CHALLENGES TO MENTAL HEALTH SUPPORT FOR REFUGEES AND ASYLUM SEEKERS:

ACCESSIBILITY, CULTURAL BARRIERS, AND LONG-TERM CARE GAPS

BY

ODEMWINGIE, OSAHON

UZOWULU, EMEKA SEBASTINE

NWITTE-EZE, EKENE

DENNY, ERIN MAE

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1. INTRODUCTION

Refugees and asylum seekers (ASR) are among the most vulnerable populations globally, having fled their countries due to war, persecution, or fear of violence. According to the 1951 Refugee Convention, refugees are individuals unable to return to their home country due to a "well-founded fear of persecution," while asylum seekers are those who have applied for asylum but await a decision. In the United Kingdom, the number of refugees and asylum seekers has risen significantly in recent years due to factors such as the easing of global travel restrictions post-pandemic, increased small boat arrivals, and the backlog in processing asylum claims. Populations from countries such as Eritrea, Syria, Afghanistan, and Albania have seen notable increases, with Iranians consistently leading in asylum applications.

The experiences of refugees and asylum seekers often involve a sequence of traumatic events, from pre-departure hardships in their home countries to dangerous journeys and the challenges of integration into a new host country. These experiences heighten their susceptibility to mental health issues such as post-traumatic stress disorder (PTSD), depression, and anxiety. However, systemic barriers—ranging from cultural and linguistic differences to bureaucratic inefficiencies and resource shortages—limit their access to the mental health care necessary to address these challenges. These barriers persist despite various policies and initiatives implemented by the UK government to improve mental health service accessibility.

This report seeks to examine the structural and societal barriers that hinder ASR access to mental health services in the UK, including limited resources, cultural and language obstacles, and geographic challenges. Focus is given to vulnerable subgroups such as unaccompanied children, pregnant women, the elderly, and LGBTQ+ individuals, who face compounded challenges requiring tailored support.

A mixed-methods approach was adopted for this study, combining secondary data from literature reviews with primary data collected through semi-structured interviews. This methodology acknowledges the literacy and language barriers often present among ASR populations, offering interviewees the freedom to express their perspectives without restrictions. The insights gained are invaluable for understanding the lived experiences of ASR and the systemic issues that hinder equitable access to mental health care.

Despite the urgent need for psychological support, gaps in service provision—including the absence of culturally sensitive care, insufficient trauma-informed approaches, and inadequate

long-term interventions—remain. Many existing services prioritize emergency care over sustainable, long-term support, leaving ASR unable to fully address their mental health needs or integrate effectively into host communities. This report not only highlights these barriers but also proposes actionable solutions aimed at bridging the gap between the mental health needs of refugees and asylum seekers and the services available to them. By addressing these systemic issues, the UK can work towards fostering resilience, well-being, and successful integration for these vulnerable populations.

1.1 PROBLEM STATEMENT

Despite the known prevalence of mental health disorders such as PTSD. Anxiety, and depression among refugees and asylum seekers, there remains a critical lack of accessible, culturally appropriate, and sustainable mental health care. Current support systems are often overwhelmed or ill-situated to meet the unique needs of the population. There is a pressing need to investigate these gaps and propose solutions to improve mental health outcomes for refugees.

1.2 RESEARCH OBJECTIVES

1. **Assess Accessibility**: Investigate barriers that refugees and asylum seekers face in accessing mental health services, including bureaucratic obstacles, resource limitations, and geographical challenges.

2. Explore Cultural and Language Barriers: Analyses how cultural attitudes toward mental health and language differences create obstacles to effective mental health care.

3. Examine Long-Term Care Deficiencies: Identify gaps in the provision of long-term mental health care and follow-up, with a focus on the sustainability of services for those experiencing chronic mental health issues.

4. Focus on Vulnerable Subgroups: Explore the unique mental health challenges faced by vulnerable groups within the refugee population, such as women, children, and LGBTQ+ individuals.

1.3 METHODOLOGY

Literature Review: A comprehensive review of existing research on mental health support refugees, focusing on service accessibility, cultural barriers, and long-term care.

Interview/Surveys: Conduct interviews or surveys with refugee and asylum seekers, mental health professionals, and service providers to understand firsthand experiences and service gaps.

This study adopted both the secondary and primary data collection methods. The collected secondary data emanated from a comprehensive review of extant literatures on barriers to mental health services for ASR within and outside the UK.

To gather primary data – aimed at having firsthand experiences and service gaps, this research conducts a semi-structured interview on official of the British Red Cross (proposed interview with mental health professionals had to be discarded due to time and accessibility factors) and NGO caseworkers who directly engage with refugees and asylum seekers in mental health programs. These caseworkers provided firsthand insights into the systemic and operational gaps in service delivery, as well as the lived experiences of their clients. The choice of this over the survey/questionnaire is informed by findings from literatures that some of the ASR might have low English literacy/competence. More so, the semi-structured interview, being open-ended in approach, shall give ample liberty for all the interviewees to express their opinions.

1.4 SIGNIFICANCE:

This research will contribute to a better understanding of the systematic gaps in mental health support for refugees and asylum seekers, offering insight for policy makers, health care providers and humanitarian organizations. By addressing these challenges, we can work towards more equitable and effective mental care for one of the most vulnerable populations in the world.

1.5 EXECUTIVE SUMMARY

This report examines the barriers faced by refugees and asylum seekers (ASR) in accessing mental health services in the UK, focusing on vulnerable groups such as unaccompanied children, pregnant women and new mothers, LGBTQ+ individuals, and elderly refugees. It identifies systemic challenges, including resource limitations, cultural and linguistic barriers, and geographic inaccessibility, while proposing evidence-based solutions to improve mental health outcomes. The primary objective of this research is to shed light on these obstacles and recommend tailored, sustainable interventions to enhance access to care.

A mixed-methods approach was employed to conduct this study. Primary data were collected through semi-structured interviews with legal and healthcare professionals, providing firsthand insights into service delivery challenges. Secondary data, gathered from an extensive review of literature, contextualized these findings and validated recurring themes. Additionally, field observations and case studies of community-led initiatives offered qualitative evidence of gaps in existing services.

The findings reveal significant resource deficiencies, including a lack of specialized mental health services, culturally competent professionals, and trained interpreters. Long waiting lists further delay treatment, compounding the mental health vulnerabilities of refugees and asylum seekers. Cultural and linguistic barriers exacerbate these challenges, as stigma around mental health often deters individuals from seeking help, while language difficulties lead to

misdiagnoses or inadequate care. Vulnerable subgroups face distinct challenges: unaccompanied children are particularly affected by trauma, separation, and language barriers; pregnant women and new mothers struggle with isolation and limited access to culturally appropriate postnatal care; LGBTQ+ refugees face systemic insensitivity and discrimination, which amplify internalized stigma; and elderly refugees experience isolation and mobility challenges, especially in rural areas.

To address these barriers, the report recommends increasing funding to enhance the availability of mental health services and hiring more culturally competent professionals and interpreters. Trauma-informed and culturally sensitive care should be integrated across all levels of service delivery, supported by mandatory training for healthcare providers and caseworkers. Community-led initiatives are vital to promoting integration and reducing isolation, and multilingual resources, along with better transportation options, should be prioritized in underserved regions. Encouraging international students to work in mental health and translation services through incentives and training programs could help address staffing shortages.

Collaboration between NGOs, government agencies, and community organizations is essential for effective policy implementation and improved service delivery. Centralized service hubs could streamline access to mental health, legal, and social support, while outreach programs in rural and remote areas would ensure equitable access for all. By addressing these systemic inefficiencies, the UK can create a more inclusive mental health care system that meets the unique needs of refugees and asylum seekers, fostering resilience and improving well-being within these vulnerable populations.

