more explanation could be given. Data presented relate directly to results.
Poor	Findings presented haphazardly, not explained, and do not progress logically from results.
Very Poor	Findings not mentioned or do not relate to aims.

8. Transferability or generalizability: Are the findings of this study transferable (generalizable) to a wider population?

Good	Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
Fair	Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.
Poor	Minimal description of context/setting.
Very Poor	No description of context/setting.

9. Implications and usefulness: How important are these findings to policy and practice?

Good	Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.
Fair	Two of the above (state what is missing in comments).
Poor	Only one of the above.
Very Poor	None of the above.

Appendix E- Summary of Included Papers in Systematic Review

Author(s) & Year	Country	Study Aim(s)	Sample & Method	Key Findings
Karakas, G., & Du Plooy, D.R. 2024	Australia	Explored the experiences of Bosnian refugees in Australia when accessing mental health services and the main barriers encountered by this population when seeking mental health services.	5 female Bosnian refugees Semi-structured interviews	The study found that participants faced significant barriers accessing mental health services, including limited awareness of services, language barriers, cultural stigma, and past trauma. While some found support helpful, others found it inadequate or culturally insensitive.
Kim, W., Yalim, A.C., & Kim, I. 2021	United States of America	Explored the understanding of refugees from Burma and their mental health service use to help improve mental health services for them.	11 Burmese refugee community leaders (6 men and 5 women) Semi-structured interviews	The study showed that participants linked mental health issues to past trauma and resettlement challenges. Key barriers to seeking help included: misunderstanding of mental health, language and cultural differences, preference for alternative treatments, and perceived unresponsiveness of mental health services.
Omar Y.S., Kuay, J., & Tuncer C. 2017	Australia	Explored the experiences, understanding and conceptualization of mental health and emotional difficulties by male, Muslim, refugee men from the Horn of Africa in Australia.	36 Somali & Eritrean male refugees 5 focus groups	This study found that participants faced significant barriers to mental health care, including stigma, cultural misunderstandings, and a lack of culturally appropriate services. Key stressors included unemployment, racism, religious challenges, and changing gender roles. While traditional supports like family and religion were helpful, limited mental health literacy prevented many from seeking professional help.
Ahmed, A., Bowen, A., & Feng, C.X. 2017	Canada	Explored Syrian refugee women's perceptions of maternal depression, their social support	12 Syrian refugee women One focus group	The study showed that while many participants scored high for depressive symptoms on the assessment part of the study, they often attributed their feelings of

		needs, the barriers to accessing maternal mental health services, and their help seeking behaviours.		"boredom" or "tiredness" to other factors, highlighting a potential misunderstanding of mental health conditions. The study also revealed significant barriers to seeking help.
Saberi, S., Wachtler, C., & Lau, P. 2021	Australia	Explored understandings of young Hazara refugees in Melbourne of mental health issues and barriers to accessing primary mental health care.	15 Hazara refugees (8 men and 7 women) One male focus group, one female focus group, and three semi-structured interviews.	This study revealed significant barriers to accessing mental health care for participants. They often associated "mental health" with severe mental illness, leading to stigma and reluctance to seek help. Cultural factors further hindered help-seeking. Language barriers and a perceived lack of cultural understanding from some healthcare providers presented additional obstacles.
Soukenik, E., Haran, H., Kirsch, J., Pyakurel, S., & Maleku, A. 2022	United States of America	Explored Bhutanese refugee's community-grounded perceptions of barriers and facilitators of mental health service utilisation	6 Bhutanese refugees (3 men and 3 women) One focus group	The study identified significant barriers included post-migration challenges, cultural stigma preventing help-seeking due to fear of shame and isolation, and mistrust stemming from concerns about confidentiality and culturally insensitive providers.
Bawadi, H., Al-Hamdan, Z., Khader, Y., & Aldalaykeh, M. 2022	Jordan	Explored the perspectives of Syrian refugees and their host communities and community leaders in Jordan on barriers and facilitators to the use of mental health services by Syrian refugees.	16 Syrian refugees (10 men and 6 women), 8 Syrian/Jordanian community leaders (5 men and 3 women). Semi-structured interviews	The study found that participants faced significant barriers to accessing mental health services, including limited awareness of mental health and available support, challenges with service affordability and accessibility, and fear of social stigma.
Bettmann, J.E., Penney, D., Clarkson-Freeman, P., & Lecy N. 2015	United States of America	Explored Somali and Somali Bantu refugees' perceptions of mental illness and their beliefs around	20 Somali refugees (10 men and 10 women) Semi-structured interviews	This study found that participants attributed mental illness to a mix of spiritual causes, trauma from war and resettlement, and biological factors. While they see value in both traditional healing practices and Western medicine, stigma, language

