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Exploring the Mental Health and Psychosocial Experiences of Asylum Seekers, Refugees and Undocumented Migrants in the Post-migration Context

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Abstract

Background and aims:

Migration phases (pre-, during and post-) are known to negatively impact on the mental health and psychosocial experiences of asylum seekers, refugees and undocumented migrants. In this thesis, the focus was on post-migration experiences. Research shows that particular areas of concern include: migration detention, the asylum system, fear of deportation, poverty, destitution, housing issues, language and communication difficulties, and poor access to care. However, more in-depth understanding of the mental health and psychosocial experiences of asylum seekers, refugees and undocumented migrants in the post-migration context is needed.

The aim of this thesis was to investigate asylum seekers', refugees', and undocumented migrants' mental health and psychosocial experiences in the post-migration context, including an exploration of social determinants of mental health and the barriers and facilitators to access to services. This was met by addressing three objectives:

To investigate asylum seekers', refugees, and undocumented migrants' mental health experiences in the context of social determinants of health. To explore how social determinants of health influence the pathway to healthcare services amongst asylum seekers, refugees, and undocumented migrants. To explore the barriers and facilitators to asylum seekers', refugees and undocumented migrants' pathways to accessing the services that they need.

Methods:

This thesis employed three methodological approaches to collect and analyse data: a systematic review and meta ethnography, Reflexive Thematic Analysis (RTA) and a re-analysis of interview data, applying the theory of Candidacy. These qualitative approaches were built on one another in a sequential manner. The systematic review included the qualitative component of 20 studies (11 qualitative and 9 mixed methods), assessed against pre-established inclusion criteria. These were analysed by applying a meta-ethnographic approach. Eighteen asylum seekers, refugees and undocumented migrants based in the Glasgow area were interviewed. RTA was the primary qualitative study. The interviews were then re-analysed using the theory of Candidacy to understand in more detail participants' journeys to accessing the services needed.

Results:

Combined, the findings from this thesis indicate that the asylum system is a social determinant of health for asylum seeker, refugee and undocumented migrant populations in the UK and internationally. For asylum seekers and undocumented migrants, the inability to work and financial insecurity stemming from Home Office restrictions were found to compound distress. In relation to mental health, psychosomatic symptoms and difficulties with sleep were found, whilst protective factors included family, friends, religion, and hobbies such as exercise and playing music. Access to care was described as arduous due to language and communication difficulties, limited availability of interpreters, and issues registering with a GP. This was due to the limited information and knowledge available to them. Often this was mitigated by third sector organisations. Access to mental health services was consistently shown to be undermined by the Western biomedical approach, which failed to consider socio-cultural factors that may further limit access.

Often, consultations relating to mental health often resulted in prescriptions for psychotropic medications, which were considered socio-culturally inappropriate by some individuals in these communities and led to the discontinuation of treatment and heightened feelings of isolation. The secondary analysis of the interviews also showed that the operating conditions that influenced access to services comprised of three levels: micro-, meso- and macro. These encompass proximal as well as broader factors that influence these populations' ability and willingness to access the services that they require.

Conclusion:

Efforts to improve asylum seekers', refugees' and undocumented migrants' access to services, including healthcare, need to consider the psychosocial and cultural

aspects of mental health in these populations. These are found to affect individuals' and communities' abilities and willingness to engage with existing services, including the NHS. Health services have a responsibility in lessening the structural barriers and inequity in access that these populations face.

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Format of the Thesis

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In Chapter 2, the broader literature is reviewed, specifically in relation to the mental health of asylum seekers, refugees, and undocumented migrants in the context of post-migration life difficulties. Here, psychosocial factors such as the asylum process, housing, poverty, destitution, and access to care are reported to impact on the mental health of these migrant groups.

Chapter 3 presents the results of the systematic review and meta-ethnography which focused on the mental health experiences of asylum seekers, refugees and undocumented migrants in the post migration context. The studies included in the meta-ethnography were conducted with populations who have settled in high income countries (HICs) in Europe, the US, Canada, Australia and New Zealand.

Chapter 4 outlines the methodological approach used in the qualitative study which included interviews with asylum seekers, refugees and undocumented migrants who live in Glasgow. The method outlined is reflexive thematic analysis (RTA), which has allowed me to map the main themes that were identified in the transcribed qualitative interviews. This chapter also outlines the theoretical concept of Candidacy (Dixon-Woods, 2005). This provides a framework for understanding pathways to accessing services, including healthcare. The candidacy comprises seven phases: *identification* as a candidate for a service; *navigation* of services to reach a point of contact with a service provider; *permeability* (i.e. the ease with which a service can be accessed); *appearing* at a service and asserting one's candidacy; *adjudication* by a professional; *offers* of, or resistance to, the service; and, finally, *operating conditions,* which includes broader contextual factors.

Chapter 5 presents the results of the reflexive thematic analysis from the interviews conducted with eighteen asylum seekers, refugees and undocumented migrants. Results identified three main themes: The asylum process; Mental health experiences; and Access to care. The subthemes included: Experiences on arrival, Living in limbo, Inability to work and financial insecurity, Resilience, Idioms of distress, Protective factors, Social support, Registering with a GP, Communication and interpretation, Waiting times to access services, Psychotropic medication and psychological therapy, Continuity of care, Healthcare access and socio-cultural factors, and Positive experiences of the healthcare system.

Chapter 6 is a secondary analysis of the transcribed interview data. In this chapter I applied the theoretical framework of candidacy to the qualitative data. This has allowed me to identify the participants' journey to accessing services and the barriers and facilitators that they encountered in the attempt to access the required services. Whilst the candidacy journey to service access is not necessarily linear, for the purpose of clarity this chapter is presented linearly. It begins with the participants' identification of themselves as candidates, through to navigation, permeability, appearing and asserting candidacy, adjudication, offers/resistance, and operating conditions. The latter were subdivided into macro-, meso-, and micro-operating conditions. Due to the multiple services required by these populations (e.g. housing financial support, asylum application process, access to healthcare), the concept of multiple candidacies was developed to understand how people navigate different systems.

Chapter 7 constitutes the discussion of the results in relation to the thesis objectives. Here the results from the systematic review and meta-ethnography, reflexive thematic analysis and the candidacy theory are brought together. The main results are then contextualised within the wider literature, and recommendations for future research are made. Finally, the implications of the findings for clinical practice and policy are discussed.

Whilst the term post-migration context is used throughout this thesis, it is important to reflect on the implications of using this term. For the meta-ethnography, the context was high income countries. This covers countries with a range of policy and social responses to asylum seekers, refugees and undocumented migrants. For the qualitative work, the context was the hostile UK asylum process, the negative representation of migration in, for example, the media and a range of other policies which contribute to the current hostile environment in the UK. This compounds and often causes the host of negative post-migration life difficulties that individuals experience in the post-migration context, and this has to be recognised. However, the term ‘post migration context’ was felt to be most appropriate as it captures the range of experiences including the impact of hostile policy responses, but also the often positive and supportive experiences provided by third sector organisations, and community-based support groups.

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This PhD project has been really challenging at an intellectual and emotional level. At times it felt like struggling against the Hydra! I would not have succeeded were it not for the generous help of several people.

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Author’s Declaration

I, Alessio Albanese, declare that, except where explicit reference is made to the contribution of others, this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution

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Definitions

Definitions of the various terms used to describe different types of migration, such as labour migration, and forced-migration for instance, are often poorly understood and erroneously used (Crawley & Skleparis, 2018). Similarly, terms such as refugee and asylum seeker are, at times, used interchangeably to describe people on the move. However, terms such as refugee and asylum seeker are fundamentally different and their inappropriate use risks creating unnecessary confusion. In the pages that follow terms such as migrant; migration; labour migrants; forced migration; refugees; internally displaced people; unaccompanied minors; *sans-papiers* (undocumented migrants); asylum seekers and stateless person(s), non-refoulment; returned refugees, returned internally displaced persons and Others of Concern will be presented along with definitions. In so doing, literature from UNHCR and the International Organisation for Migration (IOM), a UN related organisation, are referenced.

Refugee: a person who, ‘owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country’ (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). The 1984 Cartagena Declaration states that refugees also include persons who flee their country ‘because their lives, security or freedom have been threatened by generalised violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order’ (IOM, 2013).

Returned Refugees: former refugees who have returned to their country of origin spontaneously or in an organised fashion but are yet to be fully integrated. Such return would normally only take place in conditions of safety and dignity (UNHCR, 2019).

Non-Refoulment: an international principle that prevents states from expelling or returning persons to a territory where their life or freedom would be threatened. This principle is recognised as customary international law (Although enshrined in international law, different interpretations of the principle on non-refoulment exist (*see* D'angelo 2009 *for a full review*).

Asylum Seeker: a person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds (IOM, 2013).

Undocumented migrant: people who enter or remain in a country, often in search of employment, without the necessary documents and permits (UNESCO, 2021). Undocumented migrants are individuals who are not legally authorised to be in the country in which they are residing. Individuals may become undocumented after a visa runs out, having had their asylum application rejected, or if they enter the country irregularly (Ibid). Undocumented migrants are individuals with no recourse to public funds due to residing in a country without the necessary documents (e.g. Visa; Leave to Remain; Valid asylum application).

Migration: the movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification (IOM, 2013).

Migrant: any person who is moving or has moved across an international border or within a State away from their habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is. IOM concerns itself with migrants and migration-related issues and, in agreement with relevant States, with migrants who need international migration services and support (IOM, 2013).

Unaccompanied minors: An unaccompanied minor (or child) is a person who is under 18 years of age, and who is separated from both parents, and is not being cared for by an adult who by law has responsibility to do so. The jurisdiction of unaccompanied minors is governed by three main regulations: the 1951 United States Convention Relating to the Status of Refugees; the 1967 protocol, and the convention against torture (IOM, 2013).

Others of Concern: individuals who do not necessarily fall directly into any of the groups above, but to whom UNHCR extends its protection and/or assistance services, based on humanitarian or other special grounds. These include Returnees, Returned Internally Displaced Persons and persons under UNHCR's stateless persons mandate (UNHCR, 2019).

Chapter One - Introduction

Migration is a highly complex and multifaceted phenomenon that encompasses individual, social, economic and political domains. As detailed in the *Definitions* section of this thesis, several terms are used to describe the diverse range of migrant groups. Nonetheless, the word migration is often used as an umbrella term to refer to individuals on the move, whose legal status is heterogeneous. In this PhD research, the focus is on the mental health and psychosocial experiences of asylum seekers, refugees and undocumented migrants who have migrated from Low- and Middle-Income Countries (LMICs) to High Income Countries (HICs).

The United Nations High Commissioner for Refugees (UNHCR) estimates that globally, over 260 million people are international migrants (living outside their country of birth). Latest figures show that, at the end of 2020, circa 82.4 million people accounted for the overall number of forcibly displaced people worldwide. Of these, 48 million are internally displaced, 26.4 million are refugees, and 4.1 million are asylum seekers. Currently, 86% of the global number of refugees are hosted in LMICs, 78% of whom live in countries neighbouring their country of origin. The majority of displaced people worldwide (52%) are between the ages of 18 and 59 years (UNHCR, 2021).

Migration is a fluid concept and an individual’s migration status can change, quickly. This may be due to changes in legal and/or policy decisions by the host country. In the post-migration environment, migrants may find themselves in a situation of irregularity if they unlawfully overstay a visa, cross borders without appropriate permit, are born into ‘irregularity’, or remain in a country after their asylum claim received a final, negative decision (UNHCR, 2021). At times, individuals enter a country in order to submit an asylum claim, but subsequently may find themselves in contravention to the conditions of their stay. For example, if their claim is rejected and their appeals exhausted. In these instances, an individual may become an undocumented migrant (IOM, 2014; UNHCR, 2021). Whilst terms such as refugee and asylum seeker are, at times, used interchangeably to describe people on the move, their legal meaning is fundamentally different (see Definitions section of this thesis).

These differences are not just nominal but have real life implications. For example, whilst in the UK refugees are legally entitled to seek employment, have freedom of movement, and can access welfare support; asylum seekers receive a weekly statutory allowance of £40.85, must live within the dispersal area to which they are assigned, and their access to financial assistance is limited by legal and policy frameworks (UK Government, 2022). A further distinction applies to undocumented migrants who are precluded from accessing employment and welfare support and are faced with eviction once their asylum application is rejected and rights to appeal the Home Office's decision is exhausted. These individuals, in particular, are known to be at a heightened risk of destitution (Beswick &McNulty, 2015). The number of destitute undocumented migrants is difficult to know as people in these situations often do not participate in research for a variety of reasons, including fear of deportation. However, a report by the British Red Cross (Ibid) indicated that in the UK there were approximately 15,000 destitute asylum seekers, including dependents. Although during the first wave of the COVID-19 pandemic undocumented migrants in the UK received monetary support and were allowed to remain in their accommodation, evictions have since resumed and more people are now at risk of becoming destitute.

1.1 Asylum seekers, refugees and undocumented migrants in Scotland

Historically, Scotland has experienced what is known as 'negative net migration'. This means that more people leave the country than migrate into the country (Migration Observatory, 2021). However, over the past few decades that has changed and migration has seen a significant rise in Scotland. This included the number of refugees and asylum seekers. In the year ending in September 2021, the majority of asylum applications in the UK were from nationals of five countries: Iran (6,002), Eritrea (4,412), Albania (4,010), Iraq (3,042) and Syria (2,303) (UNHCR, 2021). Although the number is relatively low compared to England, currently, Scotland is the home of roughly 10% of the UK's total number of registered asylum seekers. The significant increase in the number of registered asylum seekers, most of whom reside in the Greater Glasgow and Clyde region, is attributed to the Home Office's inclusion of Glasgow City in the asylum dispersal policy issued in 1999 (Mulvey, 2014). Whilst in the UK matters pertaining to the asylum system are reserved to the UK government and the Home Office, the Scottish government has devolved powers over the provision of services, with the exclusion of housing. Issues of access to services such as healthcare and education; and policies aimed to facilitate the integration of asylum seekers and refugees in the broader Scottish community are within the Scottish government's remit (Scottish Government, 2014).

Even though the UK government has become increasingly hostile towards asylum seekers and refugees, the Scottish Government has tended to focus more on maintaining a positive policy approach based on improving the integration of individuals living within its jurisdiction. For example, this is evidenced by the implementation of the *New Scots* policy, which attempts to facilitate the integration of refugees and asylum seekers in Scotland's communities. This policy aims to '*enable all refugees and asylum seekers to integrate into the communities from day one of arrival and not just when refugee status is granted*' (Scottish Government, 2014 pg. 20).

The *New Scots* policy approach moves away from conceptualising integration as the sole responsibility of migrants and encourages the hosting population to actively partake in the process of integration (Mulvey, 2015). Strang and Quinn (2014), who contributed to the development of the New Scots policy of integration, also reported on the Scottish Government's commitment to providing for the health and wellbeing of refugees and asylum seekers residing in Scotland. Evidence of Scotland's approach to healthcare is illustrated in the provision of free healthcare access to refugees, asylum seekers and undocumented migrants to emergency and non-emergency care, including full access to primary and secondary care (Ibid). Within this policy environment, several governmental and non-governmental organisations have emerged across Scotland to support the asylum seeking and refugee population. For example, the Scottish Refugee Council, Maryhill Integration Network, and the Govan Community Project are well established organisations that are rooted in the community and provide advice, information and support to asylum seekers, refugees and undocumented migrants (Quinn, 2014).

1.2 Asylum seeker, and refugee, and undocumented migrant mental health: an overview

During the late 1960s and early 1970s, the topic of refugee and asylum seeker mental health was largely overlooked. This began to change when Post-Traumatic Stress Disorder (PTSD) was included in the Diagnostic and Statistical Manual of Psychiatric Disorders in 1980 (DSM-III) (Crocq & Crocq, 2000). The term PTSD, and its application to the experiences of refugees in humanitarian settings constitutes the beginning of what is now considered the field of refugee and asylum seekers mental health (Silove et al., 2018). This led to the gradual shaping of humanitarian psychiatry (Mollica et al., 1993).

The application of PTSD as a diagnosis to categorise the mental health of refugees was first used in refugee camps and led to the development of the Harvard Program in Refugee Trauma (HPRT). This program was first developed by the Harvard School of Public Health, and it is a multi-disciplinary program aimed at improving the care of refugees and civilians traumatised by conflict and natural disasters. Current operations include the provision of community based care for torture survivors who live in Massachusetts, including the ‘Push to Cure’ initiative, which aims to rescreen hundreds of survivors of torture in order to implement novel evidence-based treatments. Other work includes the development of a Primary Care Provider Toolkit to study how primary care providers have responded to the September 11th terrorist attack; and the implementation of the curriculum for caring for traumatised persons (developed by HPRT) and its integration into Bosnia’s medical schools in Sarajevo, Tuzla and Mostar. The Cambodian women’s oral history project is another of the ongoing projects of the HPRT program. This consists of a website which makes available the voices of Cambodian women and reveals their stories of resilience and courage during the Khmer Rouge regime. This project has the purpose of sharing these experiences with younger generations of Cambodians.

Soon after, and following the investigation of the mental health of 300,000 refugees in a Thai-Cambodian border camp by HPRT, a report was issued which declared a ‘mental health crisis’, and reported a high prevalence of depression and PTSD amongst the population studied (Ibid). This prompted the implementation of interventions based on Western psychiatry to ‘treat’ the mental health of refugee populations. However, with the expansion of ‘Western’ psychiatry, critiques of this approach to mental health began to emerge.

As I write this introduction, a systematic review has been published on the role of serotonin in depression (Moncrieff et al., 2022). The serotonin hypothesis has been one of the most influential biomedical approaches to depression and has spurred an increase in antidepressant prescription and use in the UK (Iacobucci, 2019). However, Moncrieff and colleagues (2022) found no evidence of association between levels of serotonin and the clinical experience of depression. This prompts us to further question the widespread use of antidepressants, and particularly selective serotonin reuptake inhibitors (SSRIs), to treat depression.

Critiques also focused on the use of culturally biased notions based on biomedical understandings of mental health which, it is argued, are not necessarily applicable to populations from non-Western cultures (Bracken et al., 2016; Summerfield, 2008). Research has illustrated that the phenomenology and presentations for issues such as depression vary between different cultural groups. For example, in a study that compared depression symptoms amongst Chinese and Australian groups, it was found that the Chinese group reported higher levels of somatic symptoms and fewer cognitive symptoms than their Australian counterparts (Parker et al., 2001). In addition to cultural factors, mental health experiences are influenced by gender, age, language skills, religious beliefs and level of acculturation in the host community, and migration status (Kramer et al., 2002; Golember et al., 2020; Aarenthun et a., 2021).

Studies such as these have prompted researchers and clinicians to question the reliability and validity of psychiatric diagnoses, which are based on the biomedical model (Bracken et al., 2016; Kinderman, 2019). As human beings, our experiences of the world and ourselves are mediated by biology through the brain and nervous system. However, biomedical explanations, in themselves, are inadequate at explaining complex human behaviours, cognitions and emotions (Kinderman, 2019). In recent decades it has become increasingly apparent that suffering and distress are affected by complex (and not fully understood) bio-psycho-social interactions that include, but are not limited to, biology (Borrell-Carrio’ et al.

2004). Engel (1977) is credited as one of the pioneer researchers who understood that a holistic alternative to the biomedical model was required to attend to the multi-factorial dimensions of wellbeing, and indeed poor health. Engel's model is known as the bio-psycho-social model of mental health. Engel criticised the overly materialistic orientation embodied by the biomedical model, which was, and still is, based on Western constructs related to health and illness. These can result in devaluing individuals' subjective psycho-social experiences (Borrell-Carrio' et al., 2004). Furthermore, Engel rejected the linear (cause and effect) model of understanding health related phenomena and argued that highly complex psycho-social interactions would need to be included to better comprehend health and ill-health in all its manifestations (Engel, 1977). Engel's model rejects the mind/body/environment divide. Instead, this approach focuses on the importance of understanding human experiences as happening on a continuum and within a broader social and cultural context. Whilst at its inception the 'social' aspect of the bio-psycho-social model referred to the interaction and relationship between the healthcare practitioner and the patient, ongoing research has resulted in the expansion of the 'social' to encompass a broader range of systems, actors and processes (Borrell-Carrio et al., 2004). For example, Lehman et al. (2017) applied Bronfenbrenner's (1979) theory of child development to integrate a systemic approach that included interpersonal dynamics (e.g. family) and the broader social context (e.g. culture) to better understand the influences of the social environment on health.

1.3 Psychosocial aspects of asylum seekers', refugees' and undocumented migrants' mental health

Recent research has incorporated psycho-social factors into the study of mental health in asylum seekers and refugees and broadened our understanding of issues that influence the health experiences of these populations in the post-migration environment. For example, research illustrates that asylum seekers, refugees and undocumented migrants are at an increased risk of poor physical and mental health (Steel et al., 2009); and difficult life experiences pre-migration, during the migration journey and post-migration are known risk factors for the development of mental health difficulties (Zimmermann et al., 2011). Issues around social exclusion, stigmatisation, cultural and material barriers to accessing health and social services were shown to further complicate and, at times, deteriorate the health of these populations (Quinn, 2014). Language difficulties, access to interpretation, receiving appropriate information and other socio-cultural factors such as cultural beliefs around health and illness have been found to impact on the wellbeing of these individuals (Murphy & Vieten, 2022). The central role of the UK asylum process in compounding these difficulties in the post migration environment cannot be underestimated. Punitive and harmful Hostile Environment policies implemented by the Home Office have a direct and negative impact on the lives of asylum seekers, refugees and undocumented migrants who live in the UK. These policies have contributed to the stigmatisation of entire communities and have resulted in a host of negative connotations that are now attributed to the term 'asylum seeker', which in essence means people seeking asylum. It is examples such as this that contribute to conventional language becoming negatively charged, which results in the development of intolerant and discriminatory attitudes against these individuals and communities.

In summary, this chapter has provided an overview of the broader context of this thesis. In the next chapter, I present the findings of the general literature review which covers key background information to set the scene for the systematic review and meta-ethnography (Chapter 3), which is the first findings chapter of this thesis. The literature review consisted of applying a search strategy to Medline that included terms such as asylum seekers, refugees and undocumented migrants' mental health and psychosocial experiences in the post-migration context. Books on these topics were also consulted. As well as providing background literature, chapter 2 presents the aims and research questions that were developed in light of the identified literature.

Chapter 2 Literature Review

Zimmerman and colleagues indicate that the migratory trajectory can be divided into three phases: pre-migration, the migration journey and post-migration (Zimmerman, Kiss, & Hossain, 2011). Each phase of migration poses risks for poor mental health (Ellis, MacDonald, Lincoln, & Cabral, 2008; Kirmayer et al., 2011). Adversities occurring pre, during and post-migration are known to contribute significantly to elevated rates of distress (Porter & Haslam, 2005), disabling symptoms of psychosocial stress (Hassan et al., 2016) and somatic symptoms (Morina et al., 2017). Negative pre-migration experiences include political and religious persecution, rape, torture, famine, war and ethnic conflicts, poverty, and loss (Porter & Haslam, 2005; Thomas & Thomas, 2004). When these experiences are related to mental health, exposure to torture is reported as the strongest predictor of symptoms of Post-Traumatic Stress Disorder (PTSD) among asylum seeker and refugee populations (Porter & Haslam, 2005). In adjunct, head injury, which may result from torture, was found to lead to cognitive impairment and to the development of emotional problems that may negatively affect interpersonal relationships. These, can exacerbate social isolation and unemployment. Both of which are associated with psychological distress and can further complicate the effects of psychological trauma (Doherty, Craig, Gardani, & McMillan, 2016).

While much mental health research has focused on traumatic experiences occurring pre-migration, Gorst-Unsworth and Goldenberg (1998) illustrated that for Iraqi asylum seekers who resettled in London, poor social support was more closely associated to low mood or depression than was a history of torture. Post-migration factors including discrimination, poverty, homelessness, poor access to care, and experiences of migration detention, are shown to significantly increase the risk of developing mental health problems among refugees and asylum seekers (Nakash, Nagar, Shoshani, Zubida, & Harper, 2012; Porter, 2007; Porter & Haslam, 2005). The salience of post-migration experiences on the development of severe and enduring mental health issues in asylum seekers and refugees in the UK (Cantor-Graae, 2007; Coid et al., 2008), the US and Canada (Coid et al., 2008) are well documented. In an often cited systematic review and meta-analysis, Fazel, Wheeler, and Danesh (2005) suggest that refugees are up to ten times more likely to develop PTSD compared to the general population in Western countries. While these findings are important, others recommend caution about the findings due to methodological issues (Steel et al., 2009; Bogic et al., 2015). For example, in Fazel and colleagues' (2005) meta-analysis, a negative correlation was reported whereby more methodologically robust studies show lower rates of PTSD symptoms. In a review comprising five meta-analyses, Turrini and colleagues (2017) reported the prevalence rates for anxiety, PTSD and depression to range from 20% to 80% amongst refugee survivors of torture. Their results showed heterogeneous (e.g. anxiety, depression, PTSD) yet considerable prevalence of mental health diagnoses in these populations.

A growing body of evidence indicates that PTSD is also associated with the development of psychotic symptoms in refugees as well as populations affected by conflict (Nygaard, Sonne, & Carlsson, 2017). Whilst research examining the relationship between pre-migration trauma and post-migration diagnosis of psychopathology suggests that greater exposure to trauma is associated with higher levels of PTSD symptoms, the relationship between trauma experiences and the development of PTSD remains ill-defined (de Silva et al., 2021). For example, the impact of culture on belief systems and on the experience and expression of distress results in variations amongst different ethnic groups in terms of appraisal and response (including help seeking) to traumatic events (Eisenbruch, de Jong, & van de Put, 2004; Murray, Davidson, & Schweitzer, 2010).

Associations have been identified between depression and/or depressive symptoms and post-migration factors such as social isolation or weak social support (Dalgard, Thapa, Hauff, McCubbin, & Syed, 2006; Warfa et al., 2006; Miller et al., 2002); unemployment (Dalgard et al., 2006); acculturation stress, and poor social integration (Beiser & Hou, 2006; Birman & Tran, 2008) amongst asylum seeker and refugee populations. Housing issues are also a prominent concern, which can exacerbate mental distress. For example, in a study of Somali asylum seekers in London, insecure housing, not war experiences, torture or loss of relatives, was illustrated as the most significant predicting variable for psychological distress (Dahoud & Pelosi, 1989 in Summerfield, 2008). Alemi et al (2018) have indicated the negative effects of discrimination on experiences of distress such as low mood, amongst Afghan refugees resettled in the US. Taken together, this evidence suggests that focusing solely on past events without considering post-migration life difficulties (PMLD) may result in the conflation of PTSD and depression, with distress caused by post-migration stressors (Miller & Rasmussen, 2014), and negative experiences related to resettlement (Aragona, Pucci, Mazzetti, Maisano, & Geraci, 2013). The language PMLD is an umbrella term, which encapsulates several issues, and includes the impact of unfair treatment at border zones and poor conditions in detention centres. These highly distressing experiences are documented to have a deleterious effect on individuals' mental health (Silove, Austin, & Steel, 2007). In a systematic review, longer periods of detention, and negative experiences while detained were associated with worse mental health outcomes, including high levels of anxiety, depression, PTSD, self-harm and suicidal ideation, among immigration detainees (Robjant, Hassan, & Katona, 2009).

As briefly mentioned in the introduction chapter (Chapter 1), another important issue faced by many asylum seekers, refugees and undocumented migrants in the UK is destitution. People who become destitute are often left without adequate access to food, housing and financial support (Refugee Survival Trust, 2019). Destitution consolidates a 'spiral of vulnerability' in which acute anxiety, stress, depression, feelings of extreme helplessness, powerlessness and aggregate trauma, foster (Gillespie, 2005). In light of this, Fitzpatrick et al., (2015) assert that destitution is not solely about being extremely poor and homeless, but it is also related to psychological and emotional wellbeing. Depression, which may accompany the experience of being destitute, can make people feel hopeless and less able to approach individuals and organisations for help. McColl, McKenzie, and Bhui (2008) consider destitution and inadequate access to healthcare among the most common post-migration difficulties faced by asylum seeker and undocumented migrant groups. This evidence highlights that the health and support needs of destitute asylum seekers and undocumented migrants requires further research and policy attention.

It is noteworthy that due to the uncertainty and precarity of their situations, there are higher levels of distress amongst asylum seekers and undocumented migrants compared to individuals who are granted refugee status (Silove, 1999). It is not uncommon for people to go through multiple asylum applications before an adjudication on their legal status is reached by the Home Office. This often-protracted period of uncertainty, when paired with worries around deportation and the inability to plan their future, can take a toll on people's mental health and wellbeing (Tribe, 2002). Experiences such as finding oneself in an unfamiliar area, while awaiting on the outcome of their asylum application (Bernandes et al., 2010) and feeling disempowered and lacking control over the application's outcome has been shown to have deleterious effects on psychological wellbeing (Slobodin et al., 2018). Research evidence illustrates that the legal process of migration (i.e. the asylum procedure), can have a significant and negative impact on the mental health of people seeking protection. Experiences related to the asylum system can have as much a deleterious impact on mental health as trauma that has occurred pre-migration or during the migration journey (Carswell et al., 2011; Martinez et al., 2015). It is now well documented that, in the UK, Hostile Environment policies are a social determinant of health (Weller et al., 2019; Isaacs et al., 2020). Since 2014, the UK government has passed a series of policies aimed to create a Hostile Environment for immigrants on British soil. These policies target several aspects of people's lives, and include housing, access to non-emergency care (in England and Wales), employment, welfare, education, family reunification, and migration detention (Webber, 2019).

2.1 Utilisation of mental health services by asylum-seekers and refugees and barriers to access and engagement

As outlined earlier in the introductory chapter (Chapter 1), there are differences between Scotland and the rest of the UK, particularly in relation to access to healthcare (Webber, 2019). Whilst in Scotland asylum seekers and undocumented migrants have free access to emergency and non-emergency healthcare, in England there have been policy decisions intended to limit access to non-emergency care for these migrant groups (Kang et al., 2019). Suhaiban et al. (2019) indicated that pre-migration experiences (including torture severity), post migration life difficulties and difficulties in accessing the clinical services required were significantly associated with higher levels of psychological distress in asylum seekers and refugees. Research also illustrated that for refugees and asylum seekers coming from areas of war, conflict, persecution and poverty there is a risk not only of poor access to mental health care but also of misunderstandings when encountering healthcare providers (Kirmayer et al., 2011). Furthermore, marginalised migrants are shown to have poor access to high quality primary care (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016), and mental health promotion strategies addressing their specific needs are often insufficient (Bäärnhielm, Laban, Schouler-Ocak, Rousseau, & Kirmayer, 2017). As a result, in recent years, research has focused on finding effective ways to engage migrants through improving cross cultural communication in primary care (Lionis et al., 2016; van den Muijsenbergh et al., 2014). However, less attention has been paid to consultations in mental health services (Liberati et al., 2022). For example, psychiatric epidemiological studies still use standard instruments which often do not assess regional language variations and cultural idioms of distress (Wells et al., 2018). These instruments can lead to clinicians being unable to fully comprehend the enormity of patients' loss and cultural differences in self-presentation, self-understanding, memory and identity (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003) This, in turn, can significantly and negatively impact on patient-practitioner communication, diagnosis, treatment adherence and outcomes (van den Muijsenbergh et al., 2014; Sayar, Kirmayer, & Taillefer, 2003).

Depending on context, idioms of distress represent culturally relevant and interpersonally salient means of communicating and coping with distress (Nichter, 2010). These include ways of referring to individual and collective suffering and can be used to describe distress beyond that associated with biomedical understandings of health and illness (Deacon, 2013). It is argued that the biomedical approach to understanding and treating mental health, neglects the role of the broader social environment (Albanese et al., 2021), and the diverse idioms that individuals may adopt to communicate distress (Kirmayer et al., 2003). Whilst cultural idioms of distress were included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Stein et al., 2010), the term 'cultural idioms' is often only used to refer to non-Western concepts aimed to convey distress. It has been suggested that better sociocultural and cross-cultural knowledge and cultural competency from healthcare professionals can result in the better design and delivery of interventions to promote psychosocial well-being in these populations (Hassan et al., 2016). More recent research showed that whilst there has been an increase in public, patients and carers participation in research and the development of policy pertaining to mental health, low-income communities, of which asylum seekers, refugees and undocumented migrants are often a part, have tended to remain marginalised from the co-design and development of mental health services (Rose & Kalathil, 2019). This can perpetuate, albeit inadvertently, already engrained inequalities and increase marginalisation and unequal access to health service care (Gibson et al., 2021).

The research literature has indicated that culturally rooted understandings of mental health, including its causes and clinical presentations, are important in explaining asylum seekers', undocumented migrants' and refugees' perceptions of mental health (Gong et al., 2014; Gibson et al., 2021). A lack of sensitivity to such issues can lead these populations to perceive services as not developed to meet their needs. In fact, Western models of mental health care, and the services that have resulted, are known to often lack the required cultural competence (Rose & Kalathil, 2019), and cultural humility. Cultural humility is a commitment, on the part of the clinician or researcher, to self-evaluation, self-awareness, and critique. This is geared toward identifying and redressing the power imbalances that are present in the 'clinician-patient' dynamics to produce a non-paternalistic, and mutually beneficial partnership (Tervalon & Murray-Garcia, 1998; White et al., 2021). Arguably, a lack of cultural humility can deter individuals from asylum seeker, refugee and undocumented migrant groups from accessing and engaging with the healthcare service (Gong et al., 2014). For example, Gong and colleagues (2014), discussed a lack of knowledge in mental health services, and the barriers related to mental health literacy as main issues to accessing the healthcare required by these migrant populations. This resonates with findings from Gibson et al (2021), who asserted that a lack of understanding of mental health issues is a significant impediment to help seeking behaviours amongst refugees. However, the need to promote mental health literacy has been heavily criticised and labelled as a colonial imposition on the non-Western mind, due to its over-reliance on biomedical concepts (Summerfield, 2008).

McKeary and Newbold (2010) stress that whilst the Western healthcare models are based on the premise of universality, a thorough consideration for the sociocultural identity of patients from minority ethnic groups is often absent. The authors go on to suggest that, in the specific cases of asylum seekers and refugees, cultural competence is required to meet their needs. Although refugees and asylum seekers who resettle in Western countries have potentially greater healthcare needs than the general population, these groups have a higher risk of being misunderstood when accessing health services (Ellis et al., 2011; Kirmayer et al., 2011). For example, a review shows that refugees display higher levels of medically unexplained psychosomatic symptoms compared to the general population in Western countries (Rohlof et al., 2014). Issues related to these have recently been critically discussed in the literature. For example, White et al., (2021) have described how interpreted interactions between clinicians and patients risks resulting in epistemic injustice. Epistemic injustice may occur when, in the case of interpreted-mediated clinical interactions, the way(s) that a client conceptualises distress (or wellbeing) is, willingly or unwillingly, misrecognised or misrepresented by the interpreter and/or clinician (White et al., 2021).

Furthermore, the authors argue that all stakeholders involved in multi-language communication involving interpreters (or translators) need to maintain a high level of reflexivity and critical awareness to avoid the risk of epistemic injustice. This is facilitated by a set of six prompts. These include an awareness, on the part of the clinician (or researcher), of the concepts and explanatory models employed by the individuals involved in cross-cultural communication, along with potential differences in how these models are used. The manner in which communication is used to develop a shared understanding of the topic being discussed (e.g. wellbeing) and how this, in turn, is influenced by the nature of the communication being used. It is also indicated that within cross-cultural communication the potential for ‘over-supposing/ under-telling’ by any of the individuals involved is a potential pitfall to the identification of key areas of learning for future practice (see White et al., 2021 for a full description). An awareness of issues related to epistemic injustice can help in the foregrounding of power imbalances when, as in the case of this thesis, interpreter facilitated interviews are used as part of data collection.

Research illustrates that access and engagement with mental health services from these groups is much lower compared to the general population (Kinzie et al., 2006; Laban et al., 2007). It has been reported that as few as 20% of refugees who require psychological interventions access health service care (Lamkaddem et al., 2014). The under-utilisation of healthcare by these groups risks resulting in mental health issues remaining untreated (Derr, 2016).

Empirical investigations of the potential reasons for this have shown that these migrant populations receive poor information related to available services (O'Donnell, Higgins, Chauhan, & Mullen, 2007), which places marginalised groups, of which asylum seekers and refugees are a part, at a disadvantage in terms of access to high quality primary care (van den Muijsenbergh et al., 2014). Lack of interpreting services is another potential barrier to healthcare access by asylum seekers and refugees (Said et al., 2021). Bernardes et al. (2010) illustrated that, when these services were unavailable, some refugees reported not being able to make informed choices about their treatment options. Practical factors were also identified in the literature as barriers to access and engagement with mental health services. These include a lack of appropriate interpreting services, which are shown to decrease the development of rapport and a solid therapeutic relationship, and lead to less patient satisfaction with the services provided (Ngo-Metzger et al., 2007; Macfarlane et al., 2008).

Much of the research aimed to investigate healthcare access has focused on healthcare service delivery systems (Palmer & Ward, 2007). However, service user perceptions, and cultural beliefs are noteworthy barriers to to help-seeking and engagement with services (Tribe, 2002). In addition, negative perceptions of psychiatric services, stigma and lack of information about menta health services have been indicated as significant barriers to access in these communities (Bartolomei et al., 2016). Regrettably, services that work with asylum seekers and refugees have largely been unable to effectively deal with these problems (Koesters et al., 2018). In addition to this, since the COVID-19 pandemic started, and with the increase in remote consultations, these migrant groups have also faced issues around digital exclusion (Lessard-Phillips, Fu, Phillimore et al., 2020). Additionally, post migration life difficulties rooted in language, lack of employment and housing compound the above mentioned (Maier & Straub, 2011), particularly for women (Due et al., 2021). Research findings indicated that several participants in asylum seekers and refugee communities believed that, rather than mental health services, the main sources of support are a person's family, friends, and community organisations (Piwowarczyk et al., 2014; Quinn, 2014).

These findings indicate a need to continue to explore and understand the impact of PMLD on the mental health of asylum seekers, refugees and undocumented migrants in the Scottish context. In particular, there is a need to understand how the asylum process impacts on their health and how and where people seek support. This PhD thesis investigates asylum seekers', refugees' and undocumented migrants' mental health psychosocial experiences in the post-migration context. These include the exploration of social determinants of health and the barriers and facilitators of access to services, including healthcare.

Social determinants of health encompass the wider contextual factors that are present within individuals' social environments and that affect individuals' health and wellbeing. Examples of theoretical approaches aimed to capture the complexity of the interactions between one's environment and health, include Dahlgen's and Whitehead's (1991) 'Rainbow Model'. This model included individual factors (e.g. lifestyle), social networks (e.g. community), as well as more upstream determinants such as socio-economic and environmental conditions as a lens through which health can be studied. Using the social determinants of health as a lens it is possible to include social aspects of people's health which go beyond merely individual factors to include the broader environment in which individuals live (Page-Reeves et al., 2013). In this thesis, social determinants of health refer to the interplay between individual level factors, social and community networks, and more upstream determinants of health and wellbeing (Dahlgen & Whitehead, 1991; Marmot, 2005).

2.1.1 Candidacy: an integrated framework

One of the key areas of attention in this PhD research is related to healthcare access, and how this is experienced by marginalised groups of which the asylum seekers, refugees and undocumented migrants who participated in this research are a part. Within this broad topic, potential barriers and feasible interventions to facilitate access to services are important points for empirical exploration with the view to provide policy suggestions aimed at the improvement of access to services for these populations. In order to achieve this aim, the theoretical concept of candidacy (Dixon-Wood et al., 2005) was used as a theoretical framework to explore the mechanisms of access to care. It is noteworthy that candidacy is negotiated in a dynamic manner by the individual candidate for healthcare and the service providers, which include the healthcare professionals and the broader healthcare system. The point at which this process begins, coincides with an individual considering/recognising themselves a candidate for a given service, or being identified as a candidate (e.g. mental healthcare).

Earlier conceptualisations of healthcare access attempted to describe entry to a service in terms of the 'match' between the service user and the service provider, as if these were two separate 'entities', independent of one another (Pechansky & Thomas, 1981). In addition, theories of healthcare access that predate candidacy tended to separate the concept of having access to care from that of gaining access to care (Aday & Anderson, 1974). As illustrated by Kovandžić et al. (2011), these fixed and static views of access to care, do not account for the nuanced and multifaceted nature that characterises healthcare access. Furthermore, through the exploration of healthcare access from the perspective of service users as well as service providers, the candidacy framework attempts to bridge this separation (i.e. having access and gaining access) and thus move toward and integrative approach which more fully engages with the multifarious and dynamic relations between the healthcare candidate(s) and the institutions and personnel providing care (Ibid). In order to structure and synthesise the available evidence on service access and use among underserved and marginalised groups, the theoretical concept of candidacy was developed (Dixon-Woods et al., 2005).

This framework offers a theoretical lens via which healthcare access can be understood. It does so by taking into consideration an individual's recognition/identification of being a candidate for healthcare and, simultaneously focusing on the negotiation(s) that occur with the healthcare provider in order to secure access to a given healthcare service (Dixon-Wood et al., 2006). An important aspect of this theory is the way it outlines the itinerary through which a candidate for healthcare navigates and negotiates access at various phases along the process (*as illustrated in* Figure 1). To put this concretely, the candidacy theory comprises seven phases and includes: *Identification; Navigation; Permeability; Presentation at the service; Adjudication; Offers and Resistance, and Operating conditions* (*see* Figure 2 *for a full illustration*). To reiterate on the previously mentioned, the initial phase involves an individual's self-identification as a candidate for the healthcare service. The final stage culminates with said individual accessing the service required. Importantly, the initial and final phases, and the intermediate phases that compose the candidacy framework, are non-linear. It is the peculiarity of its fluency, dynamicity and non-linearity that makes the candidacy framework a considerable contribution to our understanding of healthcare access (*see* Dixon-Wood, 2006).

2.1.2 The foundations of candidacy

A core aspect of the candidacy framework rests on the understanding that being a candidate for healthcare access is a socially constructed concept (Koehn, 2009). In so doing, it provides a space to critically analyse how candidacy is co-constructed by all the stakeholders (e.g. service users and service providers) who actively take part in this process. Furthermore, the concept of candidacy allows us to engage with the study of access to care from the perspective of the service user, by analysing the ways in which they view themselves as candidates for a particular health issue. Simultaneously it helps our understanding of how eligibility is negotiated with the healthcare professional. This, the candidacy theory suggests, is the essence of how the determination of access or refusal for a given service is construed (MacKenzie et al., 2013).

However, this does not signify that the power dynamics at play are equally distributed and afforded to service users and service providers in an equitable manner. Evidence indicates that certain groups (e.g. healthcare professionals), hold more power in the context of negotiating healthcare access and, as a result, have a more prominent 'voice' when access is being negotiated (Macdonald et al., 2016). In addition to this, there are numerous compounding factors that influence candidacy, including a person's demographics and socio-cultural background (Dixon-Woods et al., 2005; Koehn, 2009). As articulated by Koehn (2009), whilst services are designed with the intention to provide equitable access, cultural assumptions and stereotypical categorisations about certain minority groups are inversely related to the principle of equity, and can actually result in the further marginalisation of already underserved groups. The candidacy construct is therefore a useful theoretical framework aimed to question our understandings of individuals' candidacy for healthcare, and the broader influences that determine individuals' identification as candidates. These, play an important role in ultimately adjudicating access.

2.1.3 The usefulness of the theory of candidacy

The authors of the candidacy theory grappled with the complexities of operationalising concepts such as healthcare access and equity in access to services (Dixon-Woods et al., 2006). Dixon-Woods et al. (2006) argued that relying on service use statistics to understand healthcare access results in the over-simplification of otherwise complex and multifarious processes. As a result, the development of the theory of candidacy was aimed to produce a framework which critically engages and contextualises issues related to access. In so doing, it provides a theoretical lens through which we can interrogate access to healthcare by considering how access is negotiated between the individuals accessing services and the service providers. It is noteworthy to assert that this approach moves beyond the static, linear notion of 'supply and demand' transactions, and highlights the complex (power) dynamics that underscore the negotiation of access to services in each of its phases (MacKenzie et al., 2013).

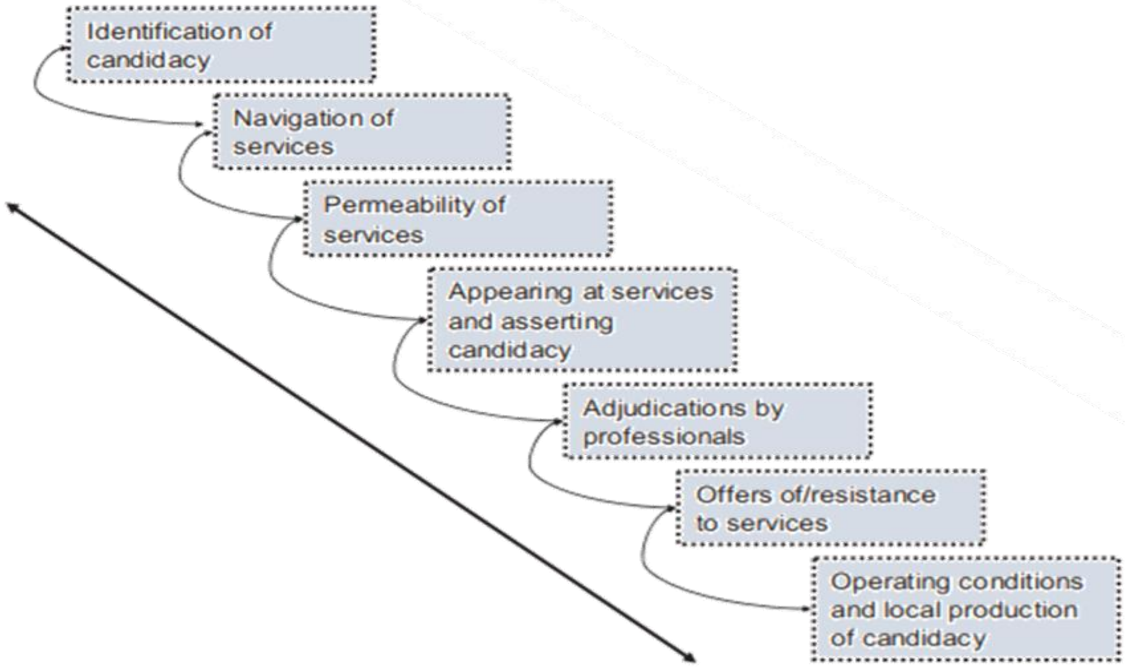

Figure 1 The candidacy model as illustrated in Mackenzie et al., 2013

When the focus is shifted specifically on the underuse of services by marginalised groups, MacKenzie and colleagues (2013) illustrate that the inequitable use of services by these populations derives from the complex and dynamic interplay of factors that exceed simple, unilateral and disjointed explanations of service access. Using candidacy, the authors argue that it becomes possible to identify the phase at which access is impaired, and potentially intervene appropriately to overcome barriers. This, in turn, is made possible by the way in which the candidacy framework divides access into phases and engages with the complex interactions that occur between service users and service providers at each phase. Importantly, barriers to access could crystallise at any of candidacy phases. For example, this could occur at the initial phase when individuals need to recognise themselves as a candidate for a given healthcare service. Another exemplification of this may be at the phase of negotiating access to a service with a service provider, at the *adjudication* phase (*see* Figure 2). It might also be in identifying a service user’s ability, or lack of it, to access a given service i.e. at the offers and resistance phase (Figure 2) (Dixon-Woods et al., 2005). One prominent example that epitomises the usefulness of candidacy as a tool that critically engages with the complexities of healthcare access is illustrated in Koehn’s research (2009). Here, the author identified that, amongst ethnic minority seniors in Canada, the most Important barrier to asserting candidacy for healthcare services was language difficulties, rather than ethnicity, as previously thought.

This research challenged conventional views related to the root cause of minority ethnic seniors not identifying themselves as candidates for accessing healthcare within the Canadian context.

To date, there has been ample research which employed candidacy. For example, MacKenzie et al (2013) explored issues of engagement and outreach in preventive care in Scotland. Chase et al., (2017) researched healthcare access for undocumented migrants in Canada, whilst Abbott et al (2017) looked at access to care within a prison in New Zealand. Kovandžić et al. (2011) used candidacy to investigate access to primary mental health care in hard to reach groups in Liverpool where the researchers identified widespread stigma and scarce information around mental health as the two most prominent barriers to equitable access to services. In this regard, Koehn (2009, p. 585) affirmed that candidacy '*account[s] most fully and systematically for the phenomenon of access and the ways in which vulnerabilities arise in relation to it*'. In addition, the candidacy framework has been applied to understand access to care for underserved and marginalised groups in the UK (O'Donnell, et al., 2007) and Australia (Coupland & Maher, 2010). These studies have affirmed the contribution of this theoretical approach to the issue of healthcare access.

Table 2-1 Description of the phases of candidacy

Phases	Description
Identification of candidacy	Denotes the point at which an individual identifies themselves as a candidate for a service.
Navigation of services	The pathway used to access a particular health service and the process an individual must undergo to achieve access.
Permeability of services	The degree of accessibility a service has. It is acknowledged that a service can be more or less permeable, and this is contingent on what the barriers to access might be.
Presentation at health service	This phase consists in an individual asserting their candidacy for a service. This however can occur at the individual's own accord or through invitation (e.g. preventive care).
Adjudication	This entails a professional deciding whether an individual is indeed a candidate for the service sought. This decision may include technical and socio-cultural considerations.
Offers and resistance	It is at this stage that offers to access a service are made. These, may be accepted or rejected.
Operating conditions and local production of candidacy	These are the influences experienced by both services users and providers, which affect the co-construction of candidacy.

More recently, a systematic review has been conducted which assessed the extant literature that employed candidacy to understand access to mental health care amongst asylum seekers and refugees (van der Boor & White, 2020). This review identified *Identification of candidacy* and *Appearance at services* as the main barriers to access to mental health services in these populations. Whilst the reasons for this are potentially multifactorial, the authors reported participants' lack of familiarity with specific symptoms and individuals' perception of symptoms as not severe enough to require professional attention (*Ibid*).

Liberati et al. (2022) used candidacy to illustrate the impact of the COVID-19 pandemic on access to secondary mental health services in England. The results highlight issues around permeability and the increased difficulty in the negotiation of access between service users and providers. These were compounded by pre-pandemic problems such as health service underfunding. Importantly, this study further confirms the value of the candidacy framework in investigating access to mental healthcare and, in addition, it extended its application to studying structural factors that influence access, for example, the asylum process (Isaacs et a., 2020).

2.1.4 Multiple candidacies

In its current form, the candidacy framework provides a considerable contribution to the health and wellbeing experiences from the perspective of individuals accessing care and those providing care. The topics of empirical research that used the candidacy approach to explore issues pertaining to access, included a variety of underserved and marginalised individuals and communities, as well as healthcare access for ethnic minority individuals (Koehn, 2009), and undocumented migrants (Chase et al., 2017). Nonetheless, further empirical research is indeed required in order to test this model and the boundaries of its utility for policy and practice (MacKenzie et al., 2013).

Potentially, its applicability goes beyond the realm of healthcare, and may be tested to assess access to services more broadly. For example, Neary et al. (2021) explored the experiences of a welfare to work programme in individuals over the age of fifty with a chronic health condition in the UK. By adapting the candidacy model, Neary and colleagues highlighted the ways in which participants navigated the welfare to work programme. In addition, the researchers investigated the role played by other decision makers such as unemployment support services and healthcare providers in supporting or hindering participants' navigation and acceptance/refusal of access to the programme offered. In yet another research article, Mackenzie and colleagues (2015) applied the candidacy framework to the understanding of the micro-, meso- and macro-factors involved in domestic abuse, and how these operate on, and influence, the lived experiences of individual women.

2.2 Research Objectives and research questions:

2.2.1 Objectives:

1. To investigate asylum seekers', refugees', and undocumented migrants' mental health experiences in the context of social determinants of health.

2. To explore how social determinants of health influence the pathway to healthcare services amongst asylum seekers, refugees, and undocumented migrants.