2. EXAMINATION OF ACCESSIBILITY BARRIERS TO MENTAL HEALTH SERVICES FOR ASYLUM SEEKERS AND REFUGEES (ASR) IN THE UK

2.1 THE CONCEPTS OF MENTAL HEALTH, ASR MENTAL HEALTH PROBLEMS AND THEIR CAUSES.

Mental health is a condition "of well-being enabling individuals to realize their abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities (WHO, 2003, p. 4). It is a state of "being generally able to think, feel and react in the ways that you need and want to live your life" (Mind, 2024, p. 4). A deterioration in this condition – "a clinically recognizable set of symptoms or behaviors associated in most cases with distress and with interference with personal functions" (WHO, 1992, p. 5) – is termed mental health problem/illness/issue/disorder (Mind, 2024) or emotional health challenge (Hewing and Clarke, 2014).

Examples of common mental health illnesses include depression, anxiety, PTSD, suicidal thoughts, and substance abuse; while uncommon ones comprise bipolar disorder and schizophrenia (Mind, 2024). In ASR, depression and anxiety which remain their common mental health disorders (Blackmore *et al*, 2020) are potentially caused by pre-departure variables in home country (e.g. structural violence like economic hardship and persecution, and

somatic violence like homicide, war and rape); departure/transit variables (e.g. life-threatening incidents/accidents and human trafficking); and post-departure/arrival and integration variables in host country (e.g. poor living conditions, acculturation hitches, problems associated with obtaining entitlement and detention, social isolation, facing return, unemployment, etc.) (WHO, 2018).

2.2 BRIEF OVERVIEW OF UK MENTAL HEALTHCARE POLICIES

The importance of mental healthcare for ASR cannot be overemphasized. In general, it enables them to deal with pressure and improve their ability to cope with life's vicissitudes in their host country (Mind, 2024). Acknowledging this, the UK government has over the years formulated and implemented myriads mental healthcare policies targeted towards addressing the emotional health illness of its citizens, as well as those of ASR.

England: In England, there exist the 2011 *No Health without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of all Ages* policy, geared towards alleviating stigma and discrimination – ensuring equal accessibility of high-quality mental health services to all mental health patients (HM Government, 2011). In 2014, the *Five-Year Forward View* policy – aimed at ensuring both mental and physical health receive more equal response, as well as expanding access and waiting time standards by 2020-2021 (NHS England, 2014; Pollard and Howard, 2021) – was formulated. Additionally, in 2017, the Mental Health Act 1983 was modernized to *inter alia,* address the unequal numbers of Black and other minority ethnic groups in detention (Garratt, 2024). The reform howbeit, excluded ASR (Pollard and Howard, 2021).

Wales: In Wales there exist the 2012 *Together for Mental Health: a strategy for mental health and wellbeing in Wales* (Llywodraeth Cymru Welsh Government, 2012) and the *Together for Mental Health Delivery Plan 2019-2022* (Welsh Government, 2020) policies which cover ASR.

Scotland: In Scotland there exist: the *2012-2015 Mental Health Strategy for Scotland* which outlined the government's priorities and commitments towards improvement of mental health services and prevention of mental health problems (Matheson, 2012); the 2014 Scottish bills, which aimed to ensure that victims of mental illness are effectively treated in a swift and easy manner; and the 2018 *Every Life Matters*, which, though aimed to prevent suicide, but was silent on ASR mental health issues (Pollard and Howard, 2021).

Northern Ireland: In Northern Ireland, there is the 2014 *Regional Mental Health Care Pathway* aimed to enhance the experiences of victims of mental health illness, as well as rendering more personalized social and health services (Rooney and Watts, 2014). Nevertheless, this policy like those of Scotland, seems silent on care for ASR (Pollard and Howard, 2021).

2.3 ACCESSIBILITY BARRIERS TO MENTAL HEALTH SERVICES FOR ASR

This review is a composite examination of accessibility hurdles to mental health services for ASR within and outside the UK. The rationale behind the former is to ascertain if such barriers have been addressed or still linger; while that of the latter is to determine if accessibility challenges to mental health services faced by ASR in other climes are also faced by their counterparts in the UK. Nevertheless, it is pertinent to state here that despite several years of implementation of various mental health policies, studies have shown that there exist some salient barriers mitigating against all-inclusive, improved and satisfactory mental healthcare services for ASR in the UK. One principal compound challenge is the issue of accessibility.

First within this composite barrier is the issue of lack of resource. In the UK, studies have shown that there is limited mental healthcare resources allocation and service rendering to ASR as the available ones are still insufficient for UK nationals (Karamanidou and Folley, 2020). Affirming this, an interviewee lamented:

> …the reality is that people are feeling stretched, many people have been living with austerity for a very long time and when you're living with austerity and you are poor yourself it is very difficult to say that's fine take some of what I've got and give it to somebody else... I'm not aware of the government doing anything about it because I don't know it's a priority, in fact it's probably the opposite (Pollard and Howard, 2021, p. 8).

One of such limited resources, though found outside the UK scenario, is lack of mental health services specifically tailored to the needs of ASR. Findings for instance, have shown that there is dearth of specialist mental health services for specific groups (e.g. refugee unaccompanied or separated children – UASC with PTSD, who need specialized trauma-centered treatment; and survivors of somatic violence now turned refugees, who need survivor-focused services) (WHO, 2023).

A second limited resource is mental health staff. In England, a 2024 investigation shows that the number of mental health nurses has declined to its 2010 status "after years of cuts" (Darzi, 2024, p. 6). Relatedly is the issue of lack of culturally competent mental healthcare professionals, as well as limited "cultural responsiveness within the design of the mental health service". These have discouraged ASR from accessing mental health services for fear of cultural assimilation (WHO, 2023, p. 42).

Fourthly is limited financial resources. Also in England, study shows that "there has been insufficient capital investment in the NHS" (Garratt, 2024, p. 34), which has made the country's mental health sectors similar to the "Victoria-era cells infested with vermin" (Darzi, 2024, p. 8). It is pertinent to emphasis here that even the problem of communication barrier occasioned by lack/variations in the availability and quality of interpreters, is fundamentally caused by this lack of financial resources needed to contract the services of these essential personnel (Patel, 2017). Accordingly, an interviewee opined that:

> The professional standards for contracting interpreters are hardly respected really because there is very little money allocated to the need for interpreting and is seen as a nuisance in the 'main' (Pollard and Howard, 2021, p. 9).

In a transnational review by the WHO, an interviewee identified the issue of succession as another rationale behind the dearth of trained and experienced interpreter as follows:

> Most of our interpreters they … don't have enough experience. So, when people become proficient, they leave for another job and leave this to a beginner. And the beginners they cannot make the things effective. So sometimes they mislead the people more often than are helpful (WHO, 2023, p. 39)

One major cause of these issues of limited resources examined above, has been traced to health policy priority question as more efforts and resources seem to be channeled toward ASR physical than mental health (Pollard and Howard, 2021). In recognition of this, the WHO reported that:

> … in most parts of the world, mental health and mental disorders are not accorded anywhere near the same degree of importance as physical health. Rather, they have been largely ignored or neglected (WHO, 2003, p. 4).

An attestation to the above views can be seen in the 2019 NHS England's £1.4bn investment in mental health services, with zero allocated funding and zero precise guidelines for the mental health of ASR (Williams, 2019). In a further affirmation, an interviewee asserted that:

> Public health is more concerned about infectious diseases with refugees, like TB, rather than mental health issues (Pollard and Howard, 2021, p. 8).

Outside lack of resources, unfamiliarity with the health systems has further compounded accessibility barrier for ASR (WHO, 2023). For instance, it has been observed that due to lack of mental health service information at the disposal of ASR, those who do access mental health services may be ignorant of their right to request for an interpreter (Poduval *et al,* 2015) or even be discouraged from accessing mental health services over health bills – charging regulations and costs anxieties (Murphy, 2020). Affirming this, an interviewee stated:

> The clients we're working with, refugees, they're not always aware they have a right to an interpreter when they go for an appointment (Pollard and Howard, 2021, p. 9).