		mental health treatment.		barriers, and a lack of culturally sensitive care often prevent them from seeking help.
Shannon, P.J., Wieling, E., Simmelink-McCleary, J., & Becher, E. 2015	United States of America	Explored the reasons why newly arriving refugees find it difficult to discuss the mental health effects of political violence.	111 refugees (34 Bhutanese (20 male, 14 female), 23 Karen (12 male, 11 female), 27 Oromo (17 male, 10 female), and 27 Somali (14 male, 13 female)) 13 focus groups	The study showed that participants experienced multiple barriers to discussing mental health beyond stigma. These include fear due to past persecution, belief that talking is ineffective, limited knowledge about mental health, avoidance due to shame or cultural norms, and cultural beliefs that discourage open discussion.
Chynoweth, S.K., Buscher, D., Martin, S., & Zwi, A.B. 2020	Italy, Bangladesh, Kenya	Explored the characteristics and impacts of sexual violence against refugee men and boys and assessed the availability and accessibility of selected services for male survivors in three refugee settings	310 refugees 55 focus groups (21 in Bangladesh, 10 in Italy, 24 in Kenya)	The study found that there were providers offering specialized medical care, legal aid, and mental health and psychosocial support for male survivors in all settings, but the demand for these services exceeded the supply. The study also highlighted barriers to service uptake among male survivors in these locations.
Coplov, C., & Knowles, A. 2023	Australia	Explored barriers and facilitators to mental health care with a community sample of young Hazara refugees in Australia.	18 Hazara refugees (9 men and 9 women) Semi-structured interviews	The study findings highlight a strong reliance on cultural and religious coping mechanisms. However, significant barriers to accessing formal mental health services were identified. Consequently, participants often preferred seeking help from informal support networks, such as family and religious leaders, over formal mental health professionals
Al Laham, D., Ali, E., Mousally, K., Nahas, N., Alameddine, A., & Venables, E.	Lebanon	Explored perceptions of mental health disorders and subsequent health seeking behaviour	46 Syrian refugees, 8 informants (3 Syrian refugees,	This study found that both Syrian refugees and Lebanese residents strongly stigmatized mental illness, viewing it as shameful and fear-inducing. Religious beliefs