3. To explore the barriers and facilitators of asylum seekers, refugees and undocumented migrants' pathways to accessing wider services (beyond healthcare) that they need.

2.2.2 Research questions:

i. How do post-migration life difficulties intersect with mental health and psychosocial experiences in asylum seekers, refugees and undocumented migrants?

ii. What are asylum seekers', refugees' and undocumented migrants' experiences of accessing mental health support in the country of settlement?

iii. What services are offered to asylum seekers, refugees and undocumented migrants in response to their psychosocial needs?

2.3 Conclusion

This chapter has provided an overview of the literature on the mental health and psychosocial experiences of asylum seekers, refugees and undocumented migrants. In so doing, phases of migration were presented along with their potential risk factors for the development of mental health difficulties. A particular focus was placed on the literature investigating the role of post migration experiences and its impact on the mental health and access to care in these populations. The literature identified areas of concern, which include migration detention, the asylum system, fear of deportation, poverty, destitution, housing issues, language and communication difficulties, and poor access to care in spite of need. The role of multiple traumatic experience in their country of origin and during the migration journey, and adverse experiences in the post-migration context and their impact on mental health (e.g. Porter & Haslam, 2005; Palmer & Ward, 2007; Aragona et al., 2013; Gibson et al., 2021) was illustrated. These included the anxiety and uncertainty about the outcome of the asylum application, and a fear of deportation (Bernardes et al., 2010; Slobodin et al., 2018), housing, unemployment, destitution (Refugee Survival Trust, 2019), social isolation (Warfa et al., 2006) and poor access to care (van der Muijsenbergh et al., 2014; O'Donnell et al., 2016).

The research thus far presented indicates the complex psychosocial interactions that can exacerbate mental health vulnerabilities in these populations. Also, the needs of asylum seekers, refugees and undocumented migrants are shown to be largely unmet, also due to service delivery systems. Based on this, the aims and objectives of this thesis were crystallised. To address these, the next chapter of this thesis presents the method and results of the Systematic Review and Meta-Ethnography.

Chapter 3 Systematic Review and Meta-Ethnography

As described in the literature review chapter of this thesis (Chapter 2), there is a prevalence of psychosocial difficulties in the post migration context, that include poverty, destitution, housing issues, poor access to care, language and interpretation difficulties, and migration detention experiences. These issues have been identified in different country settings including the UK, the US, Canada, Australia and New Zealand, and amongst different migrant populations. However, while quantitative studies provide an epidemiological overview of the data, it is important to understand how post-migration life difficulties intersect with the mental health and psychosocial experiences in these populations. In this systematic review and meta-ethnography, the literature was comprehensively searched in order to identify studies focused on the impact of post-migration life difficulties on migrants' mental health. A meta-ethnographic approach guided the qualitative data synthesis process (Atkins et al., 2008; France et al., 2019).

3.1 Aim of review

The aim of this systematic review and meta-ethnography is to explore and synthesise qualitative literature exploring the impact of post migration life difficulties on mental health amongst asylum seekers, refugees and undocumented migrants.

3.2 Methodology

3.2.1 Protocol Registration

A systematic review protocol was created and registered on PROSPERO, the International Prospective Register of Systematic Reviews (PROSPERO registration number: **CRD42018109548**).

3.2.2 Search Strategy

The electronic databases Medline, EMBASE, PsychINFO, SocINDEX, and Web of Science Core Collection were searched. A comprehensive search strategy was created and included medical subject headings, synonyms and terms related to or describing the systematic review's objectives (Appendix 1). Truncation (*) was implemented at the end of words, where appropriate, to retrieve all related words that commence with a specific stem, for example Depress*. To combine two or more terms within the search line, operators were used (e.g. ADJ, N, NEAR/) in accordance with each database's requirements. Individual search strings and key words were combined to limit the search using Boolean Logic. The finalised search strategy was then reviewed by a subject-specific librarian. Prior to conducting the search, scoping work using Medline was undertaken, and necessary search terms and strategy adjustments were finalised before running the final searches (September 2018 and March 2022). Searches were then adapted to suit each of the electronic databases' specific terminology requirements.

3.2.3 Inclusion and Exclusion Criteria

A set of inclusion and exclusion criteria were developed to reflect the focus on asylum seekers' and refugees' mental health within HICs (see Chapter 1). Only papers that focused on migration from LMICs to HICs were considered for inclusion; papers published in English from 1980 onwards were eligible. Other criteria were qualitative and mixed method studies (with a significant, data driven qualitative component). Studies had to include a specific focus on post migration life difficulties and have a clear focus on mental health (e.g. Depression, PTSD). A full account of the eligibility criteria for inclusion and exclusion is illustrated in Table 3-1.

Table 3-1 Inclusion and Exclusion Criteria

	Inclusion criteria	Exclusion criteria
Language	English language	Non-English language
Migration journey	Studies focused on migration from LMICs to HICs	Internal migration; studies conducted in refugee camps or hubs.
Timescale	1980-2022	Papers published before 1980
Study type	Qualitative Studies; mixed method studies with a significant qualitative component.	Reviews (including systematic reviews); economic analyses; quantitative studies; books; not peer-reviewed papers. Mixed-method studies whose qualitative component included questionnaires, or standardised clinical interviews. Not data driven research.
Study focus	Description of Post-migration life difficulties; focus on mental health, defined as depression, anxiety, and/or PTSD.	Focused on pre-migration or both pre- and-post migration experiences; physical health issues (e.g. HIV); post-natal depression. Testing an intervention; testing an assessment tool. Focus on health care professionals' views.
Population type	Asylum seekers and refugees.	Papers that did not clearly focus on asylum seeker and refugees populations. Papers focused on holocaust survivors former USSR, or Yugoslavia; individuals under the age of 18.
Other		Book, book chapter, thesis, dissertation, opinion piece, conference presentation, letter or any other NOT data driven research article or full-text not available.

3.2.4 Screening and Article Selection

A two-step process was followed: in the first step of the screening process, Title and Abstract were screened simultaneously. This was followed by Full-Text screening, which was the second step of the screening process. Whilst this two-steps process was followed meticulously, potential for human error leading to the exclusion of a paper based on title only cannot be completely ruled out. Papers were evaluated at each step of the review using the inclusion and exclusion criteria. Firstly, all titles were screened by AA using two screening questions focused on the study population and mental health. Titles were second screened by an independent researcher (KO, GR, EG, IM). Abstracts were screened by AA and second-screened independently by one of five reviewers (CO, SM, EG, GR, IM). In case of disagreement between reviewers, consensus was reached through discussions and resolved before moving on to the next stage of the selection process. If agreement was not reached through discussion, it was resolved independently by a third researcher. Finally, full-text review of articles was conducted. Full-text screening was completed by two reviewers, independently. Initially AA screened all the full-text articles. This was repeated by a second reviewer (KO, SM, BN) independently. If necessary, disagreements occurring at this stage were resolved by an additional reviewer.

The initial search identified 12,604 references. After the removal of 3,238 duplicates using EndNote reference management system, the remaining references (N=9,366) were exported into Distiller SR, a systematic review software system. The search was updated in March 2022, and an additional 106 papers were identified, thus bringing the total number of papers to 9472 for screening. During screening, 9,394 references were excluded, leaving 78 reference for full-text screening. Of these, 58 were excluded and 20 were included in the meta-ethnography, 11 qualitative and 9 mixed-method. Figure 3-1 shows the PRISMA chart in which reasons for exclusion are illustrated.

3.2.5 Quality Assessment Process

The quality appraisal tools, pertinent to the methodology of either qualitative studies or the qualitative component of mixed-method studies, were applied to the 20 papers included in the meta-ethnography. Mixed methods studies were assessed using a standardised, adapted version of the CASP checklist by O'Caithan, Murphy & Nicholl (2008); qualitative studies were assessed using the CASP Qualitative checklist (2018). The tools used to assess research quality considered aspects such as clarity of aims, methodological rigour and transparency, and conclusions in light of results. Each paper was given a rating of 'Good' (2), 'Fair' (1), or 'Poor' quality (0) on each of the criteria assessed. A paper was awarded a

‘Good’ if they received no ‘Poor’ or ‘Fair’ scores on any aspect of the assessment. A ‘Fair’ was awarded if the paper under review received one ‘Poor’ score and either ‘Fair’ or ‘Good’ scores on any other aspect of the assessment. Finally, a paper was considered ‘Poor’ if it was given two or more ‘Poor’ scores on any aspect of the assessment. For the purpose of transparency, studies were not excluded based on quality, and data was extracted regardless of ratings.

3.3 Theoretical Approach to Data Synthesis

A range of meta-approaches exist to synthesise data from qualitative studies and the usefulness and applicability of research findings derived from the synthesis of qualitative data is gathering support, particularly within healthcare research (Barnett-Page & Thomas, 2009). Meta-syntheses such as meta-ethnography aim to develop a deeper understanding of a phenomenon by systematically synthesising data across studies in order to identify commonalities and discrepancies (Peterson et al., 2017). In contrast with other approaches to qualitative synthesis (e.g. Narrative Literature Review), meta-ethnography allows for the development of theoretical understandings of the topic studied, based on the results of individuals studies (Britten et al,. 2002; Campbell et al., 2011).

Whilst there are several approaches that can be described within the umbrella term of meta-syntheses, some of these have limited flexibility in attempting to identify commonalities as well as differences in studies, and integrate these to reach a theoretical understanding of the issue at hand (e.g. Textual Narrative Synthesis) (Lucas et al., 2007). Other meta-syntheses approaches such as Critical Interpretative Synthesis (CIS) are valuable for synthesising a large body of research evidence, with the aim of identifying a new line of argument. However CIS, which is a development of the meta-ethnographic approach has, as its defining characteristic, the ability to integrate both qualitative as well as quantitative research data for synthesis (Dixon-Woods et al., 2005). Although useful, this approach would go beyond the scope of this systematic review and meta-synthesis. As mentioned earlier, the inclusion criteria focused only on qualitative studies and the qualitative component of mixed methods studies. In light of this, we opted for meta-ethnography.

To ensure transparency in reporting, and using a systematic step-by-step approach, the analytical process in this meta-ethnography was based on guidelines outlined by Atkins et al. (2008) and France et al. (2019). This is reported in the next section.

3.3.1 Applying Meta-Ethnography to the Included Studies

Initial data extraction focused on: Country in which the study was conducted; Country of origin of the population in the study; Number of participants; Year of publication; Aims of the study; The phase of migration on which the study focused (e.g. pre / post migration); Mental health issues on which the study focused (e.g. Depression; PTSD); Study design (e.g. qualitative, mixed-method). After this, data extraction and synthesis followed the seven-step process described and Atkins et al., (2008), and by France et al., (2019). Whilst Noblit and Hare (1988) built the foundations of meta-ethnography, this method has since developed further, and more recent research has included the addition of second and third level constructs to the analysis (Atkins et al., 2008; Britten et al., 2002).

Step 1 – Determining a research question:

As detailed earlier in this chapter, a research question was developed from an initial literature review were it became evident that there is a paucity of research focused on the question ‘How do post-migration life experiences impact on mental health in asylum seekers, refugees and undocumented migrants?’

Step 2 – Deciding the focus of the synthesis:

The specific focus of this meta-ethnography was derived from a comprehensive systematic review process, as illustrated in the PRISMA Diagram.

Step 3 – Reading the studies in detail:

The included studies were initially read in detail. This step of the process included familiarisation with the studies and an initial attuning to the studies’ identified themes. Here I began to notice and categorise how studies’ themes, though presented differently (for example, using different metaphors for mental health or distress) were related to one another. For example, as illustrated in Table 3-3, whilst Teunissen et al.’s (2014) and Quinn’s (2014) studies have different research aims, and focus on different populations, both have themes related to help seeking behaviours and access to care.

Step 4 – Determining how the studies are related

This stage of the meta-ethnography included creating a Table (3-3) in which concepts (as described by participants in the studies) and themes (as presented in the studies by researchers) from each of the twenty studies, were presented. These were taken directly from the published studies. During this step, I read all of the papers and extracted data. A sample of papers were read by my supervisors (KOD, SM, BN) and our interpretations were discussed. This step also included determining how studies were related to one another. This step of the synthesis leads to the development of first order constructs (Atkin et al., 2008).

Step 5 – Translating the studies into one another

This stage of the meta-ethnography developed directly from stage 4 and included the creation of Table 3-4, which drew the data into the three concepts of: Descriptions of community and family as a double edged sword; Access to healthcare; Mental health within a sociocultural context. In this table, the themes identified in each included study (n=20) were brought together on the basis of their reciprocal translation (i.e. similarities across studies' identified themes). Practically, this was completed by arranging each paper chronologically, and comparing themes from each paper as outlined by the authors. During this process, I remained flexible and, whenever new themes were identified, I moved backwards and forwards through papers to see whether these were also present in other papers. Themes that were identified in more than half of the included papers were candidates for inclusion in the final synthesis (Step 6) (Frances et al., 2019). This process led to the development of second order constructs (i.e. reciprocal translations of the studies' themes) (Atkin et al., 2008). Here, themes were again reported directly from the published studies (Table 3-4). I chose this approach because I did not want to begin interpreting results prematurely (Frances et al., 2019).

Step 6 – Synthesising translations to develop novel interpretations grounded in the data:

The synthesis of the data gathered through first and second order construct is described as third order construct (Atkin et a., 2008). In the present meta-ethnography, this was achieved via the interpretation of both first order constructs and second order constructs. Third order constructs lead the researcher to developing a new line of argument. This new line of argument was grounded in the data presented in tables 3-3 and 3-4.This step of the synthesis was completed initially by AA, who compared and contrasted first order constructs (see Table 3-3) and second order constructs (see Table 3-4), and developed an overarching interpretation by linking the various themes and subthemes. These were shared and discussed with the supervisory team (KO, SM, BN) in order to generate a line of argument based on mutual consent. This line of argument is presented at the end of the results section of this chapter.

Step 7 – Expressing the synthesis in a comprehensive manner

The synthesis was expressed in the form of a new line of argument. It was my aim to make the results of the synthesis accessible to as wide an audience as possible, including clinicians and policymakers who may be unfamiliar with meta-ethnographic analyses.

In the next section of this chapter I report the results of the systematic review by using a PRISMA Flowchart (Figure 1), and subsequently present each step of the meta-ethnographic process using tables. A new line of argument that was identified through the synthesis of the included studies is then illustrated. This is followed by a further synthesis of the meta-ethnographic results, a discussion of how these results can be contextualised within the wider literature, and a critical appraisal of this chapter in light of strengths and limitations.

3.4 Results

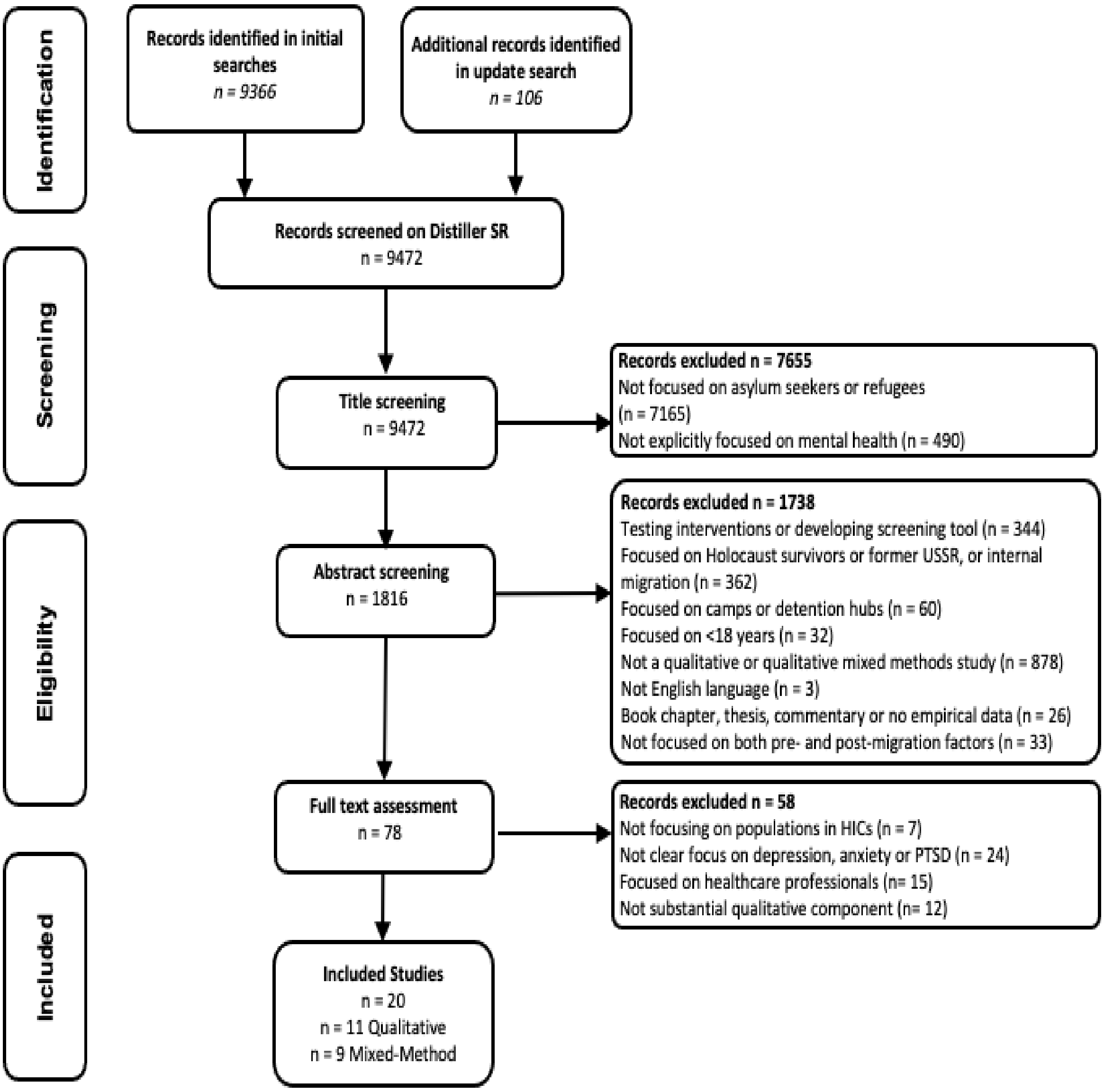

Figure 2 PRISMA Flowchart

3.4.1 Description of included studies

As shown in the PRISMA Flowchart, 20 studies were included in the review. Of these, 11 were qualitative and were 9 mixed method studies with a significant qualitative component. The included studies were conducted in 7 countries: Canada (N=2), Australia (N=6), Netherlands (N=1), UK (N=4), Germany (N=1), Norway (N=1), and USA (N=2). Of the 20 included papers, 3 studies were conducted in dual country settings: Australia and New Zealand (N=2), UK and USA (N=1). Publication dates spanned from 2006 to 2021. When reviewed for quality, 7 papers were scored Good; 8 papers were scored Fair; 5 papers were scored Poor. Full details of the data extraction and the scores attributed to each study based on quality, are illustrated in Table 3-2

3.4.2 Qualitative and Mixed Method Study Data Extraction

The tables displayed below (3-2) describe the main characteristics of the included studies (N=20). The studies are presented in chronological order, with qualitative studies being presented first. The studies' aims were taken directly from each article and, where information is missing or incomplete, the term 'not specified' is used. For the mixed-methods studies, the number of participants included in the table reflects only those who took part in the qualitative component.

Table 3-2 Main characteristics of included studies

Author(s)	Country in which the study was conducted	Country of origin of the population in the study	Number of participants / Gender / Age range	Year of publication	Aims of the study	Mental health issues on which the study focuses	Study design and Quality Score
Warfa, Bhui, Craig, Curtis, Mohamud, Stansfeld,McCroe, Thornicroft	UK	Somalia	21 12 Females 9 Males 16-65 years	2006	To explore Somali narratives and realities of geographical mobility and mental health.	Depression	Qualitative Interviews and Focus Groups Good
Kokanovic, May, Dowrick, Furler, Newton, Gunn	Australia	East Timor, Vietnam	24 17 Female 7 Male Not specified over 18 years	2010	To locate culture within the broader socio-structural context of depression care in general practice.	Depression	Qualitative Interviews Good

Author(s)	Country in which the study was conducted	Country of origin of the population in the study	Number of participants / Gender / Age range	Year of publication	Aims of the study	Mental health issues on which the study focuses	Study design and Quality Score
Donnelly, Hwang, Este, Ewashen, Adair, Clinton	Canada	China, Sudan	10 10 Women Not specified over 18 years	2011	The aim of this exploratory qualitative study was to increase understandings of the mental health care experiences of refugee women by acquiring information regarding factors that either support or inhibit coping.	Anxiety, PTSD, Psychosis	Qualitative Interviews Good
Quinn	UK	Somalia, Eritrea, Pakistan, Iran, Iraq, China and Sri Lanka	101 Not specified Not specified over 18 years	2014	To investigate the different beliefs and attitudes to mental health problems amongst asylum seeker and refugee populations in Glasgow, explore patterns of stigma and discrimination within these communities and identify barriers to help-seeking and how these could be overcome.	PTSD	Qualitative Focus Groups Good

Author(s)	**Country in which the study was conducted**	**Country of origin of the population in the study**	**Number of participants / Gender / Age range**	**Year of publication**	**Aims of the study**	**Mental health issues on which the study focuses**	**Study design and Quality Score**
Teunissen, Sherally, van den Muijsenbergh, Dowrick, van Weel-Baumgarten, van Weel	Netherlands	Burundi, Dominican Republic, Egypt Eritrea, Ghana Morocco, Nepal, Nigeria, Philippines, Sierra Leone, Somalia, Suriname, Uganda, Zambia	15 9 Male 6 Female 21-73 years	2014	To explore health-seeking behaviour and experiences of undocumented migrants in general practice in relation to mental health problems.	Anxiety, Depression	Qualitative Interviews Good
Fish, Fakoussa	UK	Not specified	10 5 Male 5 Female Not specified over 18 years	2018	To enhance and expand professional understanding and language regarding culturally diverse perspectives on mental health and well-being and establish service user-led ways to improve the tapestry of support in Plymouth.	Anxiety, Depression	Qualitative Focus Groups Fair

Author(s)	Country in which the study was conducted	Country of origin of the population in the study	Number of participants / Gender / Age range	Year of publication	Aims of the study	Mental health issues on which the study focuses	Study design and Quality Score
Smith, Raynish, Hoang, Mond, Hannah, McLeod, Auckland, Slewa-Younan	Australia	Afghanistan, Bhutan, Burma, Sierra Leone, Sudan and Iran	24 Not specified Not specified over 18 years	2019	To examine the resettlement experiences of refugees living in regional Australia, with a focus on mental health and support services, including barriers to access.	PTSD	Qualitative Interviews and Focus Groups Fair
Rowley, Morant, Katona	UK	Not specified	9 4 Male 5 Female 20-59 years	2019	To explore experiences of vulnerable refugees—having previously experienced extreme cruelty—in the first year after being granted leave to remain in the UK, with particular focus on the impact of experiences on mental health.	Depression, PTSD	Qualitative Interviews Fair

Author(s)	Country in which the study was conducted	Country of origin of the population in the study	Number of participants / Gender / Age range	Year of publication	Aims of the study	Mental health issues on which the study focuses	Study design and Quality score
Golembe, Leyendecker, Maalej, Gundlach, Busch	Germany	Iraq, Syria, Morocco, Lebanon, Kenya, Malaysia	26 21 Male 3 Female 2 Non-binary 18-46 years	2020	To investigate LGBTQ+ refugees' experiences of distal and proximal minority stressors as well as their mental health burdens during the post-migration period.	Depression, Anxiety	Qualitative Focus Groups Good
Aarethun, Sandal, Guribye, Markova, Bye	Norway	Syria	31 21 Male 10 Female 19-56 years	2021	To explore how Syrian refugees explain and prefer to seek help for symptoms of PTSD and depression and how their conceptualization of these disorders and preferred help-seeking are affected by the migration-and resettlement process.	Depression; PTSD	Qualitative Focus Groups Good

Author(s)	**Country in which the study was conducted**	**Country of origin of the population in the study**	**Number of participants in the qualitative component / Gender / Age range**	**Year of publication**	**Aims of the study**	**Mental health issues on which the study focuses**	**Study design and Quality score**
Johnson, Allotey, Mulholland, Markovic	Australia	Iraq	16 Not specified Not specified over 18 years	2009	To investigate whether Australian asylum policies and practices, which arguably violate human rights, are associated with adverse health outcomes.	Depression	Mixed-method Interviews Fair
Coffrey, Kaplan, Sampson, Tucei	Australia	Afghanistan, Iraq, Iran and other non-specified Middle Eastern countries	17 16 Male 1 Female 28-57	2010	To examine the experience of extended periods of immigration detention from the perspective of previously detained asylum seekers and to identify the consequences of these experiences for life after release.	Depression, Anxiety, PTSD	Mixed-method Interviews Fair

Author(s)	**Country in which the study was conducted**	**Country of origin of the population in the study**	**Number of participants in the qualitative component / Gender / Age range**	**Year of publication**	**Aims of the study**	**Mental health issues on which the study focuses**	**Study design and Quality score**
Simich, Este, Hamilton	Canada	Sudan	30 Not specified Not specified over 18 years	2010	To examine family and social factors that affect refugee mental health during resettlement by presenting qualitative analysis of the concept of home and its functional and psychological meanings.	Anxiety	Mixed-method Interviews Poor
Murray	Australia	Sudan	10 5 Male 5 Female 28-44 years	2012	To examine the individual and contextual factors that influence the resettlement experience for adults from Sudan being resettled in Queensland, Australia	PTSD	Mixed-method Interviews Poor

Author(s)	**Country in which the study was conducted**	**Country of origin of the population in the study**	**Number of participants in the qualitative component / Gender / Age range**	**Year of publication**	**Aims of the study**	**Mental health issues on which the study focuses**	**Study design and Quality score**
Sulaiman-Hill, Thompson	New Zealand and Australia	Afghanistan, Kurdistan	81 Not specified Not specified over 18 years	2012	To examine the resettlement experiences and provide data of well-being and psychological distress for Afghan and Kurdish refugees settled between eight and 20 years in New Zealand and Australia	Depression	Mixed-method Interviews Poor
Warfa, Curtis, Watters, Carswell, Ingleby, Bhui	UK; USA	Somalia	26 14 Female 12 Male 18-59 years	2012	To compare the post-migration life experiences of two samples of Somali refugees drawn from two urban settings in the UK (London) and USA (Minneapolis)	Depression, PTSD	Mixed-method Focus Groups Good
Sulaiman-Hill, Thompson	New Zealand; Australia	Afghanistan, Kurdistan	124 Not specified 18-70 years	2012	To explore resettlement experiences and major sources of stress and describe the coping strategies they use to deal with it.	Anxiety	Mixed-method Focus Groups Poor

Author(s)	**Country in which the study was conducted**	**Country of origin of the population in the study**	**Number of participants in the qualitative component / Gender / Age range**	**Year of publication**	**Aims of the study**	**Mental health issues on which the study focuses**	**Study design and Quality score**
Piwowarczyk, Bishop, Yusuf, Mudymba, Raj	USA	Somalia & Congo	30 30 Female 18-36 years	2014	To examine both concepts of mental illness in addition to attitudes and beliefs about treatment as well as potential barriers to accessing mental health services.	Anxiety, Depression	Mixed-method Focus Groups Poor
Yako, Biswas	USA	Iraq	5 5 Male Not specified over 18 years	2014	To explore experiences of refugees from Iraq and evaluated experiences related to acculturation in the United States.	Depression	Mixed-method Interviews Fair

3.4.3 First Order Constructs: Qualitative and Mixed Method Studies Findings and Reported Themes

The table displayed below (Table 3-3) illustrates the findings and reported themes of both qualitative and the qualitative component of mixed method studies that were included in the meta-ethnography. In this table, information related to the studies' findings is reported in a chronological order, with qualitative studies being presented first. The findings and themes described in this table are taken directly from each published study. In the interest of transparency, a contextual background of each included study is briefly outlined before the themes are presented. The results reported below comprise first order constructs.

Table 3-3 Description of first order constructs

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Warfa, Bhui, Craig, Curtis, Mohamud, Stansfeld,McCrone, Thornicroft (2006)	Qualitative	To explore Somali narratives and realities of geographical mobility and mental health	**Context:** This study was conducted in the UK, and the participants' country of origin was Somalia. In total, 21 people took part in the interviews and focus groups. 12 were females and 9 were males. Depression was the mental health issue on which the study focused. **An image of geographical mobility** Participants reported that it often took more than 5 years before most Somalis found permanent accommodation in London. Frequency of movement varied from one individual to another but, on average, was about four times in a 5-year period. The mobility occurred from one	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			relatively deprived area to another equally deprived, or even more deprived location. The moves did not seem to be related to upward mobility, at least in terms of the quality of the general socio-economic environment. This may make it more difficult to maintain continuous and effective healthcare access. **Residential movements: narratives of why and how** The reasons given for the frequent residential instability amongst the discussion group participants were related to short-term lets in temporary housing, poor housing conditions, overcrowding, bad location, racism, discrimination and poor employment opportunities. A common theme was community fragmentation and perceived discrimination in housing policy. **Perceived effects of mobility on mental health and health service utilisation** Themes of ‘stress’, ‘distress’, ‘worry’ and ‘anxiety’ precipitated by pre-migration and postmigration geographical instability emerged. Residential mobility was discussed as a risk factor for poor mental	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			health. Residential instability was often explored within a context of other risk factors including homelessness, traumatic experiences, attachment and adjustment problems, community fragmentation, language barriers, racism and discrimination. In general, participants perceived that these interacting difficult life events are associated with poor mental health. Medical services accessible to Somali refugees were services available from GP practices. However, some participants, both from the professional and lay groups, focused on how difficult it was for some Somalis to register with their local family doctors due to poor information of the healthcare system in the host country and limited language ability and limited interpretation services available.	
Tilbury (2007)	Qualitative	To explore the dimensions of sadness and loss expressed by refugees	**Context:** This study was conducted in Australia, and the participants' countries of origin were Ethiopia, Eritrea, Sudan and Somalia. The number of participants was not specified/ Also the genders of participants were not reported and age was 18 and over. Depression was the mental health issue on which the study focused.	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			African cultural differences in understanding mental distress Communities reported the absence of equivalent words for the term “depression” in any of the local languages (Amharic, Tigrigna, Somali, or Sudanese Arabic dialects). Words in these languages denoting emotional states were generally not connected with Western concepts of normal or abnormal mental states. Displaying distress or talking about it may be seen as “complaining” in Eritrean society. This was partly the result of stigmatisation of serious mental health problems. A member of the North Sudanese community spoke of the problem of community gossip networks and shame. Participants felt that “depression” was uncommon in their home country, arguing that this was due to culturally embedded protective factors and because the social conditions that produce “depression” do not exist there.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Causes of emotional distress Practical difficulties such as unemployment, housing, language difficulties, dealing with education, health and welfare bureaucracies, non-recognition of qualifications and prior experience, as well as “social” or “interactional” difficulties, such as culture shock, racism, isolation, lack of support, and intergenerational and gender conflict, emerged as the main issues that produced negative emotional reactions. Issues related to work, welfare, and language were identified as significant causes of negative emotions. Not having a job, or the loss of status resulting from a lack of recognition of overseas qualifications and work experience, produced feelings of low self-worth and stress, a sense of shame felt by the men was corroborated by women. Emotional reaction, including a loss of dignity and a sense of shame resulting from seeing oneself and perceiving to be seen as ‘begging’ on welfare, and a feeling of rejection generally, in that no one wants to employ them. Participants further emphasised bureaucratic-systemic problems, which meant long-term unemployment for many, and the ongoing	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			anxiety and frustration of having to deal with Australia's social welfare bureaucracies. These difficulties were described as compounding the financial burden of being unemployed and as both frustrating in the short term and likely to contribute to a loss of motivation in the long term. Dealing with the Immigration Department in the process of trying to bring other family members to Australia, including time delays and lack of information about the progress of applications, led to frustration and left family members in a constant state of uncertainty. Another serious strain on resources and emotions is the obligation to maintain trans-national flows of resources in the form of financial support for family 'back home'. A sense of embarrassment, obligation, and shame if one cannot fulfil this duty was also reported. Feelings of loneliness were expressed by most of the African communities. Emotional upset, including most notably anger, irritation, and bewilderment, were expressed about gender and intergenerational issues and clashes of cultural values. While the language is one of "stress," most notable is a sense of disempowerment and confusion.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Kokanovic, May, Dowrick, Furler, Newton, Gunn (2010)	Qualitative	To locate culture within the broader socio-structural context of depression care in general practice.	**Context:** The study was conducted in Australia, and the participants' countries of origin were East Timor and Vietnam. 24 people took part in the interviews. 17 were female and 7 were male. Age was not specified but the study included participants aged 18 and above. Depression was the mental health issue on which the study focused. **Causes of distress** The causes of distress that emerged in this research include: traumatic experiences and circumstances of escape, war and persecution; the sense of cultural and physical displacement and distance; changes in family structures and relations, and issues of structural disadvantage upon settlement. The harsh and unknown physical world around them mirrored internalised fears about their future, and emphasised a deep sense of loss of belonging and connection. Cultural distance is increased by the location and concentration of refugees in a limited number of often socially disadvantaged places. Participants understood this as a significant factor, making it difficult to integrate with the host community. Family	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			is described as central to both East Timorese and Vietnamese participants. In addition, the memory of a pre-existing social fabric that nourished and sustained, was contrasted with the more socially fragmented society in which they now found themselves. This was identified as a source of distress. Participants had to negotiate contrasting systems of meaning in relation to the family in the post-migration context. This was often radically different from their own. The dominance of parents present in many Vietnamese and East Timorese families often creates intergenerational differences. Great emphasis on education and expectations to 'succeed' in an upwardly mobile society were identified as a source of distress. Some participants found themselves left alone to carry that responsibility. Another prominent cause of distress and sense of guilt were family members 'left behind'. Marital relationships breakdown was central to accounts of distress. Women described the pain of 'being abandoned' by their husbands, emotional and physical abuse – humiliation, rape and infidelity. Others talked about the social and cultural pressure to remain in dysfunctional	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			marriages. Financial difficulties were a particular concern for men, alongside accounts of not being able to fulfil responsibilities towards their families due to unemployment, work injuries and chronic illness. Some recounted distress resulting from extended experiences of bullying at work in Australia. Negative experiences related to presenting to the doctor with what, for individuals, are legitimate bodily symptoms of deep distress stemming from their traumatic refugee experience, social dislocation and family dysfunction. This was met with the doctor's immediate process of re-constructing the manifestations of distress as psychological dysfunction. The doctor interpreted the problem as having its roots lying deeply within the person. While one's many-layered social identity and embeddedness may be implicated in causing distress, the solution is seen as 'peeling this away' and getting to the 'individual' self. A recognition of the stigmatising effects of mental illness, particularly in Asian communities, often prompted GPs to avoid using the term 'depression' in their dialogue with the patient. Instead they would use or make	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			reference to, worries, sadness, stress, or tension. Issues such as housing and employment / financial conditions were seen as major contributors to distress by family doctors. The quality of the doctor-patient relationship was often seen as instrumental in the patient's recovery from depression.	
Donnelly, Hwang, Este, Ewashen, Adair, Clinton (2011)	Qualitative	The aim of the present research was to examine the experience of extended periods of immigration detention from the perspective of previously detained asylum seekers and to identify the consequences of these experiences for life after release. Aim from the abstract is: The purpose of this exploratory qualitative study,	**Context:** The study was conducted in Canada, and the participants' countries of origin were China and Sudan. 10 people took part in the interviews, all of which were female. Age was not specified but the study included participants aged 18 and above. Anxiety, PTSD and Psychosis were the mental health issue on which the study focused. **Personal experience with biomedicine: fear and lack of awareness** Most participants indicated that they suffered from mood disorders, anxiety disorders, and PTSD. Many of them voiced lack of sleep, fatigue, paranoid feelings, psychosis, and suicidal thoughts. Participants communicated that they trusted Western biomedicine and its	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
		informed by the ecological conceptual framework and postcolonial feminist perspectives, was to increase understanding of the mental health care experiences of immigrant and refugee women by acquiring information regarding factors that either support or inhibit coping.	effectiveness in treating mental illness. They acknowledged the importance of accepting being mentally ill, seeking medical assistance, and following the medical regimen. Participants who took prescribed medications stated that medications helped them control a range of emotions, sleep better, and suppress impulsive, irrational, and suicidal thoughts. However, not all participants accessed mental health care services in a timely manner. Some participants waited until their problems increased beyond their control before reaching out for help. Therefore, by the time they sought professional and medical help, it was usually in the crisis phase of the problem. Some of the individual factors that delayed their help-seeking included fear of discrimination and stigmatization, denial of mental illness, fear of the unknown consequences of being diagnosed with mental illnesses (i.e., deportation, separation from family, losing children). The lack of awareness and knowledge regarding mental health issues coupled with cultural beliefs and practices, delayed some participants' decision to seek treatment.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			System barriers: lack of appropriate mental health services Most participants in the study consistently voiced a concern that the current health care system does not meet their health care needs. Several participants identified that they have benefitted from attending counselling services. However, limited English language skills and a lack of professional interpretation within health care services impaired most of the other participants from accessing or benefitting from the available mental health counselling services. In addition, family members often too deeply involved in their family member's situation, failed to translate the exact message of distress voiced by a relative. The lack of professional interpretation services in various languages was a significant barrier for immigrant and refugee women to access the available mental health care services. Another barrier was the lack of information about the available mental health services. Several participants perceived that their health care providers did not spend	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			adequate time with them; this led to disappointment and distrust. **Informal support systems and self-care practices** Social support was identified to be the most important component in coping with mental illness. Loss of family and community support, loneliness, isolation, powerlessness, feelings of dependency, and lack of support systems were still commonly raised as dominant issues. Family was identified to be the most crucial, protective factor for emotional health and well-being. On the other hand, being ignored, invalidated, and laughed at when voicing distress were significant barriers to reaching out for help. Several participants expressed resentment about their experiences of not being accepted and understood by their own families and friends. Importantly, knowledge and awareness of mental illness by their family members were reported as pivotal components in continuing to access proper treatments and professional interventions. Participants mentioned the importance of expanding their social support networks to stay connected with others and to improve	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			mental well-being. It is noteworthy that while spiritual practices were identified as sources of strength and hope, such beliefs can also deter women from accessing Western biomedicine treatment.	
Quinn (2014)	Qualitative	To investigate the different beliefs and attitudes to mental health problems amongst the asylum seeker and refugee populations in Glasgow, explore patterns of stigma and discrimination within these communities and identify barriers to help-seeking and how these could be overcome	**Context:** The study was conducted in The UK, and the participants' countries of origin were Somalia, Eritrea, Pakistan, Iran, Iraq, China, Sri Lanka. A total of 101 people took part in the focus groups , and gender was not reported. Age was not specified but the study included participants aged 18 and above. PTSD was the mental health issue on which the study focused. **Causes of mental health problems** Many people related the causes of mental health problems to the status of being an asylum seeker, and the low social status associated with this. Many indicated that they had swapped the stress of living in a war-torn or impoverished country with the stress of the uncertainty and isolation of living in the UK. This was exacerbated by the constant fear of detention and deportation. Participants reported that their lives as asylum seekers are dominated	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			by loneliness, isolation, racism and feeling homesick **Help seeking** People would be more likely to help if the problem was mild, such as stress or low mood. Participants were also more likely to help someone with a mental health problem if they knew the person, and especially if it was a family member; they had knowledge about mental health issues; or they knew people with mental health problems. Some interviewees also commented on possible links between marriage and mental health problems. Some felt that having a mental health issue would decrease their chances of getting married (mostly for female participants from Asia). The stigma associated with mental health problems can be a barrier to help seeking behaviours. Participants were asked about getting help for mental health problems and who they would go to for help if they had a mental health problem. For most groups, participants said that they would initially seek help from trusted friends or family if the problem was considered mild. It is noteworthy however, that some participants would prefer to	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			seek help outside the family and community because of the potential for gossip. For more severe problems, it was acknowledged across all groups that people would seek medical help first, usually from a GP. In most groups, there is a sense that people would be reluctant to seek help because they want to hide the problem. Some participants mentioned that they felt that asylum seekers are not trusted, and are not listened to, by the authorities, leading to a sense of hopelessness that may discourage asylum seekers from seeking help. **Sources of support** Participants in each group said they would use the Scottish Refugee Council as one of the first points of contact if they needed help. The main housing provider was also cited as an important source of help, although there were some negative comments about accommodation providers. Language was expressed as being the main barrier to communicating and accessing support.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Teunissen, Sherally, van den Muijsenbergh, Dowrick, van Weel-Baumgarten, van Weel (2014)	Qualitative	To explore health-seeking behaviour and experiences of undocumented migrants in general practice in relation to mental health problems.	**Context** The study was conducted in the Netherlands, and the participants' countries of origin were Burundi, Dominical Republic, Egypt, Eritrea, Ghana, Morocco, Nepal, Nigeria, Philippines, Sierra Leone, Somalia, Suriname, Uganda, Zambia. A total of 15 people took part in the interviews, of which 9 were male and 6 were female. Participants were aged between 21 and 73 years. Anxiety and Depression were the mental health issue on which the study focused. **Contact with general practice** Participants discussed grave difficulties in accessing primary care. It often took up to 6 years to gain access to a GP (Netherlands). The primary reason Undocumented Migrants (UMs) visited the GP was because of physical symptoms. Only 2 of the 15 participants mentioned mental health problems immediately when asked for the reasons they visited the GP. One of them mentioned psychological problems as reason for encounter, and another mentioned the need for psychotropic prescriptions. Overall, the GP	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			still seemed to be perceived as a doctor who cures only physical issues. **Experiences of primary care** None of the UMs had experience with an interpreter in primary care and various respondents even expressed concerns and dislike for interpreters during the medical encounter. This was mainly due to privacy reasons. The majority of the UMs were satisfied with their GP encounters. Three main reasons for satisfaction include: effective treatment, positive personal qualities of the GP, and a good doctor–patient interaction. A lack of personal interest from the GP, and a lack of providing information and health education were indicated by participants as negative features of GP encounters. Another theme that emerged in several interviews was the reliance on safe self-medication (e.g. paracetamol). Many UMs expressed aversion towards this approach. It was mentioned that better explanation of the underlying motivation for this approach would nurture understanding and improve overall satisfaction (i.e. better doctor-patient communication).	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Help seeking behaviour for mental health problems Although it is clear that a proportion of the participants visited their GP with mental health problems, UMs indicated that medical care was sought only after other means had failed. In this regard, the concept of the GP being a 'last resort' emerged consistently throughout the data, with UMs exploring alternatives first. These included undertaking activities to divert oneself (walking, reading, watching TV, spending time with friends, working, joining community activities), asking advice from others (friends, pastor) and turning to God. One migrant reported using a friend's psychotropic medication when he had no access to care. Some UMs explained they preferred to keep mental health problems to themselves because of fear of gossip in their community (Dominican Republic, Morocco, Ghana, Somalia), fear of being shunned (Sierra Leone, Somalia) or because that was understood (culturally and socially) as the correct way to deal with mental health problems in the country of origin (i.e. the Philippines). A respondent from Sierra Leone described that the stigma associated	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			with mental health problems in African communities often causing patients to lose all their friends. In addition, help-seeking alternatives seemed unaffected by their migration status, as all but two UMs told they would do the same if they had a residence permit. **Barriers in accessing professional healthcare** Reasons for the GP being considered a last resort for treatment of mental health problems were classified under two main categories: general barriers and barriers specific to mental healthcare. A lack of knowledge about the right to medical healthcare and where and how to attain it was a major theme highlighted across the interviews. Fear of prosecution was mentioned as important in deterring respondents from visiting the GP. A third important factor was fear of financial costs. Mistrust in 'Dutch doctors' was also mentioned as a deterrent by the Somali participants. Practical barriers that impeded access to medical care included distance to the medical centre, inability to pay for transport and having to cancel work for the appointment. The majority of	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			the interviews reported that a GP was responsible for treating physical problems and had no expertise in managing mental health problems. The perceived attitude of the GP also kept respondents from talking about their mental problems. **Solutions to mental health problems** When possible solutions to mental health problems were discussed, all UMs agreed that receiving a residence permit was the most important factor. Their current undocumented status was discussed as causal to their mental health problems: work, income, accommodation and freedom of travel. However, nearly all UMs emphasised that medication alone could not solve anything. Many were reluctant to take psychotropic drugs. Interviewees mentioned a preference toward the GP as a means of support and as someone who listened, encouraged and provided professional advice.	
Fish, Fakoussa (2018)	Qualitative	This project sought to enhance and expand professional understanding and language regarding	**Context:** The study was conducted in the UK, and the participants' countries of origin were not specified. 10 people took part in the focus groups, 5 were female and 5 were	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
		culturally diverse perspectives on mental health and well-being and establish service user-led ways to improve the tapestry of support in Plymouth.	male. Age was not specified but the study included participants aged 18 and above. Anxiety and Depression were the mental health issue on which the study focused. **Decrease in mental health** Linked with people's statements about the positive impact of connection, a lack in social environment was discussed as being implicated in the deterioration of mental health and well-being. Participants commented on the detrimental impact of negative social experiences, due to racism or misconceptions about refugees. Many contributors commented on the importance of language, both in terms of acting as a potential barrier to connecting and sharing issues and feelings of importance with others. Language barriers were considered a hindrance to explaining mental health issues and internal states to others. Significant levels of stigma and taboo (within their own ethnic community)around experiencing poor mental health and how this can pose a barrier to seeking support were discussed by participants.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			The system The detrimental impact of the asylum seeking system on mental health and wellbeing was discussed by many. Even after people have gained refugee status, anxiety continues as a result of the temporary nature of their status. Also difficulties with housing and job-seeking requirements can cause considerable additional stress. Several contributors expressed the view that availability and access to mental health and well-being services was often unclear and referral to specialist mental health services were only made if asylum seekers disclosed experiences of torture in their claim forms. The importance of mental health and well-being services that are accessible to females from cultures in which women are not permitted to go out on their own or enter rooms alone with a male was discussed. Many contributors felt that the meaning and understanding of mental health was diverse and often unclear to different people and that the concept of there being various levels or grades of mental ill health was not always commonly understood. Interviewees often discussed having a more dichotomous understanding	

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			and thinking of poor mental health as an extreme. Isolation and loneliness, particularly for women, as a contributor to poor mental health and well-being was discussed by a few participants. The sense of the asylum system itself being experienced as a potential 'killer' for people was reported. Participants spoke about the levels of stress induced by being left in limbo, the interview questions you are forced to endure and the depression induced by not being able to take up work during this long 'waiting' period. **Support of good mental health** Participants discussed the importance of having meaningful occupation. This can, in turn, provide them with a sense of purpose and a distraction from otherwise anxiety provoking negative thoughts. The theme of occupation appeared strongly interwoven with the asylum seeking process, as asylum seekers are legally prohibited from taking a job. This strongly interferes with people's wishes to contribute. Most participants highlighted the positive influence of connection with others on their mental health and well-being. Several people highlighted the need for opportunities to	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			connect with others from outside of their own cultural and linguistic background. Barriers to connection included language issues, lack of community spaces, cultural differences (often poorly understood by services), gender and discrimination. Participants discussed the role for local services to become more aware of cultural and religious issues and issues affecting females in order to make access more appropriate. Participants felt that service users should and could have more input and leadership within developing services for their own needs. Support, either from peers or professionals, was identified as very significant for maintaining good mental health and well-being in the stressful circumstances of seeking asylum or becoming a refugee.	
Smith, Raynish, Hoang, Mond, Hannah, McLeod, Auckland, Slewa-Younan (2019)	Qualitative	To examine the resettlement experiences of refugees living in regional Australia, focusing on mental health and support services, including barriers to access.	**Context:** The study was conducted in Australia, and the participants' countries of origin were Afghanistan, Bhutan, Burma, Sierra Leone, Sudan, Iran. 24 people took part in the interviews and focus groups, and the participants' gender was not specified. Age was not specified but the study included participants aged 18 and above. PTSD was	Fair

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			the mental health issue on which the study focused. **Mental health of former refugees** Difficulties accessing employment, housing and learning English were described as major stressors. Trauma from past experiences continued to disturb many, including the guilt and responsibility felt for family back home, which negatively affected daily functioning. **Barriers to accessing mental health services** Limited grasp of English, and difficulty understanding the Australian health system, hindered access. Reliance on children to interpret during appointments was considered a major issue. Participants spoke of cultural misunderstandings relating to treatment, which adhered to a Westernised medical model, failing to incorporate participants' culture or beliefs. The absence of trauma-informed care was also mentioned as an issue.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Rowley, Morant, Katona (2019)	Qualitative	To explore experiences of vulnerable refugees—having previously experienced extreme cruelty—in the first year after being granted leave to remain in the UK, with particular focus on the impact of experiences on mental health	**Context:** The study was conducted in the UK, and the participants' countries of origin not specified. 9 people took part in the interviews, 5 female and 4 male. Participants' age was between 20 and 59 years. Depression and PTSD were the mental health issue on which the study focused. **Experiences in transition** Respondents' lived experiences were impacted by practical issues in the transition period, therefore we provide an overview of the most significant challenges described after receiving leave to remain. This provides context for respondents' accounts of their mental health and wellbeing. Four major themes captured transition experiences: issues in the first 28 days before withdrawal of Home Office support; difficulty interacting with services and the public; financial concerns; and housing problems. **Mental health** Low mood was frequently reported in relation to the challenges described in the transition period. Vulnerability and housing	Fair

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			worries were reported more frequently by female participants, particularly those with children across both genders, feelings of safety and relief upon attaining leave to remain quickly faded, as the stressors experienced whilst claiming asylum were replaced by new concerns. These centred around uncertainty about the future and having to rely on services such as the council. The effects of past trauma continued into this transition period; all participants had a diagnosis of PTSD and many were experiencing continuing debilitating symptoms such as nightmares and flashbacks. Participants regularly reported that PTSD symptoms could be triggered by new problems experienced in the post-migration context. **Interpersonal Relationships** Post migration experiences seemed to disrupt relationships. Participants described feeling lonely, with a lack of social support. In their roles as single mothers some participants explained how problems increased isolation, for example being moved away from support networks, and not being able to find work.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Golembe, Leyendecker, Maalej, Gundlach, Busch (2020)	Qualitative	To investigate LGBTQ+ refugees' experiences of distal and proximal minority stressors as well as their mental health burdens during the post-migration period.	**Context:** The study was conducted in Germany, and the participants' countries of origin were Iraq, Syria, Morocco, Lebanon, Kenya, Malaysia. 26 people took part in the focus groups, 2 were non-binary, 3 were female and 21 were male. Age was between 18 and 46 years. Anxiety, and Depression were the mental health issue on which the study focused. **Experiencing Discrimination** All participants reported experiences of discrimination in a multitude of ways at some point after their arrival in Germany: in various contexts (e.g., privately, institutional), based on various attributes (e.g., race, religion, gender identity), and from various offenders (e.g., white Germans, other refugees). Participants reported discrimination experiences based on numerous and intersecting attributes. Specifically, participants explained that they are discriminated against based on their gender identity/sexual orientation, their status as refugees.	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Mental Health Burdens Most participants reported distress, while also reporting low satisfaction with their lives. The following themes were established: internalizing problems and continuous suffering. Realizing that their mental health status has worsened in comparison with premigration seemed to be additionally distressing to some participants. Participants reported various mental health burdens, most often internalizing problems. These included symptoms of depression (i.e., hopelessness and negative affect), anxiety, exhaustion, and loneliness. Some participants tried to cope with their internalizing symptoms through substance abuse and self-harm.	
Aarethun, Sandal, Guribye, Markova, Bye (2021)	Qualitative	To explore how Syrian refugees explain and prefer to seek help for symptoms of PTSD and depression, and how their conceptualizations of these disorders and preferred help-seeking are affected	**Context:** The study was conducted in Norway, and the participants' country of origin was Syria. 31 people took part in the focus groups, of which 10 were female and 21 were male. Participants' age was between 19 and 56 years. Depression and PTSD were the mental health issue on which the study focused.	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
		by the migration-and resettlement process.	**The Nature of the problem** A few of the participants, both male, and female, used labels associated with psychological problems to describe the character's reactions, but PTSD was never named. Even though the participants never explicitly mentioned PTSD, they not only recognized the vignette character's situation, but also specifically identified with the outlined symptoms. These included nightmares, difficult memories, and thoughts of homeland and family. One of the men explicitly stated that the PTSD-character was depressed, and a few others recognized that part of the problem was psychological. Some of the participants said that they knew people who suffered from similar symptoms. Others fully distanced themselves and people their network from the symptoms displayed. **Preferred help-seeking and coping strategies** The preferred help-seeking behaviours were similar across the two vignettes but varied between men and women. Participants discussed several different help-seeking strategies, including challenges and barriers to seeking help	