The second accessibility barrier are bureaucratic obstacles. In a transnational literature review, the first two identified bureaucratic hurdles stifling ASR access to mental health services, were the issue of lack of time and the inflexibility of services. These are due to the fact that only few mental health services for ASR remained accessible outside official hours and during weekends. Second are refugees' rigid work schedules which stifled attendance, as some

employers may not grant time off work for them to attend mental healthcare appointments. Other identified bureaucratic bottlenecks include: challenge in locating services, complex booking systems, rigid appointment schedules, and long waiting lists and times (WHO, 2023). In regard to waiting time in the UK, research revealed that almost:

> a quarter of mental health patients (23%) wait more than 12 weeks to start treatment, due to lack of consultant psychiatrists... Over two fifths (43%) say that the wait… has caused their mental health to worsen... More than three quarters (78%) of those in a hidden waiting list ... were forced to resort to emergency services or a crisis line in the absence of mental health support – including 12% going to A&E, 7% ringing 999, 16% contacting 111 and 27% turning to a crisis line (the Royal College of Psychiatrists, 2022, pp. 1-2).

In a 2024 finding in England, it was admittedly reported that:

> Access and waiting time standards are in place for early intervention in psychosis services and NHS talking therapies for anxiety and depression. These standards are being met but there are concerns that people may face additional waits within services (Garratt, 2024, p. 1).

The third accessibility barrier are geographic factors. For instance, it has been observed that some areas in the UK with larger refugee resettlement have more mental health needs than others (Karamanidou and Folley, 2020). Also, certain areas with long years of association with ASR, tend to be more experienced and hospital in the provision of mental health services to ASR than others (Pollard and Howard, 2021). An interviewee amplified this as follow:

> In the areas like central London where we see refugees all the time, attitudes are generally positive, but other areas of the UK maybe it’s not like that. They don’t have the long history of receiving migrants and refugees, with services experienced in delivery to this population... (Pollard and Howard, 2021, p. 8).

2.4 FINDINGS ON ACCESSIBILITY BARRIERS TO MENTAL HEALTH SERVICES FOR ASR IN THE UK

i. Based on Interview Question 1, response shows that the UK specialist mental health services are:

> insufficient [and] the specialized services [are] not really up to standard… For a very civilized country [like the UK], the mental health service is not up to standard. It hasn't been developed… not because there are not qualified people around,

> [but because] there is no resource for them to reach so many people.

ii. Sequel to Interview Question 2, the interviewee admitted:

a. That there are mental health staff, but they are not enough. Findings show that because the need for mental health services is “massive”, it becomes problematic for the available “staff or people or personnel to reach those needs.”

b. That among mental health service providers, there is “lack of understanding of cultures, religions… of these people [ASR], who come over”. For example, it was revealed that “the person which we referred, they [mental health providers] were not really trained properly to be aware of the persons’ [culture]. Comparatively, while the UK mental health service providers might understand British teenagers with suicidal thoughts, they lack such understanding of ASR, whom, from different cultural settings, have escaped several death traps.

However, findings further show that the cultural competence of UK mental healthcare workers:

> depends on the persons you come across; how much one makes themselves aware. Though there could be totally qualified mental health member of staff: doctor, nurse, former caseworker, etc. but it just depends on the individual, how much they spend their time to become aware of that particular culture of the other people [ASR].

iii. In regards to Interview Question 3:

a. The interviewee responded that they work with interpreters.

b. On the availability of quality interpreters, the interviewee’s adopted case study revealed:

> the people from Iran and people from Afghanistan, they both speak Farsi, but different dialect [and] different phrases, but the Home Office might bring an interpreter [with] not much [suitability]… At that time, there wasn't many Afghans to become an interpreter, so mostly Iranians. An Iranian was translating to this person but... it [was] quite tricking because they have different phrases for their governments, military ranks… and so a lot of problems start from that… and I was begging all the authorities [to] please make sure we get the right interpreter to the right person and that's misunderstanding quite a lot…

Using another case study, the interviewee further narrated:

> at the moment Vietnamese and Chinese have a lot of problems because there are not enough interpreters… [with] understanding [of] what's going on with their lives. [For instance] the only thing he [a Vietnamese asylum seeker] knew was “I'm tired” and that's all he was saying “I'm tired”; [and] because he couldn’t communicate with anybody, he couldn't get in touch with them. So, it [the issue of lack of interpreter] is a one big block… I'm not saying maybe it's better now… then it wasn't OK. I think… there are languages that are very difficult like the Chinese languages.

iv. In relation to Interview Question 4, the interviewee replied “I have no experience”.

v. On Interview Question 5, while acknowledging the fact that the demand for mental health service “is so high” the interviewee lamented that the UK:

> waiting list is too long… the waiting list is horrendously wrong. I think three months, for somebody who's got the mental health issue, three months is a far too long. That person could do anything: can harm himself, can harm somebody else, and do something else. [To tell someone in a mental problem] you stay in this level until three months and then you get appointment, it's not good enough... No, it's not good enough.

vi. Based on Interview Question 6, the interviewee asserted that the Tees Valley has “a lot of charity organizations” whom ASR always come in contact with and get references to where they can always seek mental health services. In this regard, it was revealed that “there are good organizations around this area.” However, on the issue of sufficiency or otherwise of mental health resources, the interviewee responded “I can't really answer… I think it's pretty good.”

2.5 DISCUSSION OF FINDINGS

i. From the first findings, there is correlation between the interviewee’s response and reviewed literature. That is, while literature reviews stated that there is lack of mental health services specifically tailored to the needs of ASR; the research findings affirmed that the UK specialized mental health services are “insufficient” and “not really up to standard… not because there are not qualified people around, [but because] there is no resource for them to reach so many people.” The last part of this statement also confirmed reviewed literatures and answered Question 6. That is, lack of resources (finance, mental health staff and facilities), hinder ASR accessibility to mental health services in the UK.

ii. Part (a) of the second findings also confirmed literature review that there is limited number of mental health staff in the UK and this by logical extension, hinder ASR access to mental health services. As aptly put by the interviewee, the need for mental health services is "massive", but the service providers "are not enough." Thus, it becomes problematic for the few available "staff or people or personnel to reach those needs."

Part (b) of the second findings similarly confirmed the reviewed literatures that lack of culturally competent mental health care providers hinders accessibility. That is, the interviewee's response show there is "lack of understanding of cultures, religions… of these people [ASR], who come over" on the part of the UK mental health care providers. Nevertheless, it was observed that this issue is relative, as it "depends on the persons you come across". That is, "how much they [UK mental health care providers] spend their time to become aware of that particular culture of the other people [ASR]."

iii. Part (a) of the third findings revealed that UK mental health sectors do engage the service of interpreters. However, part (b) of same, affirmed reviewed literatures that lack of qualified interpreters hinders ASR access to mental health services in the UK. For instance, it was observed that due to lack of qualified interpreters to translate the Afghan version of the Farsi dialect, officials might utilize the available – Iranian Farsi speakers, with different dialect. This, according to the interviewee, "is quite tricking because they have different phrases for their governments, military ranks" etc., thus, resulting to "a lot of problems and misunderstanding…" Findings also showed that "at the moment, Vietnamese and Chinese have a lot of problems because there are not enough interpreters… [with] understanding [of] what's going on with their lives. Hence, the issue of lack of qualified interpreters "is a one big block" hindering ASR access to mental health services in the UK.

iv. The interviewee's response to Interview Question 4 "I have no experience" might be due to that fact that they don't attend to the referred patients (ASR), rather, they always interact with them and refer them afterward. This however, shall constitutes an area for future research in order to accept or reject reports in literature review.

v. From the fifth findings, there exist correlation between reviewed literatures and the fieldwork. That is, there exist a waiting list – that "is too long… horrendously wrong [and] not good enough", which hinders ASR access to mental health services.

vi. The sixth findings show that the Tees Valley has "a lot of charity organizations" constantly interfacing with and referring ASR with mental illnesses to the appropriate mental health institutions. Nevertheless, the interviewee's response was unable to confirm or reject reports in reviewed literatures pertaining the lack of mental health resources (finance, staff, and facilities) required to tackle the increasing mental health challenges of ASR in the Tees valley. As in (iv) above, this shall also constitute another area for future research so as to accept or reject findings from reviewed literatures.