2020		among Syrian refugees and the Lebanese population in Wadi Khaled.	5 Lebanese residents) 8 focus groups with refugees, 8 semi-structured interviews with informants	significantly shape perceptions and treatment of mental illness. Consequently, participants preferred seeking help from religious healers than mental health professionals. The study also highlighted geographical isolation, economic hardship, and the Syrian refugee crisis as contributing factors to mental illness in this context. Fear of stigma, lack of knowledge about mental health services, and financial constraints emerged as key barriers to accessing professional mental health care.
Grupp, F., Moro, M.R., Nater, U.M, Skandrani, S., & Mewes, R. 2019	Germany	Explored help-seeking intentions and beliefs about cures for Post-Traumatic Stress Disorder held by Sub-Saharan African asylum seekers residing in Germany	26 Asylum Seekers (10 Eritrean, 8 Somali, and 8 Cameroonian) 8 focus groups (3 Eritrean, 3 Somali, 2 Cameroonian)	This study found that participants often preferred to seek help from religious figures and general practitioners over mental health professionals. This preference is likely influenced by cultural differences in understanding mental health and structural barriers within the German healthcare system.
Lechner-Meichsner, F., & Comtesse, H. 2022	Germany	Explored illness beliefs and treatment expectations of refugees regarding symptoms of Prolonged Grief Disorder for the first time.	14 Arab refugees, 9 Sahara-African refugees Semi-structured interviews	The study revealed that participants often attributed PGD to a complex interplay of factors. Traumatic experiences were frequently cited as significant contributors. Additionally, some refugees held supernatural beliefs, attributing PGD to curses or fate. The challenges of adapting to a new country were also perceived as contributing factors. When it came to healing from PGD, refugees emphasized the importance of social support networks, particularly from family and their communities. Religious coping mechanisms played a significant role for many.
Burford-Rice, R., Due, C., & Augoustinos, M.	Australia	Explored culturally specific knowledge about	11 refugee Hazara women from the Afghan	This study found that participants faced significant barriers to accessing mental health services.

2022		conceptualizations of mental health within the female Hazara Afghan refugee population. Also explored preferred strategies for coping with mental health problems, and perceived efficacy of Australian mental health services.	Community Semi-structured interviews	These barriers include cultural stigma, differing understandings of mental illness, domestic violence, language barriers, and limited awareness of available support.
Branam, L.S., Yigit, I., Haji, S., Clark, J., & Perkins, J.M. 2023	United States of America	Explored Kurdish refugee beliefs about mental health and identify spaces for refugee service programs to design mental wellness support services in culturally responsive ways.	10 Kurdish refugees (5 men and 5 women) Semi-structured interviews	The study found that the upheaval of resettlement led to significant social network loss, leaving individuals feeling isolated and without crucial support systems. Additionally, participants reported experiencing economic hardship and stress stemming from their professional qualifications not being recognized, forcing them into lower-paying jobs and creating a sense of loss. These social and economic challenges were identified as major barriers to mental well-being. Furthermore, perceived stigma surrounding mental health issues and fear of gossip within the community prevented individuals from seeking professional help. Despite these barriers, participants emphasized the importance of social interaction and connection as a valuable form of support for mental health.
Melamed, S., Chernet, A., Labhardt, N.D., Probst-Hensch, N., & Pfeiffer, C. 2019	Switzerland	Explored social resilience towards migration related mental health challenges of Eritrean asylum-	10 male Eritrean asylum seekers Semi-structured interviews	This study found that participants often viewed mental health as a binary state (well vs. unwell) rather than a spectrum, leading them to rely heavily on their social networks for support. However, they faced

		seekers and refugees living in Switzerland.		barriers to accessing formal mental health care due to cultural differences in understanding mental health, stigma surrounding mental illness, and practical obstacles like language barriers and costs.
Quinn, N. 2014	United Kingdom	Explored the different beliefs and attitudes to mental health problems amongst the asylum seeker and refugee populations in Glasgow, patterns of stigma and discrimination within these communities and barriers to help-seeking.	101 asylum seekers 10 focus groups	This study revealed that migration, particularly within the context of seeking asylum, negatively impacts mental health and well-being. This negative impact is exacerbated by experiences of stigma and discrimination. Additionally, cultural beliefs surrounding mental health within the communities themselves also contributed to stigma.
Poudel-Tandukar, K., Jacelon, C.S., Chandler, G.E., Gautam, B., & Palmer, P.H. 2019	United States of America	Explored cultural factors that affect mental health-seeking support among Bhutanese refugees living in Western Massachusetts.	67 Bhutanese refugees 8 focus groups	This study found that the unique challenges of being newly resettled, including cultural dependence, pressure to acculturate, and experiences of social isolation, significantly impact this population's mental health. Participants reported feeling isolated and lacking adequate support, highlighting the need for interventions that foster social connectedness and provide culturally sensitive resources. The study also emphasizes the significance of family in Bhutanese culture.
Rae, S. 2016	United Kingdom	Explored how Somali male refugees in the UK understand the Western construct of depression	12 Somali male refugees 3 focus groups, 8 semi-structured interviews	The study found that participants' cultural stigma surrounding mental illness often led to concealment and a reluctance to seek help. Additionally, language barriers and a lack of equivalent terms for mental health concepts in the Somali language made it challenging for individuals to articulate their experiences and understand available