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			(e.g. accessing care). In addition, there was also some discussion of different individual coping strategies. Male participants focused more than the women on individual self-help strategies and active coping strategies such as exercise. Despite this emphasis on seeking social support, cultural stigma connected to mental health issues affected the way, to whom, and to what extent participants considered it appropriate for the vignette characters to communicate their emotional distress. **Professional support.** The women in both the depression- and PTSD-interviews discussed how going to a psychologist often has a negative connotation in the Syrian culture Generational differences characterized all the male groups' discussions on preferred help-seeking strategies. The younger men suggested seeking formal support such as psychological treatment to a larger extent than the older men, who expressed more scepticism. Those who were sceptical towards seeking professional help in the depression-interviews, also described the symptoms as being caused by social or	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			relational reasons. An important finding is how the help-seeking and coping strategies discussed by the participants seemed to be affected by the migration and resettlement situation. Participants indicated that there is a difference between how they would seek help in Syria and in Norway for a problem. In Syria, relying on the social network would be the preferred strategy. Seeking social support was the first preferred strategy in Norway as well. However, some participants explained that because social support structures are not present in their original form in Norway and that the cultural stigma connected to professional help was perceived to be very different in Norway and Syria, they found it easier to seek professional (mental) health services in Norway if needed.	
Johnson, Allotey, Mulholland, Markovic (2009)	Mixed method	The aim of this study was to investigate whether Australian asylum policies and practices, which arguably violate human rights, are associated with	**Context:** The study was conducted in Australia, and the participants' country of origin was Iraq. 16 people took part in the interviews, and the participants' gender was not specified. Age was not specified but the study included participants aged 18 and above. Depression was the mental health issue on which the study focused.	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
		adverse health outcomes.	**Psychosocial variables associated with adverse mental health outcomes** Specific psychosocial variables (e.g. social support) that were associated with adverse mental health outcomes. Temporary Protection Visa (TPV) refugees revealed that they felt socially isolated owing to policy restrictions on reuniting with family members, and the structural barriers that prevented them from fully participating in society (e.g. not being able to access government-funded English tuition). Interviewees were particularly sensitive to not wanting to overburden important social ties. This was particularly the case with women, many of whom expressed the desire not to contribute additional stress to their children and husbands. **Policy restrictions** TPV holders perceived that they had little agency over their lives and they expressed anger at the lack of control over the refugee determination process. Their anger and frustration were compounded when after gaining refugee status, the policies in place imposed further barriers to achieving resettlement goals. Family reunion, access to language facilities, education and	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			employment remained out of their reach. Anger for interviewees was more likely to be directed inward at themselves, rather than expressed externally. Some internalised the dominant stereotype of asylum seekers as being 'undeserving,' or interpreted their experiences as god's punishment for previous wrongdoings. Others felt diminished by the treatment they had received by the Australian government. This was more often the case with interviewees with poor language skills, and who lacked education, were unemployed and had diminished family or other support.	
Coffrey, Kaplan, Sampson, Tucei (2010)	Mixed method	The aim of the present research was to examine the experience of extended periods of immigration detention from the perspective of previously detained asylum seekers and to identify the consequences of these	**Context:** The study was conducted in Australia, and the participants' countries of origin were Afghanistan, Iran, and other, non-specified Middle-Eastern countries 17 people took part in the interviews, 16 were male and 1 was female. Participants' age was between 28 and 57 years. Anxiety, PTSD and Depression were the mental health issue on which the study focused.	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
		experiences for life after release.	**Detention environment** Participants spoke of an environment characterised by confinement and deprivation. All made reference to loss of freedom and the harshness of conditions in the detention centres. Six participants who had been detained in off-shore centres were particularly aggrieved, and spoke about the deprivation of the detention environment. All participants referred to the disturbing effect of experiences such as witnessing mass riots, beatings of detainees by detention officers, fighting between detainees, acts of self-harm, suicide attempts, hunger strikes, and detainees who had become severely mentally unwell. Almost all participants expressed fears of being harmed by the detention environment. Injustices experienced whilst detained fell into the following three broad categories: being subject to criminalising, punitive and humiliating practices and behaviours; instances of apparent disregard for due process relating to visa applications; and experiences relating to the perceived arbitrariness, inhumanity and senselessness of rule-making in detention. All participants spoke of a sense of isolation	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			and alienation, accentuated by the loss of family and other significant relationships while detained. Hopelessness and demoralisation were dominant and recurring themes for almost all participants. **Post-release environment, mental health and relationships** All participants experienced severe difficulties following release from detention, which continued after gaining permanent residency. These were manifest as ongoing experiences of insecurity and injustice, difficulties with relationships, profound changes to view of self and mental health symptoms. About half the participants spoke of resorting to isolating themselves. Among the reasons provided for isolation were a need to avoid noise and the company of others; a preference for quiet thinking rather than socialising, and to stay away from untrustworthy people. A prominent recurring theme for almost all participants was their perception that they had changed irrevocably as a person. These changes were articulated primarily in relation to a sense of having failed in their role as	

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			protectors and providers for their families, and as a more general loss of agency. Participants lived with significant symptoms of depression, anxiety and PTSD, low quality of life, and persistent and debilitating problems with concentration and memory. For five participants the level of hopelessness was such that suicidal ideation was a prominent feature in their interviews. A majority of participants described regulating their psychological state after detention through activity and avoidance of distressing thoughts. These participants occupied themselves with prayer, study, work or sport. They indicated that these activities helped with depression.	
Simich, Este, Hamilton (2010)	Mixed method	To examine family and social factors that affect refugee mental health during resettlement by presenting qualitative analysis of the concept of home and its functional and psychological meanings.	**Context:** The study was conducted in Canada, and the participants' country of origin was Sudan. 30 people took part in the interviews, and participants' gender was not specified. Age was also not specified but the study included participants aged 18 and above. Anxiety was the mental health issue on which the study focused.	Poor

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Emotional support For Sudanese participants, the lack of social support received from extended family members who are not in the resettlement country contributed to a sense of loss and displacement. Increased safety in the country of refuge was perceived as minor comfort considering the loss of customary social support. **Fulfilling social roles and expectations** The concept of home was also described positively in terms of family roles and responsibilities to extended family members. The traditional interdependence and mutual support that is perceived to be a strength of Sudanese families can become a burden when families are divided and adults must support family members both in Canada and 'back home'. **Problem solving and conflict resolution** In contrast to the ideal family life in Sudan, Sudanese households in Canada can be marred by intergenerational strife, increased anxiety, mounting frustration, and fewer sources of social support. Significant concerns from both women and men about the stability of Sudanese	

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			marriages in Canada also emerged. Most striking was the association of increased family conflict with the loss of elders who customarily mediate to resolve such problems in the country of origin. **Perceived impact on community mental health** Mental health was associated with social support available at home, whereas mental distress was associated with social deprivation in Canada. Not having a sense of home, made coping with resettlement stresses a lonely experience. This deterred formal support-seeking, and increased mental distress. Home life in Canada was perceived to be a source of mental distress, because conflict was seen to increase when social support and other personal resources decreased. When facing difficulties, Sudanese refugees rely on one another. However, informal family and community supports alone cannot meet all of participants’ settlement and health needs.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Murray (2012)	Mixed method	To examine the individual and contextual factors that influence the resettlement experience for adults from Sudan being resettled in Queensland, Australia.	**Context:** The study was conducted in Australia, and the participants' country of origin was Sudan. 10 people took part in the interviews, 5 male and 5 female. Age was between 28 and 44 years. PTSD was the mental health issue on which the study focused. **Initial impressions of resettlement** They emphasised aspects of the initial resettlement program that provided a general orientation to life in Australia. The importance of orientation and initial supports was influenced by previous exposure to western culture, which varied across participants. **Negative influences on resettlement experiences** Participants cited the government resettlement programs as having a negative influence on their life in Australia. Participants reported they were dissatisfied with the generalised nature of the programs and the lack of cultural understanding by resettlement service providers. Participants described specific aspects of the resettlement program,	Good

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			including lack of response from service providers regarding family concerns and problems with the healthcare systems. Discrimination was a significant negative influence on their experiences in Australia. People talked about experiencing discrimination within the larger community, i.e. the work environment and in trying to secure a job or housing. **Positive influences on resettlement experiences** People reported receiving assistance at particular points in time that influenced their settlement trajectories. Three participants talked about assistance they received from people and organisations in applying for jobs and learning how to navigate the job market. Participants talked about specific people, such as their romantic partners or members of the Australian community as being significant sources of support in their lives. **Definitions of the good life** Participants repeatedly emphasised social dimensions when defining 'the good life', with all but one of the participants	

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			highlighting the fundamental importance of social ties that underscore the collectivistic Sudanese culture.	
Sulaiman-Hill, Thompson (2012)	Mixed method	To examine the resettlement experiences and provide data of well being and psychological distress for Afghan and Kurdish refugees settled between eight and 20 years in New Zealand and Australia.	**Context:** The study was conducted in both New Zealand and Australia, and the participants' countries of origin were Afghanistan and Kurdistan. 81 people took part in the interviews. Participants' gender was not specified. Age was also not specified but the study included participants aged 18 and above. Depression was the mental health issue on which the study focused. **Main sources of distress** Themes reported by the majority of participants responding to this question, reflected ongoing psychological difficulties related to past experiences, re-traumatization and news from home. Participants reported too much time to introspect, and generally poor mental health. This theme was termed 'Thinking too much', and was a common descriptor used by study participants for introspection and depressive and anxiety symptoms. Separation from family, especially those	Poor

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			still in conflict settings, was another major source of stress. Feeling overwhelmed was also experienced by a number of male respondents. "Thinking too much" was also the main concern for females, but separation was relatively more important than for males. A similar proportion of males and females felt overwhelmed and constrained in their lives. Stressors identified by women more than males included disempowerment, status dissonance, and social isolation. **Coping strategies** Exercise was the most commonly mentioned way of dealing with psychological distress. Although used by both men and women, three quarters of the people discussing exercise were men. Socializing was the second most common method of dealing with stress. This was favoured by women. Over half of the women interviewed reported discussing their problems with friends or family. Since it was often considered inappropriate to discuss some concerns with men or people outside the direct family group, phoning mothers and sisters overseas was almost universally reported, despite the cost.	

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			These family members were able to provide a level of emotional support that was otherwise lacking in their post-resettlement environment. Avoidance strategies and relaxation techniques were used equally by both men and women, however, religious practices such as reading the Qur'an and praying proved particularly important for females.	
Warfa, Curtis, Watters, Carswell, Ingleby, Bhui (2012)	Mixed method	To compare two samples of Somali refugees drawn from two urban settings in the UK (London) and USA (Minneapolis).	**Context:** The study was conducted in both the UK and USA, and the participants' country of origin was Somalia. 26 people took part in the focus groups, 14 female and 12 male. Participants' age was between 18 and 59 years. PTSD and Depression were the mental health issue on which the study focused **Political discourse on migration, thwarted aspirations and psychological distress** Participants from London felt that their new identity as refugees devalued their past lives and ruptured their personal narratives and meanings about their lives. The London participants particularly saw the attitudes of some public service	Good

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			providers towards refugees as disrespectful, dehumanising and disempowering. The Minneapolis lay group also noted the negative status attached to the refugee identity. Both Minneapolis and London groups made references to a perceived link between a devalued refugee identity and psychological distress. **Unmet expectations, material conditions, changing gender roles and poor mental health** Somalis find it difficult to integrate or overcome the initial cultural shocks they have experienced. This is partly because of the marked distance between the high living standards some Somali refugees had expected in the host nations and the actual reality of the difficult life situations. This was compounded by the stigma of being a refugee and having to take on a new refugee identity. **Pre-migration social status, loss of homeland and mental illness** Participants discussed the mismatch between pre-migration life expectations and status and post-migration realities of refugee existence and status. An area of	

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			crucial disagreement was the mental health consequences of unmet expectations due to changes in Somali traditional gender roles. This, according to the male professional, has contributed to the men's mental health instability. For Somali men, this seems to undermine their self-perceptions of their masculinity, with dire consequences for their self-esteem and thus mental well-being. Gender roles were also seen to affect women's mental wellbeing. While the financial benefits of long working shifts was seen as essential for adequate survival, it was also perceived as a contributing cause of mental illness and social problems such as marriage breakdowns. Somalis from Minneapolis and London linked various psychological problems with a host of perceived pre and post-migrations risk factors. These were interconnected and included the loss of 'homeland', stigmatised refugee identity, unmet expectations and difficulties in the process of settlement in the host nations. Specifically, poor socioeconomic conditions and loss of former social and professional status, changes in gender roles, challenges to masculinity and thwarted aspirations,	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			were all seen as related to psychological distress.	
Sulaiman-Hill, Thompson (2012)	Mixed method	To explore resettlement experiences and major sources of stress and describe the coping strategies used to deal with it.	**Context:** The study was conducted in both New Zealand and Australia, and the participants' countries of origin were Afghanistan and Kurdistan. 124 people took part in the focus groups. Participants' gender was not specified. Participants' age between 18 and 70 years. Anxiety was the mental health issue on which the study focused. **Positive aspects of life** The importance of living in a safe and secure environment was the most highly regarded feature of participants' lives, mentioned by all groups. Lifestyle features, societal organisation and friendly, welcoming people were also valued. A few participants mentioned education and opportunities for women; however, these appeared to be less important in the long-term than for those more recently arrived.	Poor

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Negative aspects of life Social/family/isolation was the most common theme discussed, and was widely spread amongst Afghan and Kurdish respondents in both Australia and NZ, and by gender and age group. Lack of extended family was a particular concern, and a few women attributed limitations of their own educational or employment opportunities to absence of family support for child minding. **Main sources of distress** Discrimination and job opportunities were seen as a particular challenge. This theme encompasses concepts of aimlessness, where participants' lives lack a sense of purpose or direction and they continue to be demoralised by the challenges of trying to get ahead and succeed, given inherent systematic constraints facing them, such as lack of recognition of overseas qualifications and discrimination. This, in conjunction with re-traumatisation from knowledge of ongoing conflicts in their home country and separation from family, continues to impact on the lives of these former refugees many years after settlement.	

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
Piwowarczyk, Bishop, Yusuf, Mudymba, Raj (2014)	Mixed method	To examine both concepts of mental illness in addition to attitudes and beliefs about treatment as well as potential barriers to accessing mental health services.	**Context:** The study was conducted in both the USA, and the participants' countries of origin was Somalia and Congo. 30 people took part in the focus groups, all of whom were female. Participants' age was between 18 and 36 years. Anxiety and Depression were the mental health issue on which the study focused. **Definitions of mental health problems** Mental health concerns only in very extreme situations (i.e. severe mental health issues). These include engaging in erratic or noticeable behaviours such as 'removing their clothing'; only in these types of situations would help be sought and possibly acquired. **Causes of and beliefs about mental health problems** There were a paucity of words to describe these problems in the past and, generally, a denial of the existence of emotional difficulties except to describe those with serious mental illness. Many difficulties were placed in the context of ordinary life or related to the immigration experience that the participants described.	Poor

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			Barriers to seeking professional mental health services There are traditional ways within the community of dealing with mental health problems. People are expected to turn to families, friends, and religious leaders. There will be pressure from the community not to seek formal mental health services. It is expected that one will turn to wise people in the community. Psychiatric services are not routinely sought in the participants' countries of origin.	
Yako, Biswas (2014)	Mixed method	To explore experiences of refugees from Iraq and evaluated experiences related to acculturation in the United States.	**Context:** The study was conducted in the USA, and the participants' country of origin was Iraq. 5 people took part in the interviews, all of whom were male. Participants' age was not specified but participants were 18 or above. Depression was the mental health issue on which the study focused. **Context of leaving Iraq** Respondents shared similar experiences of fear and violence and reported fleeing their homeland with only their passport, marriage licenses, the clothes they were wearing, and the money they had.	Fair

Author & Year	Study type	Study aims	Findings / Reported Themes	Quality Score
			This is not what we expected to find Respondents said that the US was not the 'heaven' they believed it to be. Most, if not all of the resources they had was spent during the 'waiting period'. Many participants found themselves in dire financial situations soon after arrival. **Suggested alternatives** All participants identified the same three areas as the greatest needs required to be met in order to improve the condition of new refugees: adequate housing in safe environments, financial aid for at least a year or two, and an English speaking programme for at least one whole year since English is too difficult to learn in less.	

The table above (Table 3-3) outlines the themes and main finding from each of the included studies which compose the identified first order constructs. In summary, the table indicates that there are three main levels to consider when exploring how post-migration life experiences intersect with mental health in asylum seekers, refugees and undocumented migrants. These include issues that affect individuals at a personal level, such as:

- Language issues and interpretation (e.g. Aarethun et al., 2021; Smith et al., 2019).
- Gender, with men reporting higher levels of anger as a response to emotional difficulties (e.g. Tilbury, 2007).
- Age, with older people less likely to access mental health services due to cultural beliefs and perceived stigma (e.g. Aarenthun et al., 2021).
- Religion (e.g. Golembe et al., 2020).
- Community (e.g. Fish & Fakoussa, 2018), and family (e.g. Warfa et al., 2006; 2012).

Community and family in particular were perceived as supportive but also, in some cases, hindering in relation to help seeking behaviours (Quinn, 2014). Whilst family was described as a central source of support in some studies (e.g. Kokanovic et al., 2010; Donnelly et al., 2011; Rowley et al., 2019), family and community prejudice in relation to mental health could also lead to feelings of marginalisation amongst individuals who experienced mental health difficulties (e.g. Quinn, 2014; Aarenthun et al., 2021). Stigma from family, friends and one's own ethnic community were also considered as barriers to accessing mental health care (e.g. Quinn, 2014; Fish & Fakoussa, 2018). In one study, which included people who identify as LGBTQ+, discrimination by the host community was the main source of post-migration difficulty described by participants (Golembe et al., 2020).

At a broader level, participants talked about the negative impact of the asylum system and how issues pertaining to it also ramify into financial, unemployment (e.g. Tilbury, 2007; Quinn, 2014), housing e.g. poor housing conditions Warfa et al. (2006; Tilbury, 2007; Fish & Fakoussa, 2018; Smith et al., 2019; Rowley et al., 2019), and their inability to fully participate in society. For example, via employment restrictions for asylum seekers (e.g. Johnson et al., 2009). For individuals who have experienced protracted migration detention, the aftermath included worsening of mental health and experiencing social isolation and internalised stigma (e.g. Coffrey et al., 2010). In this context, third sector organisation were described as the sole accessible source of community support aside from family and friends (e.g. Quinn, 2014). Limited geographical mobility due to National immigration controls, and the restrictions these pose on movement was described to impact on healthcare access and on mental health, and resulted in community fragmentation and difficulties registering with a GP (e.g. Warfa et al., 2006; Kokanovic et al., 2010; Teunissen et al., 2014). Once access to a GP was achieved, some studies showed that difficulties around language and interpretation were preventing individuals from receiving the healthcare they required (Teunissen et al., 2014), including access to counselling services (e.g. Donnelly et al., 2011). On the other hand, positive experiences of accessing care include good doctor-patient relationships and GPs' positive and supportive qualities (e.g. Teunissen et al., 2014).

Mental health was also discussed in relation to idioms of distress as participants in some of the studies did not always view their emotional states as being accurately captured by biomedical concepts (e.g. depression) (Tilbury, 2007; Kokanovic et al., 2010). This, in some cases, hindered access to services also due to stigmatising views present within the community in relation to psychiatric diagnoses (Quinn, 2014). However this was not the case for all the selected studies. For example, Donnelly et al., (2011) reported that several participants welcomed biomedical interventions for their mental health symptoms. Other issues that hindered access to healthcare included receiving appropriate information and poor understanding of the healthcare system in the host country (Smith et al., 2019). In terms of accessing mental health support, age was identified as a barrier and older people expressed more distrust in western psychological services than younger people did (Aarethun et al., 2021). Studies also mentioned that religion was a primary help-seeking behaviour rather than healthcare services as accessing help from a religious community figure was considered more culturally appropriate (Piwowarczyk et al., 2014). The coping strategies identified in the studies included religiosity and engaging with one's own religious community, and physical exercise (e.g. Sulaiman-Hill & Thompson, 2012).

3.4.4 Second Order Constructs: Illustrating how studies' findings and themes translate into one another

After the initial data extraction (Table 3-2) and the identification of first order constructs as these were presented by the authors of each individual study (Table 3-3), the next step of this meta-ethnography includes the development of second order constructs (Table 3-4). In order to achieve this, the different themes that were identified in the included papers (i.e. first order constructs) underwent the process of reciprocal translation (Aitken et al., 2008). This process does not include interpretations of the data (Frances et al., 2019). Instead, this step includes the documentation of the ways in which themes from different studies translate into one another. The translation of the studies, as discussed earlier in this chapter, allows for the identification of patterns and common themes across the studies. In order to facilitate reciprocal translation, studies were compared in a reflexive manner. The identified commonalities and themes were labelled based on their saliency and are reported in Table 3-4. Here, both qualitative studies and mixed methods studies are reported together to highlight that our aim was to integrate studies based on their reciprocal translation rather than study design. In the interest of consistency and clarity, studies are presented chronologically with qualitative studies being presented first.

Through the process of reciprocal translation, second order constructs were identified: Descriptions of community and family as a 'double edge sword'; Access to mental healthcare; Mental health within its sociocultural context. Descriptions of community and family as a double-edged sword refers to the dual function of these social networks which, at times, are a source of support (e.g. participating in community gatherings; having the support of one's family during difficult times). However, for other individuals, these same networks are discussed as a source of stigma and distress (e.g. LGBTQ+ individuals; women). Access to mental healthcare identified that due to factors such as lack of interpreting services, or limited knowledge of the healthcare system (e.g. how to register with a GP) participants in the selected studies struggle to access the healthcare they require, particularly in relation to mental health. Finally, mental health in its sociocultural context pertains to gender and intergenerational barriers that exist in relation to experiencing and expressing difficulties related to mental health.

Importantly, a key distinction between access to mental health care and mental health within its sociocultural context is that the latter does not include the healthcare system *per se*, but rather issues pertinent to cultural beliefs (e.g. religion) and social aspects of mental health experiences (e.g. discrimination, intergenerational conflict, gender). In order to become eligible for inclusion in Table 3-4, themes had to be present in at least half of the included studies (N=20) (Frances et al., 2019).

Table 3-4 Description of second order constructs

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
Warfa, Bhui, Craig, Curtis, Mohamud, Stansfeld,McCrone, Thornicroft (2006)	Community fragmentation was discussed in light of perceived discriminatory housing policies. Culture and religion were considered positive aspects of community, however, within the Somali community, professional participants viewed Somali people as nomadic and this word was used in a disparaging way to refer to less educated Somalis. This could be due to factors such as professional training, acculturation experiences in Britain, and moving away from identifying with Somali people. Residential mobility was also associated with fewer social networks and poorer mental health. Family adjustment issues due to frequent moving were also reported, in the context of distress. Establishing some kind of social and cultural	Residential mobility, healthcare access, and registering with a GP, along with getting prescriptions and appropriate translation services, were considered important barriers by participants. In addition, residential mobility was illustrated to potentially discourage professionals from pursuing housing solutions or healthcare interventions if the Somali community is seen frequently moving. In turn, residential mobility can compromise delivery of care and adherence to treatment. Either because of dissatisfaction with healthcare provided in primary care or difficulties registering with a family doctor, interviewees mentioned accessing emergency department when unwell. Participants with unmet healthcare needs had high rates of contact with refugee services and, to a lesser extent with doctors other than GPs and psychiatrists. Also	Residential mobility / instability was discussed as detrimental to mental health. This was discussed as an overarching risk factor for mental health and included homelessness, post-traumatic experiences, attachment, adjustment, community fragmentation, language issues, racism and discrimination. Health, and the social effects of constant change of address, and common mental and physical health problems among Somali refugees were prominent. Movement is generally from a relatively deprived area to another. This includes short lets in temporary accommodation, poor housing conditions, overcrowding, racism and discrimination, as well as poor employment opportunities. Due to racism and racial abuse and violence some Somalis were forced to flee their permanent residence. Having to accept allocated temporary housing for

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	understanding of the environment in which they have moved is considered one of the main problems by participants.	problems related to professionals' unfamiliarity with the cultural and medical practices of Somali refugees were also viewed as barriers to accessing care. GPs in Somalia would take thorough examination, taking considerable time in consultations. This, however, is not always possible in the UK, leading to unmet expectations relating to the healthcare system.	fear that refusal can jeopardise their chance of better housing offers (however, often moving between areas of deprivation) was a considerable source of stress and worry. Residential instability, homelessness, past trauma as well as poor language were considered detrimental to mental health.
Tilbury (2007)	In relation to mental health, community gossip and stigmatisation were reported. Expressions of distress by individuals were seen as complaining by members of the community. In addition, the study reports high levels of stigmatisation of individuals suffering from severe mental health problems. Expectations from family back home, and demonstrating successful resettlement were also sources of stress. Also	Language and cultural understandings of mental health are often seen as a barrier to accessing services.	Biomedical concepts of mental health meant little to rural and less educated Ethiopians in this study. There were differences in knowledge and understanding of depression between rural and urban interviewees. In urban areas these terms (anxiety and depression) are used, albeit in their native language. Participants related the saliency of social issues to mental health in the form of negative emotional reactions. Feelings of low self-worth and stress stemming from experiences of not having a job,

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	feeling as a guest in new country and experiences related to being a refugee were considered stressful too. Lack of community support and traditional practices of regular, often daily visits, which ensured people felt connected and problems were dealt with before they became more prominent mental health issues (e.g. depression) were viewed as important though, at times, lacking in the new environment. This, paired with a lack of social support and social connection were discussed as important negative experiences. Also, racism, stigma and discrimination from broader community were mentioned by participants.		lack of recognition of educational achievement and lack of recognition of work experience were often discussed. Also, housing, employment, gender issues/inequality, racism, culture shock, poor access to services, isolation, lack of support and lower status, were discussed by participants as being related to negative emotional reactions. Difficulties related to family re-unification and living in limbo, whilst at the same time having to maintain trans-national flows of resources was discussed as highly stressful. Mental health was related to broader social issues such as loneliness, isolation, sense of loss and lack of support, survival guilt, fear about relatives' wellbeing, and not knowing family's whereabouts – these experiences were discussed in terms of 'burning inside and being hunted', which the participant also related to Western psychiatric categories of major depression and anxiety.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
			Men discuss emasculation and gender issues and difficulties related to adapting to a new country: unemployment, loss of status, gender based aggression (to women) and aggression toward children. Stress related to disempowerment and confusion (perceived loss of role in the family) and somatisation. From mothers' viewpoint, loss of traditional family relations was mostly a depression causing issues for children. This is interwoven with intergenerational conflict and was distressing for both young and old individuals in the community. This intergenerational conflict for young people is in relation to values that are anathema to those present in Australia and bring conflict with African parents, causing loss of respect and leading parents to feel even lower sense of control and self-worth. These, in turn, impact on their experiences of mental health.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
Kokanovic, May, Dowrick, Furler, Newton, Gunn (2010)	A recognition of the stigmatising effects of mental illness, particularly in Asian communities, often prompted GPs to avoid terms such as 'depression' and instead use words like worries, sadness, stress, tension (these words tend to encompass experience rather than diagnostic categories). In this case, the 'external community' tries to adjust to the needs of the patient, based on potential marginalising attitudes which stem from the patient's own community. Experiencing stigma (e.g. fear of being a burden to family/friends – fear of causing loved ones stress or worry) prompted individuals to avoid reaching out (i.e. engaging in help seeking behaviours). However, participants also reported feeling guilt or shame if they did not disclose issues to family members.	Importance of avoiding the imposition of Western views on mental health which are embodied by the biomedical model. In addition, respecting cultural differences and providing timely access to professional interpreters was seen as important. Presenting to GP with bodily symptoms of deep distress was frequent. However, GP's response was to immediately engage in a process of re-constructing the manifestations of distress as psychological dysfunction. Culturally-based 'moral -values' and patient's definition of the problem was met with resistance by GPs. GPs tended to peel away patients' culturally embedded and value laden understandings of mental health and provided a medical/psychological explanation for patients' issues. Whilst participants discuss many-layered social identity as implicated in causing distress, the solutions (from healthcare professionals) is	Radically different cultural meanings found in Australia (self-identity and contrasting systems of meaning) were identified as contributing to patients' distress. One interviewee, went to their GP with complaints of feeling angry due to living in poverty and isolation, in substandard accommodation, and caring for father with no support. Gender differences in distress (e.g. being a single mother) were also evident. As patients accept doctor's views (e.g. depression) their own understanding is lost (this shows that language is more than mere words, it is understanding -important to bare this in mind in relation to English proficiency and healthcare access / satisfaction). East Timorese and Vietnamese patients were often reluctant to view depression as an illness. East Timorese and Vietnamese participants emphasised the importance of practical help e.g. GP writing a letter of support for permanent

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
		seen as getting to the individual's issue (i.e. psychologising /diagnosing). Cultural differences made the attribution of reported symptoms to depression difficult for GPs. Mental health is viewed as a collective and family problem rather than 'illness' in these communities. Instead of mis-understanding what 'mental health is', perspectives from participants emphasise communal reliance rather than individual identity. In this research there is a clear sense of participants' rejection of the idea of 'internal dysfunction' [bio-psychiatric understandings]. Nonetheless, GPs emphasised being guided by patients' own model of 'illness' & cultural expressions and experiences of distress. Doctor-Patient relationship was key in negotiating 'depression' between doctors and patients in patients' recovery from 'depression'. Uncertainty around GP knowledge of mental health, and importance of finding acceptable and sustainable ways of accessing care	residence, assisting in finding accommodation, helping solve relationship difficulties.

Author(s)	Descriptions of community and family as a ‘double-edged sword’	Access to healthcare	Mental health within a sociocultural context
		were often mentioned by patients. However, once a GP was accessed, satisfaction was high. A considerable barrier to access to mental health care was fear of deportation. Another was lack of knowledge of the healthcare system.	
Donnelly, Hwang, Este, Ewashen, Adair, Clinton (2011)	Family was identified as the most crucial protective factor for mental health. Expanding social support to improve mental health, and a lack of support added to the burden of caring for family members. This highlights the complexity of caring for family members affected by severe mental health problems. Support systems such as family, friends, and ethnic community were seen as crucial, powerful and protective. However, negative marital relationships (e.g. being emotionally and sexually abused by spouse), and the	Help seeking was often delayed for mental health due to discrimination, stigmatisation (from own community), denial, fear of the unknown consequences of diagnosis (e.g. deportation, family separation, losing children), fear of discrimination from ethnic community and, more generally, stigma. Participants discussed personal determination, willpower and the importance of person’s personality and level of self-acceptance for help seeking behaviours. These include positive self-talk and reaching out for help with mental health.	Difficulties discussing mental health within a western based understanding of mental health – lack of cultural sensitivity leads to further isolation. Also, gender hierarchy and male domination affects mental health in women. Canadian healthcare system not perceived as sensitive to cultural needs of migrants, resulting in further isolation Knowledge and awareness of mental illness by family members were important components in continuing to access treatment,

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	burden related to care for relative with poor health, and community stigma (from one's own ethnic community) about experiencing mental health issues were also indicated as detrimental to wellbeing. Some participants waited until problems grew beyond their control before accessing healthcare services. Participants discussed this issue in light of attitudes to mental health in the community.	Participants' personal experiences (or lack of experiences) related to biomedicine, and their fear and lack of awareness in relation to mental health issues was influential to their help seeking for mental health problems. Language issues reduce access to healthcare, and participants' ability to and confidence in reaching out for help. Timely access to care was also delayed or absent because of mistrust in Western biomedicine. This was discussed in relation to lack of knowledge / information; stigma / taboo associated with having mental health issues, and poor knowledge of mental health and related services. Participants expressed feeling that the current health care system does not meet their needs. Lack of professional interpretation, coupled with participants' limited language abilities and cultural differences in discussing mental	thus making education of family members important Religion and religious beliefs were reported as deterrents from accessing Western biomedical treatment.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
		health disables many from accessing and benefitting from available mental health and counselling services, including community-based health programmes. Confidentiality was also a potential barrier to accessing mental health services, which included lack of knowledge regarding available mental health services.	
Quinn (2014)	First port of call would be family and friends for most groups. However, in relation to help seeking behaviours, participants differentiated between mild mental health, for which they sought help from trusted friends and more severe mental health, which prompted them to access a GP. Nonetheless, in the instance of seeking professional care, it was mentioned that they (i.e. friends) would take the unwell person secretly to a doctor,	Participants felt that AS are not trusted or listened to by the authorities (including GPs). This leads to a sense of helplessness/hopelessness which discourages help seeking. Groups indicated the importance of public education in relation to improving access to mental health care (Iranian/Pakistani), television school and colleges (Somali), group events or using the internet (Sri Lankan). Barriers also include language (most groups), resistance to change because of strongly held	Stigma in relation to mental health translates into stigma towards people with mental health issues. (i.e. in the African women's group this translates to 'rejection' – Iraqi/Iranian, fear of violence or being accused of a crime if seen with person with mental health problem – Pakistani women interviewees equated mental health with becoming an outcast i.e. not receiving a marriage proposal.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	due to stigma in the community. This was explicitly discussed also by participants in the Sri Lankan group, where it was mentioned that the last place you would go to for support is your own community because of shame. Throughout this research, participants from different backgrounds discussed that the source of mental health support (i.e. family and friends) can also become a source of shame. Outside of one's immediate community, sources of support included third sector organisations and the main housing provider.	beliefs and overall unpopularity of mental health (Sri Lankan). Also, asylum seekers did not feel comfortable accessing GPs and opening up about mental distress due to stigma from their own community (about going to a GP for mental health reasons) and internalised stigma. In adjunct to this, self-perception of asylum seekers as not trusted in the host country. Importance of maintaining confidentiality was frequently mentioned by participants.	
Teunissen, Sherally, van den Muijsenbergh, Dowrick, van Weel-Baumgarten, van Weel (2014)	Alternatives to seeking GP help for mental health included working (when possible), reading, watching TV, joining community activities and asking advice from friends. However, fear of 'gossip' within the community is reported as a source of stigma	Not all interviewees were registered with a GP: one did not know she had the right to medical care, and one for fear of deportation mentioned not getting registered. Access to care was thwarted due to residential mobility and it took up to 6 years to gain access to a GP in the first	Physical symptoms were prevalent, only 2 of 15 interviewees mentioned mental health problems immediately when asked for reason for visiting GP. Of these, one mentioned psychological problems and another expressed needing psychotropic medication.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	(from participants from Dominican Republic, Morocco, Ghana, Somalia) fear of being shunned (Sierra Leone, Somalia) and, for participants from the Philippines, discussing mental health was not seen as acceptable by their own community or indeed in their country of origin. Third sector organisations played an important role in facilitating access to professional mental health care.	place. The role of the GP was mainly seen as doctor who cures only physical problems. GP competence in relation to mental health is questioned within interviews. Two undocumented migrants reported going straight to the emergency department when confronted with serious illness – these were the 2 not registered with a GP. Language difficulties and the use of family members as interpreters were mentioned in the context of barriers to accessing care. Using family members as interpreters was also discussed by participants as a threat to confidentiality, as was the understanding of their medical information being kept in a PC. Doctor-patient relationship was seen as very important. This was more easily achieved through doctor performing a physical examination (as this was expected by participants). Negative GP experiences included perceived	Solutions to mental health problems were seen from the standpoint of solving social issues e.g. receiving a residence permit and solving problems related to work, income and housing. These were perceived by interviewees as problems resulting from their undocumented migrant status. Asking GPs to help with residence permit e.g. through writing medical reports to authorities or advising patients on where to get shelter and food. Therefore, attempting to address some of the structural context of distress.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
		lack of personal interest in the patient, lack of information, and lack of health education during consultation. The GP was seen as a last resort for help with mental health. General barriers to health care access included fear of persecution; fears related to financial costs of accessing care (Netherlands); lack of knowledge of the healthcare system; paying for transport to reach healthcare point of contact, and losing a day's work to attend appointment with GP. A barrier specific to accessing mental health care was cultural i.e. the notion that 'mental health is not for doctors to cure, but rather a part of everyday life'. Other barriers specific to mental healthcare included: perceived external and internalised stigma associated with mental health. However, once GPs are accessed for mental health issues, GPs were seen as helpful.	

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
Fish, Fakoussa (2018)	Barriers to social connection included language problems; lack of community spaces; cultural differences; gender differences; perceived discrimination. Importance of connection on wellbeing was discussed along with relationships and sharing a journey with others. This contributed positively to people with, and recovering from, mental health issues. Several people highlighted the importance of connecting with individuals from outside of their own linguistic and cultural community/background.	Broader social discourse about independence and being able to 'handle' difficulties without support led participants to equate seeking support to feeling like a failure. Issues related to access to healthcare included unclear pathways to access, importance of co-production of services with people who access them was also considered important to improving access. Furthermore, access to care could be improved by more input and leadership within developing services for people who can actively advocate for their own needs. Connecting 'mind health' and 'body health', in a more culturally acceptable manner to discuss mental health would also ameliorate healthcare access. Participants reported perceiving mental health issues as untreatable. This makes access to services even more difficult. Lack of cultural sensitivity and lack of gender sensitive mental health	Housing issues and issues with overcrowding were mentioned as impacting wellbeing. Relationships and 'sharing the journey' with others was particularly important. The asylum system (discusses as THE SYSTEM) was reported in interviews as 'a killer', and is viewed by participants as having a direct effect on mental health. Even after refugee status has been achieved, anxiety continues as a result of the temporary nature of their status (i.e. temporary protection visa) as well as housing and job seeking requirements, which can cause considerable additional stress. Meaning and understanding of mental health was diverse and often unclear to different people. Mental health issues were seen as extreme issues by some participants. Isolation and loneliness were discussed as a contributor to poor mental health for women. This ties in with difficulties in finding connections

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
		services was also discussed as a barrier e.g. females being visited by a male GP. It was mentioned as important for healthcare professionals to be sensitive to these issues. Availability and access to mental health and wellbeing services was often unclear and referral to specialist mental health services were only made if asylum seekers disclosed experiences of torture in their claims. Important role of local services (see Quinn & others), also from participants' own culture and religion is seen to improve accessing healthcare services. Medical help however was perceived as important, along with religion.	with others in the community. On the other hand, having a meaningful occupation is seen as a protective factor. Participants discussed importance of education which can lead to opportunities (protective factor). Education was also discussed more broadly, i.e. education of asylum seekers and refugees around mental health problems, education of the public about asylum seekers and refugees' circumstances, and the education of professionals around cultural differences. These were all seen as crucial in improving mental health and wellbeing. The importance of peer and professional support in the stressful circumstances of seeking asylum were also reported by participants.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
Smith, Raynish, Hoang, Mond, Hannah, McLeod, Auckland, Slewa-Younan (2019)		Importance of employing culturally sensitive, trauma-informed, and discriminatory-free practices across health services would improve access. Barriers to accessing services included language issues and access to professionals interpreters.	Importance of avoiding the imposition of Western views on mental health which are embodied by the biomedical model. This was mentioned in addition to respecting cultural differences and providing timely access to professional interpreters.
Rowley, Morant, Katona (2019)	Experiences in in the yearly years post migration were reported to relationships. Participants described feeling isolated, with a lack of social support. The difficulties described in establishing relationships appeared to exacerbate loneliness. For example, some were afraid that people in the host community would not understand their circumstances and history. Interpersonal difficulties related not only to building and maintaining relationships, but also to sustaining family		Housing problems were extensive and reportedly affected all respondents. The most frequent problems related to housing was instability and moving, with just 48 hours' notice. The low quality of temporary accommodation was also particularly problematic, including overcrowding and a lack of basic provisions such as functioning windows. Often, the subjective experience of housing problems was aggravated by trauma in participants' pasts. Some environments were especially inappropriate given past experiences of human trafficking, torture and imprisonment. Low mood was

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	life were prominent in the respondents.		frequently reported in relation to these challenges. Most participants described worry about the future. Whilst financial difficulties contributed to this, housing issues were regarded as particularly anxiety provoking and there were reports of feeling vulnerable due to inappropriate accommodation. Vulnerability and housing worries were reported more frequently by female participants, particularly those with children. Low mood and anxiety made accessing employment and education increasingly difficult. All participants had a diagnosis of PTSD and many were experiencing continuing debilitating symptoms such as nightmares and flashbacks. Participants regularly reported that PTSD symptoms could be triggered by the problems experienced in post migration environment.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
Golembe, Leyendecker, Maalej, Gundlach, Busch (2020)	All participants reported experiences of discrimination in at some point after their arrival in Germany. These were reported in various contexts (e.g., privately, institutional), and were based on various attributes (e.g., race, religion, gender identity), and from various offenders (e.g., white Germans, other refugees). Consequently, participants reported continuously needing to conceal their sexual orientation/gender identity in Germany, for example, from friends, co-workers, or family, in order to protect themselves. For instance, one participant explained that they stayed with relatives who wanted to change their sexual orientation. In consequence, they tried to hide their identity from their family as much as possible.	A trans* participant described a specific situation when they were seeking treatment at a hospital and felt discriminated against for being both trans* and not able to speak German.	Many participants reported various mental health burdens, most often internalizing problems. These included symptoms of depression (i.e., hopelessness and negative affect), anxiety, exhaustion, and loneliness. Aside from concrete psychological symptoms, some participants also reported feeling continuously distressed by their situation during the post-migration period. While several participants emphasized that their well-being has not improved in comparison with premigration, others even reported that their mental health has worsened in Germany.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	Another participant explained that concealing their sexual orientation/gender identity is a process that intensified for some LGBTQ+ refugees in Germany, showing how identity concealment may be used as a strategy to protect themselves from possible harassment.		
Aarethun, Sandal, Guribye, Markova, Bye (2021)	Post-migration stressors such as economic challenges and unemployment were viewed as causing the symptoms (mental health) to persist or increase over time, we found that both men and women talked about participation in the society of settlement in the form of integration into the new society, as an important coping strategy. An important finding is how the help-seeking and coping strategies discussed by the participants seemed to	The many challenges navigating in the system were also a topic in the female group. Particularly problematic was accessing general practitioners due to waiting times and language difficulties. Generational differences characterized all the male groups' discussions on preferred help-seeking strategies. The younger men suggested seeking formal support such as psychological treatment to a larger extent than the older men, who expressed more scepticism.	Even though the participants never explicitly mentioned PTSD, they specifically identified with the outlined symptoms in the interview (these included nightmares, difficult memories) One of the men explicitly stated depression, and a few others recognized that part of their problem was psychological. We observed a generational gap in the labelling of symptoms. Younger participants explicitly used the term depression when talking about symptoms, whereas

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	be affected by the migration and resettlement situation. Participants indicated that there is a difference between how they would seek help (for mental health) in Syria and in Norway. In Syria, relying on the social network would be the preferred strategy. Loss of social network and separation from family members were presented as important stressors. Disruptions of social networks meant that reaching out to family and friends (the help-seeking strategies that participants would have chosen in Syria) was not an option in Norway for some of our participants. At the same time, it is important to stress that the cultural stigma associated with seeking	A few of the oldest participants in the PTSD-interview said that you can become sick, or sicker, if you see a psychologist, and highlighted that there is nothing a psychologist can do. Challenges with the health system were highlighted as barriers to seeking professional support. Navigating in the system, miscommunication with doctors, language barriers, and the many challenges connected to seeking help using an interpreter were mentioned as important. However, some participants explained that because social support structures are not present in their original form in Norway and that the cultural stigma connected to professional help was perceived to be very different in Norway and Syria, they found it easier to seek professional(mental)	the older participants to a greater extent discussed it as reactions to social problems. Participants using the term depression in the male group were further divided. Some talked about depression as being sick. Others used the label depression and emphasized that depression is something everyone can experience. Important stressors that were discussed included degradation or loss of social networks, culture-related difficulties, and problems with the bureaucracy. Difficulties getting a job, economic challenges, and language barriers.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	professional help did not seem to have vanished completely after settlement in Norway. Many of the women interviewed seemed more hesitant to seek professional help themselves or recommend the same treatment to a friend.	health services in Norway, if needed.	
Johnson, Allotey, Mulholland, Markovic (2009)	Gender differences were placing excessive burden on women to care for children, and due to 'gender roles' women tended to keep their worries to themselves. When mentioning the future, women discussed anxieties not only about themselves but their children too. Men were more autonomous (i.e. family context less prominent), however, for men, personal loss of status and professional		Participants discussed feeling socially isolated due to policy restrictions on family reunion, and unable to access government funded English tuition which would help them 'integrate'. Main source of support and accommodation is from other people with temporary visas. This made participants feel like a burden and was an experience discussed as emotionally draining. These issues (i.e. staying with other individuals on a Temporary Protection Visa (TVP)) were exacerbated when Iraqi TPV

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	identity were important issues. This was discussed in the context of stigma both external (within one's socio-cultural background) and internalised (due to being an asylum seeker / refugee). This was expressed through anger for men (research also shows that anger in men is a symptom of depression).		holders were applying for permanent protection and many felt additional anxiety about the outcome of their claims. Interviews with temporary protection visa refugees showed social isolation to be resulting from policy restrictions, including inability to re-unite with family members and structural barriers that prevent them from fully participating in society (e.g. lack of employment opportunities).
Coffrey, Kaplan, Sampson, Tucei, 2010	Relationship difficulties with family and friends were reported as a result of traumatising experiences in detention. This leads to participants experiencing stigma from broader society. This is compounded by ongoing language difficulties and a thwarted sense of belongingness in new environment.	Experiences in detention also led to distrust in relationship(s) with professionals and services. All participants expressed their frustration at the inadequacy of the health care available to them. A majority spoke of delays in accessing health care and medication. About half said they thought their health concerns had been trivialised. About half also said that they did not trust health	Migration detention – the inadequacy of the healthcare available , delays in accessing healthcare, not feeling understood by healthcare provider; suicide ideation, self-harm, violence; hunger strikes; mental health issues deteriorating; being held in isolation; sense of powerlessness (hopelessness/ helplessness) confinement and deprivation. All participants talked about the disturbing effect of experiences such as witnessing mass riots,

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	A prominent recurring theme for almost all participants was their perception that they had changed irrevocably as a person. These changes were articulated primarily in relation to a sense of having failed in their role as protectors and providers for their families, and this resulted in loss of agency. Relationship issues were also reported in this context.	care professionals in detention. One man, who had been treated for severe depression, said that at times he felt he was being punished rather than cared for by healthcare providers in detention.	beatings of detainees by detention officers, fighting between detainees whilst being detained. Almost all participants expressed fears of being harmed by the detention environment. All interviewees made reference to loss of liberty and the harshness of the conditions in the detention centre, and how these impacted on mental health. Experiences in detention led to internalised stigma, loss of agency (disempowerment), impaired capacity to learn (cognitive), and thus a diminished ability of acquiring new skills. Every participant reported multiple instances of injustices experienced in detention. These injustices fell into the following three broad categories: being subject to criminalising, punitive and humiliating practices and behaviours; instances of apparent disregard for due process relating to visa applications; and experiences relating to the

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
			perceived arbitrariness, inhumanity and senselessness of rule-making in detention. One man, who was isolated following a suicide attempt, described being held in isolation for more than 40 days, during which time he recounts a further steady decline in mental health, to the point where it was necessary to transfer him to an outside psychiatric treatment facility. All participants spoke of a sense of powerlessness and disenfranchisement with respect to the visa application process. Hopelessness and demoralisation were dominant and recurring themes for almost all participants. Four participants, who were released from detention on bridging visas, had no source of income, and depended on a non-government agency to provide all

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
			assistance. Eventually all participants had work rights but had great difficulty securing stable jobs.
Simich, Este, Hamilton (2010)	Lack of social support which used to be received from extended family members back home who are not in resettlement country contributed to a sense of loss and displacement. The increased sense of safety in the country of arrival, was outweighed by loss of social support. Traditional interdependence and mutual support 'back in Sudan' can become a burden, as adults need to provide support for both family in Canada and back in Sudan. Furthermore, this can bring strife and intergenerational conflict. In addition, positive mental		Mental distress is associated with social deprivation in Canada. This was compounded by not having a sense of home (thwarted belonging), resettlement stress, loneliness, lack of support. Not having a sense of home, and its associated social support and shared experiences, made coping with resettlement stresses a lonely experience, deterred formal support-seeking, and magnified mental distress. One participant suggested that family conflict and lack of conflict resolution had long term consequences linked to diminishing hope and increased stress.

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	health equates with emotional support and fulfilling social expectations of caring for family members both in Canada and Sudan. For the participants, positive mental health is associated with having emotional support, meeting family expectations related to caring for one's family. Both of these were impaired in the country of settlement. Participants acknowledge that informal family and community supports alone cannot meet all their settlement and health needs.		
Murray (2012)	Discrimination from broader community was reported as a significant stressor. Because of discriminatory attitudes by the host community, which portrayed the Sudanese community as violent,	English language difficulties impaired access to healthcare. In addition, healthcare, education and providers of other services lacked the ability to assess individual needs before providing support. Lack of response from	Discrimination related to work environment in trying to secure a job and housing were reported as stressful life experiences. Respondents also mentioned importance of receiving financial aid from family and friends to

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	Sudanese people became scared of their own community. Religion was discussed as important for mental health and wellbeing, as well as developing social ties and feeling accepted by the host community.	service providers regarding family concerns and problems with the healthcare system (difficulties with healthcare access) were prominent amongst participants. However, help for individuals' mental health and social issues was also sought and obtained from the Sudanese as well as the broader Australian community. Help from community organisations - and help received in terms of initial orientation in Australia, provided by resettlement programme was particularly helpful.	'make it' to Australia. Language difficulties were also mentioned as a significant issues for resettlement. Participants described feeling dissatisfied with resettlement programme as it lacked cultural sensitivity and understanding of the issues faced by participants. This cross cultural and social understanding, which is perceived as absent, was also included as important in the understanding of a 'good life.'
Sulaiman-Hill, Thompson (2012)			Conflict in the country of origin and separation from family (loss) were reported as significant stressors. In addition, previous occupation (job), social position (status), current reality in the place of resettlement, social isolation, lack of respect/ discrimination, language difficulties, economic challenges, disempowerment, lack of control,

Author(s)	**Descriptions of community and family as a 'double-edged sword'**	**Access to healthcare**	**Mental health within a sociocultural context**
			reliance on others and social support were considered important source of stress by participants.
Warfa, Curtis, Watters, Carswell, Ingleby, Bhui (2012)			Political discourse on immigration thwarted aspirations (hopelessness) and increased psychological distress. Mental health was contextualised in light of unmet expectations (post migration), material conditions (poverty), changing gender roles, loss of status for men and loss of traditions. Pre migration social status, and loss of it in post migration, loss of homeland (thwarted belonging) were all linked to poor mental health. Also, participants discussed discrimination, attitudes of public services deemed disrespectful, dehumanising, disempowering,

Author(s)	Descriptions of community and family as a ‘double-edged sword’	Access to healthcare	Mental health within a sociocultural context
			stigmatising and resulting in a sense of resignation (helplessness) and powerlessness (hopelessness). Devalued refugee identity and psychological distress and stigma related to being a refugee were discussed by participants. This, particularly in the early stages post-migration (first year), is believed to make refugees vulnerable to distress. This was reported as partly due to the mismatch between pre-migration expectations and status and post-migration realities of being a refugee, and the low status this entailed. Changing gender roles were amongst the factors that were seen to take away prestige and dignity from Somali men. Gender roles were also seen to affect women’s mental wellbeing, although it would be difficult to assert whether men or women

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
			were more affected by the reverse gender roles in the post-migration environment. Participants attributed psychological problems to pressures of sending money to relatives back home. In addition, loss of 'homeland', stigmatised refugee identity, unmet expectations and difficulties in the process of settlement in the host nations were mentioned as important stressors contributing to poor mental health.
Sulaiman-Hill, Thompson (2012)	Feeling aimless, hopeless, and experiencing family and community tension and the pressure(s) this poses on individuals, family hierarchy, acculturation and integration in host country were discussed by interview participants. Fragmentation of communities and social isolation were detrimental to mental health.	Professional help such as seeking a doctor's help, taking medication or counselling was only mentioned by male participants. Participants discussed improvement of settlement policies and better cross-cultural education of the public in relation to the refugee experience as beneficial to their feelings of	Employment, social position (low social status), unmet expectations, disempowerment, reliance on others and dependence on welfare, in addition to social isolation and language and housing issues were mentioned by both male and female participants as detrimental to wellbeing. The

Author(s)	Descriptions of community and family as a 'double-edged sword'	Access to healthcare	Mental health within a sociocultural context
	The first point of contact in relation to help seeking were family members and friends to discuss social problems. In addition, religious practices were particularly important for females. Women participants considered it inappropriate to discuss concerns related to distress with men or people outside the direct family group. This was discussed through the lens of external stigma as perceived by the community. Over half of women mentioned discussing problems with family or friends.	distress and amelioration of stigma.	major sources of stress reported included past experiences, re-traumatisation by current affairs and news from back home, and too much time to introspect. Thinking too much was a common descriptor used by participants to refer to depressive and anxiety symptoms. Amongst females, disempowerment and social isolation were more prominent than in males.
Piwowarczyk, Bishop, Yusuf, Mudymba, Raj (2014)	Personal problems were discussed in the context of immigration experiences. For participants, family and friends were key to support rather than professional	Psychiatric services are not routinely sought. A lack of understanding of mental health needs from a Western perspective, and the general negative attitudes toward medication and the social	Participants also indicated that they had limited insight in relation to their mental health needs. The causes of emotional problems were associated to daily conflict by participants, and many

Author(s)	Descriptions of community and family as a ‘double-edged sword’	Access to healthcare	Mental health within a sociocultural context
	services. Furthermore, participants prioritised traditional ways of coping,. These included family, friends and religion (religious leaders) to cope with stress and depression (sadness). Participants discussed the stigma related to ‘mental illness’ within the community. As a result of this stigma, which is at times also present amongst family members, participants were often reluctant to discuss their experiences of distress. Participants discussed that if it is found that someone is seeking mental health services, the person can be ostracised. Participants reported that there can be pressure from the environment including from both family and clergy to stop medication, even if these are prescribed. Participants	stigma associated with psychotropic medication prompted participants to avoid accessing healthcare. The lack of cultural sensitivity of services and cultural differences in talking to strangers about private information related to mental health is an additional barrier to healthcare access. The actual role of mental health professionals and particularly psychiatrists is often poorly understood. Participants reported that it is not clear what symptoms can be actually treated in relation to mental health. People will often defer to the pastor (in relation to the appropriate treatment to distress), and wait for an answer through prayer rather than seeking health services.	of these difficulties were placed in the context of ordinary life, or related to migration experiences.