2.6 CONCLUSION/RECOMMENDATIONS

This work examined resources limitations, bureaucratic and geographic variables hindering accessibility to mental health services for ASR in the UK. Findings showed that:

> the very reason they came over [is] to get somewhere and to leave things behind. [Thus,] they leave home with the hope of being better, being away from danger, being away from bullets, being away from domestic violence. Getting to the reaching point [they] get so many hurdles/blockages which of course affect their mental health.

On some major post-departure causal variables of ASR mental illness, it was observed that although some do:

> reach their goal and do pretty well… I can tell you with my experience of so many years working with asylum and refugees, I think 90% are traumatized by our (UK) governments, our country, and afterwards the system of immigration in this country”

Nevertheless, though the same UK governments have tried “to give more encouragement for the mental health team to reach more people… it's just very difficult for a lot of people to reach mental health treatment”. In conclusion, it is pertinent to know that there exist correlations between reports in literature review and findings (i), (ii), (iii) and (v). Howbeit, the fourth and sixth responses did not enable the researcher to accept or reject findings from literature review.

To tackle these barriers, the followings are hereby recommended:

i. There should be “more and more staff, more people [and] more bodies to reach” to meet the mental health needs of ASR. To actualize this, as well as addressing the issue of long waiting list, suggestions from fieldwork advised the UK government “to spend some time and money to train people, to get resources”, to get more qualified people, and ensure there are mental health services in every public department and every corner.

ii. Mental health workers should be trained to be more aware of the culture of their patients (ASR) including all they have gone through and the reasons why they are in the UK.

iii. Since international students constitute one major source of cultural and language diversity in the UK, governments should encourage them via training and other incentives to take up part-time jobs (during term time) and/or full-time jobs (during summer holiday) in the mental health and translation sectors.

iv. The UK Government should engage the services of charity organizations like the Crisis Team, who are not only fully aware of mental health issues faced by ASR, but have been in the frontline of efficiently addressing the mental health challenges of ASR.

v. GPs should ensure ASR with mental health needs are referred “very quickly”.

vi. To further deepened accessibility, there should be a resident mental health personnel and department in every GP.

vii. Modern smart translator devices with diverse language inbuilt system/capacity, should be used to tackled the problem of shortage of interpreters.

3. CULTURAL AND LANGUAGE BARRIERS AFFECTING ACCESS TO MENTAL HEALTH SERVICES FOR REFUGEES AND ASYLUM SEEKERS IN THE UK

3.1 CULTURAL BARRIERS

Cultural norms and beliefs play a critical role in shaping attitudes toward mental health. In many cultures, mental illness carries significant stigma, discouraging individuals from seeking help. Additionally, concepts of mental health may differ; for example, conditions like depression might be understood as physical ailments or spiritual issues rather than psychological disorders.

Case Example: A study conducted in the UK revealed that Somali refugees often describe mental health struggles in terms of physical symptoms, such as headaches or fatigue, due to cultural perceptions of illness. This mismatch complicates diagnosis and treatment.

3.2 LANGUAGE BARRIERS

Limited English proficiency is a major obstacle for many refugees and asylum seekers. Without adequate interpretation services, communication between patients and healthcare providers can break down, leading to misdiagnoses or incomplete care.

Challenges include:

- Inconsistent availability of interpreters, particularly those trained in mental health contexts.
- Dependence on family members for translation, which can compromise confidentiality.

Case Example: A Syrian refugee described difficulties explaining symptoms of PTSD to a general practitioner due to a lack of Arabic-speaking interpreters.

3.3 CONSEQUENCES OF BARRIERS

The inability to access mental health services can have severe consequences:

- Delays in receiving treatment exacerbate conditions.

- Increased risk of social isolation and economic hardship.
- Higher burden on emergency and crisis intervention services.

3.4 EFFORTS TO ADDRESS BARRIERS

The UK government and non-governmental organizations (NGOs) have implemented initiatives to support refugee mental health. Examples include:

- NHS services offering interpretation.
- The Justice First have Staff who assist with translation.
- Community-based mental health programs tailored for specific cultural groups.

However, these efforts are often underfunded and lack consistency across regions.

3.5 RECOMMENDATIONS

To improve access to mental health services for refugees and asylum seekers:

- **Expand Interpreter Services:** Ensure consistent availability of interpreters with mental health training.
- **Cultural Competence Training:** Provide healthcare providers with training to understand cultural nuances.
- **Community Outreach:** Partner with refugee organizations to raise awareness of mental health services.
- **Policy Reform:** Increase funding for targeted mental health programs for refugees.

3.6 CONCLUSION

Cultural and language barriers create significant obstacles for refugees and asylum seekers seeking mental health services in the UK. These challenges exacerbate existing vulnerabilities and prevent many individuals from accessing the care they urgently need. Addressing these issues demands a comprehensive and coordinated response.

Enhanced interpreter services are essential to bridge the communication gap, ensuring that language differences do not impede diagnosis or treatment. Additionally, cultural competence training for healthcare providers is crucial to foster understanding and empathy, enabling professionals to tailor care to the diverse needs of this population. Community engagement initiatives further complement these efforts by building trust, reducing stigma, and creating support networks that encourage individuals to seek help.

By prioritizing these strategies, the UK can create a more inclusive and responsive mental health system. Such efforts will not only improve access to care but also empower refugees and asylum seekers to rebuild their lives with dignity, resilience, and hope.

4. EXAMINE LONG-TIME CARE DEFICIENCIES

4.1 GAPS IN LONG TERM MENTAL HEALTH CARE

Refugees and asylum seekers face unique mental health challenges stemming from pre-migration trauma, migration experiences, and post-migration stressors. Chronic mental health issues, if left untreated, can severely impede their capacity to adapt and thrive. While short-term interventions are often available, long-term mental health care remains inadequate, creating a critical gap in service provision (Pollard and Howard 2021). Some of the gaps in long-term mental health care include Inconsistent access to services, cultural and linguistic barriers, shortage of trained mental health professionals, fragmentation and lack of follow-up, unsustainable funding and policy frameworks (Morris et al. 2009, see also see also; Pollard and Howard 2021).

Inconsistent Access to Services (Mental Health Foundation 2024). Refugees and asylum seekers frequently encounter significant barriers to accessing mental health care. Many live in remote or underserved areas where mental health services are limited

or non-existent. Even in urban settings, navigating complex healthcare systems can be overwhelming, especially for individuals unfamiliar with the language or bureaucratic requirements. Additionally, some host countries prioritize immediate or acute health needs over chronic mental health management, leaving those with long-term conditions without adequate care.

Cultural and Linguistic Barriers (Mental Health Foundation 2024). Cultural and linguistic differences present significant obstacles to effective mental health care. Many refugees come from cultural backgrounds where mental health issues carry a strong stigma, discouraging individuals from seeking help. Furthermore, a lack of culturally sensitive care can alienate patients, leading to miscommunication or mistrust. Language barriers compound these issues, as many refugees struggle to find mental health professionals who can communicate in their native language or understand the nuances of their cultural experiences.

Shortage of Trained Mental Health Professionals (Pollard and Howard 2021). The global shortage of mental health professionals is particularly pronounced when it comes to serving refugees and asylum seekers. Few clinicians are specifically trained to address the unique challenges of trauma and displacement, such as intergenerational trauma or culturally specific expressions of distress. This shortage leads to long wait times and inconsistent care, further discouraging refugees from pursuing treatment.

Fragmentation and Lack of Follow-Up (Mental Health Foundation 2024). Mental health services for refugees often lack integration and continuity. Care is frequently provided by multiple organizations, each with its own protocols and limited communication with other providers. This fragmentation results in poor coordination, making it difficult for patients to receive consistent care. Follow-up is also a significant challenge, as refugees may move frequently or face disruptions in access, causing many to drop out of treatment prematurely.

Unsustainable Funding and Policy Frameworks (Mental Health Foundation 2024). Mental health care for refugees is often funded through short-term grants or emergency aid programs, which are not designed to support sustained service delivery. When funding ends, programs are discontinued, leaving patients without access to care. Moreover, many host countries lack comprehensive policies that prioritize the long-term mental health needs of refugees, relying instead on temporary or stopgap measures that fail to address systemic gaps.