				resources. The study also highlighted that Somali culture often attributed mental health problems to supernatural causes, leading individuals to rely on traditional healing methods rather than Western medicine. This cultural understanding, coupled with misconceptions and distrust of Western mental healthcare practices, creates significant barriers to accessing professional help.
Teunissen, E., Sherally, J., Van Den Muijsenbergh, M., Dowrick, C., Van Weel-Baumgarten, E., & van Weel, C. 2014	Netherlands	Explored the experiences of undocumented migrants around help seeking for mental health problems, barriers and facilitators experienced when accessing care, and specific needs and expectations.	15 undocumented migrants (9 men and 6 women) Semi-structured interviews	This study found that participants faced significant barriers to care. These barriers included stigma surrounding mental health, fear of legal repercussions due to their undocumented status, and financial constraints. As a result, undocumented migrants often relied on informal support systems, such as friends and religion, for their mental health needs. However, when they could access care from general practitioners, they reported high levels of satisfaction, primarily due to the positive attitude of GPs and the perceived effectiveness of treatment.
Tonui, B.C. 2022	United States of America	Explored the perceptions of mental health services offered to Rwandan refugees in the U.S. Examine how social, linguistic, and cultural issues in resettlement shape mental health and wellbeing.	13 Rwandan Refugees Semi-structured interviews	This study found that participants often held traditional beliefs about mental health, leading to stigma and reluctance to seek help. Their challenges are compounded by post-resettlement difficulties, including communication barriers due to language differences, financial strain from unemployment or low-wage jobs, and the enduring impact of past trauma experienced during the Rwandan genocide and displacement.

Valibhoy, M.C., Szwarc, J., & Kaplan, I. 2017	Australia	Explored the barriers to accessing mental health services faced by young people from refugee backgrounds.	16 refugees (7 men and 9 women) Semi-structured interviews	This study showed that participants faced significant barriers to accessing mental health services. Many participants reported a strong stigma surrounding mental health issues within their communities, coupled with limited understanding of available services. This often led to a preference for informal support networks, such as family, friends, and religious figures, over formal mental health care. Furthermore, distrust in formal systems stemming from past experiences, language barriers, and fear of judgment created additional challenges. The study also highlighted a lack of culturally appropriate services, limited accessibility due to factors like transportation and cost, and a general disconnect between existing services and the unique needs of this vulnerable population.
Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. 2005	United Kingdom	Explored how young Somali female asylum-seekers and refugees understand psychological well-being	5 female Somali refugees One focus group	This study showed that while participants demonstrated resilience in the face of significant adversity, they also faced considerable pressure to conform to cultural and religious expectations. This often resulted in a tendency to conceal their distress, making it difficult to identify those who need support. The study emphasizes that their understanding of mental health is deeply intertwined with their cultural and religious beliefs. Despite recognizing the value of support, these women encountered significant barriers to accessing mental health services.

Appendix F- Ethics Approval Form

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Understanding Health and Mental Health Professionals' Perspectives Around Recovery for Refugees and Asylum Seekers: A Grounded Theory Study.

Application ID: ETH2324-1747

Dear Lara,

Your application was considered on 23rd June 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **5th March 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Stanley Musgrave

Deputy Chair, FMH-sREC

Appendix G- Disseminated Poster

Appendix H- Online Participant Information Sheet Copy

v3, 12.06.2024, ETH2324-1747

Participant Information Sheet

University of East Anglia

Thank you for your interest in taking part in this research study (ETH2324-1747).