Author(s)	Descriptions of community and family as a ‘double-edged sword’	Access to healthcare	Mental health within a sociocultural context
	reported feeling confused when there is a conflict between what the pastor recommends and what one’s physician recommends. From the interviews it is clear that there is significant stigma in the community related to both having a mental health problem and seeking professional treatment.		
Yako, Biswas (2014)		Difficulties in accessing healthcare are linked to financial difficulties as healthcare is not free in the US.	Participants found themselves living in areas of criminal activity (e.g. drug dealing), living in substandard housing, found themselves unemployed and discriminated against and in financially strenuous situations. Difficulties of life in the US and loss of status compounded experiences of distress. Learning English is a key component of the experience, and was linked to wellbeing.

3.4.5 Line of Argument Synthesis

Based on the findings of first order constructs and second order constructs, a new line of argument was developed (Aitken et al., 2008). The evidence identified in this systematic review and meta-ethnography indicates that there are three main themes pertaining to the mental health and psychosocial experiences of asylum seekers and refugees in the context of post-migration life difficulties: Descriptions of community and family as a double-edged sword; Access to healthcare; Mental health within a socio-cultural context.

The meta-ethnographic analysis shows that asylum seekers', refugees', and undocumented migrants' communities are both protective and risk factors in relation to mental health experiences and access to healthcare. Important implications related to socio-cultural nuances in which mental health is experienced by the populations included in the selected studies were also identified. These are related to help seeking behaviours, which are mediated by individuals' understandings and acceptance of Western-based concepts of mental health.

Within this context, barriers in accessing care are highlighted and illustrated as constituting potential barriers to individuals who intend to approach healthcare providers about their experiences of distress and/or emotional difficulties. Furthermore, it can be argued that, in their current form, mental health services are inadequate and fail to truly meet the complexity of the mental health and psychosocial needs of asylum seekers, refugees and undocumented migrants in the post migration environment.

By applying a language of mental health that is rooted within the biomedical model, services inevitably omit to address the complex, often unmet needs of these populations. In light of this, we argue for the need to create services (including mental health services) that are co-designed and co-developed by asylum seekers, refugees and undocumented migrants.

Although not immediately apparent within the selected studies, it is important to acknowledge that there is an overarching fundamental issue that encompasses the themes presented in this line of argument synthesis: the asylum system. As discussed in Chapter 1, issues related to the punitive and harmful actions of state policies (e.g. the Hostile Environment policies in the UK), significantly contribute to the issues outlined in this synthesis. Issues of power, and the victimisation of racialised communities are central to the negative experiences described in this meta-ethnographic synthesis.

3.5 Discussion

3.5.1 Reflecting on the Systematic review and Meta-Ethnography's aim and findings

This section illustrates evidence from the included studies using the identified themes with the aim to address this chapter's aim:

> The aim of this systematic review and meta-ethnography is to explore and synthesise qualitative literature exploring the impact of post migration life difficulties on mental health amongst asylum seekers, refugees and undocumented migrants.

3.5.2 Community and family as a double-edged sword

A total of 16 studies included, to varying degrees, the theme of the community as a double-edged sword (Donnelly et al., 2011; Quinn, 2014, Kokanovic et al., 2010; Teunissen et al., 2014; Tilbury et al., 2007; Warfa et al., 2006; Fish & Fakoussa, 2018; Coffrey et al., 2010; Simich et al., 2010; Sulaiman-Hill & Thompson, 2012; Piwowarczyk et al., 2014; Hohnson et al., 2009; Murray 2012; Rowley et al., 2019; golembe et al., 2020; Aarenthun et al., 2021). Whilst within all of the above studies community, as well as family and friends were discussed as important sources of support in the context of difficult mental health experiences, the ways in which community was perceived as a double-edged sword differed in detail. For example, issues related to experiencing stigma, discrimination, and abuse were present in the studies.

Donnelly et al. (2011) illustrated that family was a crucial protective factor for mental health issues. Participants reported that expanding family support improves mental health and, inversely, a lack of support adds to the burden of caring for family members. However, negative marital relationships (e.g. intimate partner violence; neglect; abuse) were seen as detrimental to mental health and wellbeing. In some of the included studies, community attitudes were a strong negative influence in the decision to access professional care for mental health (Quinn, 2014; Kokanovic et al., 2010; Teunissen et al., 2014). Community fragmentation due to residential mobility was reported to compound mental health issues experienced by participants (Warfa et al., 2006). Lack of community spaces and language problems impaired connection with people from one's own ethnic community as well as the broader community in host country (Fish & Fakoussa, 2018). Due to traumatising experiences of detention participants reported relationship difficulties with family and friends. This further intensified a sense of stigma and thwarted belongingness that was experienced by participants (Coffrey et al., 2010). Traditional interdependence was also shown as a potential burden that participants experienced in the post-migration period as adults need to provide for family in the host country as well as to family in the country of origin. This negatively affected, and at times worsened, the mental health of interviewees (e.g. Simich et al., 2010).

Community fragmentation (see Warfa et al., 2006) and social isolation were prominent aspects of participants' experiences in relation to mental health post-migration (Sulaiman-Hill & Thompson, 2010). Community stigma and discrimination, particularly from participants' own ethnic community in relation to experiencing distress were often reported. This was also associated with external pressure to discontinue medication (Piwowarczyk et al., 2014). Gender differences and an excessive burden on women who tended to keep worries to themselves for fear of being stigmatised was reported in the included studies (Johnson et al., 2009; Kokanovic et al., 2010; Sulaiman-Hill & Thompson, 2010). One study that included the experiences of LGBTQ+ individuals in the post-migration context reported that level of discrimination from one's own, as well as the host community, were such that participants felt compelled to hide their gender identity. This was reported to increase feelings of isolation and distress (Golembe et al., 2020).

3.5.3 Access to healthcare

Accessing healthcare was discussed in 15 studies (Donnelly et al., 2011; Quinn, 2014, Kokanovic et al., 2010; Teunissen et al., 2014; Tilbury et al., 2007; Warfa et al., 2006; Fish & Fakoussa, 2018; Smith et al., 2019; Coffrey et al., 2010; Sulaiman-Hill & Thompson, 2012; Piwowarczyk et al., 2014; Murray, 2012; Yako & Biswas, 2014; Golembe et al., 2020; Aarethun et al., 2021). Within this theme, barriers to accessing care included perceived discrimination and stigmatisation due to gender identity (Golembe et al., 2020), which diminished participants' willingness to seek professional help for mental health. Donnelly et al. (2011) reported that help seeking was delayed due to discrimination and stigmatisation from one's own ethnic community. Fear of the unknown consequences of diagnosis, including deportation, family separation impacted on participants' help seeking behaviours (Warfa et al., 2006). Participants discussed individual resilience factors, including positive self-talk in helping with mental health difficulties and, conversely, fear and lack of awareness related to biomedicine was influential in help seeking choices, or lack thereof (Piwowarczyk et al., 2014). Distrust in the biomedical approach led participants to delay of avoid accessing professional mental health services. Similarly, limited language proficiency also diminished participants' ability to seek counselling services (Kokanovic et al., 2010).

Quinn (2014) described that participants felt distrusted or not listened to by the authorities, leading to a sense of hopelessness and helplessness which, in turn, discourages professional help seeking. Perceived stigma from one's own ethnic community (*see* Descriptions of community and family as a double-edged sword) also plays a part in participants' willingness to open up about mental health difficulties (Quinn, 2014). Kokanovic et al. (2010) illustrated the importance of avoiding the imposition of 'Western' views on mental health. As cultural differences are important, idioms of distress that are relevant to individuals should not be dismissed, because this can deter future professional help seeking (Piwowarczyk et al., 2014; Smith et al., 2019).

Access to care was also hindered by difficulties registering with a GP due to lack of information (Teunissen et al., 2014), language difficulties (Warfa et al., 2006; Kokanovic et al., 2010) or poor availability of professional translation services (Aarethun et al., 2021). Participants discussed the importance of culturally informed practices in improving access to care (Kokanovic et al., 2010; Teunissen et al., 2014; Smith et al., 2019). Due to poor knowledge of the healthcare system, emergency departments were also used (Tilbury, 2007). At times, significant barriers to help seeking and healthcare access resulted in participants seeking help via 3rd sector organisations (Quinn, 2014). Coffrey et al (2010) described that difficult detention experiences led to distrust in relationships with professionals, including healthcare professionals. This was mentioned in light of the inadequacy of the healthcare system available to participants while being detained. Sulaiman-Hill & Thompson (2012) indicated the importance of an improved understanding of the refugee experience, which would lessen the feeling of stigma that was prevalent amongst interviewees when discussing healthcare access. Piwowarczyk and colleagues (2014) outlined barriers to healthcare access that include a negative attitude to the medicalisation of mental health. This points to the importance of providing culturally appropriate interventions that are acceptable to participants.

3.5.4 Mental health discussed within a socio-cultural context

The socio-cultural context of mental health experiences was prominent, and was present in all of the 20 included studies. In the research papers, often participants mentioned difficulties in discussing mental health using a biomedical framework (Donnelly et al 2011; Kokanovic et al., 2010; Tilbury, 2007), also because participants often presented with physical symptoms, and felt these were at times overlooked or psychologised, which led to an increased sense of isolation (Teunissen et al., 2014). Also, biomedical conceptualisations of mental health meant little to participants who did not come from urban areas (Tilbury, 2007; Kokanovic et al., 2010). Often, mental health problems were seen to be caused by social problems (e.g. Teunissen et al., 2014), such as gender hierarchies affecting women (Donnelly et al., 2011).

Stigma towards people with mental health difficulties (Quinn, 2014), unemployment, housing issues, poverty, homelessness, the hostility of the asylum system, worries about family re-unification (Warfa et al., 2006; Fish & Fokoussa, 2018; Tilbury, 2007; Teunissen et al., 2014), housing issues and overcrowding (Yako & Biswas, 2014), gender identity and discrimination (Golembe et al., 2020), financial difficulties (Rowley et al., 2019), and generational differences (Aarenthun et al., 2021), were all considered negative influences on mental health. In addition, cultural meanings related to leaving home behind and having to support families both in the country of resettlement and 'back home' (Warfa et al., 2006) and living in limbo whilst awaiting visa permit (Tilbury, 2007), were considered as socio-cultural influences on mental health. Coffey and colleagues (2010) also report the impact of migration detention and the disturbing effects related to experiences of confinement and deprivation, witnessing violence, and stigma as well as lack of income when released from detention. Simich et al. (2010) indicate social deprivation and isolation in the host country as constituting vulnerabilities for the development of mental health issues. Feeling lonely and lacking formal support from community in relation to conflict resolution was also reported to negatively influence participants' mental health (Piwowarczyk et al., 2014).

Employment, thwarted social status, unmet expectations, housing issues and a sense of disempowerment were also mentioned in the included studies (e.g. Sulaiman Hill & Thompson, 2012). In relation to the contextual factors impacting on asylum seekers and refugees' mental health in the post migration environment, Warfa and colleagues (2012; Johnson et al, 2009; Golembe et al., 2020) discuss political discourse around migrants and crushed aspirations alongside discrimination and stigma. In one study, participants discussed their mental health as being worse in the post migration context in comparison with pre-migration. This was explained by participants in conjunction with experiencing discrimination (Golembe et al., 2020). Furthermore, some participants in Golembe and colleagues' study also reported being discriminated by other refugees as well as family members and the host community, due to gender identity (i.e. identifying as LGBTQ+).

3.5.5 Comparison with the wider literature

In 2016, Li and colleagues conducted a literature review on the relationship of post migration stress and mental health in refugees and asylum seekers. Whilst valuable in illustrating the importance of socioeconomic, interpersonal and immigration policy factors that hinder mental health, one of the main limitations of this review is that it narrates quantitative research evidence, without providing a comprehensive synthesis of the reviewed studies. In so doing, the review is quite descriptive in scope and thus, it does not engage with the nuances outlined in this chapter. In a systematic review, Satinsky et al.'s (2019) provided important information on the potential mechanisms that underline mental health service underutilisation amongst refugees and asylum seekers. However, the analysis was limited to synthesising contact coverage and omitted detail on service quality, barriers to access, and an assessment of satisfaction with services once accessed. With the exception of studies included in the review, there is a scarcity of research exploring the role that families and communities can have as a potential barrier to accessing mental health services. This was despite widespread knowledge regarding inequalities in mental healthcare access amongst asylum seekers, refugees and undocumented migrants. Kirmayer et al., (2011) report that refugees underutilise mental health services in Western countries in the post migration period. Similarly to the results described in this systematic review and meta-ethnography, Kirmayer and colleagues (2011) attribute the underutilisation of mental health services to structural and cultural barriers (e.g. the biomedical approach to mental health), in HICs. Hynie (2018) reported that, refugees' ability to overcome traumatic experiences that occurred pre-migration is strongly influenced by social determinants of health, which include employment opportunities, housing issues and access to care in the country of settlement.

It becomes clear that, applying a social determinants of health approach to the post-migration experiences of asylum seekers, refugees and undocumented migrants includes developing services that are culturally appropriate. However, there is limited evidence to suggest that 'Western' mental health services are culturally competent (Bhui et al., 2007). In relation to the ambivalence of family and communities, research conducted with immigrant groups, beyond those included in this chapter found similar results. For example, Kiselev et al., (2020) identified that family conflict, acculturation in the host community and discrimination were linked to poor menta health, and these can also limit access to mental health care in these populations. In a recently published literature review, Partow et al., (2021) reported that stigma and discrimination from the broader community, increased the risk of mental health issues in LGBTQ+ populations. Religion and being part of a religious community, which is often uncritically described as a protective factor for mental health, has also been found to increase feelings of marginalisation and stigmatisation within LGBTQ+ populations, reportedly due to a mainly heterodominant culture and negative LGBTQ+ perceptions (Cyrus, 2017; McCormick et al., 2021).

3.5.6 Methodological strengths and limitations

To assess the quality of the included studies, quality appraisal tools were used to assess the quality of the papers included. To guide this process, published guidelines were followed (O'Caitan et al., 2008; CASP, 2018). The quality appraisal process resulted in 7 papers receiving a score of Good, 8 papers receiving a score of Fair, and 5 papers receiving the score of Poor. It is apparent that the qualitative component of mixed-method studies consistently scored lower in the quality appraisal. Whilst we cannot fully discount the fact that these papers may be of poorer quality, differences in quality scores between qualitative and mixed method studies could be due to published mixed method studies having less space for illustrating the rigour of their qualitative analysis due to journals' word limits. This might have prevented the inclusion of further detail and nuanced coverage by authors. In addition, the use of different quality scoring tools meant that more questions were asked of mixed method studies, hence an increased risk of these scoring 'Poor' on one or more questions.

There are other limitations related to this systematic review and meta-ethnography, which may be considered as sources of bias in the results presented. For example, publication bias, where pertinent studies have not been published. The choices around search criteria, choice of databases searched, choice of inclusion and exclusion criteria, and the reporting of research funding and potential researchers' conflicts of interest in the selected studies. In particular, there may be bias due to the participation of some population groups and less participation from others, such as undocumented migrants. These issues may have had an impact on the development of the systematic review results and the line of argument that was identified through meta-ethnographic analysis.

Whilst the papers were not excluded on the basis of quality, the conclusions from the meta-synthesis warrant caution as some less robust results were included in the development of our new line of argument. The choice of including the qualitative component of mixed method studies is one of the strengths of this systematic review and meta-ethnography. This has allowed us to identify papers which, although using different methods, reported results that augmented those of qualitative studies. Drawing generalisable conclusions was not the aim of this systematic review and meta-ethnographic synthesis. Instead, we aimed to engage with the nuances within and between studies. In order to guide this process and complete it in a rigorous and transparent manner, guidelines from Atkins et al. (2008) and France et al. (2019) were applied. This process also included robust study criteria for literature selection and screening; a thorough data extraction and method of synthesis; and the inclusion of a strong review team composed of independent reviewers from different research and professional backgrounds. This mitigated the impact of subjective biases and enhanced the accuracy of the conclusions reported. However, a noteworthy methodological limitation is that all included studies are cross-sectional. Whilst this methodological design is effective in exploring participants' experiences, the addition of a longitudinal component to the studies (e.g. follow up interviews) may have increased the depth of individuals' experiences over-time. Whilst studies that focus on asylum seekers, refugees and undocumented migrants are highly heterogeneous (see Chapter 2), there were commonalities between studies. These include mental health experiences in the context of post-migration difficulties and access to healthcare.

3.5.7 Gaps in literature

The meta-ethnographic approach to analysing the qualitative evidence provided an opportunity for the identification of gaps within the selected literature. Due to differences in terms of population and research focus between studies there appears to be differences in relation to how post migration experiences impact on individuals' mental health and psycho-social wellbeing. As evident in Table 3-3 there are a higher number of studies being rated poor or fair, amongst the studies that focus on refugees rather than asylum seekers. These studies are also mixed-method in the main, and have a less prominent qualitative component for analysis than purely qualitative studies have.

There is a paucity of research exploring issues that affect individuals who have just received refugee status and/or temporary leave to remain, and the difficulties they face once the welfare and housing support are discontinued. This gap in knowledge has also potentially tragic implications in terms of becoming homeless or destitute despite receiving refugee status. The studies included in this systematic review and meta-ethnography included a limited number of individuals that are undocumented migrants, who may have a different set of needs and encounter post-migration difficulties that differ from the populations included in this study.

3.5.8 Chapter summary

This chapter presented a comprehensive systematic review which explored mental health in the context of post-migration life difficulties amongst asylum seekers and refugees. The meta-ethnographic synthesis that derived provides novel knowledge that adds to the available literature. The review synthesised 20 studies, and included qualitative research (N=11) and the qualitative component of mixed-method studies (N=9). This synthesis concludes that the literature on this topic is nuanced and that there is a complex interaction between culture, migration status, mental health and psychosocial experiences. This chapter has illustrated that social connections, family and community, can also be a source of stigma and distress in asylum seekers, refugee and undocumented migrant communities. Similarly, low accessibility to appropriate and culturally acceptable mental health services presents a barrier for these individuals and can, inadvertently, widen already existing inequalities in access to healthcare. What has emerged from this synthesis is that the very conceptualisation of mental health toward a biomedical approach, prominent in Western countries, is often at odds with culturally embedded, idiomatic understandings of distress that these population reported as important to them.

As a result of the systematic review and meta-ethnography presented in this chapter, the initial research plan included a Participatory Action Research (PAR) method and the use of photo-voice and focus groups discussions (Appendix 2 for a review). The plans for this study were advanced and ethics approval had been granted by the University of Glasgow's Ethics committee. However, as the COVID-19 pandemic reached the UK, this research plan was no longer feasible. My supervisors and I had to devise a contingency plan. This included conducting interviews with asylum seekers, refugees and undocumented migrants using an online video platform. The next chapter illustrates the methodology used for two qualitative analyses that compose the additional two results chapters of this thesis. The first applies Reflexive Thematic Analysis to the 18 transcribes interviews. And the second uses the theory of Candidacy to re-analyse the data gathered.

Chapter 4 Methodology

A qualitative method was selected for this thesis. Data gathering was completed via the use of semi-structured interviews, and the analysis of the data gathered included two methodological components. The first is reflexive thematic analysis (RTA) and the second is the theory of candidacy. Initially, a discussion on the epistemological and ontological paradigms that underpin the methods employed in this research are presented, along with a rationale for the chosen approaches to research. As the data gathered from the interviews was analysed twice, via the use of two different methods, in this chapter, RTA (Braun & Clarke, 2006) is outlined first, before an illustration of the theory of candidacy (Dixon-Woods et al., 2005). Ethical considerations that informed the planning of this research are also presented.

4.1 Epistemology and ontology

Selecting the appropriate method presents researchers with several challenges (Blaikie, 2000). These include the selection and the implementation of epistemologically and ontologically informed approaches to conducting research. A working definition of epistemology is: '*the possible ways of gaining knowledge of social reality, whatever it is understood to be. In short, claims about how what is assumed to exist can be known*' (Blaikie, 2000 pg. 8). Whilst epistemology is concerned with answering the question: 'how we know what we know?', ontology focuses on the 'philosophy of reality' (Krauss, 2005) and is described by Blaikie (2000 pg. 8) as: '*claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other*'. Thus, ontological assumptions are concerned with what we believe constitutes social reality.

The way(s) in which research is approached varies in relation to the epistemological and ontological 'world views' that a researcher brings to the research process (Byrne, 2022). To describe these, Kuhn uses the term paradigm (Kuhn, 1970). A paradigm has, at its core, the representation of the world as we perceive it, and also how we relate, identify and interact with it (Ibid).

Crotty (1998) expands on this definition of paradigm by adding: *'[paradigms] are the parameters and the boundaries for scientific research and […] scientific enquiry is carried out strictly in line with it'* (pg 35). Traditionally, two major paradigms have influenced the development of scientific research: positivism and interpretivism or constructivism (Ponterotto, 2005). The paradigm that a researcher selects influences the way in which the research is approached, research questions are devised, and how the data are collected and analysed.

4.1.1 Positivism

The positivist perspective is often synonymous with the 'scientific method' and is underpinned by the assumption that an objective reality exists independently of human consciousness. Furthermore, this epistemological assumption frames knowledge as objective, independent of a researcher's beliefs and subjective experiences (Crotty, 1998). It presupposes a realist ontology and the existence of an objective reality that can be accessed (Kuhn, 1970). For positivists, knowledge is replicable by following logically derived hypothesis and a pre-established method to originate confirmatory evidence (Charmaz, 2006). To explain reality, positivism relies on principles of cause and effect, and adopts technical ways to measure such reality. For example, by employing the experimental method to investigate hypothesis and the use of statistical analysis. Within the field of Public Health, the results derived from such studies are used to generalise, predict and quantify human behaviour (and experiences) in the name of replicability and falsification (Kuhn, 1970). However, researchers have realised that the complexity of human experiences which develop contextually in an ever changing social, cultural and political environment are not always quantifiable and accessible via the use of experimental methods (Byrne, 2022). For example, research focusing on the 'why' and 'how' in the study of human experiences is not necessarily accessible via the positivist paradigm (Patton, 2002).

4.1.2 Interpretivism or Constructionism

These debates have resulted in the emergence of interpretivism or constructivism (Ponterotto, 2005). Whilst interpretivists acknowledge that reality exists, this is not considered a monolithic, objectively accessible entity, but rather relative and multiple. Interpretivists tend to produce knowledge that is focused on capturing individuals' meaning(s) and subjective experiences of reality. As a result, they acknowledge that the interpretations derived from the research process (e.g. sampling, conducting interviews, analysis), cannot be unbiased and objective (Ponterotto, 2005; Alharahsheh & Pius, 2020). This paradigm is associated with qualitative research methods. In defining qualitative research, Strauss & Corbin (1990 pg 17) state: '*any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification*'. In qualitative research, data are typically collected using interviews, focus groups and/or observations. These are analysed using approaches such as Grounded Theory, or methods such as Thematic Analysis (Byrne, 2022). Interpretivist methods encourage researchers to be transparent about their subjective positioning in the research process as a way of mitigating one's own biases, as these influence the development of a research project and its analysis. Furthermore, for interpretivists context is key, and it is through the understanding of the context in which research is situated that an interpretation is meaningful (Patton, 2002). This research paradigm is particularly applicable when the researcher aims to collect in-depth information based on participants' lived experiences of the phenomena studied. In brief, interpretivism or constructionism stresses that knowledge is the result of human beings' active 'construction' (or meaning-making), rather than it simply existing and being received passively by them (Ritchie & Lewis, 2003).

4.2 Reflexive Thematic Analysis

This study focuses on exploring asylum seekers', refugees' and undocumented migrants' mental health and psychosocial experiences in the post-migration context in the city of Glasgow. To investigate this, an interpretative (or constructivist) approach was considered most appropriate. The key advantage of this paradigm is that it allows for the in-depth exploration of participants' subjective experiences, in a constructivist sense, where aspects such as subjectivity, reflexivity and interpretation are assets in knowledge production (Braun & Clarke 2019). Specifically, reflexive thematic analysis (RTA) (Braun & Clarke, 2006) was chosen. RTA is one approach to conducting Thematic Analysis (e.g. Boyatzis, 1998). RTA differs from other thematic analysis approaches in three main ways: coding reliability; codebook approaches; reflexivity (Braun & Clarke, 2019). As presented by Boyatzis (1998) and Joffe (2012) coding reliability aims to reach a high level of consensus amongst different researchers when coding the data. Here, the researcher(s) aims to reach consensus amongst coders also by applying positivistic methods such as Cohen's Kappa. Within RTA, when more than one coder is involved in the analysis, the aim is to approach the data in a collaborative and reflexive manner to achieve richer interpretations rather than simply seek consensus (Braun & Clarke, 2014). Approaches that implement a codebook, including framework analysis (Smith & Firth, 2011) and template analysis (Brooks et al., 2015) limit the scope of reflexivity as these tend to focus on summarising themes rather than facilitating interpretation (Braun et al., 2019). Instead, the application of a reflexive method to thematic analysis stresses the importance of the researcher's active role in engaging with the data, and producing the results (Braun & Clarke, 2019). The codes and themes that are selected in the analytic process are rooted in the researcher's interpretations, identification of meaning, theoretical knowledge and assumptions. Due to the importance of subjectivity in knowledge production, the analysis may not be reproduceable by two or more researchers in the same way. Rather, RTA emphasises the importance of '*the researcher's reflective and thoughtful engagement with the data and the analytic process*' (Braun & Clarke, 2019 p. 594). Factors such as the researchers' analytical skills, experience, and resources (e.g. time), have an impact on the results produced (Ibid).

In line with other qualitative methods, RTA also does not intend to provide a 'correct answer'. It is noteworthy that in RTA themes are not pre-defined with the purpose of finding codes. Instead, themes are identified via the organisation of codes around a 'central organising concept' (Braun & Clarke, 2006; 2019). In the case of the present study, the central organising concept was 'Post-Migration Life Experiences'. The centrality of this concept derives from the researcher's prior knowledge of the broader literature (see Systematic Review and Meta-Ethnography chapter for a full review), which provided the background on which the interview protocol was devised (see Appendix 3). However, this does not mean that a Grounded Theory approach (Glaser and Strauss, 1967) was used in this study. If a constructivist, grounded theory approach had been used, the focus would have been on the identification of a theory 'grounded' in the social processes that participants described. This would have resulted in inducing a theory from the data (Hawker & Kerr, 2016), which is not this study's aim. Instead, the aim of the study was to investigate asylum seekers', refugees' and undocumented migrants' subjective mental health and psychosocial experiences.

4.2.1 RTA and epistemology

Braun and Clarke (2006), first conceived of RTA as a flexible qualitative methodology, not bound to any specific theoretical structure. However, in later publications they illustrated the importance of positioning one's use of RTA within an epistemological and ontological context. For example, Braun & Clarke (2016) indicated the importance of delineating where, based on a continuum (rather than all or nothing), the researcher's positioning in relation to the analysis is situated. This includes whether the approach to coding is inductive or deductive, latent or semantic, and whether an experiential or critical orientation is employed.

In summary, a deductive, or theory-driven stance presupposes that the researcher produces codes in line with a pre-existent conceptual understanding of the data. In contrast, a researcher who employs an inductive, or data driven approach, would tend to derive codes that are reflective of the data without an *a priori* theoretical stance (Joffe, 2012). This study used an inductive coding frame. However, pre-existing ideas and theoretical concepts rooted in the literature informed data collection. In so doing, the data was collected in a manner which focused on certain aspects of individuals' post migration life experiences (e.g. mental health; access to care; the asylum process). Nonetheless, the coding developed in the analysis did not attempt to 'fit data' in an existing framework. Instead, codes and themes were developed from the data. In order to limit the influence of prior knowledge on the analysis, I used 'bracketing skills'. These include the researcher identifying and limiting the influence of their own assumptions and biases on the analytical process (Fischer, 2009). This was facilitated by continuously revisiting the data and engaging in discussions with supervisors.

In RTA, semantic coding pertains to the identification of codes in their explicit, literal sense. In so doing, the production of codes reflects a descriptive analysis of the data gathered. Latent coding, on the other hand, moves beyond this and seeks to identify underlying assumptions and latent meanings that underpin the semantic level of the data. In using latent coding, the analytical process becomes more interpretive, and poses a stronger emphasis on the researcher's active role in identifying codes and themes (Braun & Clarke, 2021). In this study, a mixture of semantic and latent level coding were used to both summarise and interpret the data gathered. An experiential orientation emphasises the centrality of how a given situation or phenomenon is experienced by the participants. The focus is on the meaningfulness of an experience to the participants in terms of internal states (e.g. thoughts, feelings). Instead, a critical orientation would prioritise the theoretical understanding of the meaningfulness of participants' experiences to interrogate the social contexts in which these occur (Braun & Clarke, 2014). In order to explore the mental health and psychosocial experiences in the post migration context, this study employs both an experiential and critical orientation to investigate participants' internal experiences and their social context.

4.2.2 Practical application of RTA

Braun and Clarke (2006; 2014; 2016; 2017; 2019; 2021) have outlined six phases to facilitate the analysis using RTA. I use the term phases rather than steps to highlight that this analytic approach is not necessarily linear, and the researcher may move backwards and forwards between phases during the analysis. To facilitate this process and ensure transparency, all of these phases were completed on NVIVO 12. The phases included:

1. Becoming familiar with the transcribed data by reading and re-reading the interview transcripts and engaging with the semantic meaning of the data. During this phase notes and annotations were made.
2. The development of a coding framework aimed at capturing key aspects of the data, including patterns and analytic ideas that were salient to the research question. To ensure that salient codes were not missed, this process was verified by reviewing codes as the analysis progressed.
3. Based on the selected codes, themes were identified and developed. These included subthemes that were connected to specific concepts.

4. These themes were reviewed and cross-checked in light of new codes. The relationship between themes was structured by mapping how themes related to one another.
5. Themes are named. This phase is critical in identifying a narrative that encompasses themes and subthemes, and how these are salient to answering the research question.
6. The analysis is illustrated and the results are presented in a clear manner.

4.2.3 Validity

Research validity broadly describes in terms of how 'truthful' the results of the research are. To ensure that the research adheres to this 'standard', methods have been developed. For example, triangulation is one manner in which the validity of a research project can be augmented. Triangulation may include presenting the results to participants to comment on the researcher's interpretations; maintaining awareness of the broader context in which the research was conducted and how this may influence the interpretation of results; and integrating data that may contradict or challenge certain aspects of the results. However, in line with RTA, and to ensure transparency, triangulation of the analysis aimed to achieve richer interpretations of the data, rather than seek consensus (Braun & Clarke, 2013). Finally, this ensured a high level of transparency throughout the research process. I worked on every phase of the analytical process as the main data analyst (see the 6 phases illustrated above). However, my supervisors contributed to shaping the analysis. After data collection was completed and the recordings transcribed, a sample of three transcripts were read and coded independently by AA, KO and SM. Coding and interpretation of these three transcripts was then discussed in joint supervision meetings. I then continued data analysis independently for all of the interview transcripts, with joint meetings scheduled at fortnight intervals to discuss the development of the analysis with my supervisors. I implemented supervisors' feedback throughout the analysis and the writing up of the results.

4.2.4 Reliability

In brief, the term reliability when applied to qualitative analysis refers to the level of consistency provided across the full data set. When applied to RTA, reliability involves the careful description of each passage and process included in the analysis. One of the practical ways to ensure this is systematic reporting of the results and the steps through which the results were derived, with a clear data driven 'trail' of the researchers' interpretations (Lewis & Ritchie, 2013). The principles outlined above along with their practical applications were upheld throughout the research process to ensure a high research quality. I also engaged in reflexivity and kept a reflexive log.

4.3 Research Design

4.3.1 Sample

The aim was to recruit between 15 and 20 participants for the semi-structured interviews. A flexible approach to sampling was maintained, partly in light of the ongoing lockdown due to the pandemic and partly because of the potential difficulties inherent in recruiting participants from marginalised communities (e.g. digital poverty, language issues, unwillingness to engage in research). A Community Development worker and key informant working at a charity based in Glasgow assisted with recruitment and of the 20 participants initially contacted 18 people expressed a willingness to participate. Potential interviewees who expressed a willingness to receive further information about the study were sent the Information Sheet (Appendix 4) and Consent form (appendix 5) via email. The interviews were conducted between the 20th of November and the 18th of December 2020. Participants were recruited in relation to pre-defined inclusion and exclusion criteria (Appendix 6). These included: being over 18 years of age; being a refugee, an asylum seekers, or an undocumented migrant; residing in Glasgow; being able to provide informed consent.

4.3.2 Procedure

On the day of the interview, the researcher reiterated the main concepts present in the information sheet and consent form (with an interpreter, where appropriate) and gave participants the opportunity to ask any questions or further elucidation. The consent forms were sent to participants after they spontaneously opted-in for participation and following an initial phone conversation between the researcher and the potential participant who provided their number and consent to being contacted via the Key Informant. Participants who consented to take part in the study were allocated a study identification number. These were kept in a password protected, encrypted file. At this point, each participant was once again reminded that participation in the study was voluntary, and withdrawal would not affect their asylum claim or welfare. In addition, participants were reminded that they could withdraw their participation at any point. All the interviews were conducted via Zoom. Before the recording started participants were asked whether they would consent to the interview being recorded (this was also discussed with participant previously, during the recruitment process and was illustrated in information sheets and consent forms). If they agreed, their verbal consent was also sought and recorded. This was done along with a reminder that recording could be stopped at any time if they so wished. As people in these communities are considered a potentially vulnerable group, the researcher was alert at any signs of distress and was ready to respond in an empathic manner. As described in the approved Ethics form, a protocol was in place to ensure full debriefing and a list of organisations to contact in case the interview resulted in distress – this was also valid for the researcher. Zoom interviews were recorded and saved on an encrypted University account, which is password protected and only accessible to the researcher.

4.3.3 The Interviews

The data was gathered using semi-structured, in-depth interviews to collect the participants' views and personal experiences. Due to the ongoing COVID-19 pandemic, the interviews were conducted and recorded using Zoom. Whilst the interviews were video recorded, to protect the participants' confidentiality and anonymity, only the voice recording was sent to a professional agency for transcription. Interviews, and interview transcripts are central to interpretivist research. Furthermore, interviews offer the possibility to explore phenomena that are beyond the realm of direct observation. In so doing, the participants' worldview, as they perceive it, is presented to the researcher (Pielstick, 1998). Semi-structured interviews used open ended questions to allow for the in-depth exploration of particular issues and provide opportunities for follow-up questions (Appendix 3). In addition, skills such as building rapport, engaging in active listening and being responsive were used during the interviews. Also, when interviewing participants with limited English proficiency, questions were asked in a clear and plain manner (examples of the researcher's reflections are presented within fieldnotes - Appendix 7).

4.3.4 Interpreter Facilitated Interviews

In recent years, Glasgow has seen a sharp increase in the number of asylum seekers, refugees and undocumented migrants from East Africa and the Middle-East. Amongst the recruited individuals, the majority were from these regions. The limited English proficiency of some of the participants prompted the recruitment of interpreters to facilitate the interview process. It is important to note that the addition of an interpreter can alter the interview dynamics, and potentially impact interviewees' openness and willingness to disclose personal experiences. In addition, conducting an interview where an interpreter is mediating, can present substantial challenges around building rapport (O'Donnell et al 2007).

For example, there was an initial problem in recruiting an Oromo speaking interpreter. There are relatively few Oromo speaking interpreters available in Glasgow. However, the participant mentioned feeling comfortable speaking with an interpreter that was known to them. As the participant and interpreter knew each other, during the interview, the interpreter at times interjected by expressing his own knowledge of the participant. For example, when the participant was asked about their experience with the asylum system, the interpreter said that this question could be skipped because the participant had not completed the asylum procedure in the UK. This caught me by surprise as I wanted the participant to speak for themselves about their own experiences, without the interjection of the interpreter. I tried to mitigate this by tactfully asking the interpreter to avoid interjecting.

In another situation, a participant from a Middle Eastern country explicitly asked for an Arabic interpreter from the Maghreb, because they did not feel safe with an interpreter from the Middle East. The interpreter was from Morocco, and they managed to understand each other during the interview. However, due to the language used, which was not the participant's native language, this interview may have been less nuanced. This was reflected in the length of this interview, which was one of the shortest. More generally, the quality of interpretation varied in relation to the background and work experience of the interpreter. This may also have influenced the analysis and results. Technical issues also impacted on data collection. For example, one of the interviewees lacked access to a computer. This interview was quite difficult because, due to this, the interviewee was on speaker (on the phone) whilst the interpreter was on Zoom, translating (where the interview was recorded).

Whilst multilingual and digital interviews have the potential to increase access to research from marginalised and vulnerabilized individuals and communities, issues around digital poverty, and potential loss of meaning in translation are important aspects for consideration when engaging in digital research (Piacentini et al., 2019; 2022).

In order to mitigate the impact of interpreters on the data, I initially consulted my supervisors, and subsequently Govan Community Project (GCP), a Glasgow-based organisation that acted as a 'gatekeeper' and aided the recruitment process. GCP was key in allowing the research team to access participants who normally, due to their marginalised situations and limited language abilities, are excluded from participating in research. These consultations resulted in the identification of a high-quality professional interpreting service.

4.3.5 Ethics and REC

This research was approved by the University of Glasgow's Ethics Committee (Appendix 6). Ethical considerations were applied as part of the research process, also due to the fact that participants were considered vulnerable adults.

4.4 Applying a theoretical approach to the data

Based on the results derived from RTA and the meta-ethnographic study, a further analysis of the interviews was developed. It became evident that that access to services, including healthcare, employment and housing, were significant issues for these populations. In light of this, the data gathered from the 18 interviews was re-analysed. This time with the aim of applying a deductive (or theory driven) understanding of the data. To achieve this aim, the theory of candidacy was used (Dixon-Woods et al., 2005). During the analytical process, both semantic and latent coding were used to explore the ways in which participants' semantic meanings around their experiences of accessing services could be deductively understood using the theory of candidacy. In the second chapter of the qualitative analysis (Chapter 6), I apply the theoretical framework of candidacy as constructed by Dixon-Woods et al. (2006) to illustrate '*the ways in which eligibility for medical attention and intervention is jointly negotiated between individuals and health services*' (pg. 7) (see Chapter 2 for a fuller discussion of the theory of Candidacy). In so doing, we will implement the theory of candidacy as '*a dynamic and contingent process constantly being defined and redefined through interactions between individuals and professionals*' (Dixon-Woods et al., 2006, pg. 7). Although Dixon-Woods et al. (2006) explicitly encourage the use of the candidacy framework in wide, and underexplored branches of healthcare research, its use and application to mental health services is still limited.

In addition, the candidacy framework has an under-expressed potential for providing valuable insights into how services beyond those related to healthcare may be accessed (e.g. Neary et al. 2021; MacKenzie et al., 2015). In exploring this, the aim was to increase the candidacy model's utility in understanding and potentially improving access to services for traditionally underserved groups. The re-analysis of the interview data attempts to utilise the theory of candidacy in relation to asylum seekers', refugees' and undocumented migrants' experiences of access to services. As reported previously, the aim was to further explore themes such as access to housing, employment, and the asylum process, in addition to healthcare. The results will also entail a critical perspective on how participants discuss mental health presentations and assert their candidacy for mental health support.

As described in this chapter, two analytical methods were applied to the same dataset which comprises eighteen interviews with asylum seekers, refugees and undocumented migrants. This choice could be criticised on the basis of potentially stretching the data 'thin' rather than collecting a second data sample via additional interviews. This was, however, a pragmatic decision in response to some important practical barriers that I encountered in completing this research. The first was the challenges encountered recruiting individuals from these migrant communities. It took several months of engagement with community organisations (this process started pre-pandemic, in early 2019) to manage the recruitment of eighteen participants. Pressures related to the pandemic (both on participants and myself) further increased recruitment issues. Delays due to social distancing and lockdown restrictions, the closure of community-based organisations involved in participant recruitment, and the move to remote data collection all impacted on the ability to recruit participants. However, the data that were collected was considered rich and detailed enough to apply a second theoretical lens to the work. Some of the questions that were included in the interview protocol also focused on participants' experiences around access to services. During the semi-structured interviews, participants talked about a broad range of experiences since arrival in the UK. In consultation with my supervisors it was therefore decided to collect only one set of data, and analyse this using two analytical approaches.

4.4.1 Conclusion and next chapter

This chapter has outlined the methods used in the analysis of 18 interviews with asylum seekers, refugees and undocumented migrants. The first part of this chapter discussed the epistemological and ontological perspectives that underpinned the choice of methods. Subsequently, RTA was presented along with reasons for its selection as the analytical method. After this part of the chapter was presented, details on the study's design and procedure were illustrated. These included details on sample size and recruitment, the study's procedure, information related to the interviews and working with interpreters, and ethics.

Finally, the theory of candidacy was delineated as the approach used to deductively (re)analyse the interview data in order to better understand the journeys that participants engage in to access the services that they require. Increasing our knowledge of service access in this populations can aid the future development of services, including healthcare, and potentially offer better support to these migrant groups. In the next chapter, the results of the RTA analysis are shown.

Chapter 5 Reflexive Thematic Analysis

5.1 Introduction

As outlined in the literature review chapter of this thesis (Chapter 2), research demonstrates that the mental health experiences of asylum seekers, refugees and undocumented migrants are influenced by a host of psychosocial factors that occur in the post migration environment. The literature review highlighted the social and policy contexts in which people live, and the availability and access to resources such as housing, healthcare, employment opportunities, and the asylum process itself, as risk factors for the development and perpetuation of mental health difficulties in these populations. The systematic review and meta ethnography presented in Chapter 3 illustrated that social determinants of health also include individual experiences related to social exclusion and marginalisation from within one's own ethnic community (e.g. Sulaiman-Hill & Thompson, 2012) and from the broader community in the host country (e.g. Golembe et al., 2021).

Language and communication difficulties were identified to affect individuals (e.g. Warfa et al., 2006; Kokanovic et al., 2010), also in the context of healthcare access (e.g. Teunissen et al., 2014). This was compounded by the limited availability of interpretation services (e.g. Aarethun et al., 2021). In terms of accessing mental health care, gender differences (men being less prone to access mental health services due to cultural beliefs than women), and generational differences (older men less likely to access services than younger men) were found (e.g. Teunissen et al., 2014; Aarenthun et al., 2021). Combined, these can influence health and wellbeing via complex biopsychosocial interactions, which can result in experiencing stress, anxiety and depression (e.g. Donnelly et al., 2011). In the literature, these post-migration life experiences are often discussed in the context of social determinants of health (Pollard & Howard, 2021; Ziersch et al., 2020).

In this chapter, I will illustrate the results from the analysis of the interview data via the application of RTA (Braun & Clarke, 2006; 2013; 2017; 2019; 2021). The methodological tenets of RTA and how these were applied to the analysis of the

18 interviews conducted with asylum seekers, refugees, and undocumented migrants participants was presented in detail in Chapter 4.

5.2 The Study Participants

Eighteen participants agreed to participate in the study. Interviews were conducted via Zoom and lasted between 37 and 98 minutes. The people who took part in the study differed across demographic characteristics. A summary of demographic data pertaining to participants is detailed in Table 5-1. Participants' names were anonymised and age was not disclosed to protect their identity.

Table 5-1 Demographic data for the interview participants

Participants	Country of Origin	Migration Status	Language	Gender	Age group	Marital status
Participant 1	Nigeria	Refugee	English	Male	Young person	Single
Participant 2	Pakistan	Asylum seeker	English	Male	Middle age	Married
Participant 3	Pakistan	Asylum seeker	English	Male	Middle age	Married
Participant 4	Ethiopia	Asylum seeker	Amharic	Male	Young person	Single
Participant 5	Eritrea	Undocumented migrant	Amharic	Male	Middle age	Single
Participant 6	El Salvador	Asylum seeker	English	Male	Young person	Single
Participant 7	Jordan	Asylum seeker	Arabic	Male	Older adult	Married
Participant 8	Senegal	Asylum seeker	French	Male	Young person	Single
Participant 9	El Salvador	Asylum seeker	Spanish	Male	Young person	Single
Participant 10	Jordan	Refugee	English	Male	Middle age	Married
Participant 11	Nigeria	Asylum seeker	English	Male	Young person	Single
Participant 12	Eritrea	Undocumented migrant	Amharic	Male	Young person	Single
Participant 13	Eritrea	Asylum seeker	English	Male	Middle age	Single
Participant 14	Eritrea	Undocumented migrant	Amharic	Female	Young person	Married
Participant 15	Eritrea	Refugee	Arabic	Female	Young person	Single
Participant 16	Eritrea	Undocumented migrant	Oromo	Female	Middle age	Married
Participant 17	Eritrea	Undocumented migrant	Amharic	Female	Middle age	Separated
Participant 18	Eritrea	Refugee	Oromo	Female	Older adult	Widowed

Table 5-2 Description of the main themes and subthemes from the RTA analysis of in-depth interviews with asylum seekers, refugees and undocumented migrants.

Main Theme	Sub-themes
1 The asylum process	1. Experiences on arrival 2. Living in limbo 3. Inability to work and financial constraints 3.1 Resilience
2 Mental health experiences	1. Idioms of distress 1. Anxiety, depression and stress 2. Psychosomatic issues 3 Sleep 4 Suicide 2. Protective factors 1. The role of religion 2. Physical activity 3. Social support
3 Access to healthcare	1. Registering with a GP 2. Communication difficulties and interpretation 3. Waiting times to access services 4. Psychotropic medication and psychological therapy 5. Healthcare access and socio-cultural factors

5.3 The asylum process

The asylum process was one of the most frequently discussed issues and it was raised by most of the participants regardless of their current status. Within this topic, three sub-themes were identified: Experiences on arrival; Living in limbo; Inability to work and financial constraints. Within this context resilience factors were also described by several of the interviewees.