4.2 FINDINGS (SUSTAINABILITY CHALLENGES)

The over-reliance on non-governmental organizations (NGOs) is a critical sustainability challenge. While NGOs provide essential services, they often operate with limited resources and without long-term funding guarantees. This reliance makes the system vulnerable to disruptions when funding decreases or shifts.

Another challenge is the lack of integration between refugee mental health programs and national healthcare systems. Services for refugees are frequently siloed, preventing refugees from accessing broader healthcare resources and reducing the efficiency of mental health initiatives. This disconnect also creates disparities between refugee and host populations, fueling resentment and stigmatization.

Community engagement is another weak point in many mental health initiatives. Effective care requires trust and active participation from the communities it serves, but many programs fail to involve refugees in the design or delivery of services. This lack of engagement reduces the relevance and acceptance of mental health interventions.

4.3 RECOMMENDATIONS

To address these gaps, increasing funding and policy support is. Governments and international organizations must prioritize long-term funding models that enable sustainable service delivery. Incorporating refugee mental health care into national health systems can help ensure continuity and reduce disparities.

Improving cultural competence is another critical step. Mental health professionals should receive training on trauma-informed and culturally sensitive care to better understand the unique needs of refugees. Employing interpreters and cultural mediators can further enhance communication and trust between patients and providers.

Community-based approaches are also vital. Peer-support networks within refugee communities can provide emotional support and reduce stigma, while engaging community leaders can promote mental health awareness and encourage participation in care.

Technology offers promising solutions to many access challenges. Telemedicine can help reach refugees in remote areas, while mobile applications can provide psychoeducation, track mental health symptoms, and facilitate communication between patients and providers.

The government should enhance access to qualified interpreters and ensure their online and printed resources are readily available in the languages most spoken by asylum seekers and refugees.

Collaboration among stakeholders is crucial for sustainable progress. Governments, NGOs, and local organizations should work together to share resources, coordinate services, and establish frameworks for effective care delivery. Centralized systems for data sharing and service coordination can improve the efficiency and impact of mental health initiatives.

4.4 CONCLUSION

Long-term mental health care for refugees and asylum seekers is critically underdeveloped, with significant gaps in access, cultural competence, professional availability, and funding. Addressing these deficiencies requires a shift toward sustainable, inclusive, and integrated care models. By implementing the recommendations outlined in this report, stakeholders can build a more equitable and effective mental health system, ensuring that refugees and asylum seekers receive the support they need to recover and thrive.

5. FOCUS ON VULNERABLE GROUPS

5.1 UNACCOMPANIED REFUGEE CHILDREN

Unaccompanied refugee children face distinct challenges that require specialized understanding and support. Children, in particular, often rely on their parents or guardians to advocate for their physical and mental well-being. However, unaccompanied minors face unique difficulties when accessing mental healthcare, as they lack this essential support system. Integrated support from various services—such as child adoption centers, healthcare, education, governmental and non-governmental agencies, charities, and legal support—can help create a more holistic approach for this population. A more integrated system tends to be more effective in providing support. Given that unaccompanied refugee children are among the most vulnerable, ensuring better integration after resettlement can have a significant positive impact on their long-term mental well-being.

Unaccompanied refugee children and young people are frequently displaced to countries where they may not speak the local language. This language barrier significantly hinders their ability to express the difficulties they are experiencing, leaving them particularly vulnerable. Such isolation not only cuts them off from social and community networks but also impedes their ability to access healthcare services. Over time, this can exacerbate symptoms of mental health conditions, including anxiety and depression, and further hinder their ability to integrate into a society with different cultural norms. These challenges create significant barriers to accessing necessary healthcare, and without early intervention, may lead to long-term physical and mental health consequences.

The impact of trauma and separation on the mental well-being of refugee children is complex and multifaceted. High rates of mental health conditions, such as post-traumatic stress disorder (PTSD), anxiety, and depression, are common among this population. Unaccompanied minors, in particular, may struggle with feelings of insecurity due to the absence of their families, which can create an ongoing sense of instability. These emotions, coupled with isolation, often exacerbate existing mental health conditions, leading to heightened feelings of fear, sadness, and worry.

The experience of trauma and separation is often intertwined with grief, as many children are mourning the loss of family members or their previous lives. This multifaceted trauma requires an individualized and holistic approach to care. Effective support should involve a coordinated effort between non-governmental organizations (NGOs), healthcare providers, community organizations, and government services to ensure lasting and meaningful aftercare for these vulnerable children.

Additionally, mental health challenges may manifest in behavioural issues that make it difficult for children and young people to thrive in school settings. The inability to trust caregivers can further deepen feelings of isolation, which, over time, can hinder the development of resilience. This lack of emotional support can have long-term implications, potentially affecting their mental health into adulthood and leaving them at risk of becoming vulnerable adults. Disruptions in their education, caused by these underlying mental health issues, can limit their future opportunities and outcomes.

Trauma-informed care for unaccompanied children could greatly help to reduce their symptoms with early intervention. This cost-effective approach would ensure that this population receives targeted support specific to their needs. However, this would require more funding for training, which should extend to training foster carers who may care for refugee or asylum-seeking children. Additionally, this report advocates for specialist language support. Being able to communicate effectively will benefit integration, accessing mental health support, and education.

Access to specialized care and support for orphaned refugee children varies significantly depending on the region, with service availability often determined by local resources and the responsiveness of healthcare systems. In the UK, for example, the availability of services can differ across regions, with some areas offering more robust support networks for unaccompanied minors and others facing significant gaps in mental health and social services. The effectiveness of these services is highly dependent on local infrastructure, funding, and the capacity of specialized organizations to meet the unique needs of this population. Continued advocacy for better resourcing and coordination is critical to improving outcomes for orphaned refugee children in need of specialized care.

5.2 PREGNANT WOMEN AND NEW MOTHERS

Pregnant women and new mothers within the refugee and asylum-seeking population face similar challenges to other vulnerable groups. Mental health conditions such as PTSD, anxiety,

and postnatal depression are prevalent among this group. Pregnant women and new mothers may be fearful of legal processes and may have their symptoms exacerbated by feelings of isolation and loneliness, especially if they are separated from their support networks. A lack of physical resources to support both themselves and their children can further exacerbate symptoms, with tangible implications for their well-being. While systems are in place to support this population, there is room for improvement in order to create a more targeted approach that addresses individual needs in a holistic way.

Some women may be fleeing violence and may find themselves pregnant as a result. They may not want to remain pregnant and may seek assistance to terminate the pregnancy. While abortion services are legally available in the UK, accessing healthcare without citizenship can present challenges. Moreover, some individuals may struggle to seek help or even be aware that help is available due to cultural stigmatization of abortion in their country of origin. It is crucial that services available to all pregnant women are clearly communicated as soon as these individuals arrive in the UK and when they come forward to request help. This is another area where collaboration between services and agencies would benefit this vulnerable group. Clear communication through multilingual pamphlets, flyers, posters, and graphics would ensure that information about available services reaches those in need.

Language barriers can complicate the ability of this population to ask for help, further exacerbating mental health conditions and reinforcing stigma. Culturally, some may view mental health challenges as a sign of weakness and may fear the repercussions of seeking help. They may worry that asking for support will lead to being labelled as unfit parents, and therefore may be reluctant to reach out. Normalizing mental health conditions for this population, promoting awareness among agencies, and providing reassurance from professionals would help reduce these fears.

To combat isolation, stigmatization, and loneliness, creating spaces where individuals can talk openly is essential. Mother-and-baby groups are a well-known and popular source of support in the UK. Community centers that host these groups could take steps to create more inclusive environments for mothers from different cultures. Such spaces would help mothers connect, and refugee and asylum-seeking pregnant women could also integrate more easily by engaging with British mothers, who may offer advice on available support services, particularly for mental health.