My name is Lara Omran and I am a Doctorate student in Clinical Psychology at the University of East Anglia. I am supervised by Dr. Bonnie Teague and Dr. Kenny Chiu.

Please take the time to read the following information about the study:

Invitation Paragraph

We would like to invite you to take part in a research study to help us understand what mental health recovery means to refugees and asylum seekers.

This study is part of the Doctorate in Clinical Psychology program at the University of East Anglia. We are looking for mental health and health professionals within the East

of England who are currently supporting refugees and asylum seekers.

Before you can decide whether you want to take part or not, it is important to understand why we would like to speak to you and what speaking to you will involve. Please take time to read the following information carefully.

What is the Project's Purpose?

Recovery is made up of many things; it is made up of one's physical health and well-being, but it is also made up of one's mental health and well-being.

The journey of a refugee and asylum seeker involves many hardships due to experiences that happened before, during, and after reaching a safe country. The purpose of this project is to understand refugees and asylum seekers' experiences with and understanding of mental health recovery through the perspectives of the mental and healthcare providers that are supporting them.

There is limited research looking at refugee and asylum seeker mental health through the perspectives of their health service providers, particularly in the East of England. It is hoped that the results of this study will improve understanding of refugee/asylum seeker's

unique mental health needs and how to best support them and their recovery upon living in the East of England.

Why Have I Been Chosen?

We are inviting mental health and health professionals within the East of England who are currently supporting or have at least 6 months of experience supporting refugees and asylum seekers to attend a confidential interview with the researcher (Lara Omran).

The interview will be held online over Microsoft Teams and will be around 60 minutes long. We hope to recruit up to 10-12 participants for this research study.

Do I Have To Take Part?

It is up to you whether to take part or not. If you decide to take part, you can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

If you do decide to take part, you will be given a copy of this information sheet and will be emailed within 3-5 days with a link to the consent form and to schedule your online interview. The information you give and results

from the project will be kept strictly confidential and anonymous. No one will be able to link your name with your information, and no names will be used in the final report.

What Will Happen If I Take Part?

You will be asked some questions about your experiences in supporting refugees and asylum seekers with their recovery within your profession. You will also be asked about your perceptions of what mental health recovery looks like for refugees and asylum seekers based on your experiences working with this population.

This should take no more than one hour and will only take place once. The interview will be held online with myself (Lara Omran) over Microsoft Teams and will be recorded.

The information you give and results from the project will be kept strictly confidential and anonymous. No one will be able to link your name with your information, and no names will be used in the final report. All data will be collected and stored in accordance with the Data Protection Act 1998 on secure OneDrive servers. Recorded interviews will be transcribed (written up) and the interview recording will then be deleted.

As a thank you for your time, you will receive a £10 Love2Shop voucher.

Will I Be Recorded?

The interview will be recorded, transcribed (written up) and the interview recording will be deleted. Any identifiable information about yourself will be removed during the write-up of your interview.

The transcriptions of the interviews will only be used for analysis and illustration in presentations/paper publications. If any direct quotes are used, any potential identifying information will be removed, and you will be assigned a pseudonym.

How Will My Information Be Used?

We will need to use information from you for this research project.

This information will include your preferred name, contact details, and some demographic information (such as your age, gender, duration of working with refugees and/or asylum seekers, and ethnicity). People will use this information to do the research- people who do not need to know who you are will not be able to see your name or contact details. Your data will have a random code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results.

Anonymised data may also be used for future research. We will write our reports in a way that no-one can work out that you took part in the study.

What are the possible disadvantages and risks of taking part?

There are no immediate risks of taking part in this study. There is a potential for discomfort that may come up from speaking about working with vulnerable populations and the processes that come with navigating working with refugees and asylum seekers.

What are the possible benefits of taking part?

Taking part in this research would lead to helping us understand mental health recovery in this population and may have important implications for services that support refugees and asylum seekers with their mental health. Your experience will be a valuable contribution to an important and under looked area of refugee and asylum seeker mental health within the UK.