5.3.1 Experiences on arrival

A majority of interviewees described arrival in the UK in conjunction with migration detention, particularly at Croydon. There is a considerable body of research literature on the negative impact of migration detention on the mental health of people seeking asylum (Robjant et al., 2009; Hynie, 2018; Silove & Mares, 2018; Gleeson et al., 2020). As the participants' demographics and current migration status differed within the study sample, so did the experiences that were reported post-migration. In this context, Participant 13, a male asylum seeker, and Participant 10, a male refugee who claimed asylum upon their arrival in the UK, reported on their mental health experiences in relation to having been detained:

> *So when you arrive, they put you [in detention] this kind of thing is really depressing and very stressing (Participant 13. male, asylum seeker).*
>
> *This is one of the points that really hurts me, and I still suffer from that. I applied when I arrived at the airport after I entered because I came with visa. They know all my information. But they told me to go to Croydon [migration detention centre] (Participant 10 male, refugee).*

For one interviewee, detention was reminiscent of traumatic experiences which occurred pre-migration. Research indicates the potential retraumatising effects of migration detention, particularly for people who have been subjected to detention and/or torture in their country of origin (Porter & Haslam, 2005). This adverse life experience was discussed by Participant 7:

> *So this put me back to the experiences in [names country of origin] when I was in jail and I have tried everything to forget about this experience and so at the airport, everything came up. So because when I was arrested in [country of origin], so the body search reached a certain point that even I was completely naked and I felt humiliated so in the airport I felt as though I had the same, so all the memories came back. And I felt the same way (Participant 7 male, asylum seeker).*

von Werthern et al. (2018) reported that time spent in detention in the host country is a significant post-migration stressor, and is associated with mental health symptoms, particularly anxiety, depression, and post-traumatic stress disorder (PTSD). One of the interviewees, Participant 12, a young undocumented migrant, experienced a protracted period of migration detention in the UK, which occurred whilst he was a minor. This was discussed during the interview as an ongoing post-migration difficulty:

> *Now me and my lawyer sued them already because I'm in court, we're waiting a hearing, because I was 17 years old and they put me in detention for more than one month. And it's not legal in the law as well, they put me in detention unlawfully (Participant 12, male, asylum seeker)*

Although most of the participants in the study reported migration detention, the subjective experiences narrated by interviewees were not always negative. For example, Participant 6, a young asylum seeker who migrated with his family, said:

> *Well in Croydon I don't have too much to say because I just stayed like one week, or less than one week, I think it was like five days. But the first time…the first day I stayed like one day in the airport. After the airport they moved me to a hotel, you know, and I stayed like… I stayed there like five days, something like that, and then I get on my…I get food twice a day and I got the liberty to go to walk around the city (Participant 6, male, asylum seeker).*

Interviewees also narrated their experiences on arrival in the UK in relation to language difficulties and interpretation. Phillips's (2006) illustrates that within migration dispersal areas, interpretation support can, at times, be lacking or overwhelmed due to high levels of need and relatively few trained interpreters available. This evidence was confirmed in a recent network analysis of post-migration life difficulties, where associations between communication difficulties, interpretation and higher levels of distress were reported (Wicki et al., 2021). Whilst this aspect of participants' migration experience is discussed in different parts of this results section (e.g. interpretation and access to counselling), Participant 9 experienced language difficulties at the time of arrival, and reported needing interpretation to help him navigate migration procedures:

> *So when we arrived at the airport, we didn't know any English. So when we arrived the airport officials sent us to wait in a corridor with lots of different people who spoke different languages and that was until they found an interpreter to help us. And that's when the interpreter explained to us that we were going to be detained until they found some kind of accommodation for us (Participant 9, male, asylum seeker).*

Whilst data pertaining to the housing circumstances of asylum seekers, undocumented migrants and refugees living in the UK is limited, research has shown that the dispersal areas and migration status of asylum seekers and refugees in Glasgow impacts on their mental health and wellbeing (Kearns et al., 2017). Kearns and colleagues (2017) reported that the more deprived the area of resettlement, the more negative the health outcomes for both physical and mental health. Also, time spent awaiting a decision on the asylum application can compound this (Isaacs et al., 2020). Recently, in Glasgow, there has been a change in the housing provider from Serco to Mears, and interviewees discussed this topic during the interviews. Participant 3 and Participant 9, two asylum seekers interviewees described having a positive housing experiences with both housing providers:

> *The accommodation normally I heard that they trouble you but from my point of view I'm not facing any problem. All the time they support me, maybe I'm lucky, my housing officer is very good. He is all the time*

> *available when I need anything. A few days before, my cooker was out of order, it was not working, so I called him and he was especially on vacation but he managed that […] from my point of view, I don't face any problem with the Serco team and Mears team, both of them…Serco was starting and after Serco, then Mears took over all the arrangements in the Glasgow (Participant 3, male, asylum seeker).*

> *Fortunately, in Glasgow we've had a lovely experience, because from the first day when Serco received us, they were very kind to us (Participant 9, male, asylum seeker)*

Some participants discussed the difficulties related to the settlement period, which occurred soon after arrival. Participant 3, an asylum seeker living in Glasgow with his family described being relocated to Glasgow without his prior knowledge or consent. The interviewee mentioned that initially he had been informed about being relocated from London to Liverpool. However, upon arriving in Liverpool Participant 3 and his family discovered that their new destination was Glasgow. From the interview excerpt, it transpires that Participant 3 was not planning to take that journey and relocating to Glasgow with his family :

> *I think maybe the management know very well but didn't explain to me when I left the Home Office but suddenly gave me when I arrived in the Liverpool station, he said, no, these circumstances changed. The family accommodation is not arranged urgently, so we have decided you can go there in Glasgow. And Glasgow duration, Liverpool to Glasgow is four to five hours. It was a very long journey and very depressing for me […] so I arrived at 8pm night-time in Glasgow on that day and everything has changed because Glasgow, I don't know how is the Scotland because I only just know about the England areas, I don't know about Scotland, so it's the first time I arrived here (Participant 3, male, asylum seeker).*

The narrative of Participant 3, and the difficulties he and his family encountered were not the only difficult experiences related to the dispersal policy and relocation to Glasgow that emerged in the interviews. Participant 13 a young single male described having to readjust to a new environment and the challenges related to being relocated to Glasgow and feeling unsupported:

> *I mean by that, they gave me a house, I don't know anywhere, I don't know what city I'm in, they didn't tell me what city was that, so I don't even know it's called Glasgow or any other thing, you know what I mean? I came from really, really far country. I never even heard of Glasgow before, you know what I mean, until I came here. I never heard of a city called Glasgow before, and even when I was here, I don't even know where I am, and from the detention centre, they didn't introduce me with any other person, any community. They left me there. I can go out but I don't know where to go (Participant 13, male, asylum seeker).*

Another aspect of the interviews that was discussed by some of the participants related to housing and, in particular, homelessness. Research illustrates refugees' and asylum seekers' housing experiences as generally difficult (Ziersch & Due, 2018; Murphy & Vieten, 2022). Local authorities, under Scottish Housing law are bound to prevent homelessness, and provide emergency temporary accommodation, if a person becomes homeless whilst seeking accommodation (Strang et al., 2018). In the interviews, a refugee participant described the challenges related to housing once refugee status was granted. The time between receiving refugee status, the cessation of government assisted housing, and being successful at finding appropriate accommodation is discussed by Participant 1 as a post-migration difficulty:

> *After I got my leave to remain one of the challenges is that I've got 28 days to leave the Home Office accommodation where I was staying and then to go to temporary accommodation. My housing officer said to me, I'm going to take you to the asylum and refugee homelessness team that they will actually look for temporary accommodation for you […] So, after that I applied to housing associations by myself. I applied to more than 16 different housing associations, even more than 16, during that period […] I was facing the homelessness route to get accommodation. (Participant 1, male, refugee).*

This experience was also discussed by another interviewee, Participant 16, an undocumented migrant. In Participant 16's case, homelessness became a reality once her asylum claim was rejected by the Home Office:

> *After also receiving decisions on my asylum claim, before applying again and between, I experienced being actually homeless or out of an accommodation (Participant 16, female, undocumented migrant).*

5.3.2 Living in limbo

Research has highlighted that the feeling of living in a state of limbo, particularly whilst awaiting a decision on the asylum claim is a post-migration experience that impacts negatively on individuals' mental health (Ziersch & Due, 2018; Isaacs et al., 2020). In the interviews, this was described by some participants as an invisible barrier. This was an area of particular concern for asylum seekers and undocumented migrants who took part in the study. For example, one participant discussed difficulties in accessing education:

> *There's always a barrier, there's always a thing that will just put you down, and even when you talk to your college about that, they will tell you, no, this is what the government policy says and they cannot just go against that, even if they know you are intelligent, you can do this course, but because of what the government says, we cannot just accept that (Participant 11, male, asylum seeker).*

Some of the participants described the barriers as like being in a liminal space. Participant 1, a refugee participant, recounted his experience whilst claiming asylum. His narrative reports on the interwoven relationship between the asylum process, a thwarted sense of agency, and mental health experiences:

> *Psychologically what I meant is that sometimes you're overthinking, mentally stressed in the sense that sometimes I didn't want to talk to anybody, I just wanted to be by myself. Sometimes I just thought that what's the purpose of life if you're trying this much that you want to do*

> *something, you want to contribute to the community you are living in, but there is the barrier (Participant 1, male, refugee).*

The length of time waiting for a decision was unknown to participants and in some cases could last years. For example, in more extreme, yet not uncommon situations, such as that of Participant 2 and his family, people waited several years to receive an adjudication on their asylum claim. In these circumstances, people lived in a protracted state of uncertainty:

> *I am an asylum seeker and living with my wife and two children and I am an asylum seeker for nine years, more than nine years [...] I know many families who are still on asylum from eight years, more than eight years, some from seven years and so, it is a lengthy progress. It is quite long, yeah (Participant 2, male, asylum seeker).*

In another interview, Participant 11, a young male from Nigeria described the toll that protracted waiting for a decision on his asylum claim years after his arrival, had on his mental health:

> *I arrived here four years and four months ago and I already claimed refugee status, but I am asylum seeker still, I am not granted refugee status and the situation is very stressful and difficult (Participant 11, male, asylum seeker)*

Although the policy restrictions affected the interviewees who were awaiting a decision on their asylum claim, there were diverse coping strategies that individuals adopted to deal with this difficult situation. Research shows that determination to cope, maintaining a positive attitude and receiving emotional support are important aspects of resilience (Hutchinson & Dorsett, 2012). For example, Participant 6 who arrived in the UK with his family, described the importance of maintaining a positive outlook in the face of adversity:

> *It's been a long time but I just trying to see this positive side of the situation because I'm having a lot of time to…you know, to use…to study by myself, improve my English, to work with my music. I'm trying to see*

> *the positive side of the situation because I still waiting for one year but in this year I haven't waste my time. I'm trying to not waste my time. I'm meeting with people as well to…you know, to speak as well, to have like contacts everywhere. I volunteer and I'm trying to spend my time the best I can (Participant 6, male, asylum seeker).*

The uncertainty related to the asylum process and the fear of deportation, were not the sole sources of difficulty in the post migration context. Participants described the mixed experiences related to, on the one hand, a sense of safety from having left their country of origin. And on the other, the difficulties of claiming asylum in the UK. These experiences were discussed in relation to individuals' current migration status. In the interviews, refused asylum seekers, who often become undocumented migrants, described their post migration life experiences in relation to the lack of material support. This is illustrated in Participant 16's description of personal safety and lack of financial security within the post migration context:

> *I can tell you my feelings in two ways: In one way I am happy here because I'm not living in fear of being killed or harassed. In another way I am not happy because I'm not receiving the right support, the right benefits that I should receive like others (Participant 16, female, undocumented migrant).*

After long waiting times, if their claim is rejected, asylum seekers can become undocumented migrants. For these individuals, access to welfare and other services becomes sporadic. For example, a female undocumented migrant described her experience of receiving an eviction notice and having her financial support discontinued as a result of the asylum claim being rejected:

> *Whilst I'm waiting for decisions in relation to my asylum application there were occasions when I was told that I should leave the accommodation in which I was living. And also there were occasions when my financial support stopped (Participant 16, female, undocumented migrant)*

For undocumented migrants this can, at times, become a permanent situation. Participant 14. discussed her experience of being an undocumented migrant as the source of her current psychosocial issues. These include financial problems and issues related to her rejected asylum application. When asked about the type of support that would be helpful to her, Participant 14 replied:

> *This is a so-called permanent situation for me, so if I get my status everything would have been sorted out, I believe. So I wouldn't say if I do like this, I would cope…there's nothing I can say related to that. What is in my head is, you know, my head is occupied by the status demand and if I get that, I believe everything would be settled, it would be okay for me (Participant 14, female, undocumented migrant).*

Several of the participants who sought asylum upon arrival on UK soil, described fear of deportation if their asylum claim was rejected. When referring to their asylum case, and the protracted uncertainty related to waiting for the Home Office's decision on the asylum application, one participant said:

> *All the time you have worries about your case, what happens in your case. You have, you can say, a hanging sword on your head about deportation (Participant 2, male, asylum seeker).*

The experience of seeking asylum is marred with unpredictability and loss of control over the application's outcome (Neil & Peterie, 2020). This sense of uncertainty and the looming fear of deportation was expressed by some of the participants. As discussed in the *Mental Health* section of this chapter (section 5.4), it is important to contextualise the experiences and attune to the language that participants use to elucidate these. For example, Participant 3 described experiencing depression in the context of fearing deportation:

> *Depression, if [home office] not accept my case, what are they going to do with me and with my family? They deport me? They send back to me? It's a very critical depression all that time in my mind (Participant 3, male, asylum seeker).*

Dermot and colleagues (2009) argue that for asylum seekers awaiting a decision on their claim, fear of deportation is intertwined with mental health and experiencing distress. In the interviews, Participant 9's and Participant 6's experiences illustrated this:

> *So I felt quite scared because as you know [country of origin] is a very dangerous country so I felt quite fearful that I may be deported back to [country of origin] and so that was quite stressful (Participant 9, male, asylum seeker).*

> *I didn't know nothing what's going on here. Like I just came here, seek asylum, but I didn't know if they will decide to take me back to my country, or something. I tried to seek some help to a lawyer and started this, like having nightmares at night thinking about what's going with my process. (Participant 6, male, asylum seeker).*

For some asylum seekers and undocumented migrant participants who are here without their family, the most important aspect of being successful with their asylum application was related to family reunification. For both asylum seekers and undocumented migrants whose entire family, or a member of their family, was still in their country of origin, described family reunification as a key issue. For example, Participant 16 and Participant 4 explain the importance of acquiring leave to remain so they can reunify with their families:

> *I'm not able to bring my children here, like the way others are doing after they obtained their leave to remain or after they obtained their papers (Participant 16, female, undocumented migrant).*

> *I have two kids. I left back two kids. I am hoping, putting great hope to get this status and gather my family together and stay together (Participant 4, male, asylum seeker).*

5.3.3 Inability to work and financial problems

The difficulties of being an asylum seeker extend to financial issues. In the UK, asylum seekers are unable to work legally until either leave to remain or refugee status is granted to them, so financial issues are often a significant problem (Aragona et al., 2013). For people like Participant 12, being unable to work and thus provide for his family, was discussed as the main barrier and a source of distress in the post-migration context:

> *Because I don't have a permit in this country I cannot work, so I cannot work, I cannot have a financial support to just help my child so that she could get a good study at school, so I cannot do that. And then sitting at home or doing nothing gets your mind to be stressed; so it's stopping you from work, and then stopping financially so that I cannot even help my family (Participant 12, male, asylum seeker).*

The inability to work was also discussed by one participant in relation to deskilling. Participant 8, a young male who, in his country of origin had professional training qualifications discussed not being able to work. This, in turn, had a negative impact on his psychological wellbeing:

> *The fact that I'm not working affects me a lot, first of all mentally, but also professionally because I work in the technology field, so if you know the technology is every day it's is progressing every day, and when you're…if you're not working that means you lose a lot, and then you fall behind (Participant 8, male, asylum seeker).*

Whilst accessing education could counteract the loss of professional skills due to long periods without working, the restrictions related to being an asylum seeker also limit educational access (Morrice et al., 2020). For example, Participant 11 describes his experience of being unable to complete a college course due to his status as an asylum seeker:

> *You are trying to do some course in college and they tell you because you don't have your leave to remain, you cannot do this course. That is one thing that any time…because it's, like, okay, you've done this particular course and you are at this point, okay, you want to do this, and they tell you, you cannot (Participant 11, male, asylum seeker).*

Restrictions to employment were not limited to asylum seekers and undocumented migrants. Refugees, once granted asylum, are legally entitled to work in the UK. However, the difficulties of finding employment were outlined by the sole refugee participant who was employed at the time of the interview. In this context, Participant 1 discussed his experience of perceived discrimination as a significant challenge to finding employment:

> *Looking for a job, getting something just to do, that's another difficult one. Even if you've got the right to work applying for a job and getting it is a challenge, because first of all your accent or the way you come across can be a barrier. So, you can be judged even before you go for the interview (Participant 1, male, refugee).*

Although this initial challenge to employment was resolved and Participant 1 was able to find a permanent job, prior to the COVID-19 pandemic, this required him to travel from Glasgow to London on a weekly basis:

> *I got a job, so I got some jobs and then I got a permanent job in London, so I had to be travelling from London to Glasgow every week (Participant 1, male, refugee).*

The inability to work and contribute to one's own financial independence was discussed by several participants. This, as described by Participant 5 has a negative impact on mental health, and ability to sleep.

> *In general it leaves big scar in my life because it is like a prison, you can't move, you can't work, you don't have freedom. As you know, I am a young man, I can work and change and engage myself in a lot of stuff, but this*

> *situation has a restriction on my life in general. No sleep sometimes, because of all this situation (Participant 5, male, asylum seeker).*

Across the interviewed participants who claimed asylum in the UK, money issues were reported as a significant problem. At the time of the interviews, asylum seekers receive a weekly allowance of £37. This was discussed as insufficient. Participant 13, a male asylum seeker illustrated the challenges related to having limited financial support:

> *Yes, most of the people now get just £37 a week, so that's really not enough, just you need a phone card, every month you need food, you need clothes, you need many kinds of things, but they just give you £37 a week if you are an adult, so that thing is really not enough. Even I have a really big money problem, now at the moment, so you have to cope with it, you know what I mean? (Participant 13, male, asylum seeker).*

The limited financial resources and the financial difficulties that individuals experienced in the post migration context were reported across the interviews.

> *My kids, the children, all the time, if you go out and go to the shopping, my kids all the time are demanding, so how can I manage that if you have only £35 a week (Participant 3, male, asylum seeker)*

The financial situation was described as even more challenging for undocumented migrants who, due to their status, only receive infrequent financial support from the Government. In the case of Participant 14, the situation is aggravated by the fact that she has a child for whom she cannot provide:

> *The thing is when the asylum claim is rejected basically financially you are affected, of course, especially having a child just makes it even more a lot worse. Therefore, for example, the financial support they offer you is not even enough for food, for that matter (Participant 14, female, undocumented migrant).*

As the COVID-19 pandemic began, and the first lockdown ensued in March 2020, government policy changed in relation to undocumented migrants. During the initial stages of the pandemic, even people for whom support had stopped due to their asylum claim being rejected, began to receive limited financial help. For example, when asked about the support he received during the first lockdown, Participant 12 mentions:

> *The only help is just for a financial one, so they have started to just give us £35 a week since the start of corona, so it's like £5 a day (Participant 12, male, undocumented migrant).*

In contrast to asylum seekers and undocumented migrants, during the first lockdown, refugees who arrived in the UK through the government's resettlement scheme were able to access Universal Credit. In contrast to asylum seekers and undocumented migrants, refugees' ability to access welfare support placed them on an equal footing with the general population in terms of welfare support:

> *The support that [I] received during the corona time, like even DWP or Universal Credit added some amount of money on top of monthly money […] so those supports have been delivered during the corona time and was helpful (Participant 18, female, refugee).*

However, the experience of refugees, who were able to access welfare support and Universal Credit during the first lockdown, was juxtaposed to the limited recourse to public funds available to asylum seekers:

> *Yes, so during that lockdown, that was remain a big debate in our system that there was help available in terms of universal credit, and in terms of people's support, general people. But when it compares to asylum seekers, when asylum seekers raised a voice and made urgent need of some increase in help, increase as 26 pence a day (Participant 2, male, asylum seeker).*

After long waiting times, if their claim is rejected, asylum seekers can become undocumented migrants. For these individuals, access to welfare and other services is even more restricted. For example, two female undocumented migrants described their experiences of receiving an eviction notice and having their financial support discontinued as a result of their asylum claims being rejected:

> *Whilst I'm waiting for decisions in relation to my asylum application there were occasions when I was told that I should leave the accommodation in which I was living. And also there were occasions when my financial support stopped (Participant 16, female, undocumented migrant)*

> *When my asylum application was declined, and after that when I was told my support is going to stop, I had to speak or I tried to get help from the Red Cross as well as from Migrant Help. I didn't have financial support for some time, for about three months (Participant 14, female, undocumented migrant).*

5.4 Mental health experiences

This section of the results chapter focuses on the mental health experiences of the participants in the study. The majority of the research participants discussed their mental health and wellbeing experiences during the interviews. Within this theme, three subthemes were identified in the interviews. These were: Idioms of distress, including anxiety, depression and stress; psychosomatic issues and sleep; suicide; Protective factors such as the role of religion and physical activity; and Social support.

5.4.1 Idioms of distress

As discussed in Chapter 2, the cultural idioms that individuals use to communicate distress do not exist in a vacuum (Summerfield, 2001). Instead, these are related to the socio-cultural context(s) in which people live. For example, Summerfield (2018) indicates that terms such as depression, anxiety and stress should also be considered under the umbrella term of cultural idioms of distress. Importantly, within Western cultures, diagnostic terms (e.g. depression, anxiety) are, at times, utilised as a form of self-diagnosis, outside of the professional realm of psychiatry

(Nichter, 2010). This was also reflected in the narrative of some of the participants who took part in the interviews, who described their mental health experiences using terminologies to express distress that are used as the international *lingua franca* to describe mental health experiences, including distress (e.g. WHO; UNHCR). Hacking (1995) put forward the principle of a 'Looping Effect of Human Kinds', which suggests that 'classificatory practices' (e.g. the application of diagnostic criteria), interact with 'classified people' (e.g. those on whom diagnoses apply). The Looping Effect, taken in its social constructivist sense, suggests that classificatory procedures generate reactions in classified individuals, and that these result in novel, intentional ways of being and behaving which create a feedback loop that continuously shapes these processes. In relation to the data presented here, one implication of Hacking's (1995) work is its relevance to the language used by participants to described their mental health experiences. Such language, used to describe psychiatric diagnoses, is not simply employed by participants but it is also shaped by them in a manner which perpetuates a dynamic feedback loop (Vesterinen, 2021). For example, participants mentioned:

> *Anxiety, stress, stuff like that, makes you feel […] things that actually, like, add to my mental health, mental illness if you want to put it that way (Participant 11, male, asylum seeker).*
>
> *I am very much upset and very much depression (Participant 3, male, asylum seeker).*
>
> *It was already impacted on my mental health and even when I was studying, I wasn't myself, I always was stressed (Participant 13, male, asylum seeker)*

Emotional acculturation is a term used to describe the way(s) in which migrants become attuned to culturally dominant practices in the host country (De Leersnyder, 2017). It is argued that cultural idioms of distress such as depression, anxiety and stress have become ways in which individuals become emotionally acculturated in the use of the host country's mental health vocabulary (Summerfield, 2018). In so doing, individuals may express emotional states that are associated with the biomedical model (see Chapter 2 for a review), and describe their experiences through illness categories in the absence of a diagnosis. Nonetheless, participants moved beyond this and expressed psychosocial factors when describing their mental health experiences. For example, the broader social circumstances in which participants live and the impact these have, are described by some of the interviewees:

> *It's depression, from you not having people that you used to know around you, you've been alone now, and some sort of anxiety (Participant 11, male, asylum seeker)*

> *It's very depressing, it's very much depressing. Still I am under depression because the Home Office rejected my appeal at this moment (Participant 3, male, asylum seeker).*

Papadopoulos (2007) argues that whilst it is pivotal to consider the potentially difficult pre, during and post-migration life experiences of forced migrants, the Western language used to describe mental health and trauma risks becoming reductionist, and void of the socio-cultural context in which distress emerges. This, in turn, sparks debates in relation to whether the biomedical language of health and illness is appropriate in conveying the culturally-bound idioms that people from diverse cultural backgrounds may use to describe their experiences (Tribe, 2002). Nitcher (2010) suggests that socially and culturally salient expressions of distress include people's experiences of social marginalisation and financial insecurity, which are inextricably linked to mental health experiences. This was apparent in the interviews where participants contextualised their experiences in light of social factors. For example, Participant 14 and Participant 16, two undocumented migrants who, having had their asylum application rejected have no recourse to public funds, said:

> *So it's a very, very stressful experience for me, very difficult time for me, especially at the moment. Life is so difficult that the child grows up so has the demand, so we can't provide enough, so it is so difficult to take (Participant 14, female, undocumented migrant).*

> *At this moment I'm not able to do things like others. I'm not equal with others. My situation is bad at the moment. I'm tormented with different thoughts. I've been keeping myself indoors in the house, no going out in other words. It's a difficult time for me, a stressing time (Participant 16, female, undocumented migrant).*

5.4.2 Psychosomatic issues

Although the prevalence and presenting features vary significantly across different cultures, the clinical presentations of somatic symptoms of distress such as fatigue, insomnia and back pain are reported as the most common expression of distress worldwide (Burton et al., 2020). These are commonly referred to as psychosomatic issues, and are considered embodied ways of conveying physical, emotional, and social meanings (Kirmayer & Young, 1998). Here, the term psychosomatic is used to represent the link between physical and mental health (Fava et al., 2017). In departing from biomedical understandings which, at times, assume a separation between physical and mental health, psychosomatic approaches integrate biological, psychological and social factors to provide a more holistic understanding of distress (Ibid). Some of the research participants referred to the link between physical and mental health during the interviews. For example, when discussing some of his current health experiences in the context of being an asylum seeker, Participant 8 mentioned:

> *But if your mind is not settled you cannot do anything, so it affects your physical body, your health, physical health […] So the mental and the physical actually it complements each other, if one is having a problem the other also definitely have a problem […] It [mental health] becomes a problem and then it develops other diseases within you (Participant 8, male, asylum seeker).*

Research illustrates that, in the context of psychosomatic issues, diagnoses such as hypertension may be culturally reinterpreted to refer to a biological condition which is affected by broader psychosocial or economic circumstances (Strahl, 2003; Isaacs et a., 2020). In one interview, Participant 4 illustrates this point:

> *[It is] an extreme situation. And it impacted on my health because I didn't have high blood pressure before; all of sudden I was told you're, you've got hypertension, you've got high blood pressure so you have to take medication (Participant 4, male, refugee).*

In another instance, Participant 14 discusses experiencing short sightedness and interpreted this in light of a biopsychosocial understanding of stress in the post-migration context:

> *I have also an eye problem at the moment, I'm short-sighted. I was having that kind of problem in the beginning but it's getting worse and worse, probably associated with my stress I'm experiencing at the moment (Participant 14, female, undocumented migrant).*

5.4.3 Sleep disturbances

Sleep-related disturbances are common in the general population, and are considered a public health issue associated to mental health experiences (Ohayon, 2011). In a prevalence study of sleep problems in asylum seekers and refugees, Lies et al. (2019) found a high occurrence of moderate to severe sleep disturbances in asylum seeking populations. The authors suggested that a combination of pre and post-migration stressor may help to explain their findings. This resonates with some of the interview data from the present research, where some participants described experiencing sleep disturbances:

> *The stress I have is, for example, normally I don't have enough sleep. I don't go to sleep until two o'clock in the morning, for example, and that's related to the stress I'm experiencing, you know, sleep doesn't come until that point, really (Participant 14, female, undocumented migrant).*

> *I can't sleep even now, it is worsening, I can't sleep currently (Participant 5, male, undocumented migrant).*

In a recent systematic review and meta-analysis, the COVID-19 pandemic was illustrated to have a negative impact on sleep. For example, Alimoradi et al. (2021) found associations between sleep and emotional issues during different stages of the pandemic. Participant 6's account of sleep difficulties during the COVID-19 pandemic resonates with these findings:

> *Currently I am in a very stressful situation because I can't identify day and the night because I'm staying without sleep, daytime and night-time all the time, so currently I'm in a very difficult situation (Participant 6, male, asylum seeker).*

Reports show an association between the COVID-19 lockdown and an increase of sleep disturbances. For example, in a survey of sleep in asylum seekers and refugees during the first COVID-19 lockdown Aragona et al. (2020) reported a worsening of sleep disturbances in asylum seeker and refugee populations. In the interviews, one participant described experiencing sleep-related problems during the lockdown:

> *Maybe after two month of the lockdown I got something like…I said I got lockdown insomnia (Participant 9, male, asylum seeker).*

Whilst the link between mental health issues and suicide is well established (Arsenault-Lapierre et al., 2004; Bachamann, 2018), there are very few studies which have assessed the association between suicidal behaviour of refugees and asylum seekers in the context post-migration experiences (Pollard & Howard, 2021). However, during the interviews, a few participants discussed experiencing suicidal thoughts. For example, Participant 1, a male refugee and Participant 13, a male asylum seeker, said:

> *At the beginning to be honest it was very, very stressful. At one time it was worrisome. At some point I was suicidal, I have to say. But in that time it was mentally draining for me at some point as well (Participant1, male, refugee)*

> *You might really take your life, the condition I was in was really hard without any of the friends' help, it's kind of hard, very hard (Participant 13. male, asylum seeker).*

One participant mentioned suicidal ideation in the context of the first COVID-19 lockdown:

> *For me, right now I feel like I'm better now but the first lockdown was something I just don't want to remember anymore. It actually almost got me to the point of maybe committing suicide (Participant 11, male, asylum seeker)*

5.4.4 Protective factors

In relation to suicide ideation, participants also discussed protective factors. Religion and religiosity are shown to be inversely correlated to suicide risk and it is suggested that the generally upheld life-affirming values of all major religions disincentivise suicide behaviours among believers (Gearing & Alonzo, 2018). In the interviews, Participant 7, Participant 10 and Participant 8, described religion as a protective factor when they were experiencing suicidal thoughts:

> *So honestly I have already thought of committing suicide and because I am Muslim and I have religious faith and beliefs so this prevents me from doing it (Participant 7, male, asylum seeker).*

> *Sometimes I didn't cope with what I had. One day I just wanted to throw myself in the front of a bus just to finish all the hassle, or train, but at the same time, I'm a Muslim, this is not allowed, to finish your life (Participant 10, male, refugee).*

> *I would say that what sustained me was my faith, because I understand that in life there are ups and downs, and then there are moments of distress, and then also the moment that you could rise up. So it's life in general. So it's my faith that sustained me throughout (Participant 8, male, asylum seeker).*

More generally, when discussing mental health experiences, a few participants mentioned physical exercise as a protective factor during the interviews. There were, however, gender differences in terms of seeing physical exercise as a coping strategy amongst participants, with male participants being more vocal about engaging in physical activity than female participants. Biddle et al.'s (2019) systematic review and meta-analysis demonstrate that physical exercise can have overall favourable effects in improving symptoms of distress. Whilst several types of physical activity were mentioned as beneficial, Biddle and colleagues (2019) reported the largest positive association for individuals who practiced team sports. In relation to this, one interview participant mentioned the beneficial effects of playing football on his mental health:

> *Like for me, when I'm playing football I tend to forget everything and that's the only thing I think really works for me, even when psychologists tell you it's okay, it's all right, I think football is something that you don't need to tell me it's okay. The moment I'm playing it, I don't even think there's a problem* (Participant 11, male, asylum seeker).

However, sport and physical exercise are not a viable option for all participants that took part in the interviews. For example, Participant 8, described that his ability to engage in physical activity was hampered due to his experience of mental distress:

> *If you want to go to the gym, people that go to the gym are people that have a settled mind; because when you're not settled in your mind it's difficult for you to go to the gym and do sport, for example, or go outside and do sport (Participant 8, male, asylum seeker).*

Another protective factor that was discussed by a few participants was music, particularly during the first lockdown when outdoor activities were restricted. Two of the interviewees talked about the positive effects of playing music as part of a group, both face-to-face (prior to the COVID-19 pandemic) and then online, during the pandemic:

> *So before lockdown happened, Govan Community Project put together a music group, which I joined. And they don't let us alone, and they used to make some sessions online. I think this is very… it's been a beautiful experience, I feel really happy to have been part of that so I suppose the main feeling is happiness because it has been such a good experience (Participant 9, male, asylum seeker).*

> *Well there is a group that basically they help asylum seekers and refugees. They bring instruments to these people and they used to meet before lockdown like once a week and rehearse and have a concert like once a week…a month, or something, once every three months, something like that. It was kind of a good experience because you meet with all musicians and they were…bring you instruments, they give you travel expenses, you know, you have…you got all these benefits (Participant 6, male, asylum seeker).*

5.4.5 Social support

There is increasing evidence of the positive association between social support and mental health in Western countries (Kawachi & Berkman, 2001; Bruce, 2002; Geriépy et al., 2016). Importantly, however, as highlighted by Geriépy and Colleagues (2016), social support is not a monolithic concept. Nuances in the types of support and their associations with individuals' diverse needs are worthy of consideration. In the interviews, when discussing social support, participant talked about a variety of contexts and sources of support. These, for participants who moved to Glasgow with their families, included family support:

> *I feel very happy, I don't feel alone because I'm living with my mum and my two brothers, we are living, we are learning, every time when we need something, and also we play music together (Participant 9, male, asylum seeker).*

> *And thank god for my family. They have been a band of support; they're always here supporting for me emotionally, socially, financially. So,*

> *they've been absolutely super. Especially my sister, she's been there all along (Participant 1, male, refugee).*

Another source of support discussed in the interviews pertains to engaging with the community and creating connections with people. Research shows that perceived emotional support during adulthood is a protective factor against mood-related issues (Santini et al., 2015). In relation to this, a few interviewees openly mentioned positive experiences within community settings. These included community experiences with people from a similar background:

> *In the community, as I told you, I met many friends, like mother figures, some of them, most of them are big brother figures, so they just make traditional food, they ask me what kind of food I like and then they cook for me, most of them, so I just go there and we have really good time, every weekend (Participant 13, male, asylum seeker).*

> *I mean, general service providers, say like Govan Community Project, they give you options like, okay, Friday, you think you're bored, why don't you come around with somebody or some people that you think they might really understand you and maybe come from backgrounds like yours, so come, just talk, play and relax (Participant 11, male, asylum seeker)*

Or, as in the case of Participant 2, community activities included meeting people from the broader community in Glasgow:

> *Whatever place in the community centre, you know, we have community centres, try to go there and try to sit with the people, you can say, Scottish people we seen many supportive people as well (Participant 2, male, asylum seeker)*

However, Quinn (2014) reports that some asylum seeker and refugee participants avoid seeking social support within the community. This was evidence in the interviews where some participants discussed avoiding community connections as these were seen as potentially dangerous. For example, Participant 10 and Participant 6 illustrate this point:

> *I don't trust…I am not part of anything, not [country of origin], not Palestinian, not Syrian, not any Arab. I am not near any Arab or any people who even have any connection to [country of origin]. I keep myself to myself (Participant 10, male, refugee).*

> *It is really hard for me to meet with other [people from country of origin] because there is a big problem in my country with gangs and I know that many people are part of these gangs and they are leaving the country because they had another problem with another gang. That's why I preferred not to move with the [country of origin] community here because everybody know that you have to know the background of these people before you could meet them because they could be related with gangs (Participant 6, male, asylum seeker).*

Gender differences in community support have been highlighted in the literature. For example, Warfa et al. (2012) describe that in patriarchal societies, women can more easily become marginalised within their own ethnic communities than men, in the post migration environment. This was reflected in one of the interviews where a female participant described being ostracised from her community after experiencing issues with her husband:

> *No, I'm not getting any support from the community at all. At a certain point I was a member of the [name of participant's community] here. As I had a problem with my husband I was expelled from this community (Participant 16, female, undocumented migrant).*

5.5 Access to care

Access to healthcare was another theme that I identified in the interview data. Within this theme, five subthemes were identified: Registering with a GP; Communication difficulties and interpretation; Psychotropic medication and psychological therapy; Waiting times to access services; Healthcare access and socio-cultural factors. In the present section of this chapter each of these subthemes is illustrated using participants' quotes.

5.5.1 Registering with a GP

Within the UK healthcare policy context, there are differences between UK nations. For example, in England, while primary care consultations and treatment are free of charge, undocumented migrants and refused asylum seekers are charged for access to secondary care. In contrast, in Scotland, both primary and secondary care are free of charge for everyone, including asylum seekers, refugees and undocumented migrants (British Medical Association (BMA), 2019). In addition, the refugee policy in Scotland permits access to medical treatment also to individuals who have submitted an application for asylum or have seen their asylum claim refused (Ibid). Nonetheless, research consistently shows an overall underutilisation of healthcare services by these migrant groups on both sides of the border (Pollard & Howard, 2021). Whilst the reasons for this are multifactorial and include language and communication difficulties, (O'Donnell et al., 2007; Kang et al, 2019), challenges related to accessing care in these populations comprise lack of knowledge about the health care system, and how to make an appointment with a GP (Cheng et al., 2015). The majority of interviewees described difficulties registering with a GP practice as one of the main challenges in accessing healthcare. For example, Participant 3 described experiencing issues during the process of registering with a GP. In particular, Participant 3's account describes the importance of acquiring an Application Registration Card to access both primary and secondary care and the challenges he and his family have encountered during the process of obtaining this card:

> *Yes, actually when I arrived in Glasgow, I didn't know about how to register in the medical…because Migrant Help gave me only one letter and they said you can go there because at that time I had an ARC [Application Registration Card] card, this is the card they give in the Home Office, so the Migrant Help told me that you can use this letter and go to a GP. At the initial stage, I am very much difficulty how to register my family in the nearest GP because at the start, my wife had some problem, shoulder problem, so nobody can see without registration. So I try myself as soon as possible and during this time, another problem occurred in my wife, the teeth problem, so without registration nobody*

> *can see you. So initially this letter is not acceptable, my GP said we need a visual picture and registration, so I said I am very new in this country, and my ARC card is under the process, and maybe after a few months I receive the ARC card, because some people receive the very initial stages, some people don't receive or after a few time the ARC card. So the ARC card is very important for those who have newly arrived in this country (Participant 3, male, asylum seeker).*

In another instance, an undocumented migrant who took part in the interviews described realising that she was not registered with a primary care practice via a conversation with her GP:

> *I told the GP about the health issues that I have been experiencing. [The GP] said that I haven't been in the system (Participant 16, female, undocumented migrant).*

Research suggests that there is a lack of awareness among asylum seekers, refugees and undocumented migrants around the structure of the NHS (e.g. primary and secondary care, emergency services) and that these migrant groups report being confused and ill-informed on how to navigate and negotiate access to care (Kang et al., 2019; O'Donnell et al., 2016). This, may have contributed to the difficulties in accessing services that were reported by some of the interview participants:

> *So I didn't know the process for the GP, anything about…I didn't know where to go if I was sick, but it's a really big problem, imagine if I had a really hard case or if I can't walk or do anything, I have no phone, no nothing to contact if I go sick really bad. There was no one there, so I don't know (Participant 13, male, asylum seeker).*

> *Initially my wife had problems, shoulder problem, and she wanted some medicine and tips from the GP and without registration nobody can see, so I take only painkiller and just wait (Participant 3, male, asylum seeker).*

The issue of registration and navigation of the healthcare system was also discussed in light of access to mental health care which, in Scotland, often requires a referral from a GP (Woods & McCollam, 2002). For individuals who already experience difficulties in accessing primary care, a referral to mental health services can be arduous. Within the interviews, this is illustrated in Participant 16's account:

> *I would like to receive mental health support and also other health related support as well…I didn't know where to go and seek help (Participant 16, female, undocumented migrant).*

5.5.2 Communication difficulties and interpretation

There has been much research examining communication difficulties and interpretation (*see* Robertshaw et al., 2017 *for a review*). Current research indicates a need for more effective communication of information on healthcare access by the Home Office to help individuals access the NHS (Hiam et al., 2018). Within the interviews, the majority of the participants reported communication difficulties and described how these negatively impact on their ability to access healthcare. For example, Participant 3 mentioned that, whilst he can communicate in English, his wife and son experience more language difficulties:

> *Actually the first challenge is the language because my English is not mother tongue. My mother tongue is Urdu, normally we spoke Urdu during normal life. Officially we don't use the English, normally we talk Urdu, so the first challenge was the language because my wife, my son didn't especially speak English frequently (Participant 3, male, asylum seeker)*

The individuals interviewed often talked about being affected by language difficulties regardless of their migration status. However, a gender difference was evidenced in the interviews and, in the main, female participants, whilst comprising a minority of the interviewees, reported more language difficulties than male participants. For example, Participant 15, an older female refugee, discussed language as a main barrier in the post-migration context. Whilst refugees generally reported fewer difficulties in terms of financial or housing support than the asylum seekers and undocumented migrants interviewed, the issue of language was a prominent challenge also for refugee participants:

> *Frankly speaking, financially and health-wise, all support thank God, everything was fine. The only first barriers that I have found here it was the language barrier, the English language, and the difficulty because I am in the 70s and I am getting too old to start learning language, that was the main barrier which was very difficult to cope with (Participant 15, female, refugee).*

Pollard & Howard (2021) argue that successful resettlement in a new country and psychosocial well-being are inextricably linked to language fluency. This is evidenced in the interviews, where participants discussed language proficiency and its impact on various aspects of their lives. When language and communication difficulties are contextualised in light of individuals' healthcare needs (both physical and mental health), it is clear that these have an adverse effect on healthcare access, outcomes, patient satisfaction, and can contribute to the inequalities in access experienced by these migrant groups (Chiarenza et al., 2019). To ameliorate this, Robertshaw and colleagues (2017) reported on the importance of using high quality interpretation, and how this can improve the delivery of healthcare in populations with limited communication skills. However, availability and quality of interpretation across mental health services was found to be inconsistent (British Psychological Society, 2017). Whilst the majority of the interview participants described language difficulties, in the context of healthcare access, interviewees also mentioned variations in availability and quality of interpreters. Similarly to Participant 3, when describing issues related to interpretation, Participant 9 mentioned the challenge this posed for a family member who required additional language support. This further highlights the heterogeneity of communication skills in these groups:

> *Another problem is that sometimes they don't provide an interpreter. For me, that's not so much of a problem but it's a problem for my mother (Participant 9, male, asylum seeker).*

The issue related to interpretation and how this impacts on the ability to access mental health support was also discussed by some of the participants. Two interviewees from the same country of origin but with different migration status, illustrated this. Whilst both were entitled to access mental healthcare in Scotland, the lack of adequate interpretation within services was a barrier that resulted in these participants being unable to receive the mental health care that they sought:

> *They tried to find or to get some Oromo interpreter over the phone maybe from somewhere else, and there was no interpreter supporting for that so I didn't get mental health support (Participant 18, Female, refugee).*

> *The psychological support through GP, even not only to psychologists or the service providers for psychotherapies, there was a problem with the GP, when attended the GPs, there was no interpreter, there was difficulty to get an interpreter for mental health (Participant 16, female, undocumented migrant).*

5.5.3 Psychotropic medication and psychological therapy

The limited availability of psychological services and long waiting times to access these, are barriers to the utilisation of mental health services (Randez et al., 2021). This has coincided with an increase in psychotropic medication which, for anti-depressants in particular, has seen a yearly increase of 10% over the past decade (Ilas & Moncrieff, 2012; Iacobucci, 2019). The experience of receiving prescription medication for mental distress was reported by several participants. For example, some of the interview participants mentioned receiving psychotropic prescriptions from their GP:

> *I told the GP about the health issues that I have been experiencing and the only thing that they said was yes, you are experiencing some stress, and they gave me some medications (Participant 16, female, undocumented migrant).*

> *So I connect with the GP and I show all that things in front of the GP, so he said you might use some medicines if you're happy to take this medicine, that might be sleeping pills and some antidepression medicines. So I said, okay, fine, these medicines are helping me in this situation so I am happy to take medicine, so he gave me a few medicines. So sometimes I'm using, sometimes I'm not using because all the time after taking this medicine, all the time I'm sleeping more (Participant 3, male, asylum seeker).*

However, in relation to taking psychotropic medication, two of the participants interviewed reported experiencing side effects:

> *Because I have no focus, I try to reduce fluoxetine and they said I hurt myself accidentally. (Participant 10, male, refugee).*

> *The doctor just see what happen with you on phone, he give me medicine on phone, this medicine has side effects, it's not good for me. After two weeks, always I cry I can't sleep, I have problem, I sleep in George Square and I also sleep in the lobby in a chair (Participant 7, male, asylum seeker).*

In one instance, Participant 12, a male undocumented migrant discussed his mental health difficulties in light of both pre- and post-migration experiences, with a particular emphasis on family reunification. Whilst Participant 12 was expecting to receive psychological therapy, he described receiving psychotropic medication instead. In this context, Participant 12 refers to the perceived inadequacy of medication in helping him overcome his mental health problems:

> *My expectation was to get a treatment, but whenever I go, I visit, they only give me that medicine, it's only the medication they are giving me. But whenever I sit home I do a lot of thinking and going back to experience, I came through the Libya, so on that process I have seen a lot of things, I even lost friends in that process. So thinking of going back through memories, that gets me stressed too much. And also even if I was*

> *able to see my child, that would also help my mental status. (Participant 12, male, undocumented migrant).*

Similarly to Participant 12, Participant 15, a refugee who was prescribed medication for her mental health difficulties discussed being unhappy with the medical treatment provided:

> *[I] became more frustrated because when found out [I] had to take depression tablets, that itself gave [me] depression (Participant 15, female, refugee).*

Whilst some of the participants had negative experiences with psychotropic medication, a few of the interviewees found the medication offered was helpful. This was illustrated by Participant 3, who also talked about the shared decision making process which led to the GP's prescription:

> *So I connect with the GP and I show all that things in front of the GP, so he said you might use some medicines if you're happy to take this medicine, that might be sleeping pills and some antidepression medicines. So I said, okay, fine, these medicines are helping me in this situation so I am happy to take medicine (Participant 3, male, asylum seeker)*

In another instance, Participant 15 talked about the positive results of prescription medication in ameliorating her experience of stress:

> *I ended up using it [psychotropic medication] for about four months, the stress tablets. It did help (Participant 15, female, refugee).*

For some of the participants, receiving psychotropic medication was not the sole therapeutic means to diminish their distress. Some of the participants mentioned psychological therapy as a potentially valuable intervention. However, due to difficulties in accessing mental health services through the NHS, some of the participants discussed accessing psychological therapy via third sector organisations:

> *Yes, counselling, the Govan Community Project is one organisations supporting these type of people they are under the situation like asylum process situation or other families with different issues, so they are handling all those things, and also Lifelink support me a few months. During the lockdown they called me every week at a certain time and they asked me a few questions repeatedly every week about my current situation. So this was a eight-week course and that was help for me, they trying to how to manage my mental depression (Participant 4, male, asylum seeker)*

> *The Lifelink giving me the mental support how to manage my depression situation, if I talk about the communities, they can help you how to manage your time at your home, what you do, like craft activity, like drawing with the kids, fun activities through Zoom, like you sitting in your room and I'm sitting in my room, so I can manage some different activities, wellbeing sessions (Participant 3 male, asylum seeker)*

One refugee participant who was active within a religious community accessed mental health support via a trainee counsellor:

> *They are like you know the training counsellors, someone that does training, so some of it was done by training counsellors, some of it was done by a pastor (Participant 1, male, refugee).*

5.5.4 Waiting times to access services

Registration with a GP, language and communication difficulties and the limited availability of adequate interpretation where not the sole challenges that participants discussed in relation to accessing healthcare. Some of the interviewees discussed long waiting times as one of the main challenges that they experienced:

> *So another barrier is perhaps access to healthcare and the waiting times to be able to access it, but that's something that's difficult for everybody (Participant 9, male, asylum seeker).*

> *I'm waiting in the waiting list because there is other people before me; that's why I'm waiting (Participant 4, male, asylum seeker).*

Research evidence identified long waiting times as a barrier to accessing care prior to the start of the COVID-19 pandemic (O'Donnell et al., 2007). However, it has since been shown that the pandemic has further impacted on waiting times, also in relation to accessing mental health care. An initial upsurge in referrals for healthcare support during the first wave of the COVID-19 pandemic, has led to a further increase in waiting times for assessment and treatment of distress (Malodynski et al., 2021). This issue was raised during the interviews:

> *Everything is done by phone and appointments are slow, everything is slow and it is not possible to see the GP because of this COVID-19 (Participant 7, male, asylum seeker).*

> *I asked to see a psychologist since I arrived in the UK and so far I haven't seen anyone and I received the letter telling me that we will let you know about an appointment in three or six months (Participant 3, male, asylum seeker).*

For people who were accessing psychological services, interruption of mental health care occurred at the time of the pandemic reaching the UK in the early months of 2020 (Rains et al. 2021). In light of this, one of the interview participants mentioned the discontinuation of therapy at the start of the first lockdown in March 2020:

> *I was referred for my mental health to other sort of body. I was following up some therapy advice with them. I completed that and again I was referred to another place for a second time, but because of the COVID-19 situation I couldn't attend this one, because you can't meet people in person currently (Participant 5, female, undocumented migrant).*

As the pandemic started, clinicians in both primary and secondary care faced challenges in delivering care. This resulted in the use of telephone and online video platforms to maintain continuity of care. Teletherapy soon became the main service delivery system for clinicians and patients, and neither of these groups had extensive experience of using these prior to March 2020. During the interviews, a few of the participants mentioned their experiences of teletherapy. For example, Participant 11 described his experience of receiving therapy over the phone as substandard. From his account it is illustrated that, for Participant 11, teletherapy is not a viable substitute to face-to-face therapy:

> *Because of this pandemic, services are like we cannot do this [face-to-face], but if you think like you need this service, you can still phone and I don't know about other people, for me if I'm talking with you on the phone, I feel like I'm just talking but if I'm seeing you, I think, okay, I think this actually means a lot to me and it actually has more impact than me just talking to someone on the phone (Participant 11, male, asylum seeker).*

The difference in perspectives that was captured during the interviews, was also reflected in participants' experiences of teletherapy. In contrast to Participant 11's, Participant 3's experience of receiving therapy over the phone was described as helpful:

> *During the lockdown they called me every week. So this was a eight-week course and that was help for me, they trying to how to manage my mental depression (Participant 3, male, asylum seeker).*

5.5.5 Healthcare access and socio-cultural factors

In light of other resettlement challenges, asylum seekers and undocumented migrants do not always give priority to healthcare. Research shows that the asylum claim, housing, access to food, and receiving adequate material support for their family are often perceived as more important; particularly if the healthcare issue experienced is not considered an emergency (Asgary & Segar, 2011; Willey et al., 2022). These findings resonate with the experience of Participant 16, a female undocumented migrant who discussed this during the interview:

> *No, I didn't go to the GP during those times [while experiencing distress], those three months. I only went to other supporting agencies, supporting organisations like government support, in order to obtain support for other things, not health ones in other words […] my priority was not actually seeking medical help because in order for you to take medication you have to eat, you have to survive. I know where it is but I didn't go there [GP practice]. I was trying to obtain other support like accommodation and food support at that time (Participant 16, female, undocumented migrant)*

When examining access to mental health services, Kiselev et al. (2020) described asylum seekers and refugees' under-utilisation of mental health services by highlighting socio-cultural barriers to access. In addition to language difficulties and mental health awareness, issues around stigma and the limited permeability of healthcare services for these groups was discussed. During the interviews, one of the participants talked about accessibility of services and, rather than discussing access *per se,* the participant's account referred to the cultural suitability of counselling, and the potential issues associated with attending psychological therapy:

> *It would be, as I said that, it is available [counselling], but I will, some people like will hesitate to go; whether is not for me, whether it is not accessible for me, whether it is not fully co-operative for me. So, there are these kinds of thoughts going on people's mind (Participant 2, male, asylum seeker).*

However, once access to healthcare care was achieved (e.g. GP, psychologist), several interview participants reported positive experiences.

> *The access to the GP […] it was really a good experience for me. It's not super-fast that you will go and the same day will get an appointment but you call and probably in three days you will get an appointment. And I*

> *think it's…I have a good experience because it's not like in my country, probably you will get sick and you will have to wait one month until they want to see you and see what is going on (Participant 6, male, asylum seeker).*
>
> *Related to health I am getting a lot of support, the doctors are trying to help me as much as they can (Participant 5, male, undocumented migrant).*
>
> *I actually had a psychologist from Glasgow Trauma Service which has been so helpful, so that's why I say, like, most services available around here really help you (Participant 11, male, asylum seeker)*

5.6 Summary

This chapter has presented the results of RTA on the data gathered through semi-structured interviews with asylum seekers, refugees and undocumented migrants. The data was divided into three main themes: the asylum process; mental health experiences; and access to healthcare. Within these themes, several sub-themes were identified through an in-depth, analytical process. The results show that the mental health and psychosocial experiences of the research participants are affected by issues that include experiences on arrival and the potential for re-traumatisation, the uncertainty related to their asylum application and the sense of precarity and the experience of living in a state of limbo that this induces. Issues related to housing and, for some, the prospect of homelessness were also discussed in relation to mental health.

The experiences that the interviewees shared, particularly in relation to their mental health and wellbeing, clearly result from Home Office policies and political decisions by the state. Through the often inhumane treatment of migrants, Home Office policies (in the UK) vulnerabilize people and create the conditions for the exacerbation of distress, and more generally, lower wellbeing in these population.

An example of the negative implications of these policies on the lives of people are reported in the results. For example, interviewees' inability to access ESOL and College courses through lack of funding or the exclusion of people seeking asylum from accessing higher and further education, were the result of immigration restrictions aimed to punish and worsen the life conditions of asylum seekers interviewees (i.e. Hostile Environment Policies). For asylum seekers and undocumented migrants in particular the inability to work and financial insecurity were found to impact the level of distress experienced. Also, in relation to mental health, psychosomatic symptoms and difficulties with sleep were prominent. Protective factors included family, friends, religion, exercise and music. Access to care was described as arduous due to language and communication difficulties, issues registering with a GP, and long waiting times, which were worsened by the COVID-19 pandemic. Some interviewees talked about teletherapy in relation to counselling and expressed ambivalent views. Whilst most participants discussed positive experiences with care once accessed, the framing of their experiences as pertaining to mental health were discussed by participant as leading to psychotropic prescriptions, and consequently some participants reported experiencing side effects.

The methodological approach used in this study has limitations worthy of further critical reflection. For example, the data included in the analysis was collected over a short period of time due to difficulties in recruitment and limitations related to the COVID-19 pandemic (*see Chapter 4 for details*). The pitfalls of this included limited scope for the further development of questions informed by the ongoing data collection. This could have benefited the analysis and results of this thesis by focusing more closely on specific aspects of the interviewees' accounts, such as the impact of the asylum system on participants' wellbeing.

As described in Chapter 4, Section 4.4, the next chapter is a secondary analysis of the transcribed interviews. In so doing, it employs the theoretical concept of Candidacy (Dixon-Wood et al., 2006) to explore participants' access to care and, more broadly, access to the services that they need. In this context, the concept of multiple candidacies is used to outline the ways in which people's Candidacy journey to access various services crystallises. The seven phases of Candidacy are illustrated linearly, starting from Identification of Candidacy (see Figure 2 in Chapter 4). The final section of the next chapter outlines how, in relation to the data, operating conditions can be subdivided into three parts: macro-, meso-, and micro-conditions. Each encapsulates specific operating conditions, which influence access to services. These were discussed in light of their impact on the mental health and psychosocial experiences of the interview participants.