5.3 LGBTQ+ COMMUNITY.

A sustained commitment by professionals working with this population is essential to better understand their unique needs. This can be achieved through a person-centered approach that integrates an understanding of cultural sensitivities, which is often recommended when working with refugee and asylum-seeking LGBT+ individuals. Furthermore, this report advocates for additional funding to ensure that adequate mental health services are readily available to support asylum seekers and refugees. Enhanced access to these services will significantly improve the efficiency of the asylum and citizenship claim process by enabling

individuals to access support earlier. This proactive approach will help ensure that cases are handled within appropriate timeframes, providing comprehensive support to this population. It is crucial to recognize that the process of proving one's sexual or gender identity can be emotionally challenging, and early intervention can help mitigate these difficulties.

The individual needs of LGBT+ refugees and asylum seekers should be prioritized. These individuals often have unique and varied experiences shaped by the societal attitudes of their country of origin, which may include stigmatization or discrimination from family, friends, or the broader society. Moreover, they may face additional challenges during the resettlement process. It is vital to consider the level of discrimination they have experienced, whether in their country of origin, refugee camps, or during resettlement, as it has significant implications for their mental health. Discrimination can lead to internalized stigmatization, reducing an individual's comfort in seeking support and engaging with services.

Fieldwork has revealed that refugees and asylum seekers fleeing violence due to their LGBT+ identities face significant challenges in proving their sexual orientation or gender identity to secure residency. Charitable organizations in the North East of the United Kingdom, such as Hart Gables, provide letters confirming a client's attendance at LGBT+ events. While these documents can be used to support an individual's asylum claim, they are insufficient by themselves to secure residency. The process of verifying LGBT+ status has been widely criticized for being arbitrary, distressing, and lacking in cultural sensitivity.

Individuals seeking refuge due to homophobic or transphobic violence are required to undergo extensive interviews that often involve deeply personal questions and investigations intended to validate their LGBT+ status. For many, particularly those who have previously faced discrimination due to their sexuality or gender identity, the prospect of engaging with authorities can be daunting. Fears of further persecution or marginalization may discourage individuals from fully trusting investigators or the organizations providing support. Given the length and complexity of the citizenship process, it is critical that this population receives timely assistance to ensure they have the necessary resources to support their residency applications.

Supporting this population during the process of seeking resettlement should include a free counselling service. The counsellors should be specifically trained to be culturally sensitive to the needs of this population. This would include having an understanding of cultural norms globally, for sessions to have access to interpreters where the counsellor may not speak the individual's language. Sessions should aim to help the individual manage their mental health symptoms, as well as to reassure them that they are safe to ask for support. In addition to mental health support services for this population being further developed, breaks in the interview process should be encouraged, particularly where difficult questions are being asked and if the individual shows signs of distress. Due to the interview process being lengthy and invasive, individuals should also be given the opportunity to opt for the interview process to run over several sessions to make it more emotionally manageable. Cultural sensitivity training should also be given to interviewers to promote empathy and understanding when asking difficult

questions, and questions should be under regular review to ensure that they are sensitive and up to date whilst obtaining the information necessary.

5.4 ELDERLY REFUGEES

Elderly refugees can face a number of challenges trying to adjust to resettling. There are some similarities to the barriers that other vulnerable groups may face, resulting in similar recommendations as unoccupied children and the LGBT+ population. Isolation can exasperate mental health conditions such as post-traumatic stress disorder, depression and anxiety all of which are common mental health conditions within the refugee and asylum seeker population. Language barriers and cultural differences can create a sense of loneliness and this population is vulnerable to experiencing difficulties in these areas. Government funding for local initiatives such as workshops designed to help with adjusting to a new life should be prioritized. During fieldwork research this idea was highlighted as the best way to support any vulnerable populations to understand more about British culture including how to understand support services available to them, learn the language, and to connect people from similar background, to access interpreters, and to reduce the feeling of isolation.

A key issue was highlighted during an interview with a lawyer who works for a charity in the North East assisting with supporting the needs of the refugee and asylum-seeking population. It was noted that frequently when people are seeking asylum or refuge, they present to the charity shortly before their appeals need to be made. This provides little time to prepare a holistic case for both legalities and signposting to agencies that provide key mental health support, as well as support to integrate into a new culture. When asked what the potential causes of this population asking for help too late in the process it was suggested that language barriers, and a lack of information provided to this population in a timely manner could be responsible. When interviewed the professional felt that this was related to a lack of information given to this population when they first arrive in the UK, and from fear of stigmatization rather than a need for greater coordination between agencies.

Community led projects help to connect this population with likeminded people can also reduce loneliness and isolation. Such projects exist but are limited due to funding and resources, and there are less of them in smaller towns and villages outside of major cities. Community charities which organize group activities, and connect refugees and asylum seekers with local families to help integrate them can make the resettlement process a little easier. Being connected to local families also helps this population to understand more about how to access services available, and can provide a sense of physical and in turn mental wellbeing. Where community-based projects exist to help this demographic outside of cities, they may not be central or easy to arrange transport, looking at accessibility for services would also be desirable especially for this population as mobility may be compromised.

There are a range of different charities and non-governmental organisations that do impactful work with refugees and asylum seekers regularly. Sharing their knowledge and expertise with governmental departments may affect positive policy change. Government offices are growing

beyond London to help promote positive policy change by creating jobs for local people who can implement policies to reflect the area. A range of offices are set up in Darlington, Department for Education, and for Levelling up, Housing and Communities outreach teams may be positive connections for people who work with this population to communicate with. This could be extremely useful for communicating what the needs of elderly refugee and asylum seeker populations are, as well as all other vulnerable groups within the refugee and asylum seeker population. Governmental departments have outreach teams that aim to create these links and this could be something that non-governmental organisations seek out to raise awareness of the mental health needs for vulnerable groups within this population.

5.5 CONCLUSION

There are numerous barriers preventing vulnerable groups within the refugee and asylum-seeking communities from accessing necessary mental healthcare. These barriers include language difficulties, lack of awareness about available services, geographical challenges, and stigma around mental health. This report highlights common themes across different vulnerable groups and proposes recommendations to address these barriers.

Research suggests that improving coordination between agencies can create a more holistic approach to supporting these populations. With limited resources, language barriers, and difficulties in accessing services in a timely manner, signposting refugees to a central, easily identifiable place with a variety of resources could streamline access to essential services. Using community centers as hubs and offering free transportation services would help address geographical barriers. Workshops could be delivered to integrate refugees into their new culture, educate them about available services, and reduce isolation, which is prevalent in these populations and often exacerbates mental health conditions.

Another key recommendation is the implementation of a trauma-informed approach. All professionals working with refugees and asylum-seekers—such as case handlers, counsellors, doctors, and teachers—should receive training on how to meet the specific needs of these individuals in a holistic, culturally sensitive manner. This would include continuous professional development where online courses and in person workshops could be delivered. As an individualistic approach should be desired when working with all refugee and asylum-seeking populations, but especially vulnerable groups, meetings where hypothetical scenarios are discussed should be actively encouraged to help professionals practice lateral thinking whilst working with these populations.

6. REFERENCES

Asylum seeker and refugee mental health www.rcpsych.ac.uk. Available at: https://www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health (Accessed: 24 November 2024).

Asylum seekers, health, and access to healthcare in initial and contingency accommodation. (2022) Doctors of the World. Available at: https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/04/DOTW-Access-to-healthcare-in-initial-and-contingency-accommodation-report-April-2022.pdf (Accessed: 25 November 2024).

BBC (2021) 'Asylum claims to UK reach highest level in nearly 20 years' *BBC News*, 25 November. Available at: Asylum claims to UK reach highest level in nearly 20 years - BBC News (Accessed 29 October 2024).

Blackmore, R., Boyle, J.A., Fazel, M., Ranasinha, S., Gray, K.M., Fitzgerald, G., Misso, M., and Gibson-Helm, M. (2020) The Prevalence of Mental Illness in Refugees and Asylum Seekers: A Systematic Review and Meta-analysis. *PLOS medicine*, 17(9), pp. 1-24.