What if I have a problem with the study?

If you have any problems with the study, you are welcome to contact myself (Lara Omran) or my supervisors (Dr. Bonnie Teague and/or Dr. Kenny Chiu)

with the nature of your concern or complaint. You can find all contact details at the end of this sheet.

If you want to speak to someone independent from the research team, please contact Professor Sian Coker (Professor of Clinical Psychology) at s.coker@uea.ac.uk with the nature of your concern or complaint.

Will my taking part in this project be kept confidential?

If you do decide to take part in either an interview, you will be given a copy of this information sheet to keep and be asked to give consent. The information you give and results from the project will be kept anonymous and confidential (unless there is a need to breach confidentiality as outlined below). No one will be able to link your name with your information, and no names will be used in the final report.

Upon completion of the consent form and confidentiality agreement, the interviews will be recorded, and transcribed (written up)- the interview recording will then be deleted. The transcriptions of the interviews will only be used for analysis and illustration in presentations/paper publications. If any direct quotes are used for illustration, any potential identifying information will be removed.

Limits to Confidentiality

Confidentiality will be respected during interviews unless there are compelling and legitimate reasons for this to be breached. These reasons would include potential breaches of professional conduct or ethical practice. During the interviews, I (Lara Omran) will discuss with you any potential reasons for breaking confidentiality to understand the context in which an incident may have occurred. This will then also be addressed with my research supervisors (Dr. Bonnie Teague & Dr. Kenny Chiu) after your interview. Following the discussions with my research supervisors, if breaking confidentiality is the final decision, this will be communicated to you.

What Will Happen to the Results of the Research Project?

At the end of the interview, you will be asked whether you would like to receive a copy of the final report of the study, once it has been completed. The anonymised findings of this research will be made available to you through an easy-read infographic, with summaries individually emailed to you if you request this. Any quotations used will be anonymised in publications of any sort.

Contact for Further Information

If you have any questions regarding this research and how your information has been used or require advice on which organisations to contact for help, please contact:

Miss Lara Omran: l.omran@uea.ac.uk (Research Team, Doctorate of Clinical Psychology)
Dr Bonnie Teague: b.teague@uea.ac.uk (Research Team, Doctorate of Clinical Psychology)
Dr Kenny Chiu: kenny.chiu@uea.ac.uk (Research Team, Doctorate of Clinical Psychology)
Professor Sian Coker: s.coker@uea.ac.uk (External Contact, Doctorate of Clinical Psychology)

Thank you for reading this information sheet and for considering taking part in this research study. You will be given a copy of this information sheet if you wish to take part.

Please indicate your understanding of this information before moving forward.

○ I understand the information that has been shared and I am interested in taking part in this study.

Appendix I- Online Consent Form Copy

v2, 04/05/2024, ETH2324-1747

Online Consent Form

University of East Anglia

Please complete this form after you have read the Information Sheet.

Title of Study: Understanding Health and Mental Health Professionals' Perspectives Around Recovery for Refugees and Asylum Seekers: A Grounded Theory Study (ETH2324-1747).

Name and Contact Details of the Principal Researcher(s):
Lara Omran, Email: l.omran@uea.ac.uk

Name and Contact Details of the Research Supervisor(s):
Dr Bonnie Teague, Email: b.teague@uea.ac.uk
Dr Kenny Chiu, Email: Kenny.chiu@uea.ac.uk

Thank you for considering taking part in this research. The

person organising the research must explain the project to you before you agree to take part. If you have any questions from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please indicate your unique participant ID as provided in the email.

Please indicate today's date (DD.MM.YYYY)

I understand that by ticking "I consent" to each box below I am consenting to this element of the study. I understand that by not giving consent for any one element I may be deemed ineligible for the study.