Chapter 6 Candidacy

In Chapter 5, a description of the main themes and subthemes derived from the reflexive thematic analysis of the interview data was presented. Chapter 2 (section 2.1.1), introduced the theory of candidacy and provided an overview of the wider research that adopted this theory. In the present chapter the focus is on the application of the candidacy framework to the interview data. To complete this, the transcribed interviews were re-analysed and the data was organised using NVIVO. The re-analysis of the data was deductive and applied the seven phases of the candidacy framework: identification, navigation, permeability, appearing/asserting, adjudication, offers/resistance, and operating conditions (see Figure 2 for a full description) to understand the interview participants' journey(s) to service access. Although the candidacy phases do not necessarily follow a linear pathway (Dixon-Woods et al., 2006; MacKenzie et al,.2013), for the purpose of clarity, in this chapter, these are presented linearly starting from individuals' identification of candidacy through to operating conditions. Operating conditions are broader, contextual conditions, known to influence each phase of the candidacy framework and therefore, service access (MacKenzie et al., 2013).

However, it is also important to pay attention to the way in which candidacy intersects with different aspects of people's identity. The concept of intersectionality describes ways in which systems of inequality intersect. These include gender, race, ethnicity, class, and migration (Bhopal, 2014). For example, issues pertaining to the fluidity of migration status, which can change over time, were analysed. It was identified that some individuals who took part in the interviews experienced different migration statuses in the UK. For example, some of the interviewees have been asylum seekers and, after their claim was refused and appeals were rejected, became undocumented migrants. These changes in migration status have had an impact on participants' candidacy journey. In addition, gender. Several women reported difficulties related to language fluency and engagement with the community, both from the country of origin and the host community. These issues were discussed in relation to cultural beliefs related to gender roles. Another salient aspect of the analysis was internalised stigma that resulted from issues around deservingness. The limitations of the theory of candidacy, which was not developed to encompass issues around (amongst others) the socio-political aspects of migration, are evident in this chapter. Nonetheless, Candidacy (Dixon-Woods et al., 2006) was chosen because it provided a structured approach to understanding facilitators and barriers to service access in the population interviewed.

6.1 Identification

The candidacy framework proposes that whether and how an individual recognises themselves as a candidate for a service is a crucial aspect to how they approach the required service (Dixon-Woods et al., 2006). In the UK, mental health policies and procedures are largely based on the biomedical model of health and illness which, as shown in Chapter 5, may not align with the way that asylum seekers and refugees from other countries and cultures view mental health and ill-health (see Chapter 5, section 5.4 and 5.5). Criticisms of the biomedical approach include its over-reliance on biological factors to explain distress (Kinderman, 2019). These tend to overlook both the psychosocial factors associated with the experience of distress, such as the asylum process, housing and financial difficulties (see Chapter 5, section 5.3), and the development of treatment that considers a person's biopsychosocial situation in a holistic sense (Deacon, 2013). When candidacy is applied to the ways in which participants identified a need to access mental health services, it is clear that the language they used to describe distress was based on Western diagnostic terms. The analysis showed that the Identification of need for mental health support was discussed by several participants using the biomedical language of mental health. Nonetheless, participants talk about mental health in the context of broader psychosocial experiences:

> *Basically, it's depression, from you not having people that you used to know around you, you've been alone now, and some sort of anxiety, thinking do you have any life, what does the future hold for you? I feel like, oh, I'm better, all those kind of fears, coping with anxiety, stress, stuff like that, makes you feel, no…so it compounds and when you are in, it makes it even worse because you just keep thinking about that stuff. So those are things that actually, like, add to my mental health, mental illness (Participant 11, male, asylum seeker).*

> *The stress I have is, for example, normally I don't have enough sleep. I don't go to sleep until two o'clock in the morning, for example, and that's related to the stress I'm experiencing (Participant 14, female, undocumented migrant)*

> *Day by day your mental health is getting worse and worse as well I never had this kind of difficulty, no, never. I never was depressed like this (Participant 13, male, asylum seeker)*

For the interviewees that discussed the psycho-social nature of their distress, these were recognised as being rooted in people's post-migration experiences. Particularly in the context of seeking asylum and applying for refugee status:

> *I arrived here four years and four months ago and I already claimed refugee status, but I am asylum seeker still, I am not granted refugee status and the situation is very stressful and difficult (Participant 5, male, undocumented migrant).*

> *But, when we see what's the reasons behind, we will, you know, we can directly say that these kinds of mental health issues, all asylum seekers are facing (Participant 2, male, asylum seeker).*

In addition to the asylum system, some of the interview participants considered the ongoing COVID-19 pandemic and its negative impact on their mental health. Whilst discussing the experiences during the first lockdown, Participant 2, Participant 6 and Participant 8, three male asylum seekers interviewees, said:

> *The COVID, I can, in general I can say that the people they spend six months in their homes, general people, everyone, without work and without any socialising, without any; and we have seen that the normal people who was very normal, they are going through this depressive. And now, we can imagine that if someone is on asylum from six or eight years and he goes through these kinds of problems (Participant 2, male, asylum seeker).*

> *Well just I started to get stress. I start to feel my flat is smaller and smaller and smaller, you know, every…all the time. I started to feel like it was like getting narrower (Participant 6, male, asylum seeker).*

> *It is depressing just staying home, going out and coming back and repeating the same procedure…pattern is very difficult and depressing….It's a very difficult thing. It is depressing just staying home, going out, coming back, staying always home, that's very depressing (Participant 8, male, asylum seeker)*

During the COVID-19 pandemic mainstream media and academic discussions highlighted the potential impact of the lockdown on mental health (e.g. Liberati et al., 2022). Although this was not directly illustrated in the interviews, it can be argued that such discussions may have aided individuals' recognition of psychosocial symptoms as relating to mental health. This, in turn, may have eased Identification of Candidacy for psychological services. For example, Participant 2 described the experience of an asylum seeker who, during the pandemic, began to experience the worsening of their mental health. The context of Participant 2's account includes difficulties intrinsic to the experiences of living in a hostel during the first lockdown:

> *Depression and things were keep adding all in his mind. He was alone here, without family, friends, in a new country, where he have a language barrier. When he go out he can't communicate with people, you know, so, and that time he was forced to go in a single room, spend his time there. So, all these things, you can say that, you know, keep adding more in his mind, and he became in a negative way (Participant 2, male, asylum seeker)*

In this context, the difficulties experienced in the post-migration environment, coupled with feeling socially isolated, were compounded by the pandemic and the lockdowns that followed. An example of this was illustrated by Participant 18, a female refugee:

> *It's mental health, [I] feel like unworthy and lonely person who lives with no one here (Participant 18, female, refugee).*

One important aspect that can be recognised in Participant 2's and Participant 18's accounts is the way in which they identify the psychosocial dimensions of mental health. This was further illustrated by other interviewees who, whilst identifying mental health as important, also talked about other needs for which they identified as candidates. During the interviews, a few undocumented migrant interviewees spoke about how, at times, their most basic needs, such as food, were not met. For example, Participant 16 illustrates how, whilst access to healthcare is available free at the point of access, healthcare is not considered a priority and other needs take precedence:

> *My priority was not actually seeking medical help because in order for you to take medication you have to eat, you have to survive. I know where it is but I didn't go there. I was trying to obtain other support like accommodation and food support at that time [...] I didn't go to the GP during those times, those three months. I only went to other supporting agencies, supporting organisations like government support, in order to obtain support for other things, not health ones in other words (Participant 16, female, undocumented migrant).*

Participant 16's account shed a light on the challenging reality of being an undocumented migrant. Importantly, for some interviewees who took part in the research, healthcare is only one aspect of their Candidacy journeys. Several structural barriers have been identified that limit healthcare access in these populations, including the asylum system and financial difficulties (Asif & Kienzler, 2022). Also, there are other services for which asylum seekers and undocumented migrants identify as candidates - chief amongst these is being granted refugee status (Keygnaert et al., 2014). Also, access to education and employment are shown as important for the mental health of these populations (Borsch et al., 2019). During the interviews, some participants discussed their identification of candidacy for other services such as education and employment, and the importance these have for them:

> *Yes, the main thing I'm looking is status, if I get a paper I want to study. What I want is to get granted status then I want to study (Participant 4, male, asylum seeker).*

> *Because I do not have permit in this country I cannot work, so I cannot work. I cannot have a financial support (Participant 12, male, undocumented migrant).*

> *I cannot work here. I'm not allowed to work. I can do that volunteering, nothing else. I can't get money from another source (Participant 6, male asylum seeker).*

6.2 Navigation

Following from individuals identifying themselves as candidates for healthcare, the next phase of the candidacy framework involves navigating the system to find a point of contact with the required service (Liberati et al., 2022). In relation to this, Dixon-Woods et al. (2006; Koehn, 2009) show that a significant amount of effort may be needed to find a way through the system. Being able to navigate access successfully, and reaching a point of contact with the appropriate service, depends upon an individual having the necessary resources and knowledge. In the case of asylum seekers, refugees and undocumented migrants, the systems they are required to navigate are often disjointed, and include diverse services such as the Home Office, housing, education, employment, and healthcare. Some of these services are more local (e.g. GP), whereas others are national and may require protracted journeys (e.g. Home Office). When this is coupled with often insufficient information being provided on the appropriate ways to navigate the required services efficiently, difficulties in navigating services become even more evident. In the interviews, participants described challenges in navigating services, including GP practices. The successful navigation of GP practices requires knowledge that includes how to register with a GP (see Chapter 5, section 5.5.1). Some interview participants talked about not knowing how to navigate the procedures required for registration at a local GP practice and reach a point of contact with the healthcare service:

> *I didn't know, to be honest with you, frankly speaking. I didn't know, I had no idea don't know anything, I don't know if people have problems where they have to go. I don't know any system or how this will work. I had no idea, to be honest with you, I don't know (Participant 15, female, refugee).*

> *So I didn't know the process for the GP, anything about…I didn't know where to go if I was sick, but it's a really big problem, imagine if I had a really hard case or if I can't walk or do anything, I have no phone, no nothing to contact if I got sick really bad, just at the house. There was no one there, so I don't know (Participant 13, male, asylum seeker).*

Several participants described registering with a GP service using an Application Registration Card (ARC) which is issued when an asylum application is submitted. For some participants, third sector organisations were instrumental in aiding navigation of healthcare services. For example, one of the participants in the interviews described navigating access to healthcare, and registration with a GP practice, via Migrant Help:

> *When I arrived in Glasgow, I didn't know about how to register in the medical…because Migrant Help gave me only one letter and they said you can go there because at that time I had an ARC card, this is the card they give in the Home Office, so the Migrant Help told me that you can use this letter and go to a GP (Participant 3, male, asylum seeker).*

Interviewees' experiences in navigating a point of contact with the service(s) that they identify as candidates for, were idiosyncratic and dependent on having the information and the resources required (Piacentini et al., 2019). However, in contrast to the extracts above, Participant 6 described the ease with which he was able to access healthcare, beyond the GP practice:

> *I can get access to dentist. If I need glasses I can get glasses. It wasn't like difficult to learn this service, medical service. Thankfully I haven't get sick since I get here…since I came here and I still find just I went to the dentist because I needed something but it was really easy, I just carry*

> *out this documents that I needed and it was very easy to get an appointment for dentist (Participant 6, male, asylum seeker).*

In terms of navigating other systems that they identify as candidates for, participants described difficulties in navigating the asylum process, and other related services such as housing. This is not solely due to individuals' knowledge of the system but also due to lack of information on how the system can be navigated:

> *How to apply [for] asylum and I have given all that deal why I came here, what is my current circumstances, why is my life threatened, and I lived with my friend so he suggested to me you can take an appointment in Croydon and you go there and then you can apply asylum. Because I didn't understand how to start asylum, so I didn't apply in the airport […] I didn't know how to get the Home Office because this was the first time for my procedure (Participant 2, male, asylum seeker).*

Similarly to challenges related to navigation of healthcare services described above, asylum seekers' and refugees' successful navigating of services other than healthcare resulted from sign-posting by third sector organisations (Quinn, 2014; Piacentini et al., 2019). During the interview, Participant 3 described how he learned to access food banks and community organisations. Importantly, the navigation of these services does not follow a linear, standardised pathway known to all newly arrived migrants. Sign-posting by charities, including Migrant Help, became important:

> *Actually I visited first time Migrant Help, they helped me. So they gave me the Scottish Refugee Council address, so Scottish Refugee Council helped me out and guided me where you find food banks, where you find communities to engage your life near to my home, so they gave me a few contact lists, so I contacted different communities like Govan Community, and Maryhill Integration Network and also the Unity Centre. So these organisations help all the asylum seekers and refugees in Glasgow how to manage your life if you have any fund issues (Participant 3, male, asylum seeker).*

Whilst navigation was described by several participants, the interview data showed that, once someone identified themselves as needing a service, the process of navigation began in an unstructured manner, rather than via a clear and well-defined pathway. This is problematic because the asymmetry in information provision and knowledge is a potential barrier to equitable access to services. For example, some asylum seekers, refugees, and undocumented migrants may have difficulties in acquiring the information needed to efficiently navigate and reach a point of contact with a service. This is further explained by Participant 9, who illustrates how he attempted to navigate the system in search of support using the internet:

> *I try to like have a look on internet hoping I get support from the NHS, or something like that, but many people don't know what to get access to many things. Thankfully I could do many things at the beginning. Yeah, I mean Home Office, when you come here, they don't give you a lot of information. You have to look around, you have to find a lot of things by yourself (Participant 9, male, asylum seeker).*

However, the availability of digital means, internet access, and the knowledge required to use technology was not always accessible to the individuals interviewed. For example, Participant 14, a female undocumented migrant, talked about having difficulties in acquiring the knowledge required to navigate a point of contact with services because she did not have access to the internet. In Participant 14's account the connection between migration status, access to education, and service navigation becomes evident:

> *Thankfully when I was in college, I was using wi-fi but at the moment because I am not in college this is also becoming a problem (Participant 14, female, undocumented migrant).*

During the interviews, I also asked about navigation to access mental health services. A few of the participants mentioned either primary care as the point of contact or, alternatively, participants again described accessing Migrant Help, a Scotland-wide charity created to support asylum seekers and refugees:

> *I didn't know where to go and seek help apart from going to the GP (Participant 16, female, undocumented migrant)*

> *There is mental health facilities available, they can access through...they can access through GP or they can access through Migrant Help (Participant 2, male, asylum seeker).*

6.3 Permeability

After individuals have moved through the initial phases of candidacy, namely Identification and Navigation, they may reach a point of contact with a service. The degree of porosity, or ease of access, of the service sought within the candidacy framework is called Permeability (Dixon-Woods et al.,2006). The level of permeability that different services have varies, and services for which entry is difficult (i.e. services with low permeability) may require individual candidates to meet additional criteria at the time of access (e.g. having a referral). In contrast, services with a higher degree of porosity for which entry is easier (i.e. more permeable services) are more easily accessed and require fewer resources on the part of individual candidates (Liberati et al., 2022). Whilst navigation was, at times, challenging, the high porosity of GP services, which most participants were able to access, was highlighted in the interviews. Primary care was often considered by participants as a point of contact for a variety of needs. It can be argued that, in the absence of knowledge and information on how different services may be accessed, individuals try to find the way to access services which they perceive as more porous (e.g. GP services). This point was articulated by some of the participants within the interviews and is reported in the experience of Participant 16, an undocumented migrant. This also resonated with Participant 15 and Participant 4 two asylum seekers, and Participant 2, a refugee. These interviewees have different migration status. Nonetheless, they report accessing primary care for issues pertaining to both physical and mental health:

> *I didn't know where to go and seek help, apart from going to the GP. I would like to receive mental health support and also other health related support as well (Participant 16, female, undocumented migrant).*

> *I didn't know what to do, basically, but then when I started crying a lot and finding difficulty to cope with the situation, I went and saw the doctor, the GP (Participant 15, female, refugee).*

> *Yes, they gave me some paperwork. I gave it to health centre and they said whenever I have any problem, I'm sick, they told me I can visit to get treatment (Participant 4, male, asylum seeker).*

> *My wife, she have gone through some, you know, depression issues and for this one, she have contacted the GP (Participant 2, male, asylum seeker).*

During the interviews participants described primary care, and in particular GP practices as the more porous services. The permeability of primary care was also discussed by some participants in the context of registering with a GP practice. Whilst in Scotland health care is free at the point of need to everyone, regardless of their migration status, the permeability of services also depends on individuals' capacity to register with a practice (as seen in the Navigation phase of this chapter in section 6.2). In the interviews it was described that a lack of knowledge in terms of what is required to access healthcare in Scotland can diminish the degree of permeability a service has. This was discussed by some of the interviewees, and is articulated in the excerpts from Participant 3 and Participant 9, two asylum seekers who described their interactions with health care providers in the context of experiencing difficulties in permeating primary care services:

> *Yes, and initially my wife had problems, shoulder problem, and she wanted some medicine and tips from the GP and without registration nobody can see […] my GP said we need a visual picture and registration, so I said I am very new in this country, and my ARC card is under the process, and maybe after a few months I receive the ARC card, because some people receive the very initial stages, some people don't receive or after a few time the ARC card. So the ARC card is very important for those who have newly arrived in this country (Participant 3, male, asylum seeker).*

> *So we had to wait to receive a letter [ARC], for instance, that granted us access to all different types of healthcare like GP and dentist, medicine, et cetera. (Participant 9, male, asylum seeker).*

At the start of the COVID-19 pandemic, the permeability of GP practices and other support services accessed by the interview participants decreased as services went online and reduced, or stopped, seeing patients face-to-face. In this context, the permeability of services such as hospital, GP appointments and third sector organisations were affected by operating conditions (i.e. the COVID-19 pandemic):

> *For appointments with hospitals, so everything is done by phone and appointments are slow, everything is slow and it is not possible to see the GP because of this COVID-19, and even when we get in touch with the organisations such as Scottish Refugee Service, so it's done by phone and it's very slow as well. And this concerns all asylum seekers (Participant 7, male, asylum seeker).*

> *I called them in the morning, why haven't I seen the doctor, he told me I'm going to see him a month ago, I'm supposed to see him in November or October, in his own words he said that, why didn't I see him? And they told me we don't know anything, you have to wait, she said you have to wait. And they still haven't given me any date to see a doctor (Participant 13, male, asylum seeker).*

Interviewees described accessing services with varying degrees of permeability. The accounts illustrated that service porosity depends on factors such as the type of service sought, and how permeable a service is, but also the knowledge and resources that individual candidates have about the service. Differences in services' permeability show that there is not a clear and defined pathway that all interview participants are aware of, and that leads them to access the service(s) needed. In contrast, nuances related to broader operating conditions influence access (see the operating conditions section of this chapter for a full review). For example, Participant 14, an undocumented migrant who took part in the study described experiencing difficulties in using services such as dental and eye care, which she attributed to her migration status. However, in Scotland, Participant 14 and her child are entitled to access all healthcare services. This highlights that some interviewees are not always aware about their entitlements when it comes to accessing care:

> *So overall what happened is basically overall access to the services is not bad, I do not have much problem about that. However, for dental treatment and eye treatment, I've got difficulty. For example, I cannot get dental care because, I don't know, because of my status, so optician as well, for example, I could not have that glasses. My child has never had a check-up, for example, in the dentist, still because of my status, I believe (Participant 14, female, undocumented migrant).*

The low level of permeability, particularly in relation to secondary care, was also identified in the interviews. For example, Participant 4 described that waiting times hinder a service's porosity, even after a referral had been granted. In addition, Participant 5 documented the impact of COVID-19, which compounded pre-existing issues within services:

> *Currently what I'm looking for is to get the support of the psychiatrist, that is what I'm expecting […] I'm waiting in the waiting list because there is other people before me; that's why I'm waiting (Participant 4, male, asylum seeker).*

> *I was referred for my mental health to other sort of body. I was following up some therapy advice with them. I completed that and again I was referred to another place for a second time, but because of the COVID-19 situation I couldn't attend this one, because you can't meet people in person currently (Participant 5, male, undocumented migrant).*

6.4 Appearing/Asserting

In the candidacy framework, Dixon-Woods (2006) described the concept of appearing at a health service in relation to asserting or claiming candidacy for professional support. Being able to assert one's own candidacy for a service also requires skill and resources. These include a level of articulacy which allows for the formulation of the presenting issue for which professional attention is sought

(Liberati et al., 2022). In the interviews, the participants outlined a variety of difficulties that made appearing at services, and asserting candidacy, a challenge. An issue that most of the participants raised was related to language abilities:

> *They don't know about how to fill the form, they don't know how to read, especially not reading the signs, those who are coming from Libya, Syria, Saudi Arabia, they only just read Arabic (Participant 3, male, asylum seeker).*

> *The first barrier I think is language here because many people come here and they don't know nothing about English, they cannot speak English, they can just maybe just say hello and that's all. Well I'm not sure how can they get more support for that (Participant 6, male, asylum seeker).*

> *Another factor is that of a language barrier…even though I have to learn how to speak English, it becomes a big barrier to me to communicate (Participant 8, male, asylum seeker).*

Whilst asserting candidacy can be a challenge that intertwines with language skills, it is acknowledged that another important aspect of candidacy is its cultural and social construction (Piacentini et al., 2019). It is well-established that both cultural and social norms can inform participants' engagement with services. For example, the cultural concepts that participants see as relevant can shape participants' perceptions of health, and therefore the identification and assertion of candidacy for a service. Furthermore, Patel and colleagues (2018) illustrated that culture is a crucial aspect of healthcare. Therefore, the meaningful integration of culture in individuals' health-related experiences is noteworthy. For example, Participant 2 mentioned that people in his community expressed hesitancy in asserting candidacy for services such as counselling even if they identify as candidates for such service. Participant 2 attributed this to cultural factors:

> *I've seen some people, they need counselling, they need a…but they are not going to, they are not willing to […] there are a lot of reasons in our…culture-wise. It would be, as I said that, it is available, but I will,*

> *some people like will hesitate to go; whether is not for me, whether it is not accessible for me, whether it is not fully co-operative for me. So, there are these kinds of thoughts going on people's mind (Participant 2, male, asylum seeker).*

The role of culture in asserting candidacy was further illustrated in individuals' ability and willingness (or the lack of it) to assert candidacy, and was described by Participant 15, a refugee participant, and Participant 11 an asylum seeker. The potential for stigmatisation or the belief that they may be stigmatised based on pre-existent cultural notions around personal responsibility and blame, negatively influenced willingness to assert one's candidacy for mental health support:

> *I didn't show anything, I kept it in. I hide it. Maybe that's why I had more difficulty and I was crying and running out of breath, because in our culture, there is something like when something happened, people would say probably they have done something wrong, it's not people's fault, it's your own fault. Therefore, [I] preferred not to share information with other people (Participant 15, female, refugee).*

> *You're bottling those problems on your own because you feel some people might not really understand your big issues. Sometimes I feel like probably I might be the problem, you understand, because sometimes you feel you want to talk, somebody's there, but you feel like the person might not really understand you and you think, like, okay, let me just handle the problem or let me just stay on my own without talking to anyone (Participant 11, male, asylum seeker).*

It has been argued that broader societal ideas around migration and being a migrant can influence a person's sense of deservingness and entitlement to the healthcare services sought, which can negatively impact the candidacy journey (Chase et al., 2017; Kline, 2019). Willingness and the ability to access healthcare services is also shown to be influenced by feelings of internalised stigma, self-criticism and depression (Teunissen et al., 2014). For example, Participant 6, a male asylum seeker talked about asserting candidacy to a service and experiencing difficulties in disclosing his migration status in the process:

> *Even at the beginning to say to someone like why I was here it was…I didn't want to…even to say to someone I'm an asylum seeker it was like…it wasn't easy to say to someone I am asylum seeker (Participant 6, male, asylum seeker).*

In addition to psychosocial and cultural aspects of asserting candidacy, the availability of means through which individuals may be able to assert their candidacy for a service were discussed. These included issues with communication, which became increasingly more important as the pandemic limited face-to-face contact and both contacting services and appointment scheduling were conducted remotely. For example, Participant 13, a male asylum seeker, described not having access to a phone as a barrier to asserting candidacy:

> *No one checks on you, I had no one to check on me at that time. I had nothing to contact on, no one can contact me, even if they want, I don't have nothing to contact and I don't have a phone, nothing, and in the house, there was no house phone, so it's kind of complicated, yes? There should be some kind of thing to contact with a person. They give to some asylum seekers for the house, just some service and if they don't have a phone, how do they contact them? (Participant 13, male, asylum seeker).*

Participant 16 also described that asserting candidacy for support also occurred in the complex matrix of various difficulties co-occurring. Here, Participant 16 discusses mental health in the context of heightened stress and experiencing financial problems. In relation to how these relate to the candidacy framework, Participant 16 describes the Red Cross as a point of contact for asserting candidacy. This may be due to the porosity and material support (e.g. money) that the Red Cross may provide in the absence of information or knowledge on other suitable points of contact:

> *When my asylum application was declined, and after that when I was told my support is going to stop, I had to speak or I tried to get help from the Red Cross as well as from Migrant Help. While doing so there has been a time when I hate myself … I was experiencing stress up to I hate my life.*

> *Although I was accommodated I didn't have money to survive on, so I have to go to the Red Cross people in order to be supported (Participant 16, female, undocumented migrant).*

Literature related to one's assertion of candidacy for mental healthcare outlines that issues such as age and gender also play a role in asserting candidacy for mental health care. For example, older women are reported as less likely to access services for issues such as depression (Dixon-Woods et al., 2005; Koehn, 2009). Illness identity (Macdonald et al., 2016), which describes a person's potential ambivalence as to whether the issue experienced is 'deserving' of professional attention was also identified in the data. During the experiences of mental health difficulties, some interviewees expressed feelings of burdensomeness, which they conceptualised as the belief that they were bothering others. This may have made asserting candidacy even more difficult, and was clearly illustrated by Participant 13 and Participant 11, two male asylum seekers who said:

> *I think, really, it's really, I think, depressing bothering someone to talk about someone's problems (Participant 13, male, asylum seeker).*

> *Because to be honest with you there are a lot of lovely people here in Glasgow since I moved here, but sometimes they just talk in such a way that sometimes you just have to, like, oh, I don't want to bother anybody with my problem, let me just stay on my own, you understand? (Participant 11, male, asylum seeker).*

For asylum seekers, migration status is an important aspect of their candidacy to services beyond those related to healthcare. However, issues related to migration status continued even once refugee status was granted. As described by Participant 1, a refugee participant, once refugee status is achieved, individuals need to assert candidacy for accommodation, amongst other needs. This can be a challenging process and not being able to secure housing can lead to the risk of experiencing homelessness:

> *So, after I got my leave to remain one of the challenges is that I've got 28 days to leave the Home Office accommodation where I was staying and*

> *then to go to temporary accommodation. My housing officer said to me, I'm going to take you to the asylum and refugee homelessness team that they will actually look for temporary accommodation for you […] I applied to housing associations by myself. I applied to more than 16 different housing associations, even more than 16 (Participant 1, male, refugee).*

6.5 Adjudication

Following from appearing at a service and asserting candidacy for professional support, the candidacy framework indicates that adjudications are made by the service providers (and institutions). Decisions about service(s) adjudication are based on individual claims to candidacy, and the judgements that professionals may infer on them. Ultimately, it is the service providers who have the final say on a candidate's adjudication of a service (MacKenzie et al., 2015). During the interviews, the participants discussed their subjective experiences in relation to the adjudication phase of the candidacy process. Some of the interviewees talked about the adjudication of professional mental health support, which occurred in the form of a referral from a primary care clinician to a secondary care one:

> *The first point I was referred to the mental doctor […] So I just went and attended his sessions. He just asked me questions regarding what's the symptoms, all what's happening to me, and I've answered with the experience I have or the symptoms I am facing (Participant 12, male, undocumented migrant).*

> *Support was available through some different organisations. At that time there was, I think, they quite help. And then there was a health centre where there is a mental health nurse. They have given different sessions, counselling (Participant 2, male, asylum seeker).*

However, in the main, participants described secondary care services such as mental health, as less porous and more difficult to access. Difficulties in the adjudication of mental health services are not peculiar to the individuals interviewed, but rather a part of the broader operating condition related to NHS services. Long waiting times, which hindered access both pre and during COVID-

19, impacted on participants' adjudication of the healthcare needs that they had presented to the service:

> *I asked to see a psychologist since I arrived in the UK and so far I haven't seen anyone and I received the letter telling me that we will let you know about an appointment in three or six months, but so far I haven't seen anybody […] I received the letter in the flat where I'm living but I asked to see a psychologist since I arrived, and I received this letter but now the pretext is the COVID-19 so that's why I haven't seen anybody so far (Participant 7, male, asylum seeker).*

> *So another barrier is perhaps access to healthcare and the waiting times to be able to access it, but that's something that's difficult for everybody (Participant 9, male, asylum seeker).*

A few interviewees illustrated that, even when adjudication of access to healthcare was positive, the ongoing COVID-19 pandemic resulted in disruptions in continuity of care. This applied to primary and secondary care, and for issues related to both physical and mental health:

> *I was following up some therapy advice with them. I completed that and again I was referred to another place for a second time, but because of the COVID-19 situation I couldn't attend this one, because you can't meet people in person currently (Participant 5, male, undocumented migrant).*

> *I went to my GP and I was diagnosed with a deficiency of Vitamin D and I was taking that medication and after that I could not do follow-up because the GP was closed because of the coronavirus lockdown, and that means that's the only medication I was on (Participant 14, female, undocumented migrant).*

In addition to the adjudication of healthcare services, as discussed in other sections of this chapter, the interview participants are also candidates for other services. The migration status that participants held at the time of interviews influenced the interviewees' candidacy journey for these services, including adjudication. In the interviews it was clear that the service to which adjudication was considered pivotal was the asylum process, and specifically gaining refugee status. The sense of powerlessness illustrated by Participant 16 is prominent amongst the asylum seekers and undocumented migrants who participated in the interviews. Here, the importance of receiving refugee status is intertwined with participants' perceived inability to influence the asylum adjudication process. In relation to this, Participant 16, a female undocumented migrant said:

> *Till you bring new evidence in relation to… We don't know whether they are going to help you or not, but we will ask for you if they are able to help you till you provide new evidence in relation to my case [...] well, every decision is not in my hand; it is in their hands. So, I can't tell you, I don't know what is going on, I can't tell you. It's not my decision; it's their decision (Participant 16, female, undocumented migrant).*

In a different yet related context, Participant 14, a female undocumented migrant also discussed the centrality of the asylum process in the adjudication of employment:

> *If I had got my status, et cetera, I could have been as everybody else, working, paid my life and I'm sure I could have relief from my stress of course as things would be in order but unfortunately that didn't happen (Participant 14, female, undocumented migrant).*

When discussions around migration are conducted, the concept of deservingness is often used, under different guises, within media and political discourse. Deservingness is a powerful tool applied to enable an invisible line of demarcation that separates individuals who are considered worthy of protection, and thus the adjudication of refugee status, from those who are not (MacKenzie et al., 2013; Huschke, 2014; Chase et al., 2017). In the excerpt below Participant 3, a male asylum seeker, described his perceptions around how different migrant groups may be considered as deserving of refugee status, based on their country of origin. This is described via a perceived hierarchy of deservingness that relates to the refugee adjudication process:

> *I realised the Home Office was not considering if you come from Pakistan and India because they're not considering they are in trouble, only they are considering Syria, Libya are in trouble. But people have different issues, all people have not the same issues, so my issues are very different, the other people have different issues, but they are considered equally, not considering separately. So I have provided all my supporting documents, but the Home Office did not accept my evidence and they were considering it like a normal life in Pakistan, but I showed everything that happened in my life in my country (Participant 3, male, asylum seeker).*

Again, the migration status of different interviewees also impacted on their entitlements and the adjudication of support that followed. For example, refugees are entitled to welfare and universal credit support:

> *Generally I'm happy in the support that I received during the corona time, like even DWP or Universal Credit added some amount of money on top of their monthly money and also the community organisations used to deliver some food, and some other organisations were helping providing some vouchers, so those supports have been delivered during the corona time and was helpful (Participant 18, female, refugee).*

In contrast to Participant 18, the experiences related to the adjudication of support were different for Participant 16, an undocumented migrant who took part in the interviews:

> *Whilst I'm waiting for decisions in relation to my asylum application there were occasions when I was told that I should leave the accommodation in which I was living. And also there were occasions when my financial support stopped (Participant 16, female, undocumented migrant).*

6.6 Offers and Resistance

The candidacy framework illustrates that, once an individual has appeared at a service, judgements about their entitlement to care are made by service providers during the adjudication phase. These may result in the service provider(s) offering access to the service that the candidate has sought, or not offering access. In the interviews most participants described how, in relation to mental health, the offers of care made by professionals were mainly in the form of psychotropic medication:

> *I went and saw the doctor, the GP, and the GP prescribed depression tablets (Participant 16, female, undocumented migrant).*

> *I told the GP about the health issues that I have been experiencing. She said that they were aware that I haven't been in the system, and the only thing that they said was yes, you are experiencing some stress, and they gave me some medications (Participant 17, female, undocumented migrant).*

> *I saw the GP, I told him about my concerns and because I have sleeping issues … and he gave me a prescription regarding the sleeping issues (Participant 7, male, asylum seeker).*

In general, interviewees reported differences in opinion regarding the offers that they received for mental health and related difficulties (e.g. sleep). Participant 3, a male asylum seeker reported accepting the pharmacological treatment offered by the healthcare provider:

> *I connect with the GP and I show all that things [symptoms] in front of the GP, so he said you might use some medicines if you're happy to take this medicine, that might be sleeping pills and some antidepression medicines. So I said, okay, fine, these medicines are helping me in this situation so I am happy to take medicine, so he gave me a few medicines (Participant 3, male, asylum seeker).*

In contrast, Participant 15, a female refugee described that being prescribed psychotropic medication made her feel worse:

> *I became more frustrated because when I found out I had to take depression tablets, that itself gave depression and I found it difficult that such a person like me with so much energy and so much optimistic towards kids and the life that I was thinking when came to the UK, I had all those dreams and now suddenly I has to take depression tablets (Participant 15 female, refugee).*

On a few occasions, interviewees talked about the side effects that they experienced, which they attributed to the medication prescribed:

> *The doctor just see what happen with you on phone, he give me medicine on phone, this medicine has side effects, it's not good for me. After two weeks, always I cry I can't sleep, I have problem (Participant 7, male, asylum seeker)*

> *Some side-effects, but I'm using a few days in the month when I am most under depression, when I feel under depression, very much under depression, so I am using this medicine but not regularly (Participant 3, male asylum seeker).*

The above interview excerpts can be formulated as examples of moral injury (Litz et al., 2009). In brief, moral injury is a concept used to describe the emotional and psychological impact of experiencing a contravention to one's moral beliefs, trust, or expectations. Whilst moral injury is not a mental health diagnosis, its repercussions can negatively affect a person's mental health and wellbeing. Griffin et al (2019; Liberati et al., 2022) discuss the concept of moral injury in relation to recursivity. Recursivity is defined as the influence that experiences related to adjudication and offers can have on informing individuals' future choices about accessing the services that they need (Rogers & Allison, 2004; Lamb et al., 2012). Whilst medication was reported by several participants as the main intervention offered, the potential side effects that participants reported could have a negative influence on future help seeking behaviours. Not having their expectations for non-pharmacological interventions met may also impact on their future decisions to access health care. This was highlighted by some interviewees who mentioned not being satisfied with the healthcare offers that they received, and is described within Participant 12’s interview extract, where the participant talked about the difference between his expectation of treatment and what was offered to him:

> *I just mentioned my problem, like the stress and depression for the GP, but the only thing I’m getting from him is just the medicines […] I’ve mentioned the stress and the depression to them. Roughly around three years ago they have referred me to other doctor, so they just didn’t order anything else, they only ordered the same medicines, which I am using; when I am stressed too much or depressed […] My expectation was to get a treatment, but whenever I go, I visit, they only give me that medicine, it’s only the medication they are giving me (Participant 12, male, undocumented migrant).*

Similarly, Participant 10 talked about a willingness to receive treatment in the form of counselling or talking therapy, but instead receiving psychotropic medication:

> *I needed listening people just to tell what I have inside me, but I was already under tablets (Participant 10, male, refugee).*

As described in the permeability and adjudication phases of this chapter, access to mental health care, which mostly occurs within secondary care, was also difficult due to the operating conditions of the healthcare system. As the pandemic started and psychological services began to be delivered remotely, one of the ways in which therapy was offered was in the form of teletherapy. This was the case for a few of the interviewees, including Participant 3, who found the service helpful:

> *Lifelink support me a few months. During the lockdown they called me every week at a certain time and they asked me a few questions repeatedly every week about my current situation. So this was a eight-week course and that was help for me, they trying to how to manage my mental depression (Participant 3, male, asylum seeker).*

This though was not the case for all the participants who accessed online psychological therapy during the pandemic. For example, in describing his experience of teletherapy Participant 11 talked about how it was not suited to his needs. This again demonstrates that once adjudication for a service is achieved and an offer is made, at times, these can be inadequate and may be unsuited to some individuals:

> *At first it was no appointment, but after a month they started giving people phone appointments, and started doing a kind of video call, which I think that's not really for me, it's not helping me (Participant 11, male, asylum seeker).*

6.7 Operating Conditions

In the original iteration of the candidacy framework, operating conditions were construed as local-level influences on service user/provider interactions (Dixon-Woods et al., 2006). However, in this chapter, the results illustrate the multifarious aspects participants' experiences. The operating conditions of the Candidacy Theory have more recently been developed to include macro-, meso-, and micro-level operating conditions (MacKenzie et al., 2013). Whilst in the context of the theory of Candidacy these conditions were developed by MacKenzie and colleagues (2013), the origins of this approach, which included individual, community, and socio-cultural factors are rooted in recent developments of Bronfenbrenner's Ecological Systems Theory (1979). The Ecological Systems Theory aimed to provide a lens through which child development could be better understood. At its inception, Bronfenbrenner's theory framed child development as a complex relational system that is affected by multiple layers that constitute the child's surrounding environment. Its principles have since been developed further and have been implemented in other fields, beyond child development. For example, the principle of micro- meso- and micro-level conditions have been applied to understanding candidacy within public sector services in the UK (MacKenzie et al., 2013).

Within the theory of Candidacy, macro, meso, and micro level operating conditions have also been researched by Liberati et al. (2022). The authors discussed how the COVID-19 pandemic has influenced operating conditions in relation to accessing secondary mental health care. In the article, the influence of the pandemic on candidacy as a macro-level operating condition is described. During the analysis of the interviews, three levels of operating conditions were identified. These can be described as macro-, meso-, and micro-level operating conditions (MacKenzie et al,. 2013). Although we acknowledge that these levels of operating conditions are interlinked and influence each of the candidacy phases discussed above, in this section, they are discussed separately. At the macro-level, operating conditions such as the Home Office's punitive restrictions on individuals seeking asylum and the negative impact these have on individuals' ability to access a variety of services, including healthcare, education, housing, and employment, were identified. The insidious effects of the Hostile Environment included uncertainty and fear (e.g. fear of deportation) in individuals seeking asylum. The far reaching consequences of Hostile Environment policies and the language used within policies is an operating condition that does not only influence individuals at a micro-level (or individual level) but it also operates at a macro-level, in the way that language is used to define individuals' social environment and influence service access.

6.7.1 Macro-Level Operating Conditions:

In their interactions with healthcare professionals, interviewees described how the biomedical model was used in relation to the adjudication of a service (e.g. mental health), and the offers that derived from the consultation (e.g. psychotropic medication). However, several participants discussed being dissatisfied with the treatment offered. This, in the previous section of this chapter, was discussed in relation to the concepts of moral injury and recursivity. However, it is also possible to view the different systems which asylum seekers, refugees and undocumented migrants have to navigate as wider operating conditions in their own right.

For example, the biomedical model of mental health, which is prevalent within primary care, can be considered as a macro-level operating condition. Current issues within NHS services delivery systems, including issues such as difficulties accessing secondary care and long waiting times, often resulted in prescriptions of psychotropic medication as the sole available option that primary care clinicians can offer to individuals. In addition, another macro-level operating condition that was identified in the interview data and had significant implications on the participants' candidacy was the asylum system. The majority of the interview participants discussed the influence of the asylum system during several phases of the candidacy journey. For example, Participant 17, a female undocumented migrant and Participant 3, a male undocumented migrant, illustrated how the asylum system impacted of their ability to access public funds which, coupled with being unable to work due to their migration status, have a negative impact on several aspects of their lives:

> *I'm not given...getting money, getting cash or money. I can't travel to wherever I want to travel, for example. If I want to go to hospital or shopping or anywhere I want to accomplish or do something, I can't travel far. So I am staying locally always. This is some of the difficulties […] for example, if I want to meet up my friend, going out, I can't. All this has substantial impact on my mental health, also on my happiness. You feel very uncomfortable and unhappy and frustrated because of all this situation because you are isolated and seeking home, always you can't travel because of what I have mentioned previously (Participant 17, female, undocumented migrant).*

In addition to financial difficulties, the impact of the asylum system on interviewees' candidacy was also described in relation to accommodation and housing:

> *Yes, because this house is under the contract with Serco and they didn't mention my name, because the Home Office step by step register your case. First they receive the case then they process the support, but that support process is almost one month, because I have given my current document, my bank statement back in the country, they asked me your circumstances, do you have any property in your country, do you have any bank statements, do you have any money to show? So after a month, I receive a card, then step by step…so initially two months is very difficult for me because all the documents received step by step (Participant 3, male, asylum seeker).*

Whilst COVID-19 was overwhelmingly reported by the interviewees as having a negative impact on their ability to access services, in the excerpt above Participant 12 mentioned receiving public funds at the start of the pandemic:

> *The main barrier, just onto the case, because I don't have a permit in this country I cannot work, so I cannot work, I cannot have a financial support to just help my child so that she could get a good study at school, so I cannot do that. And then sitting at home or doing nothing gets your mind to be stressed; so it's stopping you from work, and then the stopping financial [support] so that I cannot even help my family; that's the main barrier […] The Home Office rejected the appeal and when there is no support or any financial assistance, it was a long time ago, you apply for their help and then they give you a £60 or £70, when there was no financial help from them once or twice from them. Then sometimes after you applied they might not even accept your application […] Before the pandemic, for almost three years I didn't get any financial help from them. It's when the pandemic start they start to give me £35 (Participant 12, male, undocumented migrant).*

Whilst the COVID-19 pandemic affected individuals across the social spectrum, evidence indicates that asylum seekers, refugees and undocumented migrants were affected more severely, also because of their migration status and limited access to public funds. This may lead to a higher risk of poverty in these populations (Armstrong et al, 2020). In contrast to Participant 12's experience presented above, for the majority of the participants in the study the ongoing pandemic resulted in a worsening of their lives' situation. This inevitably influenced their candidacy journey and exacerbated the uncertainty of living in limbo. For example, Participant 8 talked about experiencing delays in the asylum application process in his candidacy journey to refugee status:

> *So the COVID situation affects all of us, and then us specially because we are in a limbo situation, so everything is closed, all the system is late in everything, the file that was supposed to be done in two months it's been taken care after eight months. So it's a worldwide situation but it's affecting everybody (Participant 8, male, asylum seeker).*

Furthermore, several participants described the pandemic's negative impact on their ability to access education and improve their English language abilities. These issues were discussed in relation to it affecting their emotional wellbeing, and their ability to socialise and engage with the broader community. In the data it was evident that the lockdown and limited scope for socialising, had a particularly negative impact on participants who were living alone. Two examples of this are articulated by Participant 8 and Participant 15:

> *The lockdown was stress, and stress, and stress again, because before the lockdown we started English classes that I was attending two or three times a week, that was actually helping me be in progress with my language skills. But with the lockdown everything just shut down and then you go back to a level zero where you were before, so it's affecting me a lot (Participant 8, male, asylum seeker)*

> *It was a very significant impact because I was going to college every day even if I was learning one word a day, that was still something progressive, I was feeling, because when I go to college, I was seeing other classmates. I'm not really a typical person who's looking for, like, very, very essential to have 100 per cent always friends and stuff, but I enjoyed being there, seeing the teacher, seeing other classmates or other people happy, talking, chatting, socially, I liked the social life. This was the impact that when the coronavirus started, everything has stopped (Participant 15, female, refugee).*

6.7.2 Meso-Level Operating Conditions

The analysis identified another layer of operating conditions, consisting of interpersonal relationships (e.g. family and friends), and the influence of community organisations. These were considered to be meso-level operating conditions. Often, the support of friends and family, coupled with engagement in community organisations and religious activities, was reported as beneficial and aided individuals' candidacy for both emotional and material support:

> *Then the church activities, friends around, family around actually helped me. Because there would be some times when I didn't have a penny then somebody in the church, somebody at home, some family member would give me some money. There would be a time that I haven't got any food and somebody would buy something or let's share this for me to have food at home. So, that has been the strongest support I've received that kept me going for this length of time. I'm happy with that (Participant 1, male, refugee).*

> *Well at the beginning my family was all my support but after that I found a church where I met a lot of nice people and I start to get…to make new friends here (Participant 6, male, asylum seeker).*

> *Friends and family really help us. And also the community, because they actually encourage us to stay strong, that the situation may change. So these are the things that actually help me throughout (Participant 8, male, asylum seeker).*

In the participants' accounts I also identified the important role that third sector and community organisations played in supporting individuals' candidacy journey. As discussed in the navigation section of this chapter, in the absence of clear governmental guidance, the vacuum in knowledge and resources is often filled by community organisations. This was evidenced in the narrative of several interviewees:

> *Few people I find here, three to four people, very hard, after six months. Three months I stay at home, I don't know about how to find the food, but a few people tell me this area is near to your home, like Iceland is near to my home, Co-operative is near to my home, so I go there to buy food but I don't know about the Asian food, where is the Asian food. So I used my mobile to find the address for Asian food. So one of the Pakistani family meet me at my son's school when I take that mission, one of the families found out in the school, he helped me out in the initial stage (Participant 3, male, asylum seeker).*

> *I've come across a lot of difficulties but I just think service providers in Glasgow have been so helpful because a lot of times you think like, oh, this is just too much, but others are trying to…even when they might not be able to solve the problem but they always want to try to help, you understand? For them sometimes there's a barrier or there's limitations to what they can do to help you out, but they usually always try (Participant 11, male, asylum seeker).*

> *Generally I get support from Govan and the Kinning community because they are also supporting me materially and also emotionally. And I was volunteering with them previously. That is a community I have. Because you are meeting up people and learning new things, new situation and people are helping so you learn stuff as well and you contribute as well. When you are engaging with people your mind has outlet where you can talk to people and also forget other stuff (Participant 5, female undocumented migrant).*

Although several of the individuals who took part in the study arrived in the UK with at least one family member, several others did not. Community organisations were particularly important for individuals like Participant 13, who arrived in Glasgow as an unaccompanied minor. In the excerpt below, he illustrates the saliency of community engagement as a way to connect with his cultural traditions and build strong, supportive relationships:

> *Yes, now in the community, as I told you, I met many friends, like mother figures, some of them, most of them are big brother figures, so they just make traditional food, they ask me what kind of food I like and then they cook for me, most of them, so I just go there and we have really good time, every weekend (Participant 13, male, asylum seeker).*

However, the heterogeneous nature of the interviewees' experiences was also identified during the analysis. Here, Participant 18, described experiencing difficulties in accessing the Oromo community in Glasgow:

> *Still there are some barriers and problems to integrate in the community, I don't know where these communities are based in Glasgow or something like that, like Oromo community or something. [I] only knew an interpreter, someone who interprets in Oromo, that's all (Participant 18, female, refugee).*

Similarly, Participant 12, a male undocumented migrant reported a lack of knowledge of the community of his country of origin and instead described receiving support from one of his childhood friends who has also migrated to Glasgow:

> *I've not heard about any Eritrean community in Glasgow. I have Eritrean friends here, and sometimes they give me a hand, whenever I have a problem they give me a hand. My first point of contact in this scenario is I have a friend who is my friend from childhood, I'll be contacting him. So he even visits me to just give me a hand or assist me; he is my first contact. Yeah, he's a friend. He's, like, a friend from childhood, so we've just passed through a lot; he has his wife and children here, so that's where I go as a first line of support (Participant 12, male, undocumented migrant).*

Gender-specific barriers related to cultural beliefs about family structure and patriarchy were also mentioned in the interviews. One interview participant described being marginalised and not receiving any help from her community. In the interview, Participant 16, an undocumented migrant, attributed being ostracised to difficulties in her relationship with her husband:

> *No, I'm not getting any support from the community at all. At a certain point I was a member of the Oromo community here. As I had a problem with my husband I was expelled from this community (Participant 16, female undocumented migrant).*

In another interview, a refugee participant discussed not trusting members of his own community who live in the UK. The context of this scepticism stems from his pre-migration experiences in his country of origin:

> *I don't trust…I am not part of anything, not Jordanian, not Palestinian, not Syrian, not any Arab. I am not near any Arab or any people who even have any connection to [country of origin]. I keep myself to myself (Participant 10 male, refugee).*

Understanding the importance of community organisations in aiding candidacy and access to services, also leads to understanding that the negative experiences of Participant 16 and Participant 10 and is important in comprehending the role of community level operating conditions in supporting or hindering access to appropriate services. Whilst the majority of the interviewees discussed the importance of engaging with one's community (from the country of origin), some interviewees also talked about their experiences of connecting with the host community. The most prominent barriers that were described in this context were related to language abilities:

> *So because we're so disconnected from what's going on outside, I would say that it would be information, because sometimes there's things in the news about things that are happening locally around us and because we don't have communication then we don't have the information (Participant 9, male, asylum seeker).*

> *[Community Centres] try to involve us in some activity, to go out for a walking; try to, whatever place in the community centre, you know, we have community centres, try to go there and try to sit with the people, you can say, Scottish people, talk to them. There was a language barrier, but we seen many supportive people as well (Participant 2, male, asylum seeker).*

6.7.3 Micro-Level Operating Conditions:

Finally, the micro-level operating conditions that were identified during the analytical process included language difficulties and the limited availability of interpreters. Research evidence indicates that language and communication difficulties are a significant barrier for access to healthcare and other required services (O'Donnell et al., 2007; Piacentini et al., 2019; van der Boor & White, 2020). Issues related to availability and quality of interpreters add to the communication barriers that these groups experience (van der Boor & White, 2020; Murphy & Vieten, 2022). In the context of the interviews, several participants discussed language difficulties as one of the main barriers to candidacy for required services. This issue was present across the different migrant groups that took part in the interviews:

> *Actually the first challenge is the language because my English is not mother tongue. My mother tongue is Urdu, normally we spoke Urdu during normal life. Officially we don't use the English, we just write English when you use the email and drafting anything officially, but normally we talk Urdu, so the first challenge was the language because my wife, my son didn't especially speak English frequently, but understand what you are talking, but don't speak properly. So this was the first challenge for me in the beginning (Participant 3, male, asylum seeker).*

> *There is a lot of factors. Another factor is that of a language barrier. If we were to be in France, for example, maybe I could communicate with somebody easily. But here is another language altogether; although I learned English at school, here when Scottish people speak they speak so quickly I can't get it, even though I have to learn how to speak English. So it becomes a big barrier to me to communicate and to mingle with the other people (Participant 8, male, asylum seeker).*

> *The only first barriers that I have found here it was the language barrier, the English language, and the difficulty because I am in the '70s and I am getting too old to start learning language, that was the main barrier which was very difficult to cope with (Participant 15, female, refugee).*

The language difficulties described by participants were also reported in relation to accessing specific services. A lack of interpreting services was articulated by several interviewees who described it as a main issue in accessing the healthcare services:

> *The people who had some language barriers, so things are quite hard for them because the interpreter facilities are not available everywhere. So, many of opportunities I have seen that they just lost it because, due to the language barrier (Participant 2, male, asylum seeker).*

> *There was a problem with the GP, when I attended the GPs, there was no interpreter, there was difficulty to get an interpreter and I had been asked if I speak any other different languages, then I was saying that I speaks, not fluently, but can try to speak Arabic, and they brought Arabic interpreter but that was different Arabic. After that, they tried to find or to get some Oromo interpreter over the phone maybe from somewhere else, and I was trying to get some support (Participant 18, female, refugee).*

More specifically, Participant 16, a female undocumented migrant described being unable to access psychological support due to a lack of appropriate interpreting services:

> *[I] been told to get support through her GP but there was a very, very big issue and problem to get interpreters and the psychological support through the GP, even not only to psychologists or the service providers for psychotherapies, there was a problem with the GP, when attended the GP, there was no interpreter, there was difficulty to get an interpreter and [I] been asked if [I] speaks any other different languages, then I was saying that I speak, not fluently, but can try to speak Arabic, and they brought Arabic interpreter but that was different Arabic. After that, they tried to find or to get some Oromo interpreter over the phone maybe from somewhere else, and I was trying to get some support […] there was no interpreter supporting for that so [I] didn't get such support, mental health support (Participant 16, Female, undocumented migrant).*

In addition to the barriers to accessing the services described above, issues related to lack of interpreters for the participants who did not speak and understand

English sufficiently well was reported by Participant 14, a female undocumented migrant. During the interview, Participant 14 talked about the lack of interpreting services as a main barrier in engaging with the school attended by her daughter:

> *The language was affecting me, for example, in nursery, they don't provide interpreters at all, for example, if you have a meeting or something like that for your daughter to discuss about anything progressing, things like that, they will call you and just you and they don't provide interpreter which means she cannot understand what's going on and things like that. You know, it affects you negatively because you should have understood what's being said about your daughter, et cetera. So this is how it's affecting me in my daily life (Participant 14, female, undocumented migrant).*

6.8 Chapter Summary

This chapter presented findings which used the theory of candidacy to analyse the interview data. The results were divided into the seven candidacy phases: identification, navigation, permeability, appearing, adjudication, offers and resistance, and operating conditions. In the interview data presented in this chapter it was clear that most of the participants were not candidates solely for healthcare. In the interview extracts it is evident that the participants identified themselves as candidates for multiple services, in addition to healthcare, including the asylum process, employment, housing and education. Whilst the participants illustrated that the operating conditions posed a considerable challenge to access, the degree of this challenge differed according to, for instance, participants' migration status, and the type of service for which they identified as candidates.