Bradby, H., Humphris, R., & Padilla, B. (2015). "Refugees and access to health care: Critical perspectives on the health of migrants." *Global Public Health*.

British Medical Association (2022). *Unique health challenges for refugees and asylum seekers - Refugee and asylum seeker patient health toolkit - BMA*. [online] The British Medical Association is the trade union and professional body for doctors in the UK. Available at: https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit/unique-health-challenges-for-refugees-and-asylum-seekers.

British Red Cross (2018). "Language as a Barrier to Accessing Health Care."

British Red Cross. (n.d.). *Research and publications*. [online] Available at: https://www.redcross.org.uk/about-us/what-we-do/research-publications#Refugee%20support.

British Red Cross. (n.d.). *The kind place: VOICES*. [online] Available at: https://www.redcross.org.uk/about-us/news-and-media/podcasts/the-kind-place-we-are-voices.

Brookes, R. et al. (2023) 'Service provider views on Mental Healthcare Access for UK asylum seekers residing in Home Office contingency accommodation: A qualitative research study', BJPsych Open, 9(S1). doi:10.1192/bjo.2023.88.

Darzi, L. (2024) Independent report: Independent investigation of the NHS in England. Available at: Independent investigation of the NHS in England - GOV.UK (www.gov.uk) (Accessed 19 October 2024).

Digital, N. (2016) Adult psychiatric morbidity survey: Mental Health and Wellbeing, England, 2014, GOV.UK. Available at: https://www.gov.uk/government/statistics/adult-psychiatric-morbidity-survey-mental-health-and-wellbeing-england-2014 (Accessed: 25 November 2024).

Durà-Vilà G, Klasen H, Makatini Z, Rahimi Z, Hodes M. Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions. Clinical Child Psychology and Psychiatry. 2013;18(4):604-623. doi:10.1177/1359104512462549 Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions - Glòria Durà-Vilà, Henrika Klasen, Zethu Makatini, Zohreh Rahimi, Matthew Hodes, 2013 (sagepub.com)

Fazel, M., Wheeler, J., & Danesh, J. (2005). "Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review." *The Lancet*, 365(9467), 1309-1314.

Frounfelker, R.L. et al. (2020) Mental Health of Refugee Children and youth: Epidemiology, interventions, and future directions, Annual review of public health. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9307067/ (Accessed: 25 November 2024).

Garratt, K. (2024). Research Briefing: Mental Health Policy and Services in England. Available at: Mental health policy and services in England - House of Commons Library (parliament.uk) (Accessed 19 October 2024).

Hewing, E., and Clarke, F. (2014) *The Qur'an & Emotional Health: An Introduction*. Felixstowe: Suffolk Mind.

HM Government (2011) No Health Without Mental Health: Delivering Better Mental Health Outcomes for People of All Ages, Department of Health. Available at: No health without mental health (publishing.service.gov.uk) (Accessed 10 October 2024).

Karamanidou, L., and Folley, J. (2020) *Reception Policies, Practices and Responses- UK Country Report, Global Migration: Consequences and Responses*. Glasgow Caledonian University.

Ladegard, K., V. Joshi, S. and E Ordonez, A. (2024). *Shibboleth Authentication Request*. [online] Tees.ac.uk. Available at: https://www-sciencedirect-com.ezproxy.tees.ac.uk/science/article/pii/S0890856722007006 [Accessed 26 Nov. 2024].

Lee, K., Kronick, R., Miconi, D. and Rousseau, C. (2024). *Shibboleth Authentication Request*. [online] Tees.ac.uk. Available at: https://www-sciencedirect-com.ezproxy.tees.ac.uk/science/article/abs/pii/S1056499323000792.

Llywodraeth Cymru Welsh Government (2012) Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales. Available at: together-for-mental-health-summary.pdf (gov.wales) (Accessed 19 October 2024).

Lowther-Payne, H.J. et al. (2023) 'Understanding inequalities in access to adult mental health services in the UK: A systematic mapping review', BMC Health Services Research, 23(1). doi:10.1186/s12913-023-10030-8.

Matheson, M. (2012) Mental Health Strategy for Scotland: 2012-2015. Available at: Mental Health Strategy for Scotland: 2012-2015 - gov.scot (www.gov.scot) (Accessed 19 October 2024).

McGarry, O. et al. (2018) Health Evidence Network Synthesis Report: What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European region? World Health Organization. Available at: https://www.who.int/publications-detail-redirect/health-evidence-network-synthesis-report-what-strategies-to-address-communication-barriers-for-refugees-and-migrants-in-health-care-settings-have-been-implemented-and-evaluated-across-the-who-european-region (Accessed: 25 November 2024).

Mental Health and Psychosocial Support UNHCR UK. Available at: https://www.unhcr.org/uk/what-we-do/safeguard-human-rights/public-health/mental-health-and-psychosocial-support (Accessed: 24 November 2024).

Mental health facts on refugees, asylum-seekers, & survivors of forced displacement American Psychiatric Association. Available at: https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Refugees.pdf (Accessed: 24 November 2024).

Mental Health Foundation (2024). The Mental Health of Asylum Seekers and Refugees in the UK. The Mental Health Foundation, UK.

Mental health: Migrant health guide (2024) GOV.UK. Available at: https://www.gov.uk/guidance/mental-health-migrant-health-guide (Accessed: 24 November 2024).

Mind (2020). "The Mental Health of Refugees and Asylum Seekers: Challenges and Recommendations."

Mind (2024) *Guide 1: An Introduction to Mental Health*. Available at: *mind-mental-and-physical-activity-toolkit-guide-1.pdf (Accessed 10 October 2024).

Morris, M.D. et al. (2009) 'Healthcare barriers of Refugees Post-resettlement', Journal of Community Health, 34(6), pp. 529–538. doi:10.1007/s10900-009-9175-3.

Murphy, L., Hopkinshaw, B., Boutros, S., Russell, N., Fifth, A., McKeown, R., and Steele, A. (2020) Healthcare Access for Children and Families on the Move and Migrants. *BMJ Paediatrics Open*. 4(1).

NHS England (2014) Five year forward view, October. Available at: Five Year Forward View (england.nhs.uk) (Accessed 19 October 2024).

NHS England (2021). "Addressing inequalities: Refugee and asylum seeker health."

O'Mara, A., et al. (2010). "Improving access to health care for vulnerable groups in the European context: Policy and practice recommendations." *BMC Public Health*, 10, 242.

Patel, A., and Corbett, J. (2017) Doctors of the World; Registration Refused: A Study on Access to GP Registration in England *DoTW UK*. Available at: Microsoft Word - Reg_Refused 2017_final.docx (Accessed 24 October 2024).

Phillimore, J. (2011). "Refugees, acculturation strategies, stress and integration." *Journal of Social Policy*, 40(3), 575-593.

Poduval S, Jones L, Murwill P, McKee M., and Legido-Quigley H. (2015) Experiences among Undocumented Migrants Accessing Primary Care in the United Kingdom: A Qualitative Study. *Int J Health Serv.* 2, pp. 320-33.

Pollard, T. and Howard, N. (2021) 'Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: A scoping review of policies, barriers, and enablers', International Journal of Mental Health Systems, 15(1). doi:10.1186/s13033-021-00473-z.

Pollard, T., and Howard, N. (2021) Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *International Journal of Mental Health Systems*, 15(1), pp. 60-74.

Rambaldini-Gooding, D., Olcoń, K., Molloy, L., Pitts, L., Lema, S., Baghdadi, E., Williams, J. and Degeling, C. (2024). Cultural Humility in Action: Learning From Refugee and Migrant Women and Healthcare Providers to Improve Maternal Health Services in Australia. *Health Expectations*, 27(6). doi:https://doi.org/10.1111/hex.70106.

Rashid, R. (2024). *'My only crime is to look for somewhere safe to live': The struggles faced by UK asylum seekers*. [online] ITV News. Available at: https://www.itv.com/news/central/2024-11-01/lgbtq-asylum-seekers-in-the-uk-the-struggles-of-fleeing-violence [Accessed 26 Nov. 2024].