	I consent	I do not consent
I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me.	○	○
I have had the opportunity to ask questions which have been answered to my satisfaction.	○	○
I understand that I can choose to not take part in the study at any time before, during, or after the interview.	○	○
I consent to the processing of my personal information (age, gender, ethnicity, occupation) for the purposes explained to me. I understand that such information will be handled in accordance with all applicable data protection legislation.	○	○
I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified.	○	○
I understand that my data gathered in this study will be stored securely. It will not be possible to identify me in any publications.	○	○
I understand that confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this were the case, we would inform you of any decision that might limit your confidentiality.	○	○
I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	○	○
I understand the potential risks of participating and the support that will be available to me should I become distressed during the research.	○	○
I understand the direct/indirect benefits of participating.	○	○
I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	○	○
I understand that I will be reimbursed for my time spent in the study. This will be in the form of a £10 Love2Shop Voucher.	○	○

	I consent	I do not consent
I agree that my anonymised research data may be used by others for future research. No one will be able to identify you when this data is shared.	○	○
I consent to my interview being recorded and understand that the recordings will be deleted immediately following transcription.	○	○
I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	○	○
I am aware of who I should contact if I wish to lodge a complaint.	○	○
I voluntarily agree to take part in this study.	○	○

Appendix J- Semi-Structured Interview Topic Guide

The following interview is being recorded for participant [ID Number].
Before we start, can I reconfirm that you are happy for me to record our discussion today? Thank you.

I would like to thank you once again for your time.

Today we will discuss your perspectives on what recovery may look like for a refugee/asylum seeker based on your professional experiences supporting this community. This discussion is around hearing about your experiences working with refugees and asylum seekers as a mental health/ health professional and sharing your thoughts. There are no right or wrong answers.

To guide our discussion today, I have some questions that we will go through today. You are never required to answer any of my questions, everything we talk about today is at your pace, and you have control over what we cover. If there is anything that I ask you that you do not want to talk about, just let me know and we will move on. Does that sound okay so far?

Everything that you share with me will be confidential and the only reason I would have to break this confidentiality is if you are at risk to yourself or others- in this case I would need to inform my supervisor, and I will let you know that I would have to break the confidentiality. This is only to keep you and those around you safe. Does that sound okay?

The discussion should last around an hour, and at the end of the discussion, I will give you your reimbursement for your time.

Are you happy to begin?

Experiences Working with Refugees and Asylum Seekers.

1. What is your current profession?
2. In what capacity do you support refugees and asylum seekers?
3. How long have you been supporting refugees and asylum seekers?
4. Has mental health ever come up in your work with refugees and asylum seekers?

1. Who is usually the first to bring up mental health, yourself or the refugees/asylum seekers?
2. Based on your experiences, what has been their attitudes/beliefs around mental health?
3. How do refugees and asylum seekers respond to being suggested or being in mental health services?
4. How confident do you feel in speaking/working with refugees/asylum seekers and their mental health?

Recovery

One of the things that we are trying to understand as part of our study is the idea of 'recovery.'

Recovery is defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles' to live a meaningful and satisfying life despite the limitations brought on by illness or difficult life circumstances.

Recovery can mean different things for different people and different cultures and is often seen in the sense of a journey of recovery from mental health difficulties.

1. What do you feel is important for refugees and asylum seekers when it comes to their recovery journey? What are they often aiming for when it comes to recovery?
    a. (Prompts: Work, Family, Religion/Spirituality, Community, Communication, Mental Health, Physical Health, Education, Meaning/Purpose, Status/Recognition, Finances, Stability, Home, Support, Environment)
2. How does recovery differ in refugees and asylum seekers compared to other groups?
3. What barriers exist that may hinder the recovery of refugees and asylum seekers?
    a. Individual level barriers
    b. Structural level barriers
4. How do you feel that your support in your work with refugees/asylum seekers fits in with their recovery?

We have come to the end of our discussion. Thank you for taking the time to share your story, experiences, and thoughts with me. Everything you have shared has been very meaningful and helpful to my study. At the end of the study, I will put together a summary of what I have found. Would you be interested in receiving a copy of that?

Thank you, I will now stop this recording.