The data from this study confirms the findings from previous research in that it identified the asylum system as a social determinant of health (Isaacs et al., 2020). The operating conditions that influenced the candidacy journey were identified as comprising of three levels: macro-; meso-; and micro-levels. The macro-level operating conditions included the biomedical model of mental health, the NHS's service delivery systems, the ongoing COVID-19 pandemic and the asylum system itself. In addition to the macro-level operating conditions presented above, and as described earlier in this chapter, language is as an operating condition which impacts individuals at both a macro- (via the language used in policy documents) and at a micro-level.

At the meso-level, the analysis identified interpersonal relationships, including family, friends, and community organisations. These relationships however are also influenced by issues around gender inequalities, the fluidity of migration status and the concept of deservingness and recourse to public funds and the welfare system (Black, 2022). These had also an impact on participants' candidacy. These were facilitators of access, and supportive of the participants. However, these were also discussed by some participants as a hinderance. This aspect of the data resonated with findings from the systematic review and meta-ethnography (Chapter 3). Finally, at the micro-level, the results presented here illustrate that problems such as being unable to interact with healthcare professionals, and the paucity of high-quality interpretation services which negatively affects participants' ability to access services such as counselling and mental health support. A thorough discussion of this thesis' findings from the systematic review and meta-ethnography, RTA, and candidacy is presented in the next chapter, which is the final chapter of this thesis.

Chapter 7 Discussion

7.1 Introduction

This thesis has investigated the post migration challenges and mental health experiences of asylum seekers, refugees and undocumented migrants who migrated from LMICs to HICs. I sought to explore the social determinants of health in these populations, and the pathways to accessing services, including healthcare access. In this chapter I will offer some reflections on the study in its entirety, by outlining the main findings before considering the study's strengths and limitations, and the implications for future research, clinical practice and policy.

7.2 Overview of the main findings:

This section of the discussion chapter provides an overview of the research's main findings and discuss these in relation to the wider relevant literature. This PhD's main aim, as detailed in the literature review chapter (Chapter 2) was to explore the mental health and psychosocial experiences of asylum seekers, refugees and undocumented migrants in the post-migration context. **Specifically, the research objectives were:**

- To investigate asylum seekers', refugees', and undocumented migrants' mental health experiences in the context of social determinants of health.

- To explore how social determinants of health influence the pathway to healthcare service amongst asylum seekers, refugees and undocumented migrants.

- To explore the barriers and facilitators of asylum seekers, refugees and undocumented migrants' pathways to accessing the services that they need.

Through a systematic review and meta-ethnography we sought to identify qualitative studies that focus on asylum seekers, refugees and undocumented migrants' mental health and psychosocial experiences in the post-migration context, within high income countries. As part of the thesis, eighteen interviews were conducted with asylum seekers, refugees and undocumented migrants who reside in Glasgow. The reflexive thematic analysis identified three main themes: the asylum process; mental health experiences; and access to care. Using the theory of candidacy, the research aimed to further understand the participants' journey to accessing services in the post migration context.

7.3 Summary of findings from each study

7.3.1 Systematic Review and Meta-Ethnography

In Chapter 3, it was found that groups with different migration rights, such as asylum seekers and refugees are often discussed together in the literature. This risks erroneously joining together individuals with diverse needs and whose migration status is fundamentally different. This, in turn, has important implications on individuals' access to welfare support, healthcare, family reunification rights and employment prospects, to mention a few. Through the meta-ethnographic process, a new line of argument was identified within the selected literature. This was that the mental health and psychosocial needs of the asylum seekers and refugee populations are often inadequately met due, at least in part, to the Western biomedical approach which can reduce complex and multifaceted post-migration experiences to a mental health diagnosis. In addition, the role of family and community – often regarded as protective and supportive – can be a detrimental influence on individuals.

As discussed in the systematic review and meta ethnography chapter (Chapter 3) of this thesis, the biomedical approach is not designed to meet the varied interpretation of socio-culturally bound, psychosocial experiences of these populations. I argue that post-migration life difficulties are often erroneously framed by researchers and clinicians as mental health experiences. It is evident that, in its current form, the healthcare system is not equipped to meet the varied psychosocial needs of these populations, and therefore a shift in emphasis is urgently required if we truly aim to attend to the needs of these migrant populations. Furthermore, this would need to go beyond the current rhetoric on improving access, in the sense of providing more of the services that are currently on offer. Instead, truly widening access requires improving culturally competent and psychosocially informed access, that has the social determinants of health at its core. Otherwise we risk, unintentionally, further stigmatisation and marginalisation of already underserved communities. In brief, what is required are services that are co-designed and co-developed by asylum seekers, refugees and undocumented migrants. These services should inform research and practice in these fields and respond to the currently unmet needs of these populations.

7.3.2 Themes from the Reflexive Thematic Analysis

The asylum process was one of the most frequently discussed issues and it was raised by most of the participants. Within this topic, three subthemes were identified via the analytical process. These were: experiences on arrival; living in limbo; inability to work and financial constraints. Most of the research participants discussed their mental health and wellbeing experiences during the interviews. Within this theme, three subthemes were identified. These were: idioms of distress; protective factors; social support. Access to healthcare was another major theme that participants discussed in the interviews. Within this theme, five sub-themes were identified: registering with a GP; communication difficulties and interpretation; waiting times to access services; psychotropic medication and psychological therapy; healthcare access and socio-cultural factors. The results suggest that social determinants of health, such as the asylum system, access to employment, financial difficulties, housing problems, and healthcare provision have potentially deleterious effects on participants' wellbeing. Importantly, the idioms of distress that participants use to describe their mental health experiences are rooted in Western concepts, and often result in biomedical interventions being offered by healthcare professionals. This approach, whilst often accepted by participants, was found to also limit participants' ability to express their psychosocial experiences that include, but are not limited to, mental health. In addition, psychotropic prescriptions were often discussed as an undesirable treatment by participants, and resulted in low satisfaction with the healthcare provided.

7.3.3 Exploring Access Using the Theory of Candidacy

The interviews were re-analysed using the theory of Candidacy. This theoretical approach is composed of seven phases (see Figure 2) and its purpose is to understand the manner in which individuals attempt to access the services that they require. The results were presented according to the seven candidacy phases: identification, navigation, permeability, appearing/asserting, adjudication, offers/resistance, and operating conditions. It is noteworthy however that these seven phases are non-linear, and that operating conditions are broad, contextual factors, known to potentially influence each phase of the candidacy framework. Whilst in the original iteration of the candidacy framework operating conditions were construed as influences that operated at the level of service delivery (Dixon-Woods et al., 2006), we argue that operating conditions are not a monolithic concept. Instead, these operated at three levels: macro-, meso-, and micro-level conditions.

The macro-level operating conditions that were identified within participants' accounts included the impact of the asylum system and COVID-19 on individuals' candidacy journey, and the NHS's service delivery systems. At the meso-level, we identified interpersonal relationships and community organisations, and how these influenced individuals' pathway to services. Finally, at the micro-level, interviewees described issues around language and interpretation, which impacted on their ability to access the services needed. Importantly, in the interview data it was clear that most of the participants were not candidates solely for healthcare. Instead, it is evident that the participants identified themselves as candidates for multiple services. These included healthcare, employment, housing, and education, as well as (for some) the asylum process itself. Participants therefore demonstrated multiple candidacies. The operating conditions of each system posed a considerable challenge to accessing services, the degree of this challenge differed in relation to factors such as participants' migration status, the type of service for which they identified as candidates, and the availability of interpretation for those who had language difficulties.

7.4 Bringing the research findings together

In the Table below (Table 7-1), the main findings from the results of the Systematic Review and Meta-Ethnography, RTA and Candidacy are presented along with a synthesis of the results.

Table 7-1 Key findings from each study and synthesis of findings

Study	Findings	Synthesis
Systematic review and meta-ethnography	• Mental health needs are often not met by the biomedical approach used within Western healthcare settings. • Complex psychological, social and cultural needs are often framed as mental health in the literature. • Language and communication difficulties, and sociocultural factors hinder healthcare access in these migrant populations. • Family, friends and communities are both a source of support and stigma.	• The Global (systematic review) and Local (interviews) dimensions of this thesis illustrates that the post-migration experiences of asylum seekers, refugees and undocumented migrants have a degree of similarity across different countries and policy setting. • All studies indicated that the mental health and multifarious psychosocial needs of asylum seekers, refugees and undocumented migrants are often unmet. • In both the meta ethnographic and interview data, the social determinants of health that impact on the mental health and wellbeing of these groups included: the asylum process, financial issues, housing, employment. The dual role of friends, family and communities could be simultaneously supportive and detrimental.

Reflexive Thematic Analysis	• The main themes included: the asylum process; mental health experiences; access to care. • The subthemes were: experiences on arrival; living in limbo; inability to work and financial problems; idioms of distress; protective factors; social support; registering with a GP. • Communication difficulties and interpretation; waiting times to access services; psychotropic medications and psychological therapy; continuity of care. • Healthcare access and socio-cultural factors; positive experiences of the healthcare system.	• These groups regularly access and use multiple services, as identified in the meta ethnography and interviews. Candidacy identified how individuals have to assert multiple candidacies in order to obtain access. • The meta-ethnography, RTA and Candidacy analyses identified that the communities to which people belong often operate as a double edged sword. • Communities were found to provide support but also have the potential for stigmatisation and marginalisation, in particular for women and LGBTQ+ individuals. • The biomedical model of mental health is not always perceived as an appropriate approach to framing mental health and can lead to community stigmatisation. Data from both the meta ethnography and interviews found that reliance on the biomedical model can potentially discourage access to mental health services even further. • Medicalisation of mental health, which stems from the biomedical approach to healthcare was identified, particularly in the interviews. Participants reported several side-effects to medication, and adherence to treatment was poor. This, in the candidacy analysis, was discussed in light of moral injury.

Candidacy Theory	• Participants reported experiences related to accessing services a variety of services. • The application of Candidacy has shown that providing access, *per se*, does not necessarily result in more accessible services. • Macro- meso- and micro-level operating conditions were identified, and encompassed local and national level influences on the candidacy journey. • Macro level: biomedical model of mental health, the NHS's service delivery systems, the ongoing COVID-19 pandemic and the asylum system itself. • Meso-level: interpersonal relationships and community organisations impacted on participants' candidacy. • Micro-level: language and communication difficulties and the availability of interpreters were identified as barriers to accessing services.	• The perceived stigma and sense of burdensomeness associated with experiencing mental health difficulties was described by several participants in the interviews. This resonated with meta-ethnographic data. • Communication and language difficulties, and lack of interpretation are barriers to accessing mental health services for these populations. This was evident across the data presented in this thesis and was shown to limit access to healthcare services, particularly counselling and psychotherapy. • Difficulties registering with a GP and limited knowledge of the healthcare system were shown as barriers to access. • Across the data presented in this thesis, the role of third sector organisations was found to be pivotal in supporting these individuals access services and receive information and practical guidance. • From the meta-ethnography, RTA and Candidacy it was clear that participants do not simply need more access to services, but also culturally competent and psychosocially informed access in order to meet their needs. • The three studies illustrated that participants do not simply need more access to services, but also culturally competent and psycho-socially informed access is required. • Multiple candidacies and the macro- meso- and micro-level operating conditions illustrated that instead of equal access, the focus should be on providing equitable access to services for these heterogeneous populations.

7.4.1 Contextualising the results in the wider literature

The results presented in this thesis illustrate the importance of the social determinants of health in exploring the mental health and psychosocial experiences of asylum seekers, refugees, and undocumented migrants. The results resonate with the wider, international literature which shows the negative impact of the asylum system across different countries settings on the mental health and wellbeing of individuals seeking asylum (Aragona et al., 2013; Dermot et al., 2009; Neil & Peterie, 2018; von Wertern et al., 2018 Robjant et al., 2009; Silverstein et al., 2021). The RTA results illustrated that the impact of the asylum system remained prominent for refugee participants who had already been granted asylum at the time of being interviewed. Li et al. (2016), showed that immigration policy factors hinder the mental health of asylum seekers and refugees in the post migration context. As discussed in Chapter 2, the UK's hostile asylum process is a significant aspect of the difficulties that asylum seekers, refugees and undocumented migrants experience in the post migration context. Other social determinants of health that align with our findings include issues around poverty (Li et al, 2016), housing, inability to work, family reunification (Coffey et al., 2010; Ziersch & Due, 2018), and the potentially stigmatising role of the community when disclosing mental health difficulties (Quinn, 2014). Importantly, my work has identified that, within the literature, asylum seekers, refugees and undocumented migrants are often discussed together as a heterogeneous group. The findings presented here show that there are several important differences in these groups. These differences impact on individuals' ability to access the services that they require (e.g. employment, welfare support, housing, healthcare) and, in turn, on the post migration life experiences that the participants discussed.

The results presented here also found that the biomedical model and the biomedical language used to describe mental health experiences, whilst frequently used by these migrant groups, is inadequate in conveying the depth and complexity of the experiences of people from diverse psychosocial and cultural backgrounds (Tribe, 2002; Papadopoulos, 2007). However, the narrowing down of complex psychosocial experiences that occur in the context of social determinants of health into psychiatric diagnoses, risks the misinterpretation of understandable responses to distress (e.g. sadness due to family separation; worry related to the uncertain outcome of the asylum application and fear of deportation), as illness. As illustrated in the WHO (2014) report on the social determinants of mental health, responses to difficult psychosocial situations leading to a loss of wellbeing need to also be considered as pertaining to mental health (i.e. in the absence of a psychiatric diagnosis). Furthermore, the World Health Organization defines mental health as "*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*" (WHO, 2013 p.12). This definition of mental health is particularly applicable to discussing the results presented in this thesis. Due to national migration policies that severely restrict individuals' ability to work and contribute to the society in which they live, the absence of wellbeing reported by the interviewed individuals takes on a new meaning, captured by social determinants of mental health (WHO, 2014), and the structural barriers imposed by national migration policies that are punitive.

Summerfield (2018) argues that terms such as anxiety and depression should also be considered as cultural idioms of distress. It has been amply illustrated that cultural idioms of distress such as depression, anxiety and stress have become ways in which individuals become emotionally acculturated in the use of the host country's mental health nomenclature (Ng et al., 2013; Nichter, 2010; Summerfield, 2018). However, during the medical encounter these terms can convey biomedical meanings that are interpreted by the healthcare professionals in the context of providing a medical intervention (Kirmayer & Young, 1998; Kirmayer et al., 2003), which may run counter to what the individual wants.

In light of this, Papadopoulos (2007) suggests that whilst it is fundamental to acknowledge that pre, during and post migration experiences of asylum seekers and refugees, the Western language used to describe mental health risks becoming overly reductionist, and thus fails to account for the socio-cultural context in which distress develops. The results of this thesis also highlight that, in its current form, the mental healthcare system tends to categorise clusters of symptoms into diagnoses that are amenable to biomedical interventions (Kinderman, 2019). Participants in this thesis reported a degree of dissatisfaction with the biomedical treatments provided and reported experiencing several side effects related to the medication taken.

Similarly to Kiselev et al. (2020), this research also showed sociocultural barriers as important factors that hindered participants from accessing care in relation to their mental health experiences. More broadly, in terms of healthcare access, Satinsky et al.'s (2019) systematic review provided valuable information on the mechanisms that contribute to mental health service underutilisation amongst refugees and asylum seekers. Issues including suspicion and distrust in the biomedical approach was reported to result in delay, or indeed, avoidance in accessing mental health services. Limited language fluency also hindered participants' ability to seek psychological therapy (Quinn, 2014). Much research has indicated the need for interpretation and language support for these migrant groups (Phillips, 2006; O'Donnell et al., 2007; van den Muijsenbergh et al., 2014; Robertshaw et al., 2017; Piacentini et al., 2019; van der Boor & White, 2020; Wicki et al., 2021). Regrettably, however, this thesis has illustrated that a lack of high quality interpretation is still an important issue for these populations.

Long waiting times were shown as barriers to accessing care, even before the start of the pandemic (O'Donnell et al., 2007). However, our results (Chapter 6) indicate that the pandemic has further impacted on waiting times. It has been suggested that an initial increase in referrals for healthcare support has led to extended waiting times for assessment and treatment of distress during the pandemic (Gagliardi et al., 2021). In addition to language difficulties, research shows that there is a paucity of information and awareness among asylum seekers, refugees and undocumented migrants around the structure of the NHS (e.g. primary care, emergency services etc) and this results in high levels of confusion and lack of knowledge on how to navigate and negotiate access to care (Kang et al., 2019; O'Donnell et al., 2016).

The results from this PhD add to this evidence by showing that for asylum seekers, refugees and undocumented migrants, these are also barriers to accessing other services, in addition to healthcare. I have outlined several factors that impact on participants' candidacy for the services that they need, including macro-, meso-, and micro-level operating conditions. This was illustrated using the concept of multiple candidacies. Previous research resonates with these results, albeit within a different population (MacKenzie et al,2015).

7.5 Strengths and limitations

The research conducted in this thesis contains both strengths and limitations, which I will outline briefly here. An important strength of this thesis is its focus on an under-researched aspect of public health, namely the mental health of asylum seekers, refugees and undocumented migrants. This topic is illustrated in the literature as a research area of substantial complexity and unmet need. The consideration of the broader post-migration psychosocial aspects of these populations' experiences has important implications for research, policy and clinical practice. The research described in this thesis has attempted to provide novel insights, and practical implications on current issues affecting these migrant groups.

Another strength of this thesis is its focus on building a theoretical understanding of mental health and psychosocial experiences of these populations and how, in turn, these experiences influence service access. Each of the three studies that comprise this PhD have been integrated in order to allow for an in-depth discussion of the findings and inform conclusions and suggestions for future research. The use of these three different qualitative approaches to data analysis has allowed the presentation of perspectives of the psychosocial experiences of these migrant population in the post-migration context. Amongst the strengths, this research managed to recruit participants from traditionally hard to reach communities and engage a diverse group of individuals; some of whom were in a particularly precarious position due to their migration status and the ongoing COVID-19 pandemic.

Deliberations and considerations were made in relation to other types of qualitative approaches that could have been used in this research. For example, some constructionist approaches to thematic analysis are also referred to as thematic discourse analysis (Taylor & Ussher, 2001). The focus of thematic discourse analysis, however, is on the role of language structure and how language is constructed to produce meaning (Taylor & Ussher, 2001). This method would have been helpful if this study aimed to focus on how asylum seekers, refugees and undocumented migrants use (or construct) language to describe their post-migration life experiences. In various interpretivist approaches to data analysis, a degree of phenomenology (i.e. a focus on individuals' perceptions of the world as it is described by them) and hermeneutics (i.e. a researcher's interpretation of individuals' descriptions) are used. These are particularly used within Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). However, IPA is best suited to small, homogeneous, purposive samples (fewer than 10 participants), and the development of themes focuses on details such as tone of voice, laughter, pauses, repetition. Furthermore, IPA focuses on identifying themes across transcripts rather than also including divergent views that may be identified in the dataset (Braun & Clarke, 2021). These aspects made IPA incompatible with the stated aim of the present study.

One feature of this project that is both a strength and a limitation relates to the participants background compared to my own. Although I am also a migrant in Scotland, I do not share either the heritage or the post-migration difficulties that the participants shared with me during the course of data collection. I was born in Italy, and as a national of a EU nation, upon moving to Scotland in 2010, I was able to access higher education, employment, and become a permanent resident of this country without a visa. Due to these significant differences potential misunderstandings may have been likely and participants may not have felt at ease sharing some aspects of their experiences with me. Conversely, not being part of the participants' communities allowed me to maintain a more objective distance from their experiences and not include, unwittingly, any prior knowledge to the analysis. Based on the findings from this thesis, which shed a light on the potentially stigmatising role that communities can have, being an outsider may have been viewed by some participants as a facilitator in sharing their experiences.

Another aspect of the research that is both a strength and a limitation is the fact that I interviewed individuals whose English was limited in terms of proficiency. Whilst this required the use of interpreters, it allowed for the inclusion of individuals whose voice is often under-represented within research settings due to their language abilities. This, one can argue, gave us an opportunity to acquaint ourselves with the difficulties these individuals encounter. However, as I recruited individuals solely through community organisations, some of the most marginalised individuals (i.e. those who do not participate in community engagement activities) were excluded, albeit inadvertently, from taking part in this research project. An additional limitation is related to the ongoing COVID-19 pandemic at the time of data collection. This resulted in the interviews being conducted online. This may have led to the exclusion of some potential participants who live in digital poverty.

Five of the participants interviewed in this research were undocumented migrants (please see Definitions section of the thesis). These individuals are particularly marginalised and vulnerabilized by UK Government practices that stem from the enactment of the Hostile Environment policies. As a result, undocumented migrants often experience destitution, homelessness, and poverty as well as language difficulties. Although they are able to access healthcare in Scotland, they are prevented from accessing other services that they need (e.g. housing, education, employment). The undocumented migrants that took part in the interviews included three females and two males, all of whom had applied for asylum in the UK. These applications for asylum had been rejected and exhausted until new evidence for their claim is provided to the Home Office. These five interviews, out of eighteen, represent a significant minority experience in the collected data and, as a result, may have skewed or influenced parts of the results presented in this thesis. Reflection on how these interviews may have influenced the overall data collection, if pondered while data collection was ongoing, would have helped to mitigate some of this impact (e.g. by informing sampling methods and research design). However, due to COVID-19 restrictions and recruitment difficulties, there was an urgency to proceed with the interviews when the opportunity presented itself.

A limitation of this PhD worthy of acknowledgement is the exclusion of the views of service commissioners, managers and healthcare staff. In the initial research protocol interviews with healthcare providers and representatives of third sector organisations were part of the research plans. Due to the ongoing COVID-19 pandemic, we decided not to interview these individuals. Whilst I acknowledge that the views of individuals from these professional groups would have added to the depth of our reflections on issues related to access to services and the suitability of the support that may be available for these migrant groups, at the time, this did not seem appropriate to me, as it would have meant asking clinicians working on the front line to take time out of clinical practice during the pandemic. Furthermore, many of the third sector organisations had reduced access and were struggling to deliver their services, and so less able to give their time to a research project.

My background as a trained clinician in Cognitive Behavioural Therapy (CBT) is also a strength and a limitation of this thesis. This, whilst helpful in aiding my understanding of the mental health experiences of the participants and appreciating the psychosocial context in which these may emerge, was something I needed to be aware of in my interview style. During the initial interviews, I realised that my emphasis was more clinical than research focused. This was quickly rectified however, as my supervisors, having listened to the interview recordings, brought this to my attention. Reflexivity and 'bracketing' (Braun & Clarke, 2021) were pivotal in changing my approach as the interviewer and ensuring that I listened to the participants as a researcher, not as a therapist. In the next section, I will provide further recommendations for future research with this population.

7.5.1 Recommendations for Future Research

In light of the results derived from this PhD project, future research with this population could benefit from employing a participatory approach to ensure that the findings, and recommendations, are fully grounded in people's daily experiences. Participatory Action Research (PAR) (Macaulay et al., 1999) involves the co-creation of research data through working collaboratively with co-participants. This research method can aid the co-creation and design of new research, based on knowledge from asylum seekers', refugees' and undocumented migrants' lived mental health and psychosocial experiences. This, in turn, could lead to the co-development of services aimed to meet their specific needs. As outlined in the pre COVID-19 research plans (Appendix 2) such research would involve recruiting a group of individuals from asylum seeking, refugee and undocumented migrant communities. Instead of interviews, focus group discussions would be part of the research design. To aid the participation of individuals whose English language abilities are limited, participatory approaches such as photo-voice could be used (Quinn, 2014) and professional interpreters would be employed. This approach aims to generate rich qualitative data, with the photo-voice technique as a means to facilitate group discussions and data gathering. This approach would add to the results presented in this thesis by including a longitudinal qualitative design, whereby participants would be asked to participate in several focus group discussions over a period of a few months at a two to three-week intervals (roughly six to eight meetings in total). The benefits of this approach would include providing time and space for individuals to further familiarise themselves with the research and the researcher and potentially, over-time, feel more comfortable sharing some of their life experiences. PAR approaches are used to more equitably balance the inherent power disparities that exist between researcher and participant. Using PAR effectively could limit these and contemporaneously help address culturally-bound differences between researcher(s) and the individuals taking part in the research. In line with the PAR ethos participants will take an active, decisional role in the research process, including the development of research questions, design, analysis of the data generated and dissemination of results.

7.5.2 Implications for clinical practice

In medicine, diagnosis is, at its essence, an attempt to describe an individual's presenting issue, understand how the issue has come about, and intervene in a way that may be helpful for them. In so doing, diagnosis is used to draw on extant knowledge of bodily function as well as dysfunction. Although diagnoses that are based on biological patters are suitable for physical issues, this *modus operandi* is essentially limited in its ability to make sense of emotional, cognitive and behavioural problems (Johnson & Boyle, 2018). Currently the diagnostic approach being deployed within mental health care in the UK tends to frame emotions and behaviours that are distressing as 'symptoms' of an underlying biological dysfunction (e.g. the low serotonin hypothesis in depression) (Moncrieff et al., 2022). The continuation of this rationale would be, from the clinician's perspective, to search for underlying biological factors that cause or are associated with, the cluster of symptoms that a person is presenting with in the clinical encounter. This often results in psychotropic medications as a first line of intervention (Iacobucci, 2019), although and the risks associated with their widespread use are becoming increasingly more apparent (Jha et al.,2018; Davies & Read, 2019; Framer, 2021).

However, moving away from the diagnosis-based approach is highly challenging, not only because it is widely used in clinical practice but, and perhaps most importantly, due to its roots in Western philosophical assumptions (Allsop et al., 2019). Based on positivism, this model for understanding health issues is often discussed as reductionist, in the sense that it reduces complex biopsychosocial experiences by focusing on their most simple, biological component. To add to this complexity, I acknowledge that some patients find diagnoses valuable to make sense of their experiences of distress, and the current system often requires individuals to have a diagnosis in order to access welfare support, and other services that they need. Within the healthcare system, diagnoses can aid communication between different professionals and across services. However, recent research illustrates that the evidence in relation to the biomedical model of mental health is scant (e.g. Deacon, 2013; Kinderman, 2019; Moncrieff et al., 2022), and clear links between psychosocial circumstances (e.g., poverty, homelessness; social isolation) and experiences of distress are increasingly more evident (McElroy et al., 2019; Lund et al., 2018; Loades et al., 2020). However, clinicians' powerlessness in tackling these (e.g. providing better housing, increasing financial support, allowing family re-unifications, improving the asylum system etc), and the long waiting lists for psychological therapy, may increase the prescription of psychotropic medication as this may be the only intervention that clinicians can offer during the clinical encounter.

The findings from this thesis support the view that, rather than diagnosing 'disorders', attending to a person's experiences of distress at an intrapersonal level and employing a psychosocial approach to mental health, encourages the understanding that feeling distress is a natural human response to highly difficult social circumstances (Godinic et al, 2020; Mahajan et al., 2022). As a response to the problems outlined above, in 2018, a pioneering group of researchers, clinicians and experts by experience, launched the Power Threat Meaning Framework (PTMF) (Table 7-1).

Table 7-2 The Power, Threat, Meaning Framework (PTMF)

Power	The operation of **POWER** within biological/embodied, coercive, legal, economic/material, ideological, social/cultural and interpersonal environments. *What has happened to you? (How has* ***POWER*** *operated in your life?)* *What are your strengths? (What access to* ***POWER*** *resources do you have?)*
Threat	The **THREAT** that the negative use of power may pose to an individual, a group, and/or a community, with particular reference to emotional distress and how this is mediated by physiology (e.g. autonomic response). *How did it affect you? (What kind of* ***THREATS*** *does this pose?)* *What did you have to do to cope / survive? (What kinds of* ***THREAT RESPONSE*** *are you using?)*
Meaning	The central role of **MEANING** in shaping our understanding, experience and expression of power and threat, and how we respond to threat (within broader social and cultural discourses). *What sense did you make of it? (What is the* ***MEANING*** *of these situations and experiences to you?)* *What is your story?*

Adapted from Johnstone & Boyle (2018)

This framework includes a novel way through which we can understand and intervene on distress. The PTMF clearly diverges from the biomedical, diagnosis-based model of mental health, in an attempt to reframe mental health from a ‘What’s wrong with you?’ approach, towards a ‘What has happened to you?’ narrative (Johnstone & Boyle, 2018). At its essence, the PTMF illustrates that emotional and behavioural difficulties are underlined by various threats that the negative use of Power poses to individuals and communities, and how these individuals and communities have learned to respond to these Threats. The PTMF considers the Meaning(s) that derive from these experiences and how broader sociocultural and political contexts can increase feelings of distress and further marginalise people. The results from this thesis support the adoption of the PTMF within clinical practice services in both primary and secondary care for clinicians who work with asylum seeker, refugee and undocumented migrant individuals and communities. This approach can allow for more culturally appropriate meanings to distress, and the exploration of how these are experienced at a psychological and social level. Although originally developed by clinicians, researchers and experts by experience to as an alternative to psychiatric diagnosis, the potential of the PTMF can be extended to centre the barriers that these population face on arrival to the UK. From the results presented in this thesis, it is evident that the asylum system is a source of poor mental health and distress in the population interviewed. Therefore, the 'What has happened to you?' approach illustrated in the PTMF could be extended to 'What has happened to you since your arrival in the UK and claimed asylum?'. This could further illuminate clinicians' ability to formulate the experiences of these populations in the context of a punitive and dehumanising asylum system. In addition, the PTMF could be augmented by the use of the Capabilities Approach Formulation of Experiences (CAFE) (White & van der Boor, 2021). In brief, CAFE aims to augment our understanding of factors present in individuals' social environment that are detrimental to mental health and wellbeing. This approach is particularly useful for identifying 'where' on a continuum of social experiences, an intervention would need to be applied and tailored to meet an individual's needs. Interventions may include other organisations to gage the support required and the facilitators and/or barriers to implementing such support (White & van der Boor, 2021; van der Boor et al., 2020b).

7.5.3 Implication for healthcare services policy

The ongoing asylum seekers' dispersal policy in Scotland means that several GP surgeries register patients from asylum seeker, refugee and undocumented migrant backgrounds. In the current healthcare context, resources allocated for mental health are scarce. This is reflected in the long waiting times for secondary care mental health services, and results in meeting the mental health needs of the population being placed on primary care clinicians. This situation, which was already difficult prior to 2020, has been further compounded by the pandemic. As a result, extra support is needed to aid the work of GPs and other healthcare providers within GP practices. The limited experience of many GPs in working with these migrant groups who often present with complex needs, coupled with already strained resources can compound the difficulties that primary care professionals face when working with these patients.

The results from this thesis echo the need for more resources and greater support required to support practice teams' delivery of care. We suggest that policy-based interventions could include a strong commitment to the provision of high quality interpretation services. Also, digitalised forms of healthcare delivery should account for, and mitigate, issues around digital poverty and the availability of translators in both primary and secondary mental health care when individuals attend appointments. The move towards more digital health care risks further marginalising these migrant groups in the coming years (Huxley et al., 2015). Whilst we welcome the addition of Link Workers and Financial Advisors within primary care practices is welcome, a focus on training all practice staff on issues pertaining to these specific migrant groups could further improve the effectiveness of these services in supporting the complex needs that these individuals experience. Finally, there is an urgent need to develop services that are co-designed by the individuals who access them. These interventions, if concentrated in areas were these migrant groups live, may also mitigate the impact that digitalised health can have on service delivery.

In addition to the implications so far mentioned, the Capability Approach (Sen, 1999; Nussbaum, 2000), is also a useful approach to aid individuals' engagement in ways of being and functioning that are important to the individuals themselves (White & von der Boor, 2021). This approach is based on the principles of individual agency, and capability. In the context of the structural issues that individuals from the asylum seeking and refugee communities are faced with (e.g. the asylum system), which present with significant barriers to agency (e.g. ability to work) and capability (e.g. limited opportunities for social engagement), the Capability Approach is a salient concept. What is important however is that the Capability Approach, and CAFE (White & vor der Boor, 2021) in particular, can effectively shed a light on these barriers and inform interventions that are tailored to meet individuals' needs in the context of these barriers. Similarly to the PTMF, CAFE is also a useful clinical tool to move beyond the disorder specific approach to understanding and intervening in support of the populations included in this thesis.

Such approaches can help the transition to a broader focus on individuals' potential and possibilities once targeted structural support is provided.

7.5.4 Implications for asylum policy

The results from this thesis' show that the UK asylum system, in its current form, has a negative impact on the mental health and wellbeing of asylum seekers, refugees and undocumented migrants. This further compounds the argument that the UK's Hostile Environment policies, and National Immigration Policies (outside of the UK) impact on these migrant groups' post migration life. The harms of these policies extend to all aspect of individuals' lives and include employment, education, housing, financial issues and access to welfare support, to mention a few. Interviewees discussed how issues pertaining to their asylum applications exacerbate mental health difficulties and compound their psychosocial challenges. As the Home Office is the entity in charge for the provision of financial support, housing and decisions related to accessing employment, improving asylum policy may also improve individuals' material conditions and psychosocial experiences. The results indicate the need for organisations such as the Refugee Council, Freedom from Torture, and community organisations that operate at the local level to campaign for the creation of more just and humane asylum policy, that place social determinants of health at the centre. Issues such as poverty, destitution and substandard housing are key areas where policy can intervene to limit the distress that these migrant groups are often experiencing.

7.6 Conclusion

This thesis has identified three core aspects of post migration life difficulties affecting asylum seekers, refugees and undocumented migrants:

i. The biomedical model of mental health as inappropriate to deal with the complex psychosocial needs of these migrant groups. This risks erroneously framing post-migration life difficulties as mental health issues.

ii. The services available are unable, in their current form, to meet the healthcare and psychosocial needs of these populations.

iii. Psychosocial, cultural, and practical barriers exist that limit access to services for these groups. This can, inadvertently, exacerbate health inequalities and unequal access to services.

Providing services that apply a social determinants of health lens is pivotal for addressing the needs of these populations. Future developments related to both policy and practice need to focus on further exploring the true potential of public health approaches within a universal care system that is truly responsive to people's diverse psychosocial needs. This could be addressed via including service users in the design and development of every aspect of the services that they access. I believe that this approach has the potential to improve both access as well as outcomes in these underserved populations.

Appendix 1 Systematic Review Search Strategy

Table 1. Keywords used in relation to three main topics: population, mental health, post-migration life difficulties.

Population	Mental health	Post migration life difficulties
• asylum • asylum seek* • migr* • migration • refugee* • undocum* migr**	• anxiety • anxiety disorders • anxiety, separation bipolar disorder • depress* • depression • depressive • depressive disorder • depressive disorder, major • disease* • disorder • disorder* • major • major depression • medically • medically unexplained symptoms • pain • pain disorder • post traumatic posttraumatic • psychophysiologic disorders • somatic • somatoform • somatoform disorder • somatoform disorders • stress • symptom* • symptoms • threat* • to • traumatic • unexplained	• access • access to care • access* • aggress* • care • centre • centre* • communicat* • destitute • destitution • detain* • detention • detiontion • difficult* • difficulties • disadvantage • disadvantaged • discriminat* • disctiminat* • documents • exclu* • exclusion • general* • health • health care health services accessibility • healthcare • homeless persons • homeless* • homelessness • housing • illness • illness* • immigration • income • issue* • issues • language • legal • legal status • life • living • loneliness marginali* • postrmigration • post • post migration • poverty

		• poverty areas • primary health care • prison • prison* • problem* • problems • procedure • process • rac* • racism • resettl* • social • social distance • social exclusion • social isolation • social* • social* exclu* • status • stigma* • violen*

Table 2 Key terms combined

Key Terms	Deprivation OR food deprivation OR cultural deprivation OR disadvantaged; Deprivation OR Social Deprivation OR Disadvantaged; Mental Health; Affective Disorder OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder; Trauma OR Emotional Trauma OR Complex PTSD OR Traumatic Brain Injury OR Posttraumatic Growth; Complex PTSD OR Posttraumatic Stress Disorder OR Post-Traumatic Stress; Poverty; Homelessness Mentally Ill OR Homeless OR Refugees; Somatization OR Complex PTSD OR Somatization Disorder OR Somatosensory Disorders OR DESNOS OR Somatoform Disorder; Anxiety OR Generalized Anxiety Disorder; Psychosis; Human Migration; Refugees (N=5,610); Asylum Seeking – interestingly, when I type terms straight into the search box bypassing thesaurus I get many more results e.g. Affective Disorder OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder; Trauma OR Emotional Trauma OR Complex PTSD; Somatoform Disorders OR Post-Traumatic Stress OR Somatization OR Complex PTSD OR Somatization Disorder OR Somatosensory Disorders OR DESNOS; Immigration; Deprivation R DE "Social Deprivation" OR DE "Food Deprivation" OR DE "Cultural Deprivation" OR DE "Disadvantaged"; "Refugees" "Trauma" OR DE "Emotional Trauma" OR DE "Complex PTSD "Immigration" Deprivation" OR DE "Social Deprivation" OR DE "Food Deprivation" OR DE "Cultural Deprivation" OR DE "Disadvantaged" with AND in between key words. These terms AND Somatoform Disorders" OR DE "Post-Traumatic Stress" OR DE "Somatization" OR DE "Complex PTSD" OR DE "Somatization Disorder" OR DE "Somatosensory Disorders" OR DE "DESNOS" affective Disorders OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR

	Bipolar Disorder Trauma" OR DE "Emotional Trauma" OR DE "Complex PTSD" with AND between terms
Merging topics	Mental Health AND deprivation OR food deprivation OR social deprivation OR cultural deprivation OR disadvantaged; Mental Health AND Deprivation OR Social Deprivation OR Disadvantaged; Refugees OR Asylum Seeking; Refugees AND Asylum Seeking; Refugees OR Asylum Seeking AND Mental Health; Refugees AND Mental Health; Refugees AND Affective Disorders OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder AND Trauma OR Emotional Trauma OR Complex PTSD OR Traumatic Brain Injury OR Posttraumatic Growth AND Complex PTSD OR Posttraumatic Stress Disorder OR Post-Traumatic Stress; Refugees AND Complex PTSD OR Posttraumatic Stress Disorder OR Post-Traumatic Stress; Refugees AND Complex PTSD OR Posttraumatic Stress Disorder OR Post-Traumatic Stress AND Trauma OR Emotional Trauma OR Complex PTSD OR Traumatic Brain Injury OR Posttraumatic Growth AND Somatization OR Complex PTSD OR Somatization Disorder OR Somatosensory Disorders OR DESNOS (disorder of extreme stress) ORSomatoform Disorders; Refugees AND Affective Disorder OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder; Refugees AND Affective Disorder OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder OR Trauma OR Emotional Trauma OR Complex PTSD; Refugees OR Affective Disorders OR Major Depression OR Postpartum Depression OR Depression OR Late Life Depression OR Recurrent Depression OR Bipolar Disorder OR Trauma" OR DE "Emotional Trauma" OR DE "Complex PTSD" OR "Somatoform Disorders" OR DE "Post-Traumatic Stress" OR DE "Somatization" OR DE "Complex PTSD" OR DE "Somatization Disorder" OR DE "Somatosensory Disorders" OR DE "DESNOS"

Appendix 2: Pre COVID-19 Research Plan

Based on the results of the systematic review and meta-ethnography, and up to March 2020, my research plans for this thesis included the development of a study that applied a Participatory Action Research approach. Based on the findings showing that language difficulties are prominent amongst asylum seekers, refugees, and undocumented migrants, I opted for the use of photo-voice. Unfortunately, the start of the pandemic in the early months of 2020 has disrupted these plans. As a result, although ethics approval had been granted (**Project Number: 200190092**) in January 2020, this study was not conducted. However, this methods is briefly illustrated in this chapter.

Participatory action research

Lewin (1946) laid out the foundations of action research by stating: '*action research [is] a comparative research on the conditions and effects of various forms of social action, and research leading to social action*' (p. 35). The aim of Participatory Action Research (PAR) is to strike a balance between creating valuable knowledge and benefiting the community in which the research is being carried out. In so doing, this study aimed to improve research practices by including knowledge and experience from community members. Three main features, described to represent participatory research are: i) collaboration; ii) reciprocal education; and iii) acting in ways that are consonant with the results developed from community-relevant research questions. This is achieved through a mutual partnership between researchers and communities, and joint decision making and research development; including design, implementation, analysis and dissemination of results. This, in turn, attempts to produce research that can be applied to the community (or communities) in which it was initially conducted and, contemporaneously, to be transferable to, or informative for, other communities. To achieve this, various methods can be implemented, including photo-voice.

Photo-voice:

Photo-voice research employs inclusive participation with the aim to identify, record, and reflect the needs of the community; promoting critical dialogue; and reaching policy makers and lobby them toward enacting social change and community improvement. Furthermore, photo-voice is a grassroots-based, activism orientated research method, grounded in problem-focused enquiry (Burris & Wang, 1997). It is based on the understanding that adding visual representation benefits empirical research due to its capacity to convey complex messages, and inspiring social change (Stanczak, 2007). In practical terms, photo-voice researchers give cameras to individuals whose voice is seldom prominent in the political sphere so that they can represent their community and narrate their everyday experiences using their own voice (Foster-Fishman, 2005). This is particularly applicable to asylum seekers, refugee and undocumented migrant individuals who, due to language difficulties, could benefit from using imagery in describing their experiences. Starting from the understanding that participants are experts in their own life and situation (Wang, Burris and Ping, 1996), photo-voice allows them to draw upon their lived experience and personal histories. The emphasis is on people being able to tell their story rather than focusing on telling the story as it is perceived from the outside-in. Whilst photo-voice is not a monolithic method, it has a general framework and a set of procedures that allow for its categorisation as a participatory research method. Wang & Burris (1999) illustrate a total of nine steps, which include: selection and recruitment of community leaders; recruitment of participants for photo-voice; introduction of photo-voice as a research method and facilitation of group discussions; informed consent; distribution of cameras and training on how to use them; propose an initial theme to be photographed; allowing sufficient time for pictures to be taken; facilitating discussion of pictures; collaborating with participants on an appropriate format to share photos within the group and to selected audiences. Photo-voice implements a combination of photography, critical pedagogy, and experience-based knowledge. Thus facilitating participants' reflective abilities and ability to communicate effectively their concerns and expose social and community problems (Sutton-Brown, 2014).

Recruitment: Photo-voice research influences, and to an extent restricts, the recruitment process. Due to the aim of using photo-voice with marginalised individuals and communities, recruitment may prove to be challenging. During the recruitment stage, the researcher approached third sector organisations and proposed the initial research idea to its members whom, if interested, can sign up to participate. Ideally, to encourage in-depth group discussions, a group size for photo-voice research will comprise between 7 and 10 participants (Wang, 1999). An initial group meeting has the aim of introducing participants to each other, outlining the methodological tenets of photo-voice, and discussing risks associated with being a photographer. This initial meeting will also provide an opportunity to inform participants about the theoretical framework on which participatory action research and photo-voice are structured.

Sampling: recruitment is restricted to the city of Glasgow mainly to avoid logistical issue. Getting people to meet in Glasgow on a regular basis, particularly if these come from other areas in Scotland would prove very difficult, if at all possible. Before the commencement of a photo-voice study, the researcher(s) will choose an initial research focus (e.g. mental health in the context of destitution/access to healthcare/asylum process etc.). After presenting this to the participants, a specific question will be created collaboratively, in an environment of inclusivity and reciprocal respect. As the topic is presented, a balance between narrowness and broadness has to be maintained to allow for a focused discussion and for creative enquiry and exploration.

i) First meeting

At the beginning of the first meeting, the aims of the project and what it entails for participants will be fully explained. Written informed consent will then be obtained; participants will be free to withdraw at any time with no impact on either their access to services or (if appropriate) their asylum claim. This will be reiterated verbally at the beginning of each subsequent meeting. Ground rules for the group will be discussed and verbally agreed within the group. Over the research period, 6 meetings will be scheduled. It is important for meetings to take place at a time and place suitable to participants. Meetings will be in a local venue easily accessible by all participants. The site will be decided upon in consultation with community leaders from a third sector organisation (e.g. Mental Health Foundation). The first two meetings are pre-planned; then participants will decide the topics of discussions. However, every meeting will follow a similar format. Each meeting will be structured as follows.

ii) First meeting - Training in ethics and camera use

At the first meeting, cameras will be distributed and training will be provided by a professional photographer. The cameras cost approximately £15-£25 each. As the emphasis of photo-voice is the content and meaning of the photographs rather than their quality, the purpose of an initial workshop on camera use will focus on presenting basic and necessary camera operations and functions. The researcher and his supervisory team will also discuss ethical principles with group participants, including the responsibilities linked with photographing and camera use (e.g. taking pictures of places, seeking consent if others are photographed, who should or should not be photographed). There will be time for participants to ask any questions. Participants will also have the chance to practice using the camera by photographing the immediate surroundings. During this time, participants will be supported by the photographer in case any technical issues were to arise. A pre-planned topic for meeting 2 will be given to the group – this will likely focus on either housing or employment. The photographs taken will be used to inform the discussion of meeting 2.

iii) Subsequent meetings 3 to 6 - Data gathering and collaborative selection and interpretation of photographs

Recordings of the meetings and photographs taken will form the data collection component of the research. Group discussions will be recorded and transcribed; field notes will also be maintained by the researcher. Photographs brought by the participants will themselves be scanned or photographed and used as part of the analytic process. Participants will be free to record as much or as little of their daily living conditions as they wish. Data collection will take the form of group meetings lasting up to 2 hours every two to three weeks for a period of three months. Group meetings will facilitate participants' understanding of the process of photo-voice and talk about their current situation , post-migration experiences, health and use of health services. As the study progresses, group meetings will focus on the photographs they bring to each session, what those photos mean to them and the 'stories' they wish to share.

In each session, the first hour will focus on the pictures that participants have taken since the previous meeting. The selected photographs – and their meaning for the participant, will be discussed with AA acting as group facilitator. In the last hour, the discussion will focus on the selection of a topic for the next meeting.

The selected topic will be the focus of participants' photographs for the next group discussion. In the final meeting (meeting number 6), the group will collaboratively select 20 to 25 pictures from across the themes explored, along with the anonymised quotes which accompany them.

iv) Data Analysis

Data analysis is based on recorded and transcribed data. Data analysis will be informed by the approach of Grounded Theory (Glaser & Strauss, 1999). This analytic process follows four stages: coding (i.e. identifying key aspects of the data); concepts (i.e. collating codes of similar content); categories (i.e. grouping similar concepts), and theory (i.e. collection of categories that detail the subject of the research). In addition, for the photo-voice study, a small number of selected pictures will be used as visual representations of the issues discussed. Anonymised quotes will be selected collaboratively with research participants to accompany the chosen images. The findings from the study will be shared back with the participants before the completion of data analysis.

v) Dissemination

The final goal of a photo-voice study is to share results with diverse audiences and influence policy change. The action-focused nature of photo-voice research allows for the findings to be framed as issues to be addressed. To achieve this, the identification of appropriate audiences including individuals and agencies to share the results with, is necessary. The audiences are likely to include the Scottish refugee Council, the Parliamentary Cross-Party Group on Health Inequalities, and local community-based organisations such as the Govan Community Project and the Maryhill Integration Network. These potential options will be deliberated upon with the research participants. The findings will also be disseminated through academic publications and conference presentations.

Compensation: Vouchers. These will be usable at more than one place (e.g. high street vouchers) and within the area(s) participants feel comfortable travelling to. Bus fares/transport reimbursement for meetings will be provided along with culturally sensitive food and drinks at meetings. Also, participants will be provided with a camera (e.g. single use cameras).

Limitations: Notwithstanding the benefits, photo-voice also has associated limitations. The most obvious is that it is time consuming and that it demands some financial resources, which vary in relation to the length of the project, group size, cameras used and number of photos and meetings. Whilst considered a research method aiming to empower individuals and communities (e.g. Castelden & Garvin, 2008), photo-voice is limited in terms of the political and social space within which it can apply its potential. This is important to keep in mind for both researchers and participants, particularly when conducting a project which is socially focused. However, photo-voice, as well as other participatory methods, can reproduce the same power dynamics that it aims to challenge (Sutton-Brown, 2014). This may be due to the fact that the balance of power and knowledge between researcher and participants may not be surmountable within the study period.

Appendix 3: Interview Topic Guide

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Interview Topic Guide for Asylum Seekers, Refugees and Undocumented Migrants

- Can you briefly introduce yourself?
- Can you describe what your experience of being in the UK has been since arrival?
- Can you tell me about some of the difficulties you have come across during your time in the UK?
- What have your mental health and wellbeing experiences been since arriving in the UK? Follow up questions will reflect participants' answers.
- What have been the main challenges of life in the UK? This question will be followed by follow-up questions based on participant's answer.
- What are the barriers that prevent or have prevented you from getting the support that you need?
- How has the COVID-19 pandemic impacted on you? This question will be followed by follow up questions based on participant's answer.
- If self-isolation is discussed in the previous question: How has this impacted on your wellbeing?
- Can you tell me what support you are receiving during the COVID-19 pandemic (i.e. healthcare, financial, family, community)? This question will be followed by other questions based on participant's answer.
- What type(s) of support do you think would make a difference to your experience of COVID-19? This question will be followed by follow up questions based on participant's answer.
- What helped you cope during difficult times?
- How, if in any way have these experiences affected your health and wellbeing?
- Can you describe what these experiences have been in more detail?
- Did you feel supported by services? If yes, how? If not, how could services help people in your situation?
- Is there anything else you would like to add?

N.B. being a semi-structured interview, participants' answers will determine the interview questions that are asked as follow-ups.

Appendix 4: Participant Information Sheet

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PARTICIPANT INFORMATION SHEET

Study title: Post migration life experiences of asylum seekers and refugees in Glasgow: a qualitative approach

You are invited to take part in a study investigating the post migration life experiences of asylum seekers and refugees in Glasgow. The study is being led by Mr Alessio Albanese, who is studying for a PhD in General Practice and Primary Care (Institute of Health and Wellbeing) at the University of Glasgow. Before deciding whether to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The study aims to understand the post migration experiences of asylum seekers and refugees who live in Glasgow and how these influence people's mental health and wellbeing. Up to 20 people who are either asylum seekers or refugees will take part in the study. The purpose of this study is to learn more about your experiences, not to provide medical help or immediate solutions to the problems that are currently affecting you.