Refugee Council (2021). *Healthcare for refugees: Where are the gaps and how do we help?* [online] Refugee Council. Available at: https://www.refugeecouncil.org.uk/latest/news/healthcare-for-refugees-where-are-the-gaps-and-how-do-we-help/.

Refugee Council (2022). "Refugee Mental Health: Accessing support in the UK."

Refugee Council (2024). The Truth About Asylum. Available at: The truth about asylum - Refugee Council (Accessed 29 October 2024).

Rooney, E., and Watts V. (2014) Regional Mental Health Care Pathway: You in Mind, Health and Social Care. Available at: June-2017-You-In-Mind-Regional-Mental-Health-Care-Pathway - DOH/HSCNI Strategic Planning and Performance Group (SPPG) (Accessed 19 October 2024).

Stewart, L. (2021) Healthcare for Refugees: Where are the gaps and how do we help? Refugee Council. Available at: https://www.refugeecouncil.org.uk/latest/news/healthcare-for-refugees-where-are-the-gaps-and-how-do-we-help/ (Accessed: 25 November 2024).

Szenkurök, V., Weber, D. and Bilger, M. (2024) Informal and formal long-term care utilization and unmet needs in Europe: Examining socioeconomic disparities and the role of social policies for older adults - International Journal of Health Economics and Management, SpringerLink. Available at: https://link.springer.com/article/10.1007/s10754-024-09378-z (Accessed: 25 November 2024).

Tahir, R., Due, C., Ward, P. and Ziersch, A. (2022). Understanding mental health from the perception of Middle Eastern refugee women: A critical systematic review. *SSM - Mental Health*, 2, p.100130. doi:https://doi.org/10.1016/j.ssmmh.2022.100130.

Tees.ac.uk. (2024). *Shibboleth Authentication Request*. [online] Available at: https://www-sciencedirect-com.ezproxy.tees.ac.uk/science/article/abs/pii/S1056499323000792 [Accessed 26 Nov. 2024].

Tees.ac.uk. (2024b). *Shibboleth Authentication Request*. [online] Available at: https://www-sciencedirect-com.ezproxy.tees.ac.uk/science/article/pii/S089085670963183X [Accessed 26 Nov. 2024].

Tees.ac.uk. (2024c). *Shibboleth Authentication Request*. [online] Available at: https://www-sciencedirect-com.ezproxy.tees.ac.uk/science/article/pii/S0890856709631907 [Accessed 26 Nov. 2024].

The BMA (2024) Unique Health Challenges for refugees and asylum seekers - refugee and asylum seeker patient health toolkit - BMA, The British Medical Association is the trade union and professional body for doctors in the UK. Available at: https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit/unique-health-challenges-for-refugees-and-asylum-seekers (Accessed: 25 November 2024).

The challenges and potential of intermediate care (2024) The Health Foundation. Available at: https://www.health.org.uk/publications/long-reads/the-challenges-and-potential-of-intermediate-care (Accessed: 25 November 2024).

The importance of meaningful integration for the mental health of asylum seekers and refugees (2024) Feature from King's College London. Available at: https://www.kcl.ac.uk/the-importance-of-meaningful-integration-for-the-mental-health-of-asylum-seekers-and-refugees (Accessed: 24 November 2024).

The King's Fund (2019). "Delivering Health Services for Vulnerable Migrants."

The Royal College of Psychiatrists (2022) 'Hidden waits force more than three quarters of mental health patients to seek help from emergency services', *The Royal College of Psychiatrists Press Release,* 10 October. Available at: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services#:~:text=10%20October%202022,for%20World%20Mental%20Health%20Day (Accessed 6 November 2024).

There were significant gaps in access to good quality care (2022) There were significant gaps in access to good quality care - Care Quality Commission. Available at: https://www.cqc.org.uk/publications/major-report/soc201920_1f_gaps-in-access-to-good-care (Accessed: 25 November 2024).

Tribe, R. (2002). "Mental health of refugees and asylum-seekers." *Advances in Psychiatric Treatment*, 8(4), 240-247.

Trueba, M.L., Axelrod, T. and Ayeb-Karlsson, S. (2023) 'Are asylum seekers and refugees provided with appropriate mental health support in the United Kingdom?', Journal of Ethnic and Migration Studies, 49(13), pp. 3163–3183. doi:10.1080/1369183x.2023.2181126.

Turrini, G. et al. (2017) 'Common mental disorders in asylum seekers and Refugees: Umbrella Review of prevalence and intervention studies', International Journal of Mental Health Systems, 11(1). doi:10.1186/s13033-017-0156-0.

UNHCR (2010). Convention and Protocol Relating to the Status of Refugees. Geneva: UNHCR Communications and Public Information Service. Available at: The 1951 Refugee Convention | UNHCR (Accessed 29 October 2024).

Welsh Government (2020) Review of the Together for Mental Health Delivery Plan 2019–2022 in Response to Covid 19. Available at: review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf (gov.wales) (Accessed 19 October 2024).

Williams, G. (2019) 'Primary Medical Care Policy and Guidance Manual', *NHS,* 17 November. Available at: NHS England » Primary medical services policy and guidance manual (PGM) (Accessed 8 October 2024).

World Health Organization - Regional Office for Europe (2018) Mental Health Promotion and Mental Health Care in Refugees and Migrants: Technical Guidance. World Health Organization. Regional Office for Europe. Available at: 9789289053747-eng.pdf (who.int) (Accessed 19 October 2024).

World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.* Geneva: World Health Organization.

World Health Organization (2003) Investing in Mental Health. Geneva: World Health Organization. Available at: *untitled (who.int) (Accessed 10 October 2024).

World Health Organization (2023) Mental Health of Refugees and Migrants: Risk and Protective Factors and Access to Care. Geneva: World Health Organization. Available at: *9789240081840-eng.pdf (who.int)) (Accessed 10 October 2024).

7. APPENDICES (INTERVIEW QUESTIONS FOR SECTION 2)

a. **Interview Questions for ASR**

1. Have you received any mental health service in the UK? If YES, did the mental health service address your peculiar emotional problem? If YES/NO, please give reason(s) for your choice of answer.
2. Would you say the service rendered and mental health professionals respectively, were culturally friendly and competent?
3. Do you have access to mental health services anytime and any day? If YES/NO, please give reason(s) for your choice of answer.
4. On a scale of 1-5 (where 1=highly dissatisfied, 2=dissatisfied, 3=fair, 4=satisfied, and 5=highly satisfied), how will you rate the UK waiting list and times?
5. Do you enjoy equal response/access to mental and physical health services? If YES/NO, please give reason(s) for your choice of answer.

a. **Interview Questions Administered to Official of the British Red Cross**

1. ASR mental health needs differ (e.g. UASC with PTSD, ASR who are survivors of somatic violence, etc.).

Based on your experience, would you say there are sufficient specialist mental health services specifically tailored to the mental health needs of ASR? If YES/NO, please give reason(s) for your choice of answer.

2. The number of ASR are on the increase, and by logical expectation, an increase in demand for their mental health services. Would you say the UK, England and the Tees Valley have:

a. sufficient number of mental health staff to address ASR mental health issues?

b. sufficient number of culturally competent mental healthcare professionals?

3. According to UK Home Office (cited in a BBC report), most ASR in the UK are non-English speakers from Iran, Eritrea, Syria, Afghanistan and Albania – hence, an indispensable need for quantitative and qualitative interpreters.

a. Do you work with interpreters? If YES/NO, please give reason for your choice of answer.

b. Would you say they are sufficient, and qualitatively available?

4. Do ASR have access to mental health services 24/7 (anytime/any day)? If YES/NO, kindly justify your choice of answer.

5. On a scale of 1-5 (where 1=highly dissatisfied, 2=dissatisfied, 3=fair, 4=satisfied, and 5=highly satisfied), how would you rate the UK waiting list and times?

6. Geographically, do you think the Tees Valley has sufficient mental health resources (finance, staff, and facilities) needed to address the growing mental health challenges of ASR?

7. Going forward, what policy improvements would you recommend?