Why have I been invited to participate?

A community volunteer or worker from *[insert name of appropriate community organisation]* has approached you to see if you are interested in participating in this research because you are either an asylum seeker or refugee, you speak English, live in Glasgow and are over the age of 18.

Do I have to take part?

No. It is up to you to decide if you want to take part or not. You are free to withdraw from the project at any time, without giving any reason for your decision. Withdrawing from this study **will not** impact on the health care or support you receive, and it **will not** impact on your asylum application.

What will happen to me if I take part?

If you are interested in taking part, you can contact Alessio Albanese via email, and give him your contact details. Alessio will then telephone you to tell you more about the study and answer any questions you may have. After this meeting, if you are still interested in participation, a consent form will be sent to you via email. You will only need to sign this if you are still interested in participating, and do not need to sign it on the day. You can withdraw from the study at any time even if you have signed the consent form.

What do I have to do?

You will attend an interview using an online video platform that you prefer (e.g. Zoom, Skype) or, if you prefer, the interview can be conducted over the telephone. The interview will last approximately one hour and you will be asked questions related to your experiences since arriving in the UK. These experiences can include your health and wellbeing, as well as some of the difficulties you may have faced since arrival. The interview will also include questions about your experiences during the COVID-19 pandemic (see Topic Guide for ASR v2 20.09.20).

What are the possible disadvantages and risks of taking part?

The interview will contain questions about your life and about your experiences. There is a possibility that some of these questions may be upsetting. For example, the discussions could evoke memories and feelings of sadness, or you might feel distressed during the interview. You are free to stop your participation at any point. You will also be given a list of contacts (such as Breathing Space, Samaritans, and the local Accident and Emergency Department at the Queen Elizabeth University Hospital Glasgow), if you would like to talk with someone outside of the research team about how you are feeling.

What are the possible benefits of taking part?

The information you provide will help to give us a better understanding of the post migration experiences of asylum seekers and refugees and how these experiences impact on people's mental health and wellbeing, in the context of COVID-19. The results could help to improve our understanding of the post migration experiences that affect the mental health and wellbeing of asylum seekers and refugees in Glasgow, as well as informing policies and clinical practice to better support people.

You will receive thank you voucher of £20 at the end of the study.

Will my taking part in this study be kept confidential?

Your participation and all of the information you provide in the study will be strictly confidential. Any personal information (including your name and contact details) will be held separately from the discussions in the focus group sessions and you will not be identifiable. Your information will be stored securely at the University of Glasgow and destroyed ten years after the project ends.

What will happen to my data?

Researchers from the University of Glasgow collect, store and process all personal information in accordance with the General Data Protection Regulation (2018). The data will be stored in archiving facilities in line with the University of Glasgow retention policy of up to 10 years. After this period, your data will be securely destroyed in accordance with the relevant standard procedures. Your data may form part of the study results that will be published in expert journals and presentations. *Your name will not appear in any publication.*

What will happen to the results of the research study?

Your identifiable information might be shared with people who check that the study is done properly and, if you agree, with other organisations or universities to carry out research to improve scientific understanding. Your data will form part of the study results that will be published in expert journals, presentations, and on the internet for other researchers to use. *Your name will not appear in any publication*.

Who is organising and funding the research?

The research is funded through a grant provided by a private benefactor and the College of Medical Veterinary and Life Science at the University of Glasgow.

Who has reviewed the study?

This project has been reviewed by the College of Medical, Veterinary & Life Sciences Research Ethics Committee.

Contact for Further Information

If you have any questions or require more information, please contact Mr Alessio Albanese
E-mail: A.Albanese.1@research.gla.ac.uk
Telephone number: 0141 330 2549

Alternatively, you can contact my supervisor Professor Kate O'Donnell
E-mail: Kate.O'Donnell@glasgow.ac.uk
Telephone number: 0141 330 8329

If you wish to speak to someone not connected with the project, you can speak to Dr David Blane
Email: David.Blane@glasgow.ac.uk
Telephone number: 0141 330 5765.

Thank you for taking the time to read this information sheet.

Appendix 5: Consent Form

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Participant Identification Number:

Title of Project: Post migration life experiences of asylum seekers and refugees in Glasgow: a qualitative approach

Name of Researcher(s): Mr Alessio Albanese, Professor Catherine O'Donnell, Dr Sara Macdonald, Dr Barbara Nicholl

CONSENT FORM

	Please initial box
I confirm that I have read and understood the Participant Information Sheet version 5 dated 20/09/2020.	☐
I have had the opportunity to think about the information and ask questions, and understand the answers I have been given.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations.	☐
I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.	☐
I agree that my name, contact details and data described in the information sheet will be kept for the sole purposes of this research project.	☐
I understand that if I withdraw from the study, my data collected up to that point will be deleted.	☐
I agree for the interview to be audio-recorded	☐
I agree for a translator to be present at the interview (if required)	☐
I understand that the recorded interview will be transcribed word by word and the transcription stored for up to 10 years in University archiving facilities in accordance with Data Protection policies and regulations	☐

I understand that the things that I say during interview may be quoted in reports and articles that are published about the study, but my name or anything else that could tell people who I am will not be revealed. ☐

I agree to take part in the study. ☐

________________________ Date________ __________Signature______
Name of Participant

________________________ __________ __________________
Name of person taking consent Date Signature
(if different from researcher)

Researcher__________________ Date________ Signature____________

(1 copy for participant; 1 copy for researcher)

Appendix 6: REC form

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College of Medical, Veterinary & Life Sciences Ethics Committee for Non-Clinical Research Involving Human Participants

APPLICATION FORM FOR ETHICAL APPROVAL

NOTES:
THIS APPLICATION FORM SHOULD BE TYPED NOT HAND WRITTEN.

ALL QUESTIONS MUST BE ANSWERED. "NOT APPLICABLE" IS A SATISFACTORY ANSWER WHERE APPROPRIATE.

The primary remit of this committee is the review of non-clinical research. However, clinical research involving humans, their tissue or data that falls outwith the remit of the NHS Research Ethics Service will also be reviewed by the MVLS committee. If your project involves NHS facilities, or is clinical research, then you must ensure that NHS REC review is not needed before applying to the MVLS REC. The review of the MVLS REC does not obviate the need for NHS review.

Please note – it is now a requirement for a Data Protection Impact Assessment (DPIA) to be completed where processes are likely to involve high-risk personal data. This is likely to be the case for many research projects. If so, you must complete this before submission for ethical review. For research involving personal data, you should give participants a Privacy Notice as well as a Participant Information sheet.

Information on DPIAs and Privacy Notices
https://www.gla.ac.uk/myglasgow/dpfoioffice/gdpr/dpia/
https://www.gla.ac.uk/myglasgow/dpfoioffice/gdpr/privacy%20notices/

Information on the General Data Protection Regulation (GDPR)
https://www.gla.ac.uk/myglasgow/dpfoioffice/

Information on Research Data Management
https://www.gla.ac.uk/myglasgow/datamanagement/

University of Glasgow policy on surveys of students for research purposes
https://www.gla.ac.uk/myglasgow/senateoffice/policies/studentengagement/studentsurveys/policyonstudentsurveys/

Project Title:

Post migration life experiences of asylum seekers and refugees in Glasgow: a qualitative approach.

Has this application been previously submitted to this or any other ethics committee?
No

If 'Yes', please state the title and reference number.

Is this project from a commercial source, or funded by a research grant of any kind?
Yes

If 'Yes', has it been referred to Research Support Office?
Has it been allocated a project Number?
Give details and ensure that this is stated on the Informed Consent Form.

Insurance Coverage and Restrictions:

Please Note: The Insurance restrictions set out below relate to research of a clinical nature. Non clinical research is not subject to restriction and no additional insurance is required

The University insurance cover is restricted under specific circumstances, including, but not limited to the following -

- **work involving the use of research participants outside Great Britain, Northern Ireland, the Channel Islands or the Isle of Man**
- **the use of hazardous materials**
- **non CE marked medical devices**
- **molecules or compounds developed and manufactured at the University of Glasgow**
- **number of participants in excess of 5000**
- **work involving research participants known to be pregnant at the time of the project**

All such projects must be referred to Research Support Office and coverage confirmed before ethical approval is sought. Please contact Dr Debra Stuart in the University's Research Governance Office: debra.stuart@glasgow.ac.uk

Please tick here if this project has been referred to the Research Support Office to confirm adequate insurance coverage. ☐

Please tick here if the project includes a technique involving incision, piercing of skin, insertion of a device or object, ingestion of medicines or food substances. ☐

Please tick here if the project involves work on human participants that will be conducted within the Imaging Centre of Excellence (ICE) ☐

Date of submission:

Name of all person(s) submitting research proposal:

1. Mr Alessio Albanese
2. Professor Catherine O'Donnell
3. Dr Barbara Nicholl
4. Dr Sara Macdonald

Position(s) held:

1. Doctoral Student
2. Professor of Primary Care Research and Development
3. Senior Lecturer in Primary Care
4. Senior Lecturer in Primary Care

School/Group/Institute/Centre:
General Practice and Primary Care, Institute of Health and Wellbeing

Address for correspondence relating to this submission:
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Name of Principal Researcher (if different from above, e.g., Student's Supervisor):
Professor Catherine O'Donnell

Position held:
Professor of Primary Care Research and Development

Undergraduate student project:
No If 'Yes', please state degree being undertaken:

Postgraduate student project:
Yes If 'Yes', please state degree being undertaken:

PhD in Public Health

For postgraduate student projects, please state whether this a research (PGR) or taught (PGT) degree: **PGR**

1. Describe the purposes of the research proposed. Please include the background and scientific justification for the research. Why is this an area of importance? Please try to describe why the research is novel and experimental.

Mental ill-health represents a significant Global Burden of Disease. It was estimated that, in 2017, 970 million people worldwide suffered from mental ill-health. Of these, 264 million had depression, and 284 million had an anxiety disorder (1). However, the prevalence of mental health issues amongst the global population is not evenly distributed. In comparison with the general population in Western countries, refugees and asylum seekers have higher rates of mood and anxiety disorders (2). The prevalence of depression in these groups varies between 5% and 44% compared to 8%–12% in the general population. Similarly, for anxiety disorders the prevalence varies from 4% to 40% compared to 5% in the general population. Specifically, post-traumatic stress disorder (PTSD) occurs more often in refugee groups, 9%–36% compared with 1%–2% in host populations (2). Evidence points to a relationship between migration-related social problems, chronic stress, and the development of anxiety and depression in asylum seekers and refugees (3); these have been attributed to a host of factors, including an elevated exposure to violent and stressful events before departure (4; 5) or during travel (6), and difficulties with resettlement and integration in a host country (7). Aragona and colleagues (8) outline a range of post migration life difficulties, including processing refugee applications, difficulties in dealing with immigration officials, inadequate access to healthcare, racial discrimination and loneliness, as important factors that impact on the mental health of these populations. To compound these complexities, culture and individuals' belief systems are reported to play an important role in the experience and expression of distress in these diverse ethnic groups (9).

The planned study focuses on understanding and potentially addressing the complexities of the interactions between post migration life difficulties and mental health in asylum seekers and refugees who live in Glasgow. Since 2000 and following the introduction of the UK Home Office's 'Dispersal policy', asylum seekers are sent to live in supported accommodation in participating cities (10). This makes Glasgow an appropriate setting for this study. Once someone's claim to stay is approved, they officially gain refugee status; and an unknown number have then remained living in Glasgow. Refugees and asylum seekers have contributed to the diversification of the city, where ethnic diversity increased from 7.2% in 2001 to 15.5% in 2011 (10). In 2015, the top three countries of origin of new arrivals in Glasgow were Somalia, Afghanistan and Syria (10). Given the higher prevalence of mental health issues amongst refugees and asylum seekers, the emphasis in this project's is on improving our understanding of the issues that may affect refugees, asylum seekers, their families and communities in the post migration period.

The research project described here forms the fieldwork for AA's PhD. Two studies are proposed. The first will focus on the post-migration experiences of asylum seekers and refugees living in Glasgow and how these experiences impact on their health and well-being, particularly their mental health. The second study will interview health care professionals and representatives of third sector organisations to draw broader conclusions in relation to how post-migration life difficulties and the social determinants of health influences and impacts on the mental health of these populations.

The **overall aims** of this work are:

- To improve our understanding of the post migration life difficulties that affect the mental health of refugees and asylum seekers in Glasgow and identify how these might affect their health and well-being.
- To explore the views and perceptions of health professionals and those working in third sector organisations in relation to asylum seekers' and refugees' mental health needs.

Objectives:

- To interview asylum seekers and refugees in Glasgow in relation to their mental health and wellbeing in the context of post-migration experiences.
- To explore how health beliefs and the wider social setting in which asylum seekers and refugees live impacts on their experience and understanding of mental health issues.
- To explore asylum seekers' and refugees' experiences of, and access to, mental health services in the post-migration period.
- To understand how health care professionals and third sector organisations respond to mental health needs in asylum seekers and refugees.
- To draw wider inferences in relation to how asylum seekers' and refugees' mental health should be addressed.

2. Describe the design of the study and methods to be used. If multiple methods are to be used, please describe them each in turn. Include details of the study sample size and how you decided this. Statistical advice should be obtained if in doubt.

The proposed research will employ two separate qualitative studies to explore the issues facing refugee and asylum seekers in the post migration period and the potential impact on mental health and wellbeing. **Study 1**: Interviews with refugees and asylum seekers using suitable video platforms; and **Study 2**: Interviews with key stakeholders, such as health professionals and representatives of third sector organisations using suitable video platforms.

Study 1. Interviews with asylum seekers and refugees using suitable video platforms.
One to one interviews using suitable video platforms (e.g. Zoom, Skype) will be conducted as a means of data collection. The interviews will include individuals from asylum seeking and refugee communities. This approach aims to generate rich qualitative data, in the form of semi-structured interviews. A **Topic Guide ()** will be used to explore the post migration life experiences of asylum seekers and refugees, and the potential impact these have on mental health and wellbeing.

Setting
Due to the COVID-19 pandemic, the interviews will take place remotely on suitable video platforms (e.g. Zoom, Skype).

Recruitment and sampling
Recruitment of asylum seekers and refugees will be facilitated through local organisations working with these populations (e.g. Mental Health Foundation; Govan Community Project). We aim to recruit in the region of 15 to 20 participants, including a mixture of asylum seekers and refugees with diverse demographics, albeit all aged 18 or above. Although the preference is to recruit participants with a range of characteristics (e.g. age, gender, sexuality, country of origin), previous experience is that this is not always possible due to the nature of the population being recruited. The inclusion criteria for this group are: English speaking asylum seekers and refugees over 18 years of age and residing in Glasgow. The interviews will be conducted in English.

Data collection for the interviews with asylum seekers and refugees
Consenting participants will be invited to participate in an interview using a suitable video platform (e.g. Zoom, Skype). Each interview will last approximately 1 hours. During the interview, participants will be asked to discuss current life experiences, related to being an asylum seeker or refugee and how these impact, if in any way, on their mental health. Each interview will be recorded and follow a set format, as outlined in the topic guide.

The semi-structured interview questions will focus on discussing a host of life difficulties (e.g. food security, housing, unemployment) as experienced by participants. Later questions, however, will focus on topics that the asylum seeking and refugee participants describe as important to them, particularly in relation to their mental health. The choice of conducting semi-structured interviews stems from the greater flexibility this method of qualitative data collection provides to allow participants to tell their story.

For participants interested in participating in a follow up interview, an interview with the option of using object elicitation will be offered. The object elicitation technique is based on the understanding that adding visual representation through objects selected by the participants themselves benefits research because of the ability of images to convey important messages, and aid participants' narrative (12).
Furthermore, for participants interested in participating in a follow-up interview, the follow-up interviews (**Follow up interview with ASR Topic Guide v1 17.09.20**) will build upon the previous, semi-structured interview, with the potential addition of object elicitation, depending on

participants' preference. If object elicitation is preferred by participants, the interview will revolve around the meaning(s) that the object has for the participant and the object's saliency in relation to the participant's current life experiences as these relate to post-migration life difficulties and wellbeing (**Follow up interview and object elicitation with ASR Topic Guide v1 17.09.20**). The object(s) that may be used are chosen by the participants themselves, and will be objects already in their possession. All interviews, will be conducted remotely, using suitable video platforms (e.g. Zoom, Skype).

The interviews will be conducted by AA. At the beginning of each session, participants will be reminded that they may withdraw from the study at any point. Interviews will be audio-recorded for later transcription and notes will also be taken to be used to augment data analysis.

Study 2: Semi-structured interviews with health care professionals and representatives of third sector organisations.

a. **Healthcare professionals.**

Recruitment and sampling
Healthcare professionals will be recruited from general practices with high numbers of asylum seeking and refugee patients. Advice on which surgeries to contact will be sought from colleagues in General Practice and Primary Care and from the Asylum Support Bridging Team. Healthcare professionals will be recruited separately from asylum seekers and refugees (i.e. they will not be the migrants' own doctors or nurses). Identified practices will be sent written information about the study, via online platforms (e.g. e-mails, social media), followed by a telephone call to see if they are interested in taking part. If yes, Alessio Albanese will send a copy of the consent form, for participants to review and sign electronically. Participants will be reminded that they can withdraw from the study at any time, without any repercussion to themselves. It is anticipated that 10 to 15 health care professionals will be interviewed using suitable video platforms (e.g. Zoom, Skype).

Setting
Interviews will be conducted remotely via suitable online video platforms (e.g. Zoom, Skype).

Data collection
Semi-structured interviews with healthcare professionals (general practitioners, nurses) will last a maximum of one hour. Please note it is not necessary to obtain NHS ethical approval for interviews with NHS staff however NHS R&D approval is being sought. Following informed consent, interviews will be digitally recorded and then transcribed.

b. **Representatives of third sector organisations:**

Recruitment and sampling
Representatives from third sector organisations in Glasgow will be identified and contacted based on our ongoing links with members of these organisations (e.g., Mental Health Foundation; Govan Community Project; Positive Action on Housing; Maryhill Integration Network) to request an interview. Identified organisations will be sent written information about the study, followed by a telephone call to see if they are interested in taking part in the study. If yes, Alessio Albanese will offer to schedule an online meeting using a suitable video platform (e.g. Zoom, Skype) to address any question that may arise from participants before formal consent is sought. It is anticipated that 5 to 10 third sector representatives will be interviewed.

Setting

Interviews will take place via a suitable online platform (e.g. Zoom, Skype).

Data collection

Semi-structured interviews will be conducted with representatives of third sector organisations working in support of asylum seekers and refugees in Glasgow. The interviews will last a maximum of an hour. Following informed consent, interviews will be digitally recorded and then professionally transcribed.

Interview schedules

Interview topic guides for both health care professionals and for representatives of third sector organisations have been developed following literature review and discussions with supervisors. The interview topic guides are attached (see **Topic Guide for HCPs v1 18.12.19**; **Topic Guide for Third Sector v1 18.12.19**).

Data analysis

Data analysis will be based on recorded and transcribed data. For both the semi-structured interviews with asylum seekers and refugees, and semi-structured interviews with healthcare professionals and representatives of third sector organisations, the data analysis will be guided by a Grounded Theory (13) approach. This analytic process follows four stages: coding (i.e. identifying key aspects of the data); concepts (i.e. collating codes of similar content); categories (i.e. grouping similar concepts), and theory (i.e. collection of categories that detail the subject of the research). Anonymised quotes will also be selected based on their saliency. The findings from the study will be shared back with the participants before the completion of data analysis.

3. How will potential participants in the study be (i) identified, (ii) approached and (iii) recruited? Give details for cases and controls separately, if appropriate

Study 1: Interviews with asylum seekers and refugees.

i. Identification

Existing links with community organisations will facilitate recruitment. Participants will be identified and recruited through community organisations selected on the basis of their experience in supporting and working alongside refugee and asylum seeking communities. Community volunteers from these organisations will help with outreach and the identification of volunteers who may be interested in participating in this study. Initial discussions with the Mental Health Foundation (MHF) indicate that they are confident that the organisation will be able to identify and recruit volunteers. The MHF is an organisation that supports a network of community subgroups and projects. Recruitment will occur within these community subgroups, provided potential participants agree to participation. Other organisations that can be approached include the Integration Networks, who COD has worked with in the past. All stages of recruitment will be conducted using suitable online platforms (e.g. Zoom, Skype).

ii. Approach

The initial invitation will come from the third sector partner (e.g. the MHF), and only those community groups or individuals that express an interest will be approached by the researcher. The researcher will then attend an online meeting using a suitable video platform, and provide further information on the study and what participation involves. During this meeting, participants will be given a brief one-page **Short Information Sheet for ASR v1 3.1.20**, written in an accessible and non-threatening style. A longer, more detailed version will be available if requested (**Participant Information Sheet for ASR v3 18.12.19**). This approach of using a short and longer more detail participant information sheet was recently used successfully in another project approved by the College of MVLS REC (Project No 200180197).

Although potential participants will be given information at this initial meeting, formal consent will not be sought at this point, thus allowing potential participants the chance to consider participation in the absence of the researcher. Community volunteers will act as conduits between the group and the researcher until final decisions on participation are made; following agreement to participate, the researcher will begin a more formal recruitment process.

iii. Recruitment

Those willing to take part will be given a consent form (**Consent Form for ASR v3 18.12.19**) for the overall study. A suitable time for the interview to be conducted will be agreed, along with a decision on the more suitable video platform for the participant. Participants will be reminded that they may withdraw from the study at any point. The inclusion criteria for this group are: English speaking asylum seekers and refugees over 18 years of age and residing in Glasgow. The interviews will be conducted in English.

Study 1: Follow-up interview with asylum seekers and refugees with the option of using object elicitation.

i. Identification

Follow up interviews with the option of using object elicitation will be offered to participants who consented to and participated in the initial semi-structured interview. At the end of these interviews, participants will be asked whether they would be interested in participating in another interview, with the additional option of choosing an object to bring to interview based on its importance and saliency in the context of the participant's current experiences related to post-migration difficulties and mental health and wellbeing. Therefore, the follow-up interviews may build upon the initial semi-structured interviews.

ii. Approach

The participants who express interest in participating in a second interview will later be contacted via email, and sent an information sheet. The participants who respond positively to this invite will be sent a consent form (**Consent Form for follow up interview with ASR v1 17.09.20**). Throughout this process, participants will be reminded that participating in the follow-up interview is voluntary and independent from their participation in the initial semi-structured interview, and that they can withdraw their consent at any time without any consequences to themselves.

iii. Recruitment

Participants who express interest in taking part in a follow up interview will be sent a consent form (**Consent Form for follow up interview ASR v1 17.09.20**). Once the form is electronically signed and returned via email, a suitable time for the interview to be conducted will be agreed, along with a decision on the more suitable video platform (e.g. Zoom, Skype) for the participant. Participants will be reminded again that they may withdraw from the study at any point even though they have signed the consent form. The inclusion criteria for this study are: English speaking asylum seekers and refugees over 18 years of age and residing in Glasgow who took part in the initial semi-structured interview. The interviews will be conducted in English.

Study 2: Semi-structured interviews with healthcare professionals.

i. Identification

On the advice of colleagues in General Practice and Primary Care or from the Asylum Support Bridging Team, emails (see **E-mail to healthcare professionals V1 07.02.2020**) will be sent to healthcare professionals that work either a) in areas with high numbers of asylum seekers or refugee or b) suggested by colleagues working in primary care. These email will invite GPs and practice nurses in practices with a high number of asylum seeking or refugee patients to participate in a semi structured interview at a time convenient to them on a suitable online platform (e.g. Zoom, Skype).

ii. Approach

Participant information sheets will be included with these emails (see **Participant Information Sheet for HCPs & Others v2 18.12.19**). AA will telephone general practices to ensure that the emails have been received and disseminated. Potential participants will be invited to contact Alessio Albanese (AA) if they are interested in participating, either by phone or email. Alternatively, AA will contact the practice by telephone approximately 1 week after sending the information. When an interested individual responds, AA will arrange a short telephone conversation with them to give them some more information about the research and the interview.

iii. Recruitment

If they remain interested, a mutually convenient date and time will be arranged for an interview to take place using a suitable online platform. They will be sent a copy of the Participant Information Sheet again, by email, so that they can read it before the interview. A copy of the consent form will also be emailed (**Participant Information Sheet for HCPs & Others v2 18.12.19;**

Consent Form for HCPs & Others v2 18.12.19). The consent form will be signed prior to the interview. AA will emphasise that consent can be withdrawn at any time, even though they have signed the form. The interviews will last approximately an hour and will be recorded digitally.

Semi-structured interviews with representatives of third sector organisations that work with asylum seekers and refugees in Glasgow:

i. Identification

On the advice of colleagues in General Practice and Primary Care, and existent links with third sector organisations that work with asylum seekers and refugees in Glasgow, AA will send invitation emails (see **E-mail to representatives of third sector organisations V1 07.02.2020**) to representatives of third sector organisations (e.g. Mental Health Foundation, Positive Action Housing, Govan Community Project) inviting them to remotely participate in a semi structured interview at a convenient time, using suitable online video platforms (e.g. Zoom; Skype).

ii. Approach

Participant information sheets will be included with these emails (see **Participant Information Sheet for HCPs & Others v2 18.12.19**). AA will telephone the recipient organisations to ensure that the email containing an electronic copy of participant information sheet have been received and disseminated. Potential participants will be invited to contact AA if they are interested in participating, either by phone or email. Alternatively, he will contact the organisation by telephone approximately 1 week after sending the information. When an interested individual gets in touch, AA will arrange a short telephone conversation with them to give them some more information about the research and the interview.

iii. Recruitment

If they remain interested, a mutually convenient date and time will be arranged for the interview to take place on a suitable video platform (e.g. Zoom, Skype). They will be sent a copy of the Participant Information Sheet again, by email, so that they can read it before the interview. A copy of the consent form will also be emailed (**Participant Information Sheet for HCPs & Others v2 18.12.19; Consent Form for HCPs & Others v2 18.12.19).** Consent form will be signed prior to the interview. AA will emphasise that consent can be withdrawn at any time, even though they have signed the form. The interviews will last approximately one hour and will take place using suitable online video platforms (e.g. Zoom, Skype), the interviews will be digitally recorded.

It is anticipated that up to 20 semi-structured interviews will be conducted with a mix of health care professionals and representatives of third sector organisations.

4. Describe the research procedures as they affect the research participants and any other parties involved. It should be clear exactly (i) what will happen to the research participant, (ii) how many times and (iii) in what order. If your research involves administration of a substance, for example saline, topical anaesthetic etc. then please give full details on the substance and manufacturer. Reference to an existing standardised operating procedure is acceptable.

Study 1: Interviews with asylum seekers and refugees:

vi) Semi structured interview;

Participant recruitment prior to the interview has been described fully in Q3. Before the commencement of the interviews, written informed consent will be obtained electronically, and verbal consent will also be recorded before the start of the interview; participants will be free to withdraw at any time with no impact on either their access to services or (if appropriate) their asylum claim. This will be reiterated verbally at the beginning of each interview. The interviews be conducted using a suitable video platform (e.g. Zoom, Skype), will last approximately one hour, and will be digitally recorded on a voice recorder or, if Zoom is used, interviews will be digitally recorded directly on Zoom.

As part of this study, interviewees will have the option of participating in a second interview as outlined in Q3, which will also be conducted online using a suitable video platform and will provide consenting participants with the opportunity to use object elicitation.

vii) Second interview with the option of using object elicitation;

Willing participants will be provided with the opportunity to participate in a second interview, with the option of using object elicitation as part of the interview. Furthermore, object elicitation is a technique used to assist data collection by facilitating participants' reflections of their lived experiences. This widely used qualitative technique functions by inviting participants to select one or more objects that hold specific, and at times special meaning for them. These could be objects that have a particular meaning in the current phases of their lives. Participants may use these to reflect on their relationship with these objects as well as the meaning(s) that they attribute to the objects. However, we anticipate that not all participants will be interested in participating in a second interview, and we will clearly state that participating in a second interview is voluntary, and independent from consent given for the initial interview. As outlined in Q3, electronic written consent will be sought from participants willing to take part in a second interview.

viii) Data Analysis;

Data analysis is based on recorded and transcribed data. Data analysis will be informed by the approach of Grounded Theory (13). This analytic process follows four stages: coding (i.e. identifying key aspects of the data); concepts (i.e. collating codes of similar content); categories (i.e. grouping similar concepts), and theory (i.e. collection of categories that detail the subject of the research). The findings from the study will be shared back with the participants before the completion of data analysis.

ix) Dissemination;

The audiences are likely to include the Scottish refugee Council, the Parliamentary Cross-Party Group on Health Inequalities, and local community-based organisations such as the Mental Health Foundation, Govan Community Project and the Maryhill Integration Network. These potential options will be deliberated upon with the research participants. The findings will also be disseminated through academic publications and, possibly webinar conference presentations.

Study 2: Interviews with healthcare professionals and representatives of third sector organisations.

i) Participant recruitment

Participant recruitment prior to the interview has been described fully in Q3. When AA hears from an interested individual, he will arrange a short telephone conversation with them to give them some more information about the research and the interview. If they remain interested, a mutually convenient date and time will be arranged for an online meeting using a suitable video platform (e.g. Zoom, Skype). They will be sent a copy of the Participant Information Sheet and Consent Form prior to the interview. On the day of the interview AA will send another copy of the participant information sheet and a consent form already electronically signed by AA. AA will emphasise that consent can be withdrawn at any time, even though they have electronically signed the form. The interviews will last approximately and hour and be recorded on a handheld voice recorder or, if Zoom is used, it will be recorded directly on Zoom.

ii) Data gathering

It is anticipated that up to 20 semi-structured interviews will be conducted with a mix of health care professionals and representatives of third sector organisations. Each will be a one-off interview, semi-structured interview with healthcare professionals (e.g. general practitioners, practice nurses) and representatives of third sector organisations (e.g. Mental Health Foundation, Govan Community Project, Positive Action Housing). These will be informed by a topic guide (see **Topic Guide for HCPs v1 18.12.19** and **Topic Guide for Third Sector v1 18.12.19).** Interviews will last a maximum of an hour and conducted at a time convenient to each interviewee using a suitable online video platform (e.g. Zoom, Skype). Interviews will be digitally recorded and transcribed by a professional transcriber.

iii) Data Analysis

Data analysis is based on recorded and transcribed data. Data analysis will be informed by a Grounded Theory approach (13). This analytic process follows four stages: coding (i.e. identifying key aspects of the data); concepts (i.e. collating codes of similar content); categories (i.e. grouping similar concepts), and theory (i.e. collection of categories that detail the subject of the research). Anonymised quotes will be selected as part of the analytic process on the basis of their saliency in conveying meaning. The findings from the study will be shared back with the participants before the completion of data analysis.

iv) Dissemination

The findings will be shared using online platforms with individual participants and third sector organisations. The findings may also be disseminated through academic publications and web-based or conference presentations.

References.

(1) WHO Mental health atlas. (2017). World Health Organisation. Geneva, 2018.

(2) WHO Regional Office for Europe (2018). *Mental health promotion and mental health care in refugees and migrants.* Copenhagen, 2018.

(3) Schulz (2008). Relational pathways between socioeconomic position and cardiovascular risk in a multi-ethnic urban sample: complexities and their implications for improving health in economically disadvantaged populations *Journal of Epidemiology and Community Health* 62 638–646

(4) Ba I, Bhopal RS. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981–2014). *Public Health*. 142:121–35.

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(6) Ottisova L, Hemmings S, Howard LM, Zimmerman C, Oram S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review. *Epidemiology and Psychiatric Science*.25:317–41.

(7) Porter M, Haslam N. (2005) Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta analysis. *JAMA*. 294:602–12.

(8) Aragona, Pucci, Mazzetti, Geraci (2012) Post migration life difficulties as a significant risk factor for PTSD in immigrants: a primary care study. *Italian Journal of Public Health.* (9) 3; 7525-8.

(9) Kirmayer, L.J. and Young, A. (1998). Culture and somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*. 60(4): 420–430.

(10) Mulvey, G. (2015). Refugee integration policy: The effects of UK policy-making on refugees in Scotland. *Journal of Social Policy*. 15; 44: 357.

(11) Wang, C., & Burris, M. (1997). Photovoice: concept, methodology, and use for participatory needs assessment. Health Education Behaviour, 24(1), 369–387.

(12) Foster-Fishman, P., Nowell, B., & Deacon, Z. (2005). Using methods that matter: The impact of reflection, dialogue, and voice. American Journal of Community Psychology, 36(3-4), 275-291.

(13) Charmaz, K. (2000). *Grounded Theory: Objectivist and Constructivist Methods*. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), Handbook of Qualitative Research, 2nd edition (pp.509-535). Thousand Oaks, Ca.: Sage.

5. What are the ethical considerations involved in this proposal? You may wish, for example, to comment on issues to do with consent, confidentiality, risk to participants, etc.

Risk to participants:

The study is voluntary and we anticipate that participants who volunteer will want to engage with the process and therefore foresee few risks for participants. However, there is a potential for sensitive topics to arise, particularly in relation to interviews with asylum seekers and refugees. The researcher will make clear to participants that they are not obliged to discuss any issues that may cause distress. If it becomes clear that a conversation or discussion is making a participant uncomfortable, the researcher will manage this by steering the conversation away from that topic or by offering that person some space and the opportunity to either leave the online video platform on which the interview is being conducted, or take a break from the interview. At the end of each focus group, opportunities for debriefing will be provided to participants by the researcher. If necessary, the researcher can provide information about the available support services (which are now offering online support during the COVID-19 pandemic) for migrants in Glasgow (e.g., the Scottish Refugee Council, Mental Health Foundation; Freedom from Torture Glasgow). Contact details of these support organisations are included in a **Support Sheet** (see **Support Sheet v2 18.12.19**).

Consent:

The research team will work to ensure that no participant feels in any way coerced or pressured to participate in the study. Participation in this study is completely optional and at the discretion of each participant. These aspects of consent will be highlighted at every step of the recruitment and research process. Participants will be regularly made aware that they can withdraw at any point during the research process without any need to provide an explanation for their decision, and without any consequence for their access and use of services or their asylum application. In relation to the data gathered, participants will be made aware of the fact that data will be confidentially destroyed in line with the University of Glasgow's General Data Protection Regulation for the disposal and confidential information destruction.

Confidentiality:

Following the focus group discussions and the interviews, the digital recording will be uploaded to a secure University of Glasgow server for transcribing. A unique ID number will be assigned to each recording. The digital recordings will be transcribed by the researcher or by a professional transcriber. All identifying information will be removed from the transcript. Digital recordings will be destroyed after the transcribing process has been successfully completed and the transcribed interview has been checked. Only the research team will have access to the files.

Ethical Considerations:

The researcher and his supervisory team will discuss ethical principles with participants. Participants will be informed about consent, confidentiality and disclosure.

6. Outline the reasons why the possible benefits to be gained from the project justify any risks or discomforts involved.

We do not anticipate that the study will be a 'risky' endeavour. Participants will not be placed in or asked to undertake risky behaviour. Although some discomfort may be experienced when discussing potentially sensitive topics, contingencies are in place to mitigate the potential impact on individual. In addition, participants will be made aware of sources for professional support which is available through third sector organisations. Moreover, the study will discuss potential life-difficulties with asylum seekers and refugees, a group who often do not have the opportunity to share their experiences and feel heard about their life circumstances. The findings may help to inform policy and practice aiming to reduce rates of mental health issues, which disproportionately affect refugee and asylum seeking groups.

7. Who are the investigators (including assistants) who will conduct the research? What are their qualifications and experience?

Alessio Albanese, BA (Hons), MSc is a PhD student in General Practice and Primary Care. Alessio has a background in Psychology (BA Hons), Global Mental Health (MSc), and is a qualified psychological therapist. Alessio has experience in conducting in depth one to one interviews and focus groups, in both research and clinical settings.

Professor Catherine O'Donnell BSc (Hons), MPH, PhD, FRCGP (Hons). Professor O'Donnell is a primary care researcher with over 20 years' experience of conducting mixed methods research in primary care and community settings. This includes conducting research with marginalised populations, including refugees and asylum seekers. She has supervised 15 PhD students to successful completion; 3 of these have conducted research into health and health care of asylum seekers and refugees.

Dr Sara Macdonald is a Senior Lecturer in Primary Care Research. She is a medical sociologist with 18 years experience of working in primary care research. She has conducted, and supervised, many studies exploring the lived experiences of patients with cancer; heart failure and other life-long illnesses. She has supervised several PhD students to completion and many MSc students.

Dr Barbara Nicholl is a Senior Lecturer in Primary Care Research and although primarily from a quantitative background she has now been involved in a number of mixed methods studies, including a BSc study on migrant health. Barbara is experienced at supervising students at BSc, MSc and PhD level.

8. Are arrangements for the provision of clinical facilities to handle emergencies necessary? If so, briefly describe the arrangements made.

No. An emergency is highly unlikely since participants will not be engaging in any activities that would require emergency facilities.

9. In cases where participants will be identified from information held by another party (e.g., a doctor or hospital), describe how you intend to obtain this information. Include, where appropriate, whether additional Research Ethics Committee approvals will be sought and gained (including overseas committees).

Key stakeholders, from the community groups outlined above, will be asked to identify suitable participants based on the inclusion and exclusion criteria for the study. Personal information will only be given to the researcher once an individual agrees to participate in the research.

10. Specify whether participants will include students or others in a dependent relationship and, where possible, avoid recruiting students who might feel to be, or be construed to be, under obligation to volunteer for a project. This is most likely to be when a student is enrolled on a course where the investigator is a teacher. In these circumstances, the recruitment could be carried out by one of the other investigators or a suitably qualified third party.

Students will not be excluded from the study on the grounds that they are a student, but they will not be deliberately recruited, and they would not be students related to any of the investigators of the study.

11. Specify whether the research will include children or participants with mental illness, physical disability or intellectual disability. If so, please explain the necessity of involving these individuals as research participants and include documentation of the suitability of those researchers who will be in contact with children or vulnerable adults (e.g., Disclosure Scotland or membership of the Protection of Vulnerable Groups Scheme).

The aim of the study is to consider mental health impacts of post-migration life difficulties, therefore it is plausible that participants may have previously or currently experienced mental health difficulties. Neither inclusion or exclusion is dependent on participants’ mental health status. The researcher has a therapeutic background and is a fully qualified psychological therapist, based in a primary care setting in Glasgow - The researcher is also a member of the PVG scheme.

12. Will payment or other incentive, such as a gift or free services, be made to any research participant? If so, please specify, and state the level of payment to be made and/or the source of the funds/gift/free service to be used. Please explain the justification for offering an incentive.

Yes. The asylum seekers and refugee participants in online interviews will receive a one-off 'thank you' voucher worth £20 at the end of their participation in the research. This voucher will be for a high street shop or supermarket.

13. Please give details of how consent is to be obtained and recorded. A copy of the proposed consent form, along with a separate information sheet, written in simple, non-technical language MUST ACCOMPANY THIS PROPOSAL FORM.

Electronic written consent will be obtained before each participant's enrolment in the study. Both the participant and researcher will sign the consent form electronically this will ensure safety in the context of COVID-19, and consent will also be sought verbally and recorded at the start of interviews. The consent form will be provided in English. Consent can be withdrawn verbally at any point. **Throughout the research and recruitment process, participants will be made aware that they can withdraw at any point without consequence to themselves.**

14. Comment on any cultural, social or gender-based characteristics of the participants that have affected the design of the project or may affect its conduct.

Asylum seekers and refugees constitute diverse groups of individuals from various cultural, social, ethnic, sexual and gender-based characteristics. These will be accounted for during recruitment. The Mental Health Foundation's community leaders will support this process.

15. Please state (i) who will have access to the data, (ii) how the data will be stored, how will access be restricted, and (iii) what measures will be adopted to maintain the confidentiality of the research participants and to comply with data protection requirements.

For studies where participant responses are recorded and transcribed at a later date, give details of storage and transcription. Please give some detail on how long data will be stored for and where. You should clarify how identifiable, anonymised research data and consent forms will be stored.

Only Alessio Albanese and his supervisors will have access to the data.

The interviews will be conducted using suitable video platforms (e.g. Zoom, Skype) and will be recorded on a digital recording device. The recordings will be uploaded onto the university network and stored in a password protected folder. The recordings will be transcribed in full either by a professional transcriber at the university. Recordings will be deleted once the file is transcribed and checked. During the transcription process interviews will be anonymised, with all names and identifying data being removed.

Electronically signed consent forms, and participant data collection will be kept in an encrypted, password protected computer file on a secure online storage system (i.e. JDrive) within the Department of General Practice and Primary Care, University of Glasgow. Access to this folder is limited to AA and the supervisory team (KO, SM, BN). Each interview will be assigned an anonymous reference code which will be written on the consent form and the data collection

form. The list of codes will be kept in a separate online folder so that the information cannot be traced back to the participant who has provided it. Only someone with access to this material (AA, KO, SM, BN) could link an individual consent form or data collection form to a transcript and thus identify the participant. Consent forms will be kept in an encrypted, password protected computer file for ten years. Contact details for participants will also be kept in a separate encrypted, password protected computer file, and not linked to the transcripts.
Digital copies of the interviews will be stored in an encrypted, password protected file folder accessible only by the research team for ten years, after which period they will be deleted. These will be confidentially destroyed in line with the University of Glasgow's General Data Protection Regulation for the disposal and confidential information destruction.

Please tick to confirm that all relevant research data generated during and after the study will be collected and held in compliance with the General Data Protection Regulation (May 2018). ☒

Please tick to confirm that you have completed a data protection impact assessment form if required. ☐

If this is not required, please specify why not;

We are currently seeking advice from the University Data Protection Office. However, as we are not processing any data and will not use identifiable personal data, we believe that a DPIA will not be required.

For guidance in this matter, please refer to the University Data Protection Office webpages:
https://www.gla.ac.uk/myglasgow/dpfoioffice/gdpr/

In regard to (ii) above, please clarify (tick one) how the data will be stored:

☐ **(a) in a fully anonymised form (link to participants broken),**

☒ **(b) in a linked anonymised form (data +/- samples linked to participant identification number but participant not identifiable to researchers), or**

☐ **(c) in a form in which the participant could be identifiable to researcher.**

If data are stored in linked anonymised form, please state who will have access to the code and personal information about the participant.

Supervisors only

The data will be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research. (https://www.gla.ac.uk/research/strategy/ourpolicies/) Please tick and give further details below

Yes, it will be held for 10 years. ☒

16. To your knowledge, will the intended group of research participants be involved in other research? If so, please justify.

It is not known whether the subjects will be involved in any other research. However since there is no obligation for anyone to take part, anyone who is already taking part in other research does not need to participate if they do not wish to.

17. Proposed starting date: October 2020 (or after ethical approval has been obtained)

Expected completion date: June 2021

18. Please state location(s) where the project will be carried out, including all overseas laboratories, hospitals and other relevant locations.

Online, using suitable online video platforms (e.g. Zoom, Skype).

19. Please state briefly any precautions being taken to protect the health and safety of researchers and others associated with the project (as distinct from the research participants), e.g., where blood samples are being taken, home visits.

The risks to the researcher are mainly those associated with out of office settings as interviews will take place remotely (the researcher is currently working from home due to COVID-19), using suitable video platforms. To manage these risks the Lone Worker Policy of the University of Glasgow will be adhered to, together with additional procedures operated within the General Practice & Primary Care Research group. As such the researcher will follow standard practice of always informing another member of the research team of his interview schedules, and calling in when the fieldwork is complete via a cell phone or computer.

Researcher safety is important. As such, options to formalise safety procedures using a lone worker telephone service run by the company *communicare* (www.communicare247.com) are being explored.

20. Please state all relevant sources of funding or support for this study.

The study is part of a PhD research being funded partly by a benefactor and partly by MVLS.

21a). Are there any conflicts of interest related to this project for any member of the research team? This includes, but is not restricted to, financial or commercial interests in the findings. If so, please explain these in detail and justify the role of the research team. For each member of the research team please complete a declaration of conflicts of interest below.

Researcher Name: ____Alessio Albanese__________________ conflict of interest **No**
If yes, please detail below

Researcher Name: ___Barbara Nicholl________________________ conflict of interest No
If yes, please detail below

Researcher Name: ____ conflict of interest Yes / No
If yes, please detail below

Researcher Name: ____ conflict of interest Yes / No
If yes, please detail below

21b). If there are any conflicts of interest, please describe these in detail and justify conducting the proposed study.

Not Applicable.

22. How do you intend to disseminate the findings of this research?
Please include details of how the study participants will be notified of the study finding. If they are not to be informed, please justify.

The research will be disseminated in a publicly available PhD thesis, as well as through published academic articles and conference presentations. In addition the researcher will work with community organisations and public health departments to determine the best ways to disseminate the research to participants and relevant bodies (e.g., through reports).

I confirm that have read the University of Glasgow's Data Protection Policy.
https://www.gla.ac.uk/myglasgow/dpfoioffice/

Please initial box AA

Name ___Alessio Albanese_____________________ Date ___17/09/2020______
(Proposer of research)
Please type your name on the line above.

For student projects:

I confirm that I have read and contributed to this submission and believe that the methods proposed and ethical issues discussed are appropriate.

I confirm that the student will have the time and resources to complete this project.

Name ____ Date _________________
(Supervisor of student)
Please type your name on the line above.

Please upload the completed and signed form, along with other required documents by logging in to the Research Ethics System at - https://frontdoor.spa.gla.ac.uk/login/

Appendix 7: Interview Field Notes

From 03.12.20, more specific questions related to the community were included. Particularly in relation to the community being both supportive and/or hindering (e.g. stigma; marginalisation). Generally, the impact of COVID on people's lives has been compounding the effects of loneliness and isolation. In some cases, language classes that gave people a sense of belonging and, concurrently, a social space to meet people came to a halt. This has had an impact on people's wellbeing and experiences of loneliness and isolation. Interestingly, the same question is often asked in different ways, and this leads to participants providing different answers. This was not readily explained to interpreters prior to the Oromo interview and we had a mis-understanding. However, this was explained afterwards to them during a phone call.

After the interviews, the majority of participants mentioned feeling happy to have participated as it felt good to talk about their experiences. For some this was the first time they discussed their story. Also, participants mentioned their availability for more questions, if required. I mentioned the same to them. They are welcome to get in touch if there is something else that they would like to discuss, and that for whatever reason they have not discussed in the interview.

In some case, participants may not have responded to questions about mental health for a multitude of reasons, potentially including knowledge of mental health in that culture (of participant) and ability of the translator to translate mental health in a way that is understandable to the participant, and whether in the culture mental health is a thing (e.g. people used words such as 'stress' to describe anxiety, depression etc.). This was present in some of the interviews so far conducted. People often mention overthinking/thinking too much/having many thoughts and feeling disturbed by these.

Possibly, interviewing interpreters on the potential pitfalls of translating is of great importance. i.e. how do issues impact on translators, what are their views on translating in counselling (e.g. in Zimbabwean, when translating physical sensations often present in response to trauma, the translation is: what do you hear in your heart). Also, from my interviews, participants discussed thinking too much anxiety (worry) depression (rumination). This, again demonstrates what has been reported in much of the literature. Cultural understandings of mental health vary greatly, to the point that what is considered a symptom of depression in the HICs (overthinking and rumination), is actually an expression of anxiety in another culture (overthinking = anxiety).

In relation to interpreting, participants have asked from an interpreter not from their region (e.g. from the Maghreb, for safety reasons) another client asked for an Arabic interpreter although their native language is Amharic (because the participant lived in North Africa for many years and prefers speaking Arabic). In relation to the mental health experiences of participants, cognitive, emotional and physical components related to experiences of trauma (and PTSD) are often not present in participants' accounts. This could hinder participants' access to services for PTSD (i.e. referrals). Here is where candidacy also becomes applicable to mental health. If a patient does not identify as a candidate due to idioms of distress and knowledge of mental health – and if the service does not see patient as a candidate for, say, Trauma focused intervention because of strict requirements such as (flashbacks, physical sensations etc.) the patient will not access appropriate services that could be helpful to them. One phrase that is recurrent for people in the asylum system is to equate the asylum system with 'being in a prison'. Also, this was discussed in supervision.

Has been in the UK for about 10 months. Limited knowledge of the place and interesting perspective, very different to that of those who've been here a longer time. Interestingly, he saw the asylum system as fundamentally benevolent, even though it is affecting his life negatively, for example, not allowing him to work.

Extremely interesting perspectives on both, having been an asylum seeker, and all the difficulties this entails and its impact on mental health, and becoming a refugee, and the related issues both social and psychological. These, is the post-refugee status period, include racism, discrimination and lack opportunities afforded to him. It is noteworthy that the participant discusses having had the most difficult of times after having been granted leave to remain as all support stopped and the participant was on the verge of becoming homeless and destitute.

Different again is the experience of interviewees who are here with their family and children. The views included worry about their families.

Another potential challenge is related to transcribers being able to attune to the different accents (mine included) present in the interviews. Upon receiving the early interviews however, transcriptions were accurate and in full.

After the interpreter left the Zoom call, the participant and I were chatting, and they told me that they would like to tell me a bit more. I asked whether he would like for this to be recorded and he said yes so we recorded another ‘bit’ in English. Although the participant finds it difficult to speak English, we understood each other well. This decision by participant could be due to the fact that before the interview we developed rapport (we met before the pandemic at GCP) and we have been in touch a few times via the telephone.

Interviewee is from east-Africa and arrived in the UK in 2016. Lives alone, children are abroad. Here I had to negotiate ‘space’ with interpreter who spoke over the participant in two occasions. However, the interpretation went well, and the interpreter spoke very good English. The participant outlined several problems that she has faced since coming to the UK. Particular attention was paid to healthcare access. This interview was conducted over the telephone whilst the interpreter was on Zoom (the interpreter was outsourced from Global Interpreting by Voice Over due to a lack of Oromo interpreters).

Appendix 8: Support Sheet

University of Glasgow | College of Medical, Veterinary & Life Sciences

At some time in all of our lives we feel down, sad or blue. If you are feeling down, or are worried about something and would like to speak to someone, please see the list of organisations below.

You may also wish to contact your GP or another healthcare professional.

If you think your life or someone's life is in danger you should visit an emergency department or call an ambulance by dialling 999.

NHS 24. Health Information and Self Care Advice for Scotland

NHS 24 provides comprehensive up-to-date health information and self-care advice for people in Scotland. If your GP surgery is closed and you can't wait until it opens, you can call NHS 24. They will direct you to the right care for you or the person you are calling for. This may be to your local Health Board's out of hours services, Accident and Emergency department, or the Scottish Ambulance Service. If appropriate, they may recommend some steps you can take to look after yourself at home.

www.nhs24.com - Tel: 111

Samaritans

Samaritans is available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

www.samaritans.org.uk - Tel: 08457 90 90 90

Breathing Space

Breathing Space is a free and confidential phoneline service for any individual, who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to. The phoneline is open 24 hours at weekends **(6pm Friday - 6am Monday) and from 6pm to 2am on weekdays (Monday - Thursday)**.

www.breathingspacescotland.co.uk - Tel: 0800 83 85 87

Queen Elizabeth University Hospital Glasgow, Accident and Emergency Department (A&E), 1345 Govan Road, G51 4TF.

The Emergency Department prioritise people who have a serious injury or accident or who have a sudden serious illness or medical condition. If you think that a life is at risk you should call 999 right away. Tel: 0141 201 1100. Location name: Langlands Drive, Level 0 - Entrance from Langlands Drive (opposite Car Park 3).

Glasgow Royal Infirmary, Accident and Emergency Department (A&E), 84 Castle Street, G4 0SF.

The Emergency Department prioritise people who have a serious injury or accident or who have a sudden serious illness or medical condition. If you think that a life is at risk you should call 999 right away. Tel: 0141 211 4000.

Scottish Association for Mental Health (SAMH)

SAMH is a Scottish mental health charity which operates an information service from Monday to Friday between the hours of 2pm and 4pm. Information service staff and volunteers can answer general mental health enquiries, advise you on your rights and signpost you to your local services. www.samh.org.uk - Tel: 0800 917 3466